

DEATHS IN CARE DISABILITY

Is the death of a person with a disability always reportable to the coroner?

No. The mere fact that a deceased person had a disability does not automatically make the death reportable under the *Coroners Act 2003*.

When must the death of a person with a disability be reported to the coroner?

The death of a person with a disability will be reportable to the coroner only if it is a 'reportable death' under the *Coroners Act 2003*. This means the circumstances of the death must meet one or more of the following specific criteria:

- the person's identity is not known
- the death is violent or unnatural or occurred in suspicious circumstances
- the death is health care related
- the probable cause of death is not known and a cause of death certificate cannot be issued
- the death occurred in care
- the death occurred in custody or in the course of a police operation.

In practice, deaths of people with a disability are most commonly reported because they died:

- from an "unnatural" cause, for example, traumatic injury, airway obstruction by foreign object, drug use, drowning, suicide or homicide
- from complications of historical trauma, for example, complication of tetraplegia arising from serious injuries sustained in a motor vehicle accident many years ago
- as the unexpected result of a health care intervention or failure to provide health care
- from an unknown cause
- while 'in care'.

What is a "death in care"?

The concept of 'death in care' is intended to ensure there is independent scrutiny of the deaths of certain categories of particularly vulnerable people namely:

- people with a disability with high support needs living in funded supported living arrangements – death in care (disability)
- involuntary mental health inpatients and forensic disability clients – death in care (involuntary treatment); and
- children in care – death in care (child protection) or death in care (adoption).

The significance of a death being reported as a "death in care" lies in the requirement under the *Coroners Act 2003* for an inquest to be held when the circumstances of the death raise concerns about the person's care. Deaths in care are reportable irrespective of the cause of death and where the person died.

When is the death of a person with a disability reportable as a "death in care" (disability)?"

This reporting category applies only to the death of a person with a disability who was living in certain types of supported accommodation services and/or who was receiving high level support as a participant under the National Disability Insurance Scheme (NDIS) in a supported living arrangement.

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In practice, this means residents of the following types of supported accommodation services:

- **‘level 3 accredited residential services’** – these are supported accommodation hostels accredited under the *Residential Services (Accreditation) Act 2002* to provide level 3 personal services to residents including external support services, medication management and health care and help with clothing and hygiene management.
- **residential services operated or funded by the Queensland Government** – these include Accommodation Support & Respite Services operated by the Department of Communities, Housing and Digital Economy for people with a primary diagnosis of intellectual disability and long-term stay wards or facilities operated by the Department of Health where people with disabilities are expected to reside on a permanent basis, for example, Halwyn Centre (Red Hill), Birribi (Rockhampton), Casuarina Lodge (Bayside), Bailie Henderson Hospital (Toowoomba), The Park Centre for Mental Health (Wacol), Charters Towers Rehabilitation Unit, Kirwan Health Campus (Townsville).
- **supported living environments** (other than a private dwelling or aged care residential service) where the person was entitled to or receiving **high level supports** funded under their **NDIS plan** and provided by a **registered NDIS service provider** – in practice, these are supported accommodation environments that are also ‘visitable sites’ monitored by the Community Visitor Program under the *Public Guardian Act 2014*.

Is the death of every NDIS participant reportable as a death in care (disability)?

No. The death of an NDIS participant is only reportable as a death in care (disability) if the person was living in a supported living arrangement with very high support needs or extreme/complete functional impairment due to their disability affecting their ability to mobilise/self-care/self-manage – in practice, these are NDIS participants whose participant plan entitles them to support for high intensity daily personal activities, assistance with daily life tasks in a group or shared living arrangement; specialist positive behaviour support that involves the use of a restrictive practice or specialist disability accommodation.

It does not apply to NDIS participants who were living in their own or with family or in an aged care residential service even if they were funded for high support needs. However, there may be other reasons that make the death of these NDIS participants reportable, for example, they died from an unnatural cause.

In practice, check the person’s NDIS participant plan and ask yourself:

1. *Is the person entitled to or receiving **high level supports** under their plan?*
If no, the death is not reportable as a death in care - disability (unless they were the resident of a level 3 accredited residential service or a residential service operated or funded by the Queensland Government)
If yes, consider Question 2
2. *Was the person living in a supported living arrangement that was not a private dwelling or with family or an aged care residential service?*
If yes, the death is reportable as a death in care (disability)
If no, the death is not reportable as a death in care - disability (remember to turn your mind to whether the circumstances of the death might be reportable for another reason).

The death of any NDIS participant must still be reported to the NDIS Quality & Safeguards Commission (www.ndiscommission.gov.au).

Refer to the State Coroner's Guidelines – *Chapter 3: Reportable Deaths* – Deaths in care for a more detailed explanation with examples – <https://www.coronerscourt.qld.gov.au/resources/legislation-and-resources#state>

Who is required to report a death in care (disability)?

Any person who becomes aware of a death reportable as a death in care (disability) is required to report the death to the coroner.

Medical practitioners should always make enquiries about the deceased's residential status and consider whether the person's death may be reportable as a death in care (disability) before they issue a cause of death certificate for a person with a disability.

There is a specific legal requirement for registered NDIS service providers to immediately report a death in care (disability) even if the client has died elsewhere than their usual place of residence, for example, in hospital or if someone else such as a hospital doctor has reported the death.

NDIS service providers should notify the Coroners Court of Queensland (CCQ) of a death in care (disability) by email to coronerscourt@justice.qld.gov.au with the subject line - Notification of death of NDIS participant. The notification should identify the deceased person, date and location of death.

When is the death of a person with a disability reportable as another category of death in care?

Death in care involuntary treatment

The death of a person with a disability will be reportable as a death in care if when the person died they were subject to involuntary assessment or treatment under the *Mental Health Act 2016* or subject to the *Forensic Disability Act 2011*.

Death in care – child protection

The death of a child with a disability will be reportable as a death in care if when the child died they were living away from their parents as a result of formal intervention under the *Child Protection Act 1999*.

Death in care – adoption

The death of a child with a disability will be reportable as a death in care if when the child died they were under the guardianship of the chief executive because they were awaiting adoption under the *Adoption Act 2009*.

Need help?

Seek advice from the Coroner Registrar, CCQ during business hours on telephone (07) 3738 7050.

Refer to the State Coroner's Guidelines – *Chapter 3: Reportable Deaths* – Deaths in care provides a detailed explanation with examples – <https://www.coronerscourt.qld.gov.au/resources/legislation-and-resources#state>