Disability Commissioner Tasmania

Submission to the Review of the Coroners Act 1995

27 July 2026

Acknowledgements

Disability Commissioner Tasmania respects the Palawa people as the Traditional Owners and continuing custodians of Lutruwita/Tasmania, where this submission was written. We honour their enduring connection to land, waters and skies, and pay our respects to Elders past and present.

We also respect, acknowledge and thank Tasmanians with disability, allies and supporters of our community whose collective lived experiences continue to shape our work. As an organisation, we are committed to inclusive and accessible engagement. We stand in solidarity with all people working to advance human rights.

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About Disability Commissioner Tasmania

The Tasmanian Disability Commissioner is an independent authority established on 1 July 2025 under the *Disability Rights, Inclusion and Safeguarding Act 2024* (the DRIS Act).[1] Disability Commissioner Tasmania refers to the office and staff supporting the Commissioner to deliver their functions under the Act.

The Tasmanian Disability Commissioner is a regulator, working to protect and promote the rights of people with disability across Tasmania/Lutruwita to create safer, inclusive and accessible communities.

While the Act gives the Commissioner a broad range of functions and powers, our work focuses on three key areas:

- Driving systemic change through the regulation of Disability Inclusion Action Plans created by government agencies (referred to in the DRIS Act as defined entities);
- Receiving and investigating reports of violence, abuse, neglect, coercion, and exploitation of people with disability; and
- Monitoring and investigating systemic issues of concern to Tasmanians with Disability.

[1] Disability Rights, Inclusion and Safeguarding Act 2024 (Tas).

About this submission

This submission is made on behalf of the Tasmanian Disability Commissioner. The Commissioner welcomes the opportunity to contribute to the review of the *Coroners Act 1995*.[2] We recognise that the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission) examined the oversight of deaths involving people with disability and identified the importance of understanding those deaths, including through recommendations relating to disability death review schemes.[3]

As such, this submission focuses on questions 84 and 164 which are directly about the deaths of people with disability. While the Review of the *Coroners Act 1995* (Tas) Issues Paper raises a broad range of issues,[4] our comments are limited to matters that have a particular impact on people with disability and the functions of the Disability Commissioner.

The approach in this submission draws on the *Convention on the Rights of Persons with Disabilities* (CRPD),[5] the findings of the Disability Royal Commission,[6] and the principles of the DRIS Act.[7]

[2] *Coroners Act 1995* (Tas)
[3] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Final report recommendations* (2023).
[4] Tasmania Law Reform Institute, Review of the Coroners Act 1995 (Tas) (Issues Paper No 33, April 2026) ('TLRI Issues Paper').
[5] Convention on the Rights of Persons with Disabilities, opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008).
[6] N3
[7] N1

Our submission

1. Deaths in disability settings

The Issues Paper considers whether deaths involving people with disability, including deaths occurring in disability settings, should constitute a separate category of reportable death under the Coroners Act.[8]

Position

We do not believe expanding the definition of a reportable death under the Coroners Act is necessarily warranted to achieve the desired oversight and outcomes.

In our view, the existing definition of a reportable death is broadly appropriate. The key issue is not the scope of the definition itself but ensuring that the existing provisions are applied consistently in practice and that all relevant circumstances are properly considered when determining whether a death should be reported to the Coroner.

Rights-based considerations

Creating a separate category of reportable deaths for people with disability risks reinforcing assumptions that people with disability are inherently vulnerable based on an existing disability and compromises a right to privacy at the end of life. Disability alone should not determine whether a death is subject to additional scrutiny from the Coroner. This is consistent with principles of equal recognition before the law, anti-discrimination and respect for the inherent dignity of persons with disability reflected in the CRPD.[9] Consistent with the purpose of the Coroners Act,[10] the primary consideration should remain the circumstances of the death.

Tasmania's disability context

There is already a national oversight framework for deaths that occur in connection with National Disability Insurance Scheme (NDIS) funded supports or services through the NDIS Quality and Safeguards Commission (the NDIS Commission).[11] This reporting requirement to the NDIS Commission enables the review and investigation of service provision provided to NDIS participants prior to and at the time of death. It also facilitates data collection and systemic reviews of deaths occurring in connection with NDIS supports and services.[12]

Only a small proportion of Tasmanians with disability are NDIS participants. While Tasmania has approximately 170,400 people with disability, only around 14,000 participate in the NDIS.[13] Any approach based primarily on disability service settings, which in many cases are NDIS service

[8] N4
[9] N5
[10] N2
[11] National Disability Insurance Scheme Quality and Safeguards Commission, *'Reportable Incidents'* (Web Page).
[12] National Disability Insurance Scheme Quality and Safeguards Commission, '*Death of people with disability*' (Web Page).
[13] National Disability Services, *2024–25 Tasmania State Budget Submission* (Submission, November 2024).

provision settings, would therefore encompass only a subset of people with disability. It may fail to capture many people with disability living in the broader community while subjecting NDIS participants to additional scrutiny based on their service arrangements rather than the circumstances of their death.

Through the DRIS Act, significant reform has been implemented in Tasmania including a new definition of disability, a new reporting mechanism for violence, abuse, neglect, coercion and exploitation, and increased oversight and authorisation requirements for restrictive practices. As most Tasmanians with disability are not NDIS participants or residing in disability settings, increased oversight of disability death outside of the NDIS landscape has merit in a Tasmanian context. This is best achieved through a disability death review function rather than an expansion of the Coroner's jurisdiction to capture disability settings.

2. Disability death review functions

The Issues Paper also seeks views on whether any disability death review function should sit within the Coronial Division or within another independent oversight body such as Disability Commissioner Tasmania.[14]

Position

Disability Commissioner Tasmania supports the establishment of a disability death review function within our office, focused on systemic review and identification of risks, trends and opportunities for prevention.

Disability Royal Commission findings

The Disability Royal Commission identified significant challenges in understanding deaths involving people with disability. It recognised that it would not be practical for a review mechanism to examine every death involving a person with disability.[15] Reviewing all such deaths would overwhelm review schemes and dilute their effectiveness. A key challenge is determining which deaths should fall within the scope of review.

The Royal Commission also noted that oversight arrangements should not be limited to deaths already captured through NDIS reporting mechanisms and that there is value in understanding deaths involving people with disability who are not NDIS participants.[16] This observation is particularly relevant in Tasmania, where most people with disability are not NDIS participants.[17]

Tasmania has established an independent disability safeguarding framework through the Act.[18] In considering the Disability Royal Commission's observations regarding death review schemes, it is important to consider how the objectives of safeguarding, systemic learning and prevention may be supported within this existing framework.

[14] N4
[15] N2
[16] N2
[17] N13
[18] N1

Disability death review models and approaches

The Victorian Disability Services Commissioner provides an example of disability-focused oversight operating at a state-level outside the coronial jurisdiction. The Victorian Disability Services Commissioner reviewed disability service provision relating to people who have died and identified opportunities for system improvement, publishing reports in the 2017-18 and 2018-19 financial years.[19]

Previous work undertaken by bodies such as the Queensland Public Advocate and the New South Wales Ombudsman has generated valuable insights into the deaths of people with disability and the operation of disability service systems.[20] However, these reviews were undertaken at particular points in time prior to full NDIS rollout and did not establish ongoing review functions of the kind contemplated by the Disability Royal Commission.

The Disability Royal Commission contemplated a more formal and ongoing disability death review scheme, with responsibility for identifying reviewable deaths, analysing trends, undertaking systemic reviews and supporting prevention activities across a broader cohort of deaths, including deaths involving people with disability outside existing NDIS reporting arrangements.[21]

Other death review models

In the absence of current state-based disability death review models situated outside of Coroner's offices, insight can be gained from other death review models such as the Child Death Review schemes in place in all six states.

The NSW Child Death Review team within the NSW Ombudsman analyses and reports on every child death in NSW to understand patterns, risks and opportunities for prevention.[22] This work informs legislation, evidence-based policy, practice and services. Notifications of child deaths are provided to the team by the Registry of Births, Deaths and Marriages and agencies such as the NSW Police, NSW Health and the Coroner.

The Queensland Independent Child Death Review Board within the Queensland Family and Child Commission (QFCC) is an example of a death review function being added to the role of an existing statutory authority. The QFCC research risk factors associated with child injuries and deaths to raise awareness with parents, carers, families and communities.[23] They also report on child deaths in Queensland and make recommendations. The Child Death Review Board conducts systemic reviews following the death of a child connected to the child protection system.[24]

The South Australian Child Death and Serious Injury Review Committee is an independent statutory body that reviews the circumstances and causes of child deaths in South Australia.[25] The Committee collects and analyses information about these deaths from government agencies

[19] Disability Services Commissioner (Vic), 'FAQs: Investigating Disability Service Provision to People Who Have Died' (Web Page); Disability Services Commissioner (Vic), Review of disability service provision to people who have died - Disability Services Commissioner (Web Page).
[20] Queensland Public Advocate, *Deaths in Care of People with Disability in Queensland* (Systemic Advocacy Report, February 2016); New South Wales Ombudsman, *Report of Reviewable Deaths in 2012 and 2013: Volume 2 – Deaths of People with Disability in Residential Care* (Report, November 2014).
[21] N**Error! Bookmark not defined.**
[22] NSW Child Death Review Team, Child Death Review Team | Working together to reduce preventable….
[23] Child Death Prevention, Queensland Family and Child Commission, Child death prevention | QFCC.
[24] Child Death Review Board, Queensland Family and Child Commission, Child Death Review Board | QFCC.
[25] Child Death and Serious Injury Review Committee, Child Death and Serious Injury Review Committee.

including the Office of Births, Deaths and Marriages, the Department for Child Protection, and the South Australian Coroner's Court.[26]

The Western Australian Ombudsman has a Child Death Review function and reviews deaths of children and young people up to 17 years of age to identify if there have been concerns for the safety and wellbeing of the deceased child, or a child relative, reported to the Department of Communities in the two years before the death occurred, or whether the deceased child was in the care of the Department of Communities.[27] These reviews look for opportunities for service improvements to prevent future deaths in similar circumstances.[28]

Victoria and Tasmania both have Consultative Councils on Obstetric and Paediatric Mortality and Morbidity, focused on reviewing cases of maternal, perinatal and paediatric mortality and morbidity to improve health services and outcomes.[29]

Outside of Child Death Review schemes, the Australian National Research Organisation for Women's Safety (ANROWS) oversees a Domestic and Family Violence Death Review Program as part of a network alongside state government agencies. The network was established in 2011 to identify, collect, analyse and report data on domestic and family violence-related deaths across Australia.[30] The network aims to identify limitations and potential areas for improvement in systemic responses to domestic and family violence. Research is conducted alongside the Coroner's Courts of Victoria, Queensland, South Australia, North Territory and Tasmania, the NSW Department of Communities and Justice, the WA Ombudsman, and the Domestic, Family and Sexual Violence Office of the ACT.[31]

A Tasmanian disability death review function

Disability Commissioner Tasmania supports the establishment of a disability death review function within the role of our office, through the expansion of our functions under the DRIS Act. This review function should focus on systemic review and identification of risks, trends and opportunities for prevention.

The Child Death Review functions in NSW, Queensland and South Australia and the ANROWS Domestic and Family Violence Death Review Program should be further considered and researched, as examples of systemic death review functions that may be appropriate to replicate in a Tasmanian disability death review function.

The function should not review individual deaths or replicate reviews undertaken by the Tasmanian Coroner and the NDIS Commission, but should facilitate collation of data to identify patterns, trends and areas where improved outcomes for Tasmanians with disability could be achieved. The function should be designed to achieve these objectives while respecting the rights, dignity, privacy and autonomy of people with disability and their families.

[26] ibid
[27] Ombudsman Western Australia, Child Death Review | Ombudsman WA.
[28] ibid
[29] Safer Care Victoria, Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) | Safer Care Victoria; Department of Health (Tasmania), Council of Obstetric and Paediatric Mortality and Morbidity (COPMM) | Tasmanian Department of Health.
[30] ANROWS, Domestic and Family Violence Death Review Program - ANROWS - Australia's National Research Organisation for Women's Safety.
[31] ibid

Death information would be required to be provided to Disability Commissioner Tasmania by entities such as Births, Deaths and Marriages, the Tasmanian Coroner, the Tasmanian Department of Health and Tasmania Police. To support the dignity and privacy of people with disability, we would support this information being provided as de-identified information.

A disability death review function should build upon Tasmania's existing disability rights and safeguarding framework and is best aligned with the functions of the Tasmanian Disability Commissioner.

Acronyms

ANROWS	Australia's National Research Organisation for Women's Safety
CRPD	Convention on the Rights of Persons with Disabilities
The DRIS Act	*Disability Rights, Inclusion and Safeguarding Act 2024* (Tas)
NDIS	National Disability Insurance Scheme
QFCC	Queensland Family and Child Commission