

State Coroner's Guidelines 2013

Chapter 7

Investigations

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7.1 Introduction

The Act bestows broad powers of inquiry on coroners that enable them to investigate deaths creatively in order to make findings or comments about the death. Over the past decade, coroners have increasingly applied a proactive case management approach to ensure they conduct appropriately thorough and efficient investigations.

This Chapter explains which deaths must be investigated and clarifies those which may not. It outlines general case management strategies coroners may consider when investigating a death and explains how certain categories of reportable death should be investigated. It encourages coroners to proactively consider potential referral issues. Finally, it explains how investigation outcomes can be reviewed.

7.2 How should deaths generally be investigated?

Legislation

Coroners Act

Sections 11, 11A, 12, 13, 14(5), 15, 16, 48 ‘investigation’

Police Powers and Responsibilities Act

Part 5 (ss.596-602)

In principle

Section 45 stipulates the findings that must be made in relation to all reported deaths. The scope of a coroner’s inquiry under s. 45 is extensive and is not confined to evidence directly related to the matters listed in s. 45(2).¹

The scope of inquiry that is appropriate in this jurisdiction was well summarised by the 2003 review of coronial practice in the United Kingdom. After listing the findings of fact similar to those referred to in s. 45(2) of our Act the committee went on to say:

Other issues to be covered should be the immediate circumstances in which the death was discovered, the events leading up to it and the actions of any individuals involved in those events, any relevant aspect of the deceased persons circumstances, situation, or history, any management or regulatory systems relevant to the protection of the dead person or others facing comparable risks, and the role of any emergency services that were or might have been summoned to the situation²

Coroners should bring a proactive case management approach to their investigations to secure the evidence needed to support their findings or comments and to ensure relevant issues are identified and investigated appropriately and in a timely way. Coroners should carefully assess the extent of investigation warranted by the circumstances of each death so finite coronial resources are applied strategically. Any

¹ *Atkinson v Morrow* [2005] QSC 092 and *Queensland Fire & Rescue Authority v Fall* [1998] 2 Qd R 162 at 170, affirmed in *Doomadgee & Anor v Clements & Ors* [2005] QSC 357

² *Death certification and investigation in England, Wales and Northern Ireland, The report of a fundamental review*, (the Luce report) The Home Office, London, 2003, p98

temptation to assume the death is from a pre-determined cause must be resisted until the cause of death and the circumstances of it have been established.

In practice

Which deaths must be investigated?

A coroner must, and may only, investigate a reportable death – s. 11(2). Chapter 3 *Reporting deaths* explains the various categories of reportable death. The coroner may not investigate the death if it is being investigated by another coroner.

By virtue of the definition of ‘investigation’, coroners may exercise their powers under the Act to conduct a preliminary examination to determine whether a death is reportable. While the Act does not prevent a coroner from ordering an autopsy as part of his or her preliminary examination, coroners should have regard to the steps set out in Chapter 5 *Preliminary examinations, autopsies and retained tissue* and Chapter 7.3 *Investigating health care related deaths* when assessing whether a death is reportable.

The coroner’s decision about whether or not a death is reportable is reviewable under s. 11A by the State Coroner or the District Court (if the investigating coroner was the State Coroner). This review mechanism is discussed in Chapter 3 *Reporting deaths*.

Chapters 3 *Reporting deaths* and 7.5 *Investigating suspected deaths* explain the coroner’s jurisdiction to investigate suspected deaths.

Only the State Coroner or the Deputy State Coroner can investigate a death in custody or a death in the course of or as a result of police operations – s11(7). Chapter 7.3 *Investigating deaths in custody* details how these deaths are investigated.

Which deaths must not be investigated or further investigated?

Deaths outside Queensland

A coroner can not investigate a death that occurred outside Queensland but which has a sufficient Queensland connection unless directed to do so by either the State Coroner or the Attorney-General – ss.11(4)(b) and s.12(1). The circumstances in which these directions are given in practice are discussed in Chapter 3 *Reporting deaths*.³

If a coroner investigating one of these deaths becomes aware the death has been reported to a non-Queensland coroner, the coroner’s investigation must stop unless the Attorney-General’s direction is for the coroner’s investigation to continue – s12(2)(e). The coroner must provide his or her investigation outcomes to the relevant non-Queensland coroner.

Indigenous burial remains

A coroner’s investigation must stop as soon as it is established that remains are indigenous burial remains – s12(2)(a). Chapter 4 *Dealing with bodies* explains how suspected indigenous burial remains should be dealt with.⁴

³ See section 3.1.2 Location of Death

⁴ See section 4.2 Dealing with possible indigenous burial remains

Authorisation of cause of death certificate where autopsy not necessary

Section 12(2)(b) enables a coroner to authorise the issue of a cause of death certificate for a reportable death in circumstances where the coroner's investigation shows an autopsy is not necessary. The coroner's investigation must stop once the coroner authorises the certificate – s12(2)(b). In practice, these deaths are reported via the Form 1A Medical Practitioner Report of a Death to the Coroner or directly by funeral directors without involving the police. Chapter 7.3 *Investigating health care related deaths* details how deaths reported this way are investigated.

Stillbirths

The coroner's power to investigate a stillbirth is extremely limited. The Act prevents a coroner from investigating how a child came to be stillborn. The coroner can only order an autopsy to determine whether a baby was born alive. If the autopsy confirms the child was stillborn, the coroner's investigation must stop – s. 12(2)(c). Chapter 3.3.1 *Stillbirths* clarifies the circumstances in which the coroner's power to investigate a stillbirth is invoked.

At the time these guidelines were published, the Government was giving consideration to extending the coroner's jurisdiction to investigate intrapartum stillbirths.

Direction to stop investigation

The State Coroner can direct a coroner to stop an investigation. Such a direction is appropriate in circumstances where the State Coroner considers the death has already been adequately investigated and there is sufficient evidence to support the making of findings without further investigation.

Investigation and case management strategies

The Act gives coroners power to direct all necessary inquiries be undertaken by the police or other agencies investigating a death, including the issuing of search warrants, requiring statements and the production of documents and the undertaking of tests and examinations etc. In some respects the powers of a coroner exceed that of a police officer investigating a crime: for example there is no need to suspect that evidence of a crime will be found in order to ground a warrant to search premises and a potential witness can not refuse to answer questions during the investigation unless they have a reasonable excuse for doing so.

Initial investigations

In the majority of cases there will be no inquest, but even if there is, flaws and inadequacies in the initial response to the notification of the death may not be able to be overcome. All investigations must commence from the premise that they are potential homicide cases. It is essential therefore that from the outset the scene is properly secured and examined and all appropriate inquiries, including concerns raised by the family member or other witnesses are canvassed thoroughly. While investigators naturally must resist making assumptions that the death was self inflicted, arose from natural causes, or was an accident, in many cases this will be readily established after initial inquiries and the investigation can then focus on whether any systemic issues require addressing. However, until that position is reached, the inquiry should continue with all of the rigour and safeguards that apply in a murder investigation.

It is important that from the outset coroners maintain oversight of investigations to ensure that all relevant aspects of the death are effectively investigated. Back tracking to recover evidence passed over is costly and frequently unsuccessful. Police will obtain all evidence required to complete the Form 1. The Coroner will then decide what level of autopsy is necessary and, after considering the results of the autopsy, what further investigation is necessary.

Proactive investigation and case management

The length of coronial investigations is a common cause of complaint. Whereas under the previous system coroners tended to be the passive recipients of investigation reports, under the current system coroners have increasingly applied proactive investigation and case management strategies to their investigations. Coroners should constantly strive to progress their investigations as expeditiously as possible. Not only is coronial performance scrutinised against formal reporting benchmarks,⁵ but more importantly delays in finalising investigations can exacerbate a family's grief.

Early identification of issues enables investigations to be progressed more efficiently. Most investigations can be progressed without having to wait for the final autopsy or investigations report. Key milestones at which investigation issues become apparent include receipt of:

- the Form 1 or supplementary Forms 1
- the Form 3 Pathologist's report to coroner after autopsy
- family concerns⁶
- preliminary clinical or mental health review reports
- witness statements
- final autopsy and investigation reports
- outcomes of other administrative or non-coronial proceedings relating to the death, for example, disciplinary investigations or criminal proceedings.

Coroners and their staff should always use the Coroners Case Management System (CCMS) and other administrative case management strategies such as regular case review meetings to monitor and progress their investigations in a timely fashion.

As discussed in Chapter 2 *The rights and interests of families*, coroners should ensure steps are taken to regularly update families about how the coroner intends to investigate the death and the progress of his or her investigation. It is important to proactively manage family expectations with realistic advice about how long each investigate phase is likely to take, for example, it can take several months for an independent expert to review investigation material and provide a report.

⁵ The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services. Coronial performance is measured by reference to a clearance rate (finalisations/lodgements) and a backlog indicator (the percentage of matters more than 24 months old). The national standard for coroners' courts is that no lodgments pending completion are to be more than 24 months old.

⁶ See also Chapter 2 *The rights and interests of families*, section 2.7 (Management of family concerns about the death)

Investigation reports

Depending on the circumstances of the death, the coroner is assisted by police (including the QPS Forensic Crash Unit) and other specialist investigative agencies such as the Australian Transport Safety Bureau, Civil Aviation Authority, Department of Transport and Main Roads (for rail fatalities), Maritime Safety Queensland (for marine fatalities), Office of Fair and Safe Work Queensland (for workplace or electrical fatalities) and the Department of Natural Resources and Mines (for mining, quarrying, petroleum and gas and explosives fatalities). The coroner's investigation is informed by investigation reports from these agencies.

Each of these agencies have procedures which if followed properly should result in an adequate investigation. However, as the circumstances which are likely to be the subject of coronial inquiry are so diverse it is impossible for those procedures to cover every eventuality and therefore coroners and their counsel assisting must be vigilant in ensuring all necessary sources of information which may bear on the coronial function are accessed. For example, on occasions some of the regulatory agencies mentioned focus their investigations only on whether a prosecution is warranted and do not necessarily extend their examination of the circumstances of the death to identifying changes to law or practice that could prevent similar deaths recurring in the future. Similarly, these investigators might not be familiar with the power under the Act to require witnesses at an inquest to answer even incriminating questions and accordingly they may not appreciate how this procedure could further an investigation. As investigations involving these agencies tend to be complex and lengthy, it is advisable for the coroner to meet regularly with the investigators to ensure the investigation is progressing and focussed, and to ensure issues outside the scope of the other agency's remit are investigated by other means.

Less complex deaths, such as those from natural causes or straightforward violent or unnatural deaths, rarely warrant a full police investigation. In these cases, the coroner should turn his or her mind early in the investigation to the extent to which further police involvement is warranted and either direct no further police investigation at that stage or issue a direction tasking only specified further investigation.

Experience has shown that inquiries into health care related deaths are better made by the coroner without further police involvement, unless a criminal offence may have been committed.

Deaths in custody are a subset of those matters which must always be exhaustively examined and accordingly the comments below relating to the investigation of those deaths are equally apposite to the investigation of other suspicious deaths.

Obtaining statements

It is important to acknowledge that participation in a coronial investigation can be equally stressful and costly for those involved in the events leading to a reportable death. For this reason and to expedite investigations, coroners should endeavour whenever possible to particularise the issues they want covered in statements or be specific about the documents or other items they require under s16 of the Act.

Non-compliance with a requirement under s16 is an offence, unless the person has a reasonable excuse. The Act specifically recognises the privilege of protection against

self-incrimination as a reasonable excuse for this purpose. However, other common law privileges such as a legal professional privilege may be claimed in response to a s.16 requirement. The State Coroner's ruling in the inquest into the death of Saxon Bird provides a useful overview of the application of legal professional privilege in the Coroners Court. In that matter, the State Coroner held that litigation privilege has no application to communications made in contemplation of or in furtherance of participation in an inquest and that advice privilege can apply to a client seeking advice as to what evidence he or she should give to an inquest.

Obtaining expert reports

The coroner may seek help from any person who he or she considers can inform the investigation.

Coroners are routinely assisted by forensic medicine officers from the Queensland Health Clinical Forensic Medicine Unit and mental health clinicians from the Queensland Health Directorate of Mental Health who review investigation material and provide preliminary opinions about the adequacy of clinical and mental health treatment. Chapter 7.4 *Investigating health care related deaths* explains how to use these resources. The forensic medicine officers can also provide opinions about the effects of alcohol and other drugs and injury interpretation.

The complexity of the circumstances of some deaths will require specialist clinical or technical expertise to assist in resolving the issues to be determined by the inquiry. If this expertise can not be obtained through QPS or other involved investigative agency, the investigating coroner may seek State Coroner approval to obtain an independent expert report. Coroners are to use the template Request to obtain expert report for this approval.

Coroners should ensure experts are appropriately briefed about the circumstances of the death and the issues about which opinion is sought. Experts should be provided with copies of all relevant investigation documents and any known relevant family concerns so they can be considered and addressed by the expert.

Referral to other investigative agencies

Suspected commission of an offence

Section 48(2) obliges a coroner who as a result of information obtained while investigating a *reasonably suspects* a person has *committed an offence* to give the information to the appropriate prosecuting authority. The information can not include information compelled under s39(2).

'*Committed an offence*' is taken to mean there is admissible evidence that could prove the necessary elements to the criminal standard. That would include the evidence necessary to rebut any defence reasonably raised by the evidence.

The use of the term '*reasonable suspicion*' is analogous to the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence but not necessarily well founded or factually correct and be a suspicion that

a reasonable person acting without passion or prejudice might hold. As a result, a relatively low level of certainty is needed to satisfy the test.

The management of a potential s. 48(2) referral is detailed in Chapter 9 *Inquests*.

Official misconduct or police misconduct

Section 48(3) gives coroners discretion to refer information about official misconduct or police misconduct to the Crime and Corruption Commission. There is no statutory threshold for these referrals.

Professional or occupational conduct issues

Section 48(4) gives coroners discretion to refer information about a person's professional or occupational conduct to a relevant regulatory body if the coroner reasonably believes the information may warrant inquiry or action by that body. The referrals most commonly made under 48(4) relate to professional conduct by registered health practitioners.

In the interests of natural justice, coroners should always give the subject of a potential referral under s. 48(4) an opportunity to respond to the basis on which the coroner proposes to make the referral.

When a referral is made to a regulatory body under s. 48(4), and the coroner has sufficient evidence to make findings, the investigation may be finalised without waiting for the outcome of the referral. The fact and basis of the referral should be noted in the findings. The coroner can always reopen the investigation and amend the findings at a later stage once informed of the outcome of the referral.

Referral of issues not relevant to coronial investigation

From time to time the coroner's investigation will identify issues that although not relevant to the cause or circumstances of the death, are more appropriately referred to another investigative agency, for example, health quality concerns that warrant investigation by the relevant health regulatory authority. Coroners should proactively refer these issues to the appropriate entity and ensure the family is informed this action has been taken.

Referrals can be made at any time during a coronial investigation.

The impact of criminal proceedings

Although the Act prevents a coroner from holding or continuing an inquest when a person has been charged with an offence in relation to the death,⁷ it does not prevent the coroner from continuing their investigation (other than by inquest), for example, the investigation of potential systemic issues can be continued while waiting for the outcome of a prosecution.

Although technically there is nothing to stop a coroner who has sufficient evidence to make findings from finalising an investigation before a prosecution relating to the death is completed, coroners should generally keep the investigation open until the prosecution outcome is known so this information can be reflected in the findings. The

⁷ Section 29 (When inquest must not be held or continued)

investigation may then be finalised without waiting for the appeal period to expire. If the conviction is successfully appealed, the coroner can reopen the investigation and amend the findings accordingly. This approach is consistent with that taken in other Australian coronial jurisdictions.

7.3 How should deaths in custody be investigated?

Legislation

Coroners Act
Sections 10, 14

See also: QPS Operational Procedures Manual (S.1.17)

In principle

Deaths in custody warrant particular attention because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained. Further, a thorough and impartial investigation is in the best interests of the custodial or police officers involved.

Elliot Johnson QC wrote in the National Report of the RCADIC:-

A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of the duties. Justice requires that both the individual interest of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.⁸

In the Commission's Interim Report, Commissioner Muirhead wrote:-

The situation demands the most thorough investigation of facts and circumstances by skilled investigators who hopefully may be regarded as impartial, autopsies performed by expert pathologists followed by thorough coronial inquires conducted by legally trained Coroners under modern legislation which enables such Coroners to make remedial recommendations.⁹

In practice

All '*deaths in custody*' must undergo an inquest. Note the extended definition given to that term by s. 10.

Correctional Centre Deaths

Experience demonstrates that some prison deaths that appear to be suicides are in fact murders. Police intelligence indicates that there are groups of prisoners whose familiarity with investigative techniques has equipped them with the knowledge to

⁸ E. Johnson, *National Report*, AGPS, Canberra, 1991, vol.1, p.109

⁹ J. H. Muirhead, *Interim Report*, AGPS, Canberra, 1988, p.58

confound inquiries by constructing false alibis and interfering with crime scenes. Investigators must be alert to the possibility of these ploys even when death initially presents as suicide. No presumption of self inflicted death or natural causes should distract an investigator from conducting an exhaustive inquiry.

All deaths in correctional centres are undertaken by officers from the QPS Corrective Services Investigation Unit (the CSIU). In consultation with the State Coroner the Inspector in charge of the CSIU has settled a standard form investigation report that will be used in these cases. Further it has been agreed that all investigations will be completed within 6 months of the date of death unless delays are unavoidable.

Additionally, the Office of the Chief Inspector (OCI), Queensland Corrective Services (QCS); may appoint independent external inspectors to investigate the death. This is not a requirement but is usually done if the death appears to be other than by natural causes or apparently relates to a systemic failure within a correctional centre. Experience has demonstrated that these reports are generally thorough and useful to the coronial investigation. The investigators appointed by the QCS OCI will often more thoroughly examine the influence of systemic issues in the death than will the investigating police officer. Counsel Assisting should therefore ensure that the OCI report and all supporting documentation (especially records of interviews conducted by the OCI investigators) is obtained and, usually, tendered at the inquest. Consideration should be given to calling one of the OCI investigators if it becomes evident to Counsel Assisting that their findings or recommendations are not likely to be accepted by the individual prison (in the case of a privately run correctional centre such as AGCC) or the QCS.

Natural Causes deaths

A growing and ageing prison population has resulted in the increased incidence of deaths in correctional centres due to natural causes. That the death is a result of natural causes should only, of course, be made once a careful initial investigation discounts the possibility of foul play or suicide.

In such cases (as with all deaths in correctional centres) the CSIU investigator must obtain all medical records relating to the deceased from both the QCS file and from any external hospital or medical practitioner involved in the provision of relevant treatment. These should be provided at first instance to the pathologist conducting the post mortem examination and then delivered to Counsel Assisting.

The primary investigative task in apparent “natural cause” correctional centre deaths will relate to the adequacy of the medical treatment afforded to the deceased while in custody. The treatment must be compared and contrasted to the treatment a non-incarcerated member of the community with an equivalent medical condition could reasonably expect. After receipt of the autopsy report Counsel Assisting should refer the investigation material to an appropriate medical practitioner and seek an assessment of the adequacy of the medical care provided to the deceased while in custody. In nearly all cases the initial referral should be made to the Clinical and Forensic Medicine Unit of Queensland Health (CFMU). Counsel Assisting should ensure that all relevant medical records have been obtained and seek the advice of the CFMU practitioner in this regard.

The extent to which further investigation is required in relation to the adequacy of care will usually be guided by the advice of the CFMU practitioner.

Deaths involving police

The OSC is bound by a tripartite memorandum of understanding (MOU) with the QPS and Crime and Corruption Commission (CCC) relating to the investigation of deaths arising from police related incidents. A copy of the MOU can be found in Chapter 11.

All deaths in police custody or that occur during a police operation will be undertaken by officers from the Ethical Standards Command of the QPS and overviewed by officers from the CCC. The exception to this would be the rare case in which the CCC exercises its power to assume control of the investigation.

As a matter of geographical practicality police related deaths in remote locations will be investigated initially by local police officers. Every effort should be made, through consultation with the QPS, to ensure that ESC investigators are urgently sent to the scene of the death. Where officers from another agency within the QPS must be assigned to conduct the investigation prior to the arrival of ESC officers (for instance, because evidence may be lost prior to the arrival of the ESC officers) the Coroner should request that the principal investigating officer be as independent as possible from the police officers apparently involved in the death. The coronial findings and extensive subsequent litigation relating to the death of *Mulrunji* set out the actual and perceived prejudice that can otherwise arise.

In most cases a full internal autopsy should be undertaken by a forensic pathologist. The pathologist should be provided with all information gathered from the scene and any witnesses that is available at the time the autopsy is undertaken. If, during the course of the investigation, evidence is uncovered that contradicts or is inconsistent with the information available when the autopsy was undertaken that information should be conveyed to the pathologist and he/she should be asked to provide a further report indicating whether the new information provides any basis to vary the conclusion of the earlier report.

All deaths in custody

In all cases investigations should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour. It should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention. The general care, treatment and supervision of the deceased should be scrutinised and a determination made as to whether custodial officers complied with their common law duty of care and all departmental policies and procedures and whether these were best suited to preserving the prisoner's welfare. Only by ensuring the investigation has such a broad focus as to identify systemic failures will a Coroner be given a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations.

In cases where preventative recommendations are made by another investigating agency prior to the inquest Counsel Assisting should investigate the extent to which the recommendations have already been accepted and implemented. This should be done by requesting a statement from a suitable representative of the department or agency which is the subject of the recommendation. The Coroner should consider

seeking such a statement in the scope drafted by Counsel Assisting pursuant to a requirement set out in a Form 25.

7.4 Investigating health care related deaths

Deaths in a health care setting can raise novel challenges:

They can raise complex clinical issues and prompt a variety of clinical opinion:

- They can invoke a range of investigative responses, in addition to that of the coroner because there are a number of other bodies obliged to investigate concerns about medical treatment.
- Most police investigators are ill-equipped to undertake the investigation of these deaths without detailed instruction.
- Medical charts should mean the preservation of evidence is not as problematic as in other cases. However, the frequent inadequacy of those records and the propensity of medical practitioners to move between hospitals, states or even countries can make the gathering of evidence more difficult.
- Because so many people die in hospital, requiring clinicians to provide detailed statements about all of them would impose an unreasonable burden and potentially impede the treatment of the living.

This section is intended to guide:

- the coroner's timely consideration of what information is required to properly investigate a health care related death
- the extent to which the coroner should investigate the death
- the coroner's assessment of what aspects of the circumstances leading to the death warrant referral to another investigative entity.

Legislation

Coroners Act

Sections 9, 10AA, 12, 45

Health Ombudsman Act 2013 (health service complaints, health practitioner discipline)

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthOmbA13.pdf>

Health Practitioner Regulation National Law Act 2009 (health practitioner regulation and discipline)

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthPracRNA09.pdf>

Hospital and Health Boards Act 2011, Parts 6 & 9 (quality assurance committees, root cause analysis and health service investigations)

<http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HHNA11.pdf>

When is a death potentially 'health care related'?

Chapter 3 discusses this category of reportable death in some detail.

To recap briefly, the Coroners Act definition of *health care related death* encompasses two broad scenarios relating to (a) the provision of health care or (b) the failure to provide health care. The definition of 'health care' is broad and encompasses primary health care provision by general practitioners, medical specialists, non-medical health practitioners and paramedics outside the hospital system, as well as emergency, medical, surgical and mental health care provided within a hospital context.

Provision of health care

The Act makes reportable a death where the provision of health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would not have expected the death to occur as a result of the health care provided to the person.

Failure to provide health care

The Act also makes reportable a death where failure to provide health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would have expected health care, or a particular type of health care, to be provided to the person.

'Death in care' investigations can often also involve consideration of the adequacy of health care provision to the deceased person, particularly when the person was a person with a disability or the subject of involuntary mental health treatment.

How can health care related deaths be reported?

Health care related deaths are reported by police using a Form 1, by hospitals on a Form 1A or by funeral directors who usually call and then fax a cause of death certificate about which they have concerns.

The majority of health care related deaths and many deaths in care are reported by hospitals, using a Form 1A. This may be preceded by a telephone discussion with the coroner about the death. Form 1As can also be generated through a hospital's internal mortality review processes.

Less frequently, a hospital will report a death to police without speaking with the coroner first – this can occur when there has been a clear-cut adverse outcome such as a surgical mishap in the operating theatre.

The Form 1A process facilitates the exercise of a coroner's power under s. 12(2)(b) of the Coroners Act to authorise the issue of a death certificate in cases where the coroner is satisfied that although the death is reportable neither an autopsy nor any further coronial investigation is necessary.

Occasionally health care related deaths are reported directly to the coroner by funeral directors. This happens when the doctor they engage to issue the cremation permission identifies the death as potentially reportable. In these cases, the funeral director submits a copy of the death certificate. Using this information, the coroner's office identifies the treating doctor/hospital and obtains the medical records for review. If satisfied the death is reportable the coroner should require the hospital to submit a

Form 1A so the demographic details and the information necessary to enable the coroner to determine whether the matter is reportable and/or warrants investigation.

Management of deaths reported via a Form 1A

CFMU review

A Form 1A will be accompanied by the death certificate and varying amounts of hospital documentation. This documentation can range from a medical or discharge summary to extracts from, or the complete, hospital records.

On receiving a Form 1A, the coroner should consider whether additional documentation is required to enable a proper consideration of the death e.g. further documentation from the hospital where the death occurred; records from another hospital where the deceased received prior treatment; records from the deceased's treating general practitioner or specialist or nursing home records.

It is recommended the coroner's review of a Form 1A be informed by a review of the medical records and death certificate by an independent doctor from the Queensland Health Clinical Forensic Medicine Unit (CFMU). The CFMU employs forensic medicine doctors whose role includes the provision of clinical advice to coroners. The CFMU review assists in the identification of any issues warranting further investigation whether by the provision and review of further medical information from a treating doctor, hospital or nursing home, or by proceeding to autopsy. This process also provides an opportunity for constructive feedback to the certifying doctor about the appropriateness of the death certificate.

When providing the Form 1A to CFMU for review, the coroner should highlight any known family concerns for specific consideration by the reviewing doctor. Sometimes the circumstances of the death may warrant discussion with the family to clarify their concerns – this can be managed by the coroner directly or with the assistance of a coronial counsellor or where appropriate, by the reviewing CFMU doctor.

The CFMU doctor may speak with the treating doctor or other members of the treating team to clarify aspects of the deceased's treatment or to clarify the certifying doctor's rationale for the stated cause of death. This can sometimes result in the reporting doctor issuing a revised cause of death certificate.

The CFMU doctor will generally provide a written response summarising the deceased's treatment, documenting the outcomes of any discussions had with the treating team and advising whether there are any concerns about the treatment provided to the deceased person. These concerns may be alleviated through the provision, and further CFMU review, of additional medical information, or the concerns may be sufficient to require further coronial investigation.

In cases where additional medical information is sought, the coroner's office should keep the family's funeral director informed of the coroner's progress in reviewing the death. This ensures the family's funeral arrangements are not unduly inconvenienced wherever possible.

On occasions, family members may be pressing for a funeral to proceed, either because the death has been reported late after funeral arrangements have been made, or because people have come from overseas, etc. In such cases the coroner can consider allowing the body to be transported to the funeral home where the ceremony will take place on receiving an undertaking the funeral director will retain possession of the body and deliver it to the mortuary if an autopsy becomes necessary. The body can't be lawfully buried or cremated without there being a valid cause of death certificate in the funeral director's possession, so the risk of proceeding in this way is slight.

CFMU review identifies no health care concerns

If the CFMU doctor considers there are no health care issues warranting further investigation, the coroner should authorise the death certificate and complete Section B of the Form 1A advising that no further investigation is required. It is helpful for a copy of the CFMU advice to be provided with this documentation when it is transmitted back to the reporting doctor/hospital for their records. Section 45(3) of the Coroners Act obviates the making of findings in these cases.

In cases where the family is known to have concerns, it can be helpful to provide a copy of the CFMU advice to the family also. This information can give families reassurance their concerns have been actively considered and the coroner's decision not to investigate those concerns any further has been informed by independent clinical opinion.

CFMU review identifies health care concerns

In cases where the CFMU identifies treatment concerns the coroner considers warrants further coronial investigation, the coroner should:

- not authorise the death certificate
- complete Section B of the Form 1A to indicate the death requires further investigation, including autopsy, and direct the reporting doctor/hospital to report the death to police who will complete a Form 1
- provide a copy of the Form 1A and CFMU advice to the pathologist, with a copy to the coronial counsellors, to notify them of the death and highlight the specific issues of concern – this helps inform the pathologist's assessment of the extent of autopsy required to investigate those issues
- advise the QPS Coronial Support Unit of the decision to require the death to be reported as a Form 1, and provide them with a copy of the Form 1A to assist in this process
- arrange for the coroner's staff to inform the family's funeral director of the coroner's decision.

Autopsy decision making

When the death is reported to police, the medical records are generally sent to the mortuary with the body. Coupled with CFMU advice (where the death was initially

reported as a Form 1A), this informs the pathologist's assessment of the extent of examination required to establish the cause of death and/or examine specific treatment concerns. It is often helpful for the coroner to discuss the case with the pathologist before an autopsy order is issued. In some cases, an external examination +/- toxicology and review of the medical records will be sufficient; others will warrant some degree of internal examination.

In some cases, the family may have already communicated specific concerns about the deceased's health care, either directly to the coroner's office or during discussion with the coronial counsellors. It is advisable to provide the pathologist with any information about the family's known concerns prior to autopsy as this may also inform autopsy decision making.

Sometimes families have concerns about the deceased's health care but equally strong concerns about autopsy. A coronial counsellor should be involved in these cases to help explain to the family the coroner's rationale for autopsy and the possible implications for further investigation of health care concerns by not proceeding with an autopsy.

Timely investigation

The efficient management of health care related death investigations hinges on identifying issues of concern early and gathering relevant information for further timely investigation of those issues.

Given the time it can take for an autopsy report to be finalised, the coroner should actively consider the following possible lines of inquiry once in receipt of the Form 3 containing the pathologist's macroscopic autopsy findings if the pathologist, the CFMU or the family have raised concerns about the treatment:

Deaths involving non-psychiatric treatment issues

- obtaining a general statement from the most appropriate senior treating clinician/s outlining the deceased's medical history, presenting symptoms, assessment, diagnosis and management
- obtaining the deceased's consultation and/or prescription history from Medicare
- obtaining a list of all clinical personnel involved in the deceased's treatment – the Queensland hospital workforce is highly mobile, so it is advisable to identify all members of the treating team as soon as possible in cases where some or all of them may be required to provide statements about their involvement in the deceased person's care
- in cases where there has been an identified 'adverse event' – obtaining statements from key members of the treating team outlining their qualifications and experience, their involvement in the deceased's treatment and more specifically, the adverse event; their version/observations of the adverse event and their thoughts about whether anything could have been done differently to prevent the adverse outcome

- obtaining copies of any relevant clinical policies, guidelines or pathways in place at the time of the death and a statement from the relevant clinical director about the extent to which the relevant policy, guideline or pathway was followed in relation to the deceased's treatment
- giving the hospital an opportunity to respond to the family's documented concerns
- requiring the hospital to provide a copy of the final root cause analysis report and/or the outcomes of any other clinical incident review or internal mortality review process undertaken in respect of the treatment provided to the deceased – as discussed in more detail below, it is helpful to issue this information requirement in the early stages of the investigation as these processes are generally commenced shortly after the death and can identify and remedy systemic issues of concern more expeditiously and effectively than a lengthy coronial investigation and inquest
- providing this additional information and the medical records to CFMU for review.

CFMU review of the medical records and additional statements or other information will assist in the identification of any issues warranting further investigation or independent expert review, pending receipt of the autopsy report.

The outcomes of the CFMU review are provided to the coroner in a formal report which should be provided to the hospital/treating clinician for response in the event it is critical of the health care provided. Natural justice requires the coroner to afford the hospital or individual practitioner in respect of whom an adverse finding or referral may be made, an opportunity to respond to any criticism of their management of the deceased person before that finding or referral is made.

The Department of Health Patient Safety Unit may also be able to provide the coroner with advice about the number and outcomes of clinical incident reviews undertaken across public health services into similar incidents.

The coroner should consider releasing a copy of the CFMU report to the family at an appropriate time, accompanied with advice about what action is proposed to be taken in respect of any concerns identified in the report.

Deaths involving paramedic response issues

- requesting the Medical Director, Queensland Ambulance Service to conduct a root cause analysis or clinical audit review of the paramedic response and provide a report on the outcomes of that review process

Deaths involving mental health treatment issues

Coroners should consider whether the treatment provided to deceased persons was adequate or whether further investigation and/or specialist review is necessary. If a review is required it will generally need to be undertaken by an independent psychiatrist.

If the review raises significant concerns about the quality of the mental health care, the coroner should consider taking the following steps:

- obtaining a statement from the most appropriate senior treating mental health clinician outlining the nature of the deceased's mental health condition, how this mental health condition was being managed, the date and nature of the deceased's last contact with the Mental Health Service and the basis of any assessment of the risk of the deceased self harming at that time
- obtaining the deceased's consultation and/or prescription history from Medicare
- obtaining a list of all key clinical personnel involved in the deceased's in-patient or out-patient treatment
- obtaining copies of any relevant clinical policies, guidelines or pathways in place at the time of the death and a statement from the relevant clinical director about the extent to which the relevant policy, guideline or pathway was followed in relation to the deceased's mental health treatment
- giving the hospital an opportunity to respond to the concerns raised in the review
- requiring the hospital to provide a copy of the final root cause analysis report and/or the outcomes of any other clinical incident review or internal mortality review process undertaken in respect of the treatment provided to the deceased.

Independent expert reviews

The CFMU report and formal responses to it or the 'Mental Health Advice to Coroner' will inform the coroner's assessment of whether further independent expert review is required. The State Coroner's approval is required before an expert is briefed to provide an opinion. The Office of the State Coroner can provide assistance in identifying an appropriate expert. All relevant investigation material, including the autopsy report, should be provided to the expert for review. The outcomes of independent expert review will inform the coroner's decision about whether an inquest is warranted.

After an independent specialist has provided a report, it will usually be appropriate to provide any of the treating clinicians whose practice has been criticised to respond to these criticisms.

Informing inquest recommendations

Once the coroner decides to hold an inquest, it is recommended that early consideration be given to possible recommendations, with a view to inviting input from relevant health care sector stakeholders for examination during the inquest.

Depending on the circumstances of the death, the coroner may consider approaching the following entities for their views on possible recommendations:

- relevant medical specialist colleges
- relevant regulatory authority e.g. health practitioner registration board or the Therapeutic Goods Administration
- relevant health industry representative bodies e.g. Australian Medical Association
- Patient Safety Service, Department of Health
- Office of the Chief Psychiatrist, Department of Health
- Drugs of Dependency Unit, Department of Health
- Private Health Regulatory Unit, Office of the Chief Health Officer, Department of Health
- Queensland Maternal and Perinatal Quality Council
- Queensland Paediatric Quality Council
- Australian Commission on Safety and Quality in Health Care.

It is preferable that this response gathering process is commenced prior to the inquest to allow sufficient time for all parties to consider the responses, and for arrangements to be made for relevant witnesses to give evidence.

Death review processes in Queensland hospitals

Prior to 1 July 2014, all Queensland hospitals were required by the former Health Quality and Complaints Commission Review of hospital-related deaths standard to ensure all hospital-related deaths were reviewed. This included all deaths that occur:

- in a public hospital, licensed private hospital or day hospital
- in public or private emergency departments, pre-admission clinics and outpatient clinics
- within 30 days of being discharged, or attending a hospital for clinical care.

The HQCC standard mandated the implementation of review processes incorporating:

1. review of all deaths by the relevant clinical team within two weeks of the death
2. independent peer review and/or mortality review committee within eight weeks of the death in circumstances where there is a concern/complaint about the deceased person's care OR a root cause analysis is commissioned OR multiple clinical units were involved in the deceased person's care
3. external review by the coroner, QPS, HQCC or other relevant entity.

The level 2 review process was intended to identify opportunities and make recommendations for improving the safety and quality of patient care.

The HQCC Review of death standards (and other HQCC standards) ceased to have effect from 1 July 2014 when the *Health Quality and Complaints Commission Act 2006* was repealed by the *Health Ombudsman Act 2013* and has not been replaced with a specific directive. The National Safety and Quality Health Service Standards, Standard 1 *Governance for safety and quality in health service organisations* requires implementation of an incident management and investigation system (criterion 1.14). In the absence of a specific directive, it is hoped this will be incentive enough for Queensland hospitals and day procedure services to continue implementing local

death review policies (which were built on the repealed HQCC standard) in order to continue meeting accreditation requirements.¹⁰

It is recommended the coroner routinely issue an information requirement for the outcomes of an internal mortality review as this information can inform consideration of whether further clinical review (by CFMU or an independent expert) or other investigation is warranted.

Clinical incident management in public health facilities

The Department of Health has a Clinical Incident Management System that guides reporting and review of *'any event or circumstance which had actually or could potentially lead to unintended and/or unnecessary mental or physical harm to the patient'*.

When an unexpected patient death occurs, it is reported in PRIME CI (a state wide clinical incident reporting information system). The incident is classified by reference to a Severity Assessment Code (SAC) – death which is not reasonably expected by the treating clinicians, patient or family as an outcome of health care is rated SAC1. This rating determines how the incident will be analysed.

A SAC1 incident should trigger a root cause analysis (RCA). This is a quality improvement technique that examines the contributory factors that led to the adverse outcome. It is a systemic analysis of what happened and why and is designed to make recommendations to prevent it from happening again, rather than to apportion blame or determine liability or investigate an individual clinician's professional competence.

The RCA process is governed by a statutory framework under the *Hospital and Health Boards Act 2011* (Part 6) and the *Hospital and Health Boards Regulation 2012* (Part 6). An RCA is mandatory for a range of reportable events including the following death scenarios - maternal death associated with labour or delivery; death associated with the incorrect medication management; death associated with an intravascular gas embolism; death resulting from the wrong procedure being performed or a procedure being performed on the wrong part of a person's body; death associated with a haemolytic blood transfusion reaction resulting from the wrong blood type being used during a blood transfusion; suspected suicide of a person receiving inpatient health care; and any other death not reasonably expected to be the outcome of health services provided to the person. These reportable events generally correspond with the list of National Sentinel Events.

An RCA may be performed in respect of the suspected suicide of a person with a mental illness who is under the care of a provider of community mental health services – the commissioning authority retains discretion about the method of analysis of these deaths, after consultation with the relevant mental health mortality review committee.

¹⁰ The NSQHS Standards developed by the Australian Commission on Safety and Quality in Health Care provide a nationally consistent statement of the level of care consumers should be able to expect from health services. They are designed to drive the implementation and use of safety and quality systems and improve the quality of health service provision in Australia. All hospitals and day procedure services are required to be accredited the NSQHS standards (www.safetyandquality.gov.au)

The RCA process involves the appointment of an RCA team comprising members who were not directly involved in the incident. The information provided to, and generated by it is protected by statutory privilege.¹¹ However, the coroner is permitted to be told, on request by the coroner, when an RCA has commenced or is stopped and to be provided with a copy of the final RCA report. The coroner is generally not provided with a copy of the complete RCA documentation (comprising a commissioning authority report, chain of events document, contributory factors diagram and final report). The final report will present a description of the reportable event, causal statements and associated recommendations, outcome measures and measure dates. It may also include discussion of any 'lessons learned', namely other unrelated opportunities for safety improvement. The Government is currently considering changes to the RCA legislation to expand the scope of RCA documentation that can be provided to a coroner.

There are also statutory protections for both RCA team members and individuals who provide information to an RCA team. They can not be compelled to produce a document or information or give evidence relating to their involvement in the RCA process or relating to any document provided to, or generated by that process.¹²

Human Error and Patient Safety (HEAPS) is an alternative analysis method used for deaths where an RCA is either not appropriate or is not required. This process guides a systemic analysis by frontline health care workers and their line manager of the factors that may have contributed to the adverse event which caused the death. The majority of clinical incidents are reviewed using this process.

It is recommended the coroner routinely issue an information requirement for the outcome of a clinical incident review (final root cause analysis report or HEAPS analysis) undertaken in respect of a health care related death. These processes can take several weeks or months to produce an outcome, but that outcome can alleviate the need for a lengthy coronial investigation or inquest if the coroner is satisfied the review has adequately identified issues of concern and made recommendations which are being implemented. The relevant senior person in a health service district should also be required to produce a statement detailing what has been done in response to the review recommendations.

For more information about clinical incident management, contact the Department of Health Patient Safety Unit via <http://www.health.qld.gov.au/psu/>

Clinical incident management in private health facilities

Private health facilities are accredited and licensed under the *Private Health Facilities Act 1999*. The regulatory scheme is administered by the Private Health Regulatory Unit within the Department of Health. www.health.qld.gov.au/privatehealth

Private hospitals also make use of the RCA process but past experience has demonstrated the private hospital sectors tends to review clinical incidents through gazetted quality assurance committees (which can have the protection of statutory privilege under the *Hospital and Health Boards Act 2011*) or through locally

¹¹ See *Hospital and Health Boards Act 2011*, Part 6 Div 2, Subdiv 5

¹² Ibid, Part 6, Div 2, Subdiv 6

implemented clinical incident management processes such as the Mater Hospital's Clinical Incident System Analysis.

Referral to another investigative agency

There can be a range of investigative responses to a health care related death, in addition to the coronial investigation:

- internal clinical incident or mortality reviews by the hospital
- root cause analysis conducted under the *Hospital and Health Boards Act 2011* (Part 6) or the *Ambulance Service Act 1991* (Part 4A)
- assessment, investigation, conciliation and/or possible disciplinary action by the Health Ombudsman
- possible regulatory action under the *Health Practitioners Regulation National Law Act 2009*
- a clinical review or health service investigation instigated by the Department of Health Director-General under the *Hospital and Health Boards Act 2011*
- assessment, investigation by the Commonwealth Office of Aged Care Quality and Compliance (in relation to health management in a licensed aged care facility)
- an ethical standards investigation by Department of Health or the Department of Community Safety (QAS)
- investigation of suspected official misconduct by the Crime and Corruption Commission
- a criminal investigation by Queensland Police Service.

When investigating a health care related death, the coroner should ascertain whether the death is or is likely to be subject to one or more of these investigative processes and ensure the relevant entity is aware of the coronial investigation.

Office of the Health Ombudsman (OHO)

The OHO is Queensland's health service complaints agency. It is an independent statutory body whose role is to manage complaints about health services and health service providers, including private and public health care facilities, ambulance service, mental health services, community health services, medical centres, pharmacies, aged care facilities and individual registered and unregistered health practitioners.

From 1 July 2014, the OHO took over the health care complaint responsibilities of the former Health Quality and Complaints Commission (HQCC), and assumed certain responsibilities from the Australian Health Practitioner Regulatory Agency for the discipline of registered health practitioners against whom serious allegations have been made.¹³

The standard-setting function and some quality monitoring functions of the former HQCC were discontinued from 1 July 2014. While the Health Ombudsman's key functions relate to health complaint management, he/she also has a role in identifying

¹³ <http://www.oho.qld.gov.au/>

and reporting on systemic health service issues, including matters relating to the quality of health services.

The OHO complaints management process involves:

- an attempt to resolve the complaint through early local resolution
- assessment– this involves obtaining advice from an independent clinician in order to determine what if any further action is required. As the CFMU review delivers more timely and comprehensive advice than the OHO assessment process, it is the preferred first step for determining what clinical or systemic issues may have caused or contributed to the death
- conciliation – this is a privileged process that may result in a financial settlement
- referral to another regulatory body such as the Australian Health Practitioner Regulatory Agency¹⁴ or relevant licensing body
- formal investigation – this is undertaken in more complex matters involving an adverse health outcome and/or potentially raise broader systemic issues e.g. treatment by more than one hospital is under scrutiny, particularly when there is strong media, political or public interest in the incident. An OHO investigation often involves interviewing witnesses, obtaining formal expert clinical opinions and making formal recommendations for improvement. When investigating a complaint, the Health Ombudsman has access to clinical advice from independent advisory committees and panels
- taking immediate action against the health provider.

There will be some health care related deaths where the role of the coroner and the Health Ombudsman converge. It is important for the coroner to consider whether the death raises issues that may be more appropriately investigated by the OHO and to liaise with senior OHO officers early to ascertain whether and if so how the OHO should be involved in the matter. It is important to bear in mind the investigation of health care related deaths forms only part of the OHO's much broader remit and its investigative resources are limited.

Chapter 11 discusses the protocol between the State Coroner and the Health Ombudsman which sets out arrangements aimed at timely notification of matters, co-ordination of concurrent investigations and information sharing between the OSC and OHO.

It is important to remember the primary purpose of the health practitioner regulatory scheme is protective, not punitive. It is focussed on protecting the public and maintaining professional standards.

The coroner should consider contact with/referral to the Health Ombudsman in the following circumstances:

- there is significant media/political focus on the circumstances of the death – as soon as possible, the coroner should request a meeting with senior OHO

¹⁴ AHPRA is the entity responsible for supporting 14 national health practitioner boards responsible for regulating the health professions- Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, dentists and allied oral health practitioners, general and specialist medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists (www.ahpra.gov.au).

officers to discuss allocation of lead agency responsibility for investigating the death

- the preliminary CFMU review identifies a potential systemic issue – a systemic issue is a problem due to issues inherent in the overall system (whether a specific unit, department, hospital or the broader health care system) rather than due to individual factors such as clinician performance. Examples of systemic issues encountered by coroners include issues relating to clinical handover; communication; documentation; recognition of patient deterioration; end of life planning; co-ordination of care; inter-hospital co-ordination; training; staffing levels; lack or adequacy of clinical guidelines/protocols, etc; work environment and availability of equipment. The coroner should request a meeting with senior OHO officers to discuss the issue and determine whether it is more appropriately referred to OHO for further investigation
- the family complains about aspects of the deceased's care that are unrelated to the cause of death e.g. clinician interaction with the family – these issues can be referred to OHO for assessment at any stage of the coronial investigation
- it is known the family intends to or has made a complaint to the OHO (or the former HQCC or AHPRA) – the coroner should consider issuing an information requirement for the outcomes of the assessment of the complaint, as this information (together with the complaint file) will inform the coroner's decision about whether further coronial investigation is warranted.
- the coroner is concerned that death may be part of a pattern of adverse outcomes in relation to a particular health provider – the coroner should request a meeting with senior OHO officer to ascertain whether OHO is aware of a number of similar deaths and to discuss how the OHO can assist the coroner's investigation i.e. assume lead agency responsibility or provide specific assistance to the coroner's investigation
- the circumstances of the death raise serious concerns about the competence or professional conduct of one or more individual health practitioners.

For example, the CFMU review may identify professional conduct that warrants referral under s. 48(4) of the Coroners Act to the Health Ombudsman for further investigation and possible disciplinary action. The threshold for the exercise of this discretion is quite low – the coroner may do so if information obtained by the investigation might cause the relevant professional regulatory body to enquire into, or take steps in relation to a person's conduct in the profession.

When considering whether a referral is warranted, the coroner should:

- note whether the CFMU review has identified an instance of 'notifiable conduct' – this concept captures practice that significantly departs from accepted professional standards. It also captures a practitioner who is impaired, practised while affected by drugs or alcohol or who engaged in sexual misconduct. It is conduct that is the subject of mandatory notification by any registered health practitioner, who in the course of practising their

profession (including a CFMU doctor), forms a reasonable belief that another registered health practitioner has behaved in a way that constitutes notifiable conduct. In cases where CFMU has identified a clinician's conduct is so deficient it meets the mandatory notification threshold, the coroner should immediately refer the matter to the Health Ombudsman, with advice to the affected practitioner about the basis on which the referral is made and advice to CFMU that the referral has been made

- otherwise, provide the clinician who may be referred an opportunity to respond to the issues identified in the CFMU report.
- issue an information requirement to the OHO to determine whether the practitioner has been the subject of previous complaints or investigations about their competence
- where it is known a complaint has been made to the Health Ombudsman (or the former HQCC or AHPRA) about the practitioner, issue an information requirement to the relevant entity for advice about the outcome of the assessment or investigation of that complaint and/or copies of the assessment/investigation documents
- consider whether the practitioner's response demonstrates an appropriate degree of insight into their professional conduct and/or evidence they have reflected and made changes to the way they now practise
- consider whether a preliminary discussion with a senior OHO officer may assist in determining whether the conduct in question meets the threshold for disciplinary action.

The coroner can make a referral to the Health Ombudsman at any time during the investigation.

In matters where the coroner decides to make a formal referral to the Health Ombudsman for further action, the coroner may be in a position to finalise his or her investigation noting the referral has been made, without waiting for the OHO assessment and/or investigation to be completed.¹⁵ The coroner should provide a copy of his/her findings to the OHO with a request for formal advice of the outcomes of the OHO process in due course. This will enable the coroner to assess whether the findings require amendment to reflect those outcomes.

In matters where the coroner declines to make a disciplinary referral, it is advisable the findings include some discussion of the basis for this decision.

¹⁵ The *Health Ombudsman Act 2013* requires investigations to be completed within 12 months of the decision to commence the investigation, but may be extended in 3-monthly periods. The Health Ombudsman must report publicly on investigations that taken more than 12 months, and must refer an investigation that takes longer than two years to the relevant Parliamentary Commission for review.

Australian Health Practitioner Regulatory Agency (AHPRA)

AHPRA is the entity responsible for supporting 14 national health practitioner boards responsible for regulating the health professions.¹⁶

Amongst other functions, AHPRA assesses notifications made about a registered health practitioner or student and on behalf of the relevant board, manages investigations into the professional conduct, performance or health of registered health practitioners. Investigations can result in the relevant board proceeding with disciplinary action ranging from counselling, caution, reprimand, voluntary undertakings, imposition of conditions on registration, suspension of registration and deregistration.

Prior to 1 July 2014, AHPRA was responsible for investigating serious allegations against Queensland registered health practitioners. However, since then the Health Ombudsman has taken responsibility for these matters. That said, AHPRA has continuing **registration** and **health monitoring** jurisdiction in respect of Queensland registrants. As noted above, the Health Ombudsman can refer a complaint to AHPRA for further action

While referrals under s.48(4) of the Coroners Act relating to an individual health practitioners can now only be made to the Health Ombudsman, there may be circumstances in which the coroner's investigation may be informed by information held by AHPRA in respect of the practitioner (eg, registration, health impairment or previous complaint outcomes). An information requirement will be required to obtain this information from AHPRA.

Office of Aged Care Quality & Compliance

The OACQC is a Commonwealth agency that administers the Aged Care Complaints scheme (www.health.gov.au/oacqc). The scheme manages complaints about government subsidised aged care services including residential aged care, Commonwealth funded Home and Community Care, community aged care packages, extended aged care at home packages and extended aged care at home – dementia packages.

When investigating a death that raises concerns about the care provided to a nursing home resident, the coroner should consider contact with/referral to OACQC in the following circumstances:

- the family has raised concerns about the care provided to the deceased which is not related to the cause of death – the coroner can refer these issues to OACQC at any stage in the investigation.
- it is known the family intends to make or has already made a complaint to OACQC – the coroner should issue an information requirement for the outcomes of OACQC's assessment/investigation of the complaint and/or the

¹⁶ The regulated professions are Aboriginal and Torres Strait Islander health practitioners, Chinese medicine practitioners, chiropractors, dentists and allied oral health practitioners, general and specialist medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists (www.ahpra.gov.au).

OACQC investigation documents as this information may assist in determining whether further coronial investigation is necessary.

- the CFMU report identifies issues of concern about the provision of care to an aged care resident – the coroner should give the relevant facility or clinician an opportunity to respond to those concerns, before referring the matter to OACQC.

The coroner can make a referral to OACQC at any time during the investigation.

In matters where the coroner decides to make a formal referral to OACQC for assessment, the coroner may be in a position to finalise the investigation noting the referral has been made, without waiting for the OACQC assessment/investigation to be completed. The coroner should provide a copy of the findings to OACQC with a request for formal advice of the outcomes of the OACQC assessment/investigation in due course. This will enable the coroner to assess whether the findings require amendment to reflect those outcomes.

Clinical review or health service investigation

The Director General, Queensland Health can appoint clinical reviewers or health service investigators to undertake an investigation into any matter relating to the management, administration or delivery of public health services. These reviews and investigations can result in recommendations aimed at improving the safety and quality, administration, management or delivery of public sector health services.

In matters where the coroner is aware Queensland Health has or is undertaking a clinical review or a health service investigation into a health care related death, it is advisable the coroner issues an information requirement for the outcomes of the investigation and the departmental or government response to its recommendations. The statutory duty of confidentiality that applies to clinical reviewers and health service investigators does not apply to the disclosure of information required under the *Coroners Act 2003*.¹⁷

Official misconduct investigations

In matters where the death is the subject of an official misconduct investigation, that investigation may or may not raise issues of relevance to the coronial investigation.

The coroner should ensure the investigating entity is aware of the coronial investigation and keeps the coroner informed of the progress of its investigation.

Conclusions

It is the coroner's responsibility to investigate the cause of the death and how it occurred. In most health care related deaths input from independent medical practitioners will be necessary.

If these matters can be established by a paper based investigation, the matter need not proceed to inquest even if the investigation establishes sub standard health care has contributed to the death – it is not the role of the coroner to adjudicate upon the

¹⁷ See *Hospital and Health Boards Act 2011*, Part 6 Div 3 & Part 9

standard of medical care. The coroner should make findings and refer concerns about the quality of the health care to the appropriate regulatory body.

However, if the cause of death or how it came about can not be established by the investigation, an inquest may be necessary.

An inquest may also be warranted to advance public health or safety and/or to reduce the chances of similar deaths occurring in future. However, if the health service district or private hospital has acknowledged the problems and taken steps to address them, there may be little left on which to focus the coroner's prevention function.

7.5 Investigating domestic and family violence related deaths

Specialist assistance is available to support the role of coroners in their investigation of domestic and family violence related deaths through the Domestic and Family Violence Death Review Unit (DFVDRU). For a significant proportion of these types of deaths there have been key predictors of a heightened risk of harm as well as missed opportunities for intervention prior to the death. There are also often similar themes, issues and identifiable risk factors that recur in many of these deaths which is why there is a benefit to a systematic review process.¹⁸

The implementation of this unit aligns Queensland with other jurisdictions who have dedicated positions focused specifically on preventing future deaths. This section is intended to guide:

- the identification and classification of domestic and family violence related deaths;
- the coroner's consideration of information that may be required to effectively investigate a domestic and family violence related death; and
- the resources available to coroners to assist with their investigations of these types of deaths.

Legislation

Coroners Act 2003

Domestic and Family Violence Protection Act 2012 s. 8, 13, 12, 19, 20.

<https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2012/12AC005.pdf>

When is a death potentially domestic and family violence related?

Domestic and family violence encompasses a range of threatening or abusive behaviour designed to control another person within an intimate partner or family relationship. This includes physically, emotionally, psychologically or economically

¹⁸ The connection between domestic and family violence and homicide, the extent of the problem and the characteristics of deadly relationships were discussed in the former State Coroner's findings of the inquest into the deaths of Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers (http://www.courts.qld.gov.au/_data/assets/pdf_file/0007/154537/cif-gold-coast-murder-suicide-20120621.pdf)

abusive behaviour that is used to control or dominate another party and causes this person to fear for their safety or wellbeing or that of someone else.

For the purposes of a coronial investigation the following criteria is used to define a 'domestic and family violence related death':

- (a) homicides or murder suicides which have occurred within the context of an intimate partner, family or informal care relationship as defined by the *Domestic and Family Violence Protection Act 2012*;
- (b) 'bystander' homicides such as a person who may have been killed intervening in a domestic dispute or a new partner who is killed by their current partner's former abusive spouse;
- (c) child deaths where there was a history of domestic violence between the child's parents/caregivers and the child dies as a result of an intentionally harmful act of one of the parents or care givers or an intimate partner of one;
- (d) suicides of a victim or perpetrator of domestic and family violence in which there is a clear link between the suicide and history of domestic and family violence, such as an incident of violence within close proximity to the death.

These criteria are not exhaustive. The context and circumstances of a death, even when it does not meet the criteria outlined above, may still support a finding that the death was domestic or family violence related.

The Domestic and Family Violence Death Review Unit

The expertise of DFVDRU is available to assist and inform coronial investigations whenever it becomes evidence that a death may have occurred within the context of domestic and family violence. It does so by providing coroners with access to specialist expertise to examine a range of factors including the circumstances of the death, prior interaction with support services, potential points of intervention as well as the nature and history of the relationship between the victim and perpetrator. The unit also assists with the identification of any systemic shortcomings and in the formulation of preventative recommendations for those matters that proceed to inquest.

Coroners are encouraged to seek advice and assistance from the unit as soon as it becomes evident that the death may have occurred within the context of domestic and family violence.

Understandably, the review process differs for individual cases dependent on the complexity of issues involved and the level of information available. Although most cases are referred to the unit at the initial stages of investigation, on occasion it may not be immediately apparent that a death is domestic and family violence related but the connection may emerge as the coroner's investigation progresses.

The primary role of the DFVDRU is to provide advice and assistance to coroners in their investigation of these types of deaths. However the unit is also responsible for the monitoring and identification of any patterns or trends in relation to domestic and family violence related deaths.

This information is invaluable in developing an evidence base to inform future coronial investigations but is also used in the development of strategic policy and practice responses to domestic and family violence across government departments and non-government services. Consequently referral and liaison with the unit by coroners, counsel assisting and other staff is strongly encouraged when a death is suspected to relate to domestic and family violence.

Management of the investigation of domestic and family violence related deaths

Upon initial notification and assessment of a suspected domestic and family violence related death, the DFVDRU will arrange for the QPS Coronial Support Unit to provide preliminary details regarding the death and any history of domestic and family violence between the victim and/or the perpetrator.

Dependent upon the availability and extent of these records a preliminary review will be conducted advising the coroner of the relationship of the death to domestic and family violence, any initial issues and proposed avenues for investigation; including where necessary, obtaining additional records from different agencies.

For a significant proportion of homicides that occur within an intimate partner or family relationship, there may be no prior contact with police in relation to domestic and family violence. A lack of police records however, should not be considered a reliable indicator that there was no abuse in the relationship. It is often the case that victims will access help and support from family or friends, health agencies or other services, as opposed to seeking assistance through the criminal justice system.

In recognition of this, and to assist the coroner in gathering relevant information, the Queensland Police Service Operational Procedures Manual contains provisions to guide police investigations of domestic and family violence related deaths (Section 8.5.23). This may include, but not be limited to, the following information:

- Previous history of domestic or family violence between the victim and perpetrator and/ or with their former partners;
- Status of the relationship at the time of the death;
- History of suicide threats or attempts;
- Drug and/or alcohol abuse or any known mental health issues;
- Factors related to the incident such as separation, new partner, financial problems, custody issues or an upcoming court appearance;
- History of stalking or obsessive behaviour; or
- Previous threats to kill (including against children or other family members).

Witness statements and other records obtained during police investigations are invaluable in providing contextual information regarding the history of the relationship between the victim and the perpetrator. Because of this the brief of evidence is

required for all domestic and family violence related homicides and it is preferable that this be routinely requested at the committal stage.

Once there is sufficient information available, the DFVDRU will provide an interim report to assist coroners in the identification of any issues warranting further investigation. After all relevant records have been received; the DFVDRU will provide a final file review covering the context and circumstances of the case as it relates to domestic and family violence. This information can subsequently be used to inform a coroner's consideration as to whether it may be within the public interest to hold an inquest or the circumstances of the case are such that they wish to proceed to making their findings.

The Centre for Domestic and Family Violence Research

The Centre for Domestic and Family Violence Research (CDFVR), Central Queensland University has been funded to provide external expert assistance to the Office of the State Coroner in the investigation of domestic and family violence related deaths.

Under this agreement an investigating coroner, or nominated representative, may provide the CDFVR with discussion papers and de-identified case material, pose questions for consideration and seek that the CDFVR provide one of the following:

- advice and assistance on the identification of relevant service providers or recognised experts;
- provide general advice in the form of a short report (e.g. types of services available within the service system); or
- provide information and advice on emerging trends or issues of relevance to the prevention of domestic and family violence related deaths and within the context of improving systemic responses to domestic and family violence.

This work is intended to compliment, not duplicate, the work of the DFVDRU, and as such decisions around accessing support from the CDFVR should be made in consultation with the Principal Researcher and Coordinator of the DFVDRU.

7.6 Investigating 'child protection' deaths

From time to time, coroners will investigate the death of a child whose life circumstances raise concerns about the family's previous or ongoing contact with the child protection system, or suggest missed opportunity for protective intervention which may have prevented the child's death. While some of these deaths may occur in the context of domestic homicide, others may not be the result of interpersonal violence but arise out of neglect, challenging behaviours or intentional self-harm. Regardless of whether or not the child was subject to formal intervention under the *Child Protection Act 1999* at the time of their death, there is considerable value in informing coronial investigations of this nature with systemic review expertise as the coroner has an important external oversight function in relation to these deaths.

This section outlines the information and specialist resources, including the expertise of the DVFVRU, available to assist coroners in the investigation of these types of deaths.

Legislation

Coroners Act ss. 8, 9

Child Protection Act 1999 s. 159P, 246AA, 246D, 246H

<https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf>

Adoption Act 2009

<https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC029.pdf>

Family and Child Commission Act 2014

<https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2014/14AC027.pdf>

When is the death of a child potentially a “child protection” death?

Thankfully, these deaths number few among the variety of child deaths reported to coroners for investigation, and of those reported to date, only a very small proportion have raised issues of concern in terms of the State’s involvement with the child and their family.

Child deaths ‘in care’

The most clear cut cases are those reported as a ‘death in care’ under section 9(1)(d) of the *Coroners Act 2003* because when the child died, he or she was subject to a formal intervention under the *Child Protection 1999*.¹⁹ In practice, this captures deaths which occur when action by the Department of Communities Child Safety and Disability Services results in the child being:

- in the custody or guardianship of the chief executive of the DCCSDS. When a child is placed in the custody or guardianship of the chief executive the Department must find an appropriate placement for the child such as home-based care (foster, kinship and provisionally approved carers) and residential care services;
- placed in care under an assessment care agreement. An assessment care agreement is an agreement between the chief executive and the child’s parents for the short term placement of the child in the care of someone other than the parents;
- subject to a child protection order granting custody of the child to a member of the child’s family other than a parent; or
- subject to a child protection order granting long-term guardianship of the child to a suitable person who is a member of the child’s family other than a parent or another suitable person nominated by the chief executive.

While these interventions are often actioned to protect the child from risk of harm, they can also be used to facilitate a child’s medical treatment, for example, when a

¹⁹ See State Coroner Guidelines Chapter 3 Reporting deaths

chronically or critically ill child from a remote community needs treatment that can only be delivered at a tertiary facility many thousands of kilometres from the child's home and family.

It is important to acknowledge that the Coroners Act operates to require the reporting of all child deaths "in care", even if the death was an expected natural causes death, for example, terminal illness, or has occurred in circumstances completely unrelated to the reason for which they were placed "in care", for example, from injuries sustained in a motor vehicle accident where the driver of the other care was at fault. These deaths generally do not raise systemic child protection issues warranting extensive coronial investigation.

However, child deaths "in care" involving interpersonal violence, neglect, suicide, accident or the tragic outcomes of reckless or challenging behaviours may warrant close examination of the appropriateness of the action taken (or not) by the State in relation to the child and his or her family.

The significance of a death being reported as a "death in care" is that an inquest must be held if the circumstances of the case raise issues about the care that was provided to the deceased person. Examples of child protection issues examined in previous child death "in care" inquests include the appropriateness of the child's placement and case management, supervision by carers and communication with and within the child protection system.

Other reportable child deaths

Child deaths are also reported under other categories of "reportable death" under the Act, most commonly sudden unexpected infant deaths or other apparent natural causes deaths where the cause of death is unknown, traumatic deaths, for example, motor vehicle accidents, suicides and accidental drug overdoses, and occasionally health care related deaths. From time to time, the deceased child will be a child who was known to the child protection system. The extent to which the State's prior involvement with the child and their family may be relevant to the circumstances of these deaths is considered by the coroner on a case by case basis.

In some cases, the circumstances of the child's death will raise questions about whether the child should have been subject to formal child protection intervention at the time of their death, and will require a careful examination of whether there were missed opportunities for this to have occurred and if so, whether earlier or different intervention or departmental involvement with the child's family may have prevented the child's death. These deaths can often reveal broader systemic deficiencies in the sense of gaps or blockages between various government and non-government agencies (health, housing, education, child protection, police) engaged with the child's family in the lead up to the death.

Information available to inform the coroner's "child protection" death investigation

Child death review outcomes

Queensland's child protection system has been the subject of a number of independent investigations and inquiries since the Queensland Ombudsman highlighted historical system failures in the Brooke Brennan Report²⁰ and the Baby Kate Report²¹ and the then Crime and Misconduct Commission report *Protecting Children: an inquiry into abuse of children in foster care*.²² Recommendations from these inquiries resulted in significant changes to the previous system of internal child protection death reviews conducted by the then Department of Families, including the establishment of the multidisciplinary Child Death Care Review Committee to provide independent and external oversight of departmental reviews of child deaths.²³ This system was changed again following recommendations made by the Child Protection Commission of Inquiry²⁴ which resulted in new child death review processes being implemented from 1 July 2014.

When investigating a death that raises potential child protection issues, coroners should routinely have regard to child death review outcomes as this review process examines case management decisions and actions taken in respect of notifications made about the deceased child and his or her family, with a view to identifying deficiencies in existing practices and procedures and making recommendations to address them. The outcomes of the child death review process can often assist in resolving or at least narrowing the issues for coronial investigation.

For deaths prior to 1 July 2014, the following reports were routinely provided to the coroner by the relevant review entity:

- the department's child death case review report – the department previously conducted a review of all deaths of a child known to the department in the last three years of the child's life; and
- the Child Death Case Review Committee report – the former CDCRC examined the adequacy of the departmental reviews and the appropriateness of the department report recommendations.

From 1 July 2014, the child death review process was changed to require:

- departmental review of a child death where the child was known to the department within 12 months of their death – a specialist internal investigation team has been established to perform this function on behalf of the child safety chief executive; and
- oversight of departmental review by an independent multidisciplinary child death case review panel formed by the Minister responsible for administering the *Child Protection Act 1999*.²⁵

²⁰

http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/brooke_brennan_report.pdf

²¹ www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/OMB-3281%20Baby%20Kate%20Report.pdf

²² <http://www.communities.qld.gov.au/childsafety/about-us/publications/protecting-children-an-inquiry-into-abuse-of-children-in-foster-care>

²³ www.cdrc.qld.gov.au

²⁴ <http://www.childprotectioninquiry.qld.gov.au/publications>;

<http://www.justice.qld.gov.au/corporate/justice-initiatives/carmody-report-recommendations>

²⁵ See *Child Protection Act 1999*, Chapter 7A Child death and other case reviews

These reports will be routinely provided to the investigating coroner via the State Coroner.²⁶

To date these reports have generally been quite comprehensive, produced to the coroner in a timely fashion and helpful in informing the coroner's consideration about whether there are issues warranting further investigation or response from the department. Coronial investigations and inquests benefit significantly from the child death review process as it uses specialist child protection expertise not otherwise readily available to coroners to identify child safety service shortcomings and propose recommendations to address those shortcomings. This can assist coroners greatly in narrowing the coronial investigation issues, progressing the coronial investigation in a timely way and informing consideration of reasonable, workable coronial recommendations in the very few child protection deaths that proceed to inquest.

Coroners should routinely seek information from the department about the status of its implementation of child death case review recommendations as this information can be very influential in a coroner's determination of whether there is a need to proceed to inquest in respect of any child safety system deficiencies identified by the coronial investigation.

While reports generated under the current child death review system will only relate to the case management of children known to the department within 12 months of their death, the Child Protection Act enables the Minister to require an investigation of departmental involvement with the deceased child or the family outside of this time frame.²⁷ If the coronial investigation identifies issues relating to the department's involvement with the child or the child's family beyond the 12 month time frame, the coroner may consider writing to the Minister seeking his or her co-operation in requiring a child death review for the relevant period.

Other departmental information

In the event the child death review outcomes do not adequately address issues arising in the coronial investigation, the coroner may consider issuing formal information requirements for information including:

- the child's departmental case file
- the outcomes of any other conducted in respect of the child or another member of the child's family or household, for example, if the child had previously suffered serious physical injury while known to the department or another child from the same family or household was the subject of a review conducted under the Child Protection Act
- statements from relevant departmental or service provider personnel addressing specific questions about the case management decisions and action taken in respect of the child
- relevant departmental policies and procedures

²⁶ See *Child Protection Act 1999*, s.246H

²⁷ See *Child Protection Act 1999*, s.246B(3)

- statement from the most appropriate senior departmental officer about the extent to which the child death review recommendations have been implemented.

Expert review

Depending on the circumstances of the child's death, the coroner may also consider obtaining an independent expert review of the child's management. State Coroner approval is required before an expert review can be commissioned.

Senior Advisor (Child Protection), Domestic and Family Violence Death Review Unit

The Senior Advisor (Child Protection) role is situated within the Domestic and Family Violence Death Review Unit to provide specialist advice and assistance to coroners in relation to child protection systems, policies and practices. This role also has responsibility for the provision of assistance with the identification of systemic shortcomings and the formulation of preventative recommendations for those matters that proceed to inquest.

The primary focus of this role is to ensure that all relevant issues pertaining to the child's death are considered, with a focus on the involvement of the DCCSDS both during and prior to the one year departmental review period. The case management process aligns with those for the investigation of domestic and family violence related deaths outlined in section 7.5 of these guidelines, and is designed to facilitate access to information about the family's prior contact with the department, police other government agencies and/or non-government organisations prior to the child's death.

Coroners are encouraged to seek advice and assistance from the unit as soon as it becomes evident the death may raise systemic child protection issues.

7.7 Investigating suspected deaths

Introduction

A finding of death or declaration of presumed death serves not only the emotional needs of a missing person's family but is a practical necessity for matters including estate administration and life insurance and superannuation claims. The Coroners Act has substantially narrowed the coroner's jurisdiction to investigate a missing person's disappearance. Previously the police, a missing person's family or another sufficiently interested person could request the coroner to investigate the cause and circumstances of the disappearance of a person who had been missing for more than 12 months.²⁸ However, the coroner's missing persons jurisdiction is now limited to only those matters where there is reason to suspect a person is dead and the death was reportable under the Act.

²⁸ See repealed *Coroners Act 1958*, s.10 – the coroner had jurisdiction to inquire into the cause and circumstances of the person's disappearance and all matters likely to reveal whether the person was alive or dead and the person's whereabouts at the time of the inquiry.

This chapter sets out the range of considerations a coroner should take into account when investigating a suspected death.

Legislation

Coroners Act
Sections 11, 14, 45

In principle

A suspected death is one in which a person is missing but no body is located – living or dead. A coroner can only investigate a suspected death upon direction from the State Coroner who must either suspect the person has died in circumstances that make the death reportable, or because the Attorney-General has directed that the suspected death be investigated. The general principle is that if the person has not been seen or heard from by those who might be expected to have seen or heard from him or her and due inquiries have been made that have produced no positive results, the circumstantial evidence may be sufficient to enable a finding of death to be made.²⁹ When making such a finding, care needs to be taken there is sufficient evidence to exclude the possibility of the missing person having assumed another identity.

In practice

Common scenarios invoking coronial investigation include persons thought to be the victim of foul play, accident or suicide though the body has never been found, and persons seen falling from a vessel or swept away in rough seas or flood waters but search and recovery efforts were unable to recover the body.

As explained in Chapter 3, missing persons are generally first reported to the QPS Missing Persons Unit. The QPS Operational Procedures Manual requires the Missing Persons Unit to refer these cases to the State Coroner as soon as a missing person is reasonably suspected of being dead.³⁰ The police report to the State Coroner should include the complete investigation file including a report as to the results of the police investigation into the cause and circumstance of the person's disappearance and suspected death. The State Coroner can then direct a coroner to conduct an investigation, including the holding of an inquest if necessary. The coroner is required, if possible, to find whether or not a death in fact happened and if so, to the extent possible, the usual findings required under s. 45(2).

The circumstances of suspected deaths vary greatly and can pose quite challenging issues for coroners. For example, if a person who is known not to be able to swim is seen washed from rocks by large waves while fishing and whose body has not been found after a week of search and recovery efforts, it may reasonably be concluded the person is dead. In such a case, a coroner can find accordingly and the death can be registered.

However, in other cases, such a conclusion may not be so readily drawn. For example, if there is some basis to suspect that the missing person may have had reason to 'disappear' or at least relocate in order to leave behind some trouble or unhappiness,

²⁹ For a useful discussion of presumption of death principles see *Riggs v Registrar of Births, Deaths and Marriages & Ors* [2010] QSC 481 (24 December 2010) per Martin J at [10]-[12]

³⁰ Section 8.5.24 *Missing person reasonably suspected of being deceased*

it may be unsafe to conclude he or she has died. In these cases the coroner must consider whether all reasonable inquiries have been made and whether it is more likely than not that those inquiries would have disclosed some evidence of the missing person's continued existence were they not dead.

Depending on the circumstances of the disappearance, checks with the Australian Taxation Office, Centrelink, Medicare, financial institutions, interstate Registries of Births Deaths and Marriages, Australian or overseas police services and immigration authorities can be useful. Evidence from family, friends, treating doctors, work colleagues, business or other associates can assist in exploring whether the missing person's life and character immediately before his or her disappearance was consistent with that of a person likely to stage a disappearance and create a false identity. However, a coroner has to be satisfied the missing person has not assumed another identity and that negative results to these checks are sufficient to conclude the person is dead. If the death is to be registered in Queensland, the coroner also needs evidence that the person died here.

The risks posed by these cases were highlighted in a New South Wales matter where the coroner found the man had drowned when his runabout was found floating, damaged and empty in a coastal waterway. Three years later the deceased was located, alive and well and charged with insurance fraud.

Many suspected death investigations will yield sufficient information for a coroner to make chamber findings. However, some disappearances may warrant an inquest to test evidence about matters including the missing person's last known movements, their state of physical or mental health immediately before the disappearance, potential third party involvement in the person's abduction and death or the opinions of survival or other relevant experts. The circumstances of the suspected death may also raise broader systemic issues such as the adequacy of police or emergency services responses to the person's disappearance that may appropriately be the subject of coronial comment.

From time to time there will be cases where despite exhaustive investigations there may still be insufficient evidence for the coroner to make a definitive finding about whether a person has died. As distressing as this may be for the person's family, 'hedge bet' findings to the effect *'I presume X to have drowned after being dragged out to sea by a strong tidal current but should he be found alive then his present whereabouts are unknown'* should be resisted.

7.8 Disposal of property in possession of the Queensland Police Service as a result of reportable death investigations

Aim of the guidelines

To provide guidance and advice to police officers in relation to the disposal of property taken into possession during the investigation of a reportable death.

The guidelines are aimed at;

- minimising the number of requests to coroners for approval to dispose of property, and
- problems and costs associated with the storage of property at police establishments, and
- returning property not needed for the investigation to the rightful owner as expeditiously as possible.

Reportable deaths and property

Section 8 of *Coroners Act 2003* outlines eight circumstances in which a sudden death is reportable. Officers should refer to the OPMs chapter 8 - Coronial Matters for details.

Section 794 of the *Police Powers and Responsibilities Act 2000* places a duty on a police officer to help a coroner in the investigation of a reportable death, including complying with all reasonable directions. Accordingly, the Queensland Police Service is responsible for conducting investigations into reportable deaths on behalf of a coroner.

Often these investigations result in police officers taking possession of property associated with a deceased person. Such property is taken possession of by a police officer for two primary reasons:

- it seized for the purpose of the investigation, (either criminal or coronial), or
- it is taken for safe keeping.

Obligations of investigating officers

Exhibits

Section 59 of the *Coroners Act 2003* provides that police officers who take possession of property for the purpose of the investigation of a reportable death (which includes suspicious deaths) are not to dispose of the property without the permission of the investigating coroner. Directions as to the disposal of the property will usually be given by the coroner checking a box on the bottom of page 2 of the relevant findings forms (i.e. 20A, 20B, 20C, 28A and 28B).

The investigating coroner will consider authorising the earlier release of property if:

- it is dangerous to retain, e.g. explosives, unstable chemicals etc;
- it is cost prohibitive to store e.g. motor vehicles, aircraft, vessels etc
- its retention may impact on the livelihood of others – e.g. business operating equipment; or
- the next-of-kin or rightful owner requests its return because of its monetary value, sentimental value or practical urgent use – e.g. baby clothing, computers, mobile phones etc which may contain important information necessary to finalise financial affairs and/or conduct funeral arrangement.

When such property is involved, at the completion of any examination or testing, officers must submit a supplementary Form 1 to the coroner seeking permission to dispose of the property in accordance with established procedures. Such supplementary Form 1 should clearly outline what is proposed to be done with the property and the basis for the proposal.

Safekeeping

The disposal of property taken possession for safekeeping can be more problematic as often the significance of the item to an investigation can be overlooked and the property returned to the owner risking its evidentiary value. Accordingly, only property clearly of no value to the investigation is to be returned or disposed of without referral to a coroner. If an officer is in any doubt the property is to be retained.

The following items may be disposed of by police assisting at mortuaries where retention is no longer required for the investigation of the death:

- A noose used by the deceased in causing their own death; and
- A helmet worn by the deceased at the time of their death.

This should only occur after the items has been examined by the forensic pathologist, photographed and recorded within the relevant QPS register.

Examples of circumstances where property can be disposed of without referral to a coroner may include;

- Clothing, personal items (wallet etc) located at non-suspicious death scenes in a public place or not their usual place of residence
- Jewellery found on a deceased
- Personal/valuable items where deceased was located at place of residence but residence may not be able to be secured, other persons reside at residence or other persons appear to have access to the residence.
- Keys taken to secure a residence or enable police to re-enter if necessary for inquiries.
- Mobile phones/address books/documents taken possession of to assist inquiries to locate Next of Kin (apart from probative value in certain cases i.e. suicide, motor vehicle accident).³¹
- Personal items may be seized for safekeeping where it becomes immediately apparent a dispute exists between NOK and there is the potential to release property to the wrong person without further inquiries being conducted.
- Property of itinerants or tourists where property is taken possession of for safekeeping due to lack of any alternate secure storage for the items.

If for any reason the attending officer is unsure, the matter should be discussed with the District Duty Officer or Shift Supervisor.

The officers who dispose of property should ensure the details are entered on QPRIME occurrence.

The Detective Inspector, Assistant to the State Coroner, may be contacted on 07 32474603.

³¹ Particular attention should be paid to the preservation of any document or recording that purports to state the testamentary intentions of a deceased person – see s 18 *Evidence Act 1981*

Review of investigation outcomes

Legislation

Coroners Act
Sections 11A, 50B

The Act establishes mechanisms for administrative review of investigation outcomes including a coroner's decision about whether a death is reportable or whether an inquest should be held, to review inquest or non-inquest findings or to re-open an inquest or non-inquest investigation. These avenues of review are intended to provide an efficient and cost-effective means of examining concerns about the way in which a death has been investigated or the basis of the coroner's findings. Families who are dissatisfied with an investigation outcome should be given clear advice about their rights to have that outcome reviewed.

Chapter 9 *Inquests* discusses the right to apply for an inquest or for a coroner's decision not to hold an inquest to be reviewed. It also explains how an inquest can be reopened, including on application by the family.

Review of decision about whether death is reportable

The Act was amended in 2009 to create a right for a person dissatisfied with a coroner's decision about whether a death is reportable to apply for an order as to whether it is a reportable death. The application is made to the State Coroner or if the State Coroner made the original decision, to the District Court.

When considering an application under s. 11A, the State Coroner may seek additional information or opinion about the death.

Reopening non-inquest investigations

The Act was amended in 2009 to enable a non-inquest investigation to be reopened by the State Coroner or the investigating coroner acting on his or her own initiative, or by the investigating coroner at the State Coroner's direction – s. 50B.

An investigation can be reopened if the State Coroner or the investigating coroner considers:

- the circumstances of the death warrant further investigation; or
- new evidence casts doubt on the findings.

The State Coroner can also reopen or direct another coroner to reopen an investigation if he or she considers the investigating coroner's findings could not reasonably be supported by the evidence.

In practice, s. 50B is activated when the coroner or the State Coroner is considering representations from a family dissatisfied with the findings or new evidence that comes to light at a later date.

When responding to a representation to have the investigation reopened, the coroner should ensure he or she provides clear reasons for any decision not to reopen the investigation or to limit the reopening to specific issues.

If the coroner reopens an investigation and undertakes further investigation, he or she must assess the extent to which the original findings require amendment and if so, issue amended findings.