

State Coroner's Guidelines 2013

Chapter 8

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8.1 Legislation

Coroners Act
Sections 45, 47, 48,

In principle

The s. 45 findings concerning the particulars of the deceased person and the death must be made whenever possible except when the investigation is stopped pursuant to s. 12(2) because the coroner authorises a medical practitioner to issue a cause of death certificate.

All findings are made to the civil standard of proof.

The law does not distinguish between findings made either before or after inquest but there are practical differences that shall be alluded to where relevant.

In practice

Set out below is some guidance as to how to approach making findings in relation to the five particulars required by s. 45(2).

8.2 The identity of the deceased

For social and legal reasons the accurate identification of deceased persons is obviously essential.

Coroners determine identity based on evidence provided by eye witnesses and medical and scientific investigations. Because that evidence can sometimes only be gained by the undertaking of an autopsy, coroners should not postpone ordering an autopsy simply because the deceased is unidentified. The coroner is only required by s. 19(5) to consider concerns about an internal autopsy 'whenever practicable'. Not knowing whom to consult makes considering their views impracticable.

It should not be thought there is a hierarchy of identification methods with say, DNA evidence being more important or reliable than visual identification. In each case the circumstances and context should be considered by the coroner when he is considering what evidence he needs to be satisfied as to the identity of the deceased. Indeed, in most cases identity is not a contentious issue. In many cases the circumstances allow the identity of the deceased to be deduced.

Visual

Visual identification by somebody intimately familiar with the deceased is the most common source of information on which coroners base findings as to identity. There is no rule of law or practice about how long the witness should have known the deceased or the proximity of their relationship. A coroner needs to consider whether the nature and extent of the relationship is likely to have imbued the witness with sufficient information to enable them to reliably identify the body. The witness is attesting to the validity of the identity of the deceased. They are not only saying; '*That is the body of the person I know as*

X', but asserting the nature of their relationship with the deceased allows them to be confident this is not a fraudulently assumed identity.

Although visual identification is by far the most common mechanism used, coroners need to be alert to the ease with which mistakes can be made. Just as the law reports are replete with cautions about relying on the eye witness identification of accused people, so coroners need to be alert to the possibility that even close relatives can make mistakes, the propensity for which increases commensurately with disfiguring injuries and decomposition. Even routine post mortem lividity or congestion can make a dead person appear very different.

Unlike other methods, visual identification is largely subjective and its reliability has not been rigorously validated in the way scientific and technological methods of identifying bodies have been. Conversely, visual identification occurs in context: the witness is only asked to identify the body because it is suspected they know the deceased. Unlike the victim of a crime asked to identify a person only seen jumping out the window, the body found in the bed next to the witness has usually been there alive, every day, for some years. Similarly, the relative asked to identify a deceased patient in a hospital ward has often visited her in the hospital in the days before the death. It is when such context is less cogent that precautions are necessary; for example, when numerous bodies have been recovered from a mass disaster, the opportunity to identify someone who looks like the relative of the witness is a real danger that must be guarded against.

The reporting police officers, morticians or grief counsellors should be consulted about the condition of the body if it is likely that may make visual identification unreliable.

Whenever possible, grief counsellors should also supervise the arrangements for and undertaking of the identification. As can readily be appreciated, the process can be very stressful for family members but research indicates it can have long term benefits in allowing the relative or friend to accept their loved one has really died.

In suspicious deaths there is sometimes reluctance on the part of police investigators to allow family members to touch the deceased but this will rarely actually ever compromise the investigation and may be quite significant for the survivors. Therefore, if investigators seek to impose such restrictions, the coroner should require a detailed explanation of the concerns: it is the coroner who controls the body, after all.

Fingerprints

Fingerprints taken from the body of a deceased person can be checked against fingerprints held by agencies such as police services or the defence forces. Positive matches can reliably identify someone even if there is little other information indicating who the deceased person is.

If there are no records of the deceased in such holdings, but there is a basis to suspect the identity of the deceased, latent prints can be lifted from household or personal items the deceased is likely to have touched.

Rigor mortis causing the fingers to flex towards the palm can make the taking of fingerprints difficult but the scientific officers or forensic pathologist working on the case should be able to overcome this relatively easily. It should almost never be necessary to remove digits or hands to take fingerprints. Applications to do so should be resisted unless a convincing written explanation is provided.

Dental identification

Forensic odontology allows comparison of the teeth of the subject body with records of the person the body is suspected to be. While the improvement in oral hygiene means many young people now do not receive restorative dentistry, most still have undergone some radiological examination which can provide ample evidence for comparison purposes.

The CT scans, x-rays or dental impressions needed for this approach to identification can usually be undertaken as part of the autopsy. The jaw should only be removed from the body in exceptional cases and the coroner should request written explanation for the need to do this.

Formal information requirements (via Form 5) may be required to facilitate the release of dental records and imaging, particularly from public health facilities.

DNA

DNA profiling can provide valuable evidence of identification. However, it is expensive and time consuming, delaying the release of the bodies in question. For that reason it should only be resorted to when other methods are inappropriate, such as mass disasters when numerous bodies have been disfigured to such an extent that visual, dental and fingerprint evidence cannot be relied upon.

Notwithstanding advances in DNA procedures, the possibility of contamination of samples by DNA from other sources is a continuing risk.

Circumstantial identification

Circumstantial evidence is a sufficient basis for making identification findings in many cases where visual, dental or fingerprint evidence is not adequate or available.

For example, when a decomposed body is found in a place where a known person was known to live alone, there are no signs of forced entry or disturbance, there is a range of indentifying documentation found and neighbours and next of kin have not seen the usual resident for some time and have no knowledge of him leaving the house, it is highly likely the body is that of the usual resident. Indeed, if it is not that person, who is it, why has he not been reported missing and where is the usual resident?

The same reasoning can apply when a car crashes and burns. Was the owner/usual driver seen getting into the car? Is there any likelihood that since that sighting he has been replaced by somebody else who has died in the crash? If not, a finding can be made that the owner/usual driver is the deceased in the car.

Complications arise if more than one person dies in an incident and they are of the same gender. In such cases personal items such as jewellery may assist but absent such artefacts, DNA comparisons may be necessary if fire has, for example, rendered dental comparisons impossible.

8.3 How the person died

'How the person died' is the equivalent to the manner of death or mechanism of death and the context in which it occurred.

It should not be given the unduly restrictive meaning of 'by what means' but should be understood to refer to 'by what means and in what circumstances the death occurred'.¹ It is broader than the medical cause of death which is referred to in s. 45(2)(e).²

When recording the manner of death, the coroner should strive to indicate whether the death was accidental or intentional. If intent is unable to be determined, that should also be explained.

In the English case of *R v South London Coroner; ex parte Thompson*³ Lord Lane said it was the coroner's role 'to seek out and record as many of the facts concerning the death as public interest requires'.

In *Hurley v Clements & Ors*⁴ the Queensland Court of Appeal acknowledged that when making a finding of how a person died, a coroner will often have to resolve other factual issues that lead to, or underpin the finding. These should usually also be included in the findings so that anyone reading them will understand how they were arrived at. Those findings of subsidiary or underpinning facts are not themselves 'findings' within the meaning of s. 45(2) - see *The State Coroner; ex parte the Minister for Health*.⁵

8.4 When the person died

The date of death may be particularly relevant to insurance claims or other matters of succession law. It should be established with accuracy whenever reasonably possible.

The issue only becomes problematic when the body is not discovered for some time after death. In all cases eyewitness and death scene evidence should be considered to attempt to establish the last date of life. The pathologist should also be asked to estimate length of time between death

¹ *Atkinson v Morrow & Anor* [2005] QSC 92 and *Atkinson v Morrow* [2006] 1 Qd R 397

² *Re State Coroner; Ex parte the Minister for Health* (2009) 38 WAR 553 at 162

³ (1982) 126 Sol J 625, 228

⁴ [2009] QCA 167

⁵ [2009]WASCA 165

and date of discovery based on the degree of decomposition and, if necessary, the age of infesting insects or larvae. If the remains are skeletal only, the time since death may only be estimated in months or even years.

In these cases the date of death is given as between dates – the last date the deceased is known to have been alive and the most recent date the pathologist estimates the death could have occurred.

When precision is not necessary or possible, consideration can be given to avoiding finding a date of death that coincides with anniversaries such as birthdays or Christmas.

8.5 Where the person died

There is generally little contention around the place of death but it is necessary for there to be a connection with Queensland for the death to be registered here.

Generally this is satisfied by the death occurring here – see s. 26(1) *Births Deaths and Marriages Registration Act 2003*. This can create difficulties when the body is not recovered. In many incidents of suspected death, once the coroner is satisfied the missing person is dead, she can conclude the death occurred in Queensland even if the precise location can not be ascertained. However, in those cases where this is not possible, the findings should still be sent to the Registrar of Births, Deaths & Marriages to enable that person to decide whether the death will be registered.

Deaths that occur in aircraft or ships that subsequently bring the body to Queensland and deaths of Queensland residents that occur overseas, can also be registered here – see s. 27(1) and (2).

8.6 What caused the person to die

This subsection focuses on the medical cause(s) of death, not the legal responsibility for it, or the circumstances in which it occurred. To that extent it is quite different from the issue of causation that frequently tests judges and magistrates presiding over criminal or civil matters. The so called chain of causation involves matters that should be dealt with in findings made under s. 45(2)(b) - How the person died. It is in that section of the findings that the external factors that led to the medical cause of death are also to be described.

This generally poses little problem in natural causes deaths: the events leading up to the death are described under 'how the person died' and the medical cause of death is listed separately in the appropriate section of the form.

If the coroner accepts the pathologist's opinion of the proximate medical cause of the death as stated in the autopsy report that can simply be adopted for the coroner's findings.

If the coroner is not disposed to accept the cause shown on the autopsy report, the issue should be discussed with the pathologist before departing from it and record in the findings the reasons if the coroner is still not persuaded.

In findings for unnatural deaths the circumstances and the cause need not be completely discretely described. For example, the circumstances of a motor vehicle accident (mva) would be described under the 'how' heading and 'multiple chest injuries – mva' could appear as the cause. Similarly, in a shooting suicide the evidence indicating the death was not an accident or a homicide would be contained under the 'how' heading with 'self inflicted gunshot wound to the head' appearing as the cause of death.

Pathologists use the same taxonomy as do medical practitioners issuing cause of death certificates, namely ICD 10 (International Disease Classification - Revision 10). That seeks to identify the most proximate cause - that which directly led to the death - and all antecedent, underlying or contributory causes. The Australian Bureau of Statistics (ABS) describes underlying causes as those '*which initiated the train of morbid events leading directly to death*'. The sequence of the decline to death should be described in chronological order where possible.

Coroners' findings are a major source of data for the ABS mortality statistics. The public benefit in the accuracy of this data is obvious. Accordingly, it is important for family members and public health policy that coroners diligently record cascading causes of death in a logical and coherent manner.

A useful booklet published by the ABS describing the system can be found at:-

[http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/475BC02643DB45EDCA25750B000E38A4/\\$File/1205055001_2008.pdf](http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/475BC02643DB45EDCA25750B000E38A4/$File/1205055001_2008.pdf)

8.7 Confirming draft findings and no inquest decision

Because chamber findings are frequently largely based on information contained in the Form 1, and because that information is gathered very soon after the death is reported to police and is provided by people who might not always be reliable informants, it is advisable to check the information with a family member. This can most easily be done by sending to that person the draft findings you intend to make and provide them with an opportunity to correct any errors. This is also a convenient time to advise the family of your inclination to finalise the matter without an inquest and to provide them with an opportunity to make submission on the issue if they wish.

There is a relevant standard form letter for these purposes.

8.8 No findings of criminal or civil liability

A coroner is prohibited by s. 45(5) and s. 46(3) respectively from including in the findings or comments '*any statement that a person is or may be*' guilty of a criminal offence or civilly liable for something.

Only an explicit statement reflecting on a person's guilt or liability is prohibited. Accordingly, there is no impediment to coroners providing a full and complete narrative of the circumstances of death nor stating their conclusions as to the responsibility of individuals or organisations for the death provided they refrain from using language that is applicable to decisions made by criminal and civil courts when they adjudicate upon the same issues. For example, in *Perre v Chivell*⁶ the Supreme Court of South Australia held that the then state coroner of South Australia did not offend the equivalent provisions of the S.A. Act when he said in his findings of an inquest into the death of an NCA officer:

Accordingly, I find...he died when he opened a parcel bomb, sent to him by Domenic Perre, and the bomb exploded in his hands.

Nylands J explained the provision only prohibited the drawing of legal conclusions from findings of fact. As long as coroners limit themselves to the first step – finding facts – the provision will not be breached.

Nor do the provisions of s. 45(5) and s. 46(3) prevent a coroner from referring to the fact that a person has been convicted of an offence in connection with the death. That is obviously not a finding of the coroner but rather a reference to the finding of another court. It may well provide support for a coroner's conclusion that the convicted accused caused the death and for a decision that an inquest is not necessary.

8.9 Burden and standard of proof

In the coronial jurisdiction there are no parties such as those who participate in criminal prosecutions or civil litigation. There are persons such as the family members of the deceased person who have a special interest and statutory rights. There are also individuals and organisations with 'sufficient interest' to get access to documents and information and to participate in proceedings. However, none of these bear a burden of proof in the usual sense. Rather, in keeping with the inquisitorial character of the jurisdiction, a coroner has to reach a comfortable or reasonable satisfaction having regard to all of the available information relevant to the questions in issue.

A coroner applies the civil standard of proof but the approach referred to as the *Briginshaw* sliding scale should be adopted.⁷ As a result, when considering whether the requisite level of satisfaction exists, a coroner should have regard to the inherent likelihood or unlikelihood of an occurrence and the gravity of the findings proposed.

That may mean different levels of persuasion or satisfaction being necessary for the various matters a coroner is required to find. For example, the exact time and place of death may have little significance and could be made on the balance of probabilities. However, the gravity of a finding that the death was caused by the actions of a nominated person would mean that a standard approaching the criminal standard should be applied because even though no

⁶ [2000] SASC 279

⁷ *Anderson v Blashki* [1993] 2 VR 89 at 96 and *Secretary to the Department of Health and Community Services v Gurvich* [1995] 2 VR 69 at 73

criminal charge or sanction necessarily flows from such a finding, the seriousness of it and the potential harm to the reputation of that person requires a greater degree of satisfaction before it can be safely made.

Presumption against suicide

There has been some controversy around the standard of proof applicable to a finding of suicide. These guidelines reflect the summary of relevant Australian and international authorities compiled by Dr Ian Freckleton SC.⁸

The development of the English law relating to suicide has been influenced by its long characterisation as a crime in that country.⁹ This led to a requirement that even a coroner's finding of suicide be proven beyond reasonable doubt. It has been held in England that "*Suicide is never to be presumed; there should be a presumption against suicide*".¹⁰

In Australia, the High Court has endorsed that presumption in contexts other than coronial.¹¹ Lesser courts, in more contemporary cases, have sought to clarify the extent of that presumption. The Full Court of the South Australian Supreme Court¹² described the presumption as "*no more than a presumption of fact, based upon common sense and common experience*". The New South Wales Court of Appeal¹³ has stated "*the language of presumption (and counter presumption) has largely been supplanted by the language of the proper inference to draw on the whole of the evidence*".

In the Canadian case of *Greening v Commercial Union Assurance Co* (1987) NJ (QL) No 428 the court considered the proper approach to applying the standard of proof when there was a submission of suicide rather than accident:

*Indeed, no proof need be adduced by the proponent of accidental death other than occurrence of the death itself since death by accident is taken as an axiomatic truth but liable to rebuttal. It follows that clear and cogent rebuttal evidence is required to tip the balance of probabilities sufficiently to justify a finding of suicide.*¹⁴

Later, in another Canadian case, it was stated:

*The evidence which will tip the balance of probabilities sufficiently to justify a finding of suicide can be described as 'clear and unequivocal', 'clear and cogent', or of 'substantial civil weight.'*¹⁵

Dr Freckleton concludes:

⁸ Freckleton, I *Complementary Health Issues* (2011) 18 JLM 467

⁹ It was only decriminalised in 1966.

¹⁰ *R v Huntback; Ex parte Lockley* [1944] KB 606 at 610

¹¹ *Mutual Life Insurance Co of New York v Moss* (1906) 4 CLR 311; *Spiratos v Australasian United Steam Navigation Co Ltd* (1955) 93 LCR 317

¹² *South Australian Health Commission v McArdle* [1998] SASC 6685 (Doyle CJ)

¹³ *American Home Assurance Co v King* [2001] NSWCA 201 at [12]

¹⁴ *Greening v Commercial Union Assurance Co* (1987) NJ (QL) No 428 per Marshall J

¹⁵ *H v ICBC* 2004 BCSC 593 per Nurnyeat J

What can be said from this brief review of the law on the subject is that a finding of suicide can only properly be made if a coroner (in Australia) concludes on the basis of evidence both that the deceased intended to engage in the act that caused their death and intended to die as a result. If they were seriously psychiatrically unwell at the time - in the old-fashioned terminology, that the balance of their mind was disturbed - they should be regarded as incapable of forming the necessary intent and therefore a finding of suicide should not be made. The contemporary operation and effect in the coronial context of the presumption against a finding of suicide is somewhat unclear but serves to emphasise that a finding of suicide can only be arrived at where there is clear evidence; in its absence, a finding of accident or an open verdict is the proper outcome.

As set out earlier, the *Briginshaw* approach suggests the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needs to be for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.¹⁶

8.10 The making of comments – preventative recommendations

Comments under s. 46 can only be made when an inquest is held. See chapter 9 for a discussion on how they should be approached.

8.11 Dissemination of findings

Section 45(4) provides that a copy of the findings in all cases must be given to a family member of the deceased who has indicated they will accept them. The standard form letter sent to the family member nominated on the Form 1 immediately after the death is reported, seeks confirmation that the recipient is the appropriate person to receive such material.

In the case of all child deaths a copy of the findings must be sent to the Family and Child Commissioner.

A copy is also sent to the Office of the State Coroner.

Section 47 provides the coroner must give a copy of the findings in relation to a death in custody or a death that happened in the course of a police operation, to the officials mentioned in subsection 2 of that section. Findings in relation to a death in care must be given to the officials mentioned in subsection 3.

The Registrar of Births, Deaths and Marriages also receives a copy in all cases.

¹⁶ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

Publication of inquest findings

Inquest findings are published on the Office of the State Coroner website.¹⁷ This is consistent with the public nature of the inquest process and now a requirement under s.46A of the Act, unless the coroner orders otherwise. Circumstances in which non-publication may be appropriate include non-publication while a person is prosecuted for an offence relating to the death or while the death is subject to some other formal inquiry, for example, a Commission of Inquiry. Coroners should consider whether the findings need to be de-identified before publication. Published inquest findings will be removed from the website if a person is subsequently prosecuted for an offence in relation to the death.

Chamber findings can not be generally distributed as they are a coronial document as defined in schedule 2 which means they are also an investigation document as defined in that schedule. Consequently, access to chamber findings is managed under the access to investigation documents under Part 3, division 4 of the Act. The operation of this regime is detailed in Chapter 10 *Access to coronial information*.

In practice chamber findings are usually given to insurance companies acting for the family of the deceased or another person involved in the fatal incident. They are also given to the hospital where the death occurred or to the medical practitioner who cared for the deceased.

Publication of chambers findings

The Act was amended in August 2013 to enable coroners to publish chamber findings on the Office of the State Coroner website if satisfied publication is in the public interest – see s.46A. Proactive publication of chamber findings may be appropriate to inform death prevention initiatives, raise public awareness about preventable deaths, to correct public misinformation or to inform profession or industry-specific regulators. The changes recognise the family's right to be consulted and have their views considered, wherever practicable, when the coroner is contemplating a public interest release.

When considering a public interest publication, coroners should also be mindful of the potential impact of publication on individuals, facilities or organisations mentioned in the findings. In many cases, the public interest will be adequately served by publishing a completely de-identified version of the findings, though some families may wish for their loved one to remain named. When assessing the extent to which findings should be de-identified, coroners should consider whether any named individuals, facilities or organisations have already been identified publicly, for example in media reports of the incident or media coverage of any commission of inquiry, criminal or other legal proceedings relating to the death. For example, it would be inappropriate for published chamber findings to name an individual or entity who is the subject of a criminal or disciplinary referral under s.48

¹⁷ www.courts.qld.gov.au/courts/coroners-court/findings

while the referral outcome is pending. However, it would be appropriate for the findings of a work-place fatality to name the deceased's employer when the employer has been convicted of an offence relating to the death.

The coroner should always notify others named in the findings of his or her intention to publish and any measures the coroner intends to take in relation to de-identifying the findings for publication, and provide a reasonable opportunity for submissions to be made about the proposed publication. For example, if the coroner wishes to publish findings which mention a specific health facility and its clinicians, the coroner should give the facility an opportunity to be heard before the findings are published. This is particularly so when the findings refer to the outcomes of a root cause analysis conducted in respect of the deceased's treatment, as this clinical review process has certain statutory protections under the *Hospitals and Health Boards Act 2011*.

Section 8.13 below discusses the need to balance the confidentiality of child protection information.

8.12 Drafting 'chamber findings'

This section contains some suggestions as to how findings should be framed. The findings required by s. 45 (2)(a), (c), (d) and (e) generally pose little problem so this section focuses mainly on (b) *how the person died*.

Include all pertinent details

It can be difficult to decide which of the numerous pieces of information uncovered by a coronial investigation should be included in a coroner's findings.

When considering what to include in any document and reflecting on how to describe it, the first question a writer should ask is 'Who is my audience?' Coroners' findings may be read by various people but the primary audience is the family of the deceased person. Accordingly, it is appropriate for a coroner to consider what facts a family member might want to know and may or may not already know about the death having regard to the authorities cited above which indicate that '*how the person died*' in this context means by what means and in what circumstances.

It is also appropriate to include a summary of the evidence which the coroner has relied upon in reaching those findings. A coroner should have regard to any concerns family members have raised and attempt to address those in the findings. The more contentious or complex the circumstances of the death, the more detail that will usually be necessary to allay concerns and adequately explain the coroner's decisions.

The source of the information may also be helpfully included in cases where esoteric technical evidence is relied upon. For example, air-crashes investigated by the Australian Transport Safety Bureau or mva's investigated by the Forensic Crash Unit.

Complete the picture

In some cases it will be appropriate to recite actions which have occurred since the death. While such matters might not strictly come within s. 45(2)(b), they will often provide answers to questions any interested reader will naturally ask and otherwise have difficulty answering. Further, such material will make clearer why the coroner has finalised the file without an inquest. These actions may arise from a prosecution in respect of the death, some form of systems review undertaken in respect of health care or other service delivery to the deceased person or the outcome of a complaint made to another investigative entity in respect of the death.

For example, if the findings describe a homicide, it is relevant to add that the perpetrator was prosecuted and the outcome of those proceedings. The conviction can provide a basis or reason for the coroner's finding that the accused caused the death as described in the indictment – it's been proven beyond reasonable doubt in the Supreme Court. Similarly, if the findings describe a problem with a hospital procedure, it is appropriate to inform the reader that a clinical incident analysis or internal mortality review such as a root cause analysis was conducted, and that the recommendations of that process have been implemented.

Social circumstances

A brief description of the deceased person's age, occupation, family situation, etc is usually appropriate:-

Edwin Jones, a retired plumber, was 66 years old when he died on 5 September 2010. Mr Jones lived with his wife in Brisbane. They had three adult children.

More background details are usually only necessary if they are relevant to understanding how the fatal events unfolded or to one or more of the other particulars:-

One of those adult children had returned to live with his parents as a result of his marriage breaking down. This seemed to cause Mr Jones considerable stress as, according to Mrs Jones, the son and father were not compatible. Mr Jones' wife indicated that this conflict seemed to lead to him regularly consuming excessive quantities of alcohol in the months before his death. On occasions, after drinking to excess, Mr Jones would have violent arguments with his son and sometimes drive away from the premises while intoxicated.

Basis of non-visual identification

If identification was at all problematic, that is visual identification was not relied upon, it is advisable to document how it was achieved. For example:

Due to the extent of post-mortem changes, visual identification was not possible. Mr Smith was identified by fingerprint/dental comparison.

or

Due to the extent of post-mortem changes, visual identification was not possible. I am satisfied the body is that of Mr Smith because it was found in the house where he had lived alone for 20 years; there were no signs of forced entry or disturbance; there was a wallet containing identification documents on the body and Mr Smith's relatives did not express any concerns the body was anyone else other than Mr Smith.

Medical or mental health history and treatment

This will usually be relevant to natural causes deaths; health care related deaths; and suicides. The extent to which this history needs to be included and the detail in which it should be described will depend upon whether there is a concern it was not adequately responded to.

If a death due to natural causes is reported because the cause could only be discovered by autopsy but it was not preceded by recent medical treatment or consultation, there is probably little need for more than a sentence or two to acknowledge that the death was not entirely unforeseeable.

Mr Smith had no history of heart disease. However, in the two weeks preceding his death, on a number of occasions he complained to his wife of chest pain he ascribed to heart burn. He sought no treatment for it.

If, however, the deceased has had extensive or very recent treatment that needs to be described so it can be demonstrated no gross failure of medical care allowed a preventable death to occur. For example:

Mr Smith had no history of heart disease. However, in the two weeks preceding his death, on a number of occasions he complained to his wife of chest pain. Three days before his death he attended on his regular general practitioner who, after a thorough examination, diagnosed him as suffering from heart burn and recommended he take antacid. Out of an abundance of caution, having regard to Mr Smith's age and his history of smoking, the GP made arrangements for him to undergo an exercise stress test three weeks hence to exclude the possibility he was suffering from coronary artery disease.

A review of the medical file by a doctor from the Clinical Forensic Medicine Unit concluded the diagnosis of heart burn was not unreasonable; Mr Smith's symptoms were atypical of heart disease; and the decision not to seek immediate hospital in-patient treatment or a sooner investigation of the possibility of heart disease was not unreasonable.

A significant proportion of people who end their own lives suffer from mental illness. In many cases the deceased is undergoing treatment at the time of

death. This does not necessarily mean the treating team has engaged in substandard care but it calls for some explanation. Questions which might warrant consideration are; why wasn't the deceased under an involuntary treatment order, and/or why wasn't the deceased in secure in-patient care? The more obvious the apparent risk of suicide proximate to the time of death, the more intensive the scrutiny of the mental health care may be.

In a case where the risk did not appear high, a report from the treating team may be sufficient. Its contents would be reflected in the findings. For example:

Mr Smith was diagnosed with schizophrenia five years before his death. In the intervening period he had numerous in-patient admissions, the last, nine months before his death.

Since then he seemed to be coping well, showing insight in relation to the need to comply with his medication regime and avoid illicit drugs. He was receiving treatment and support from the Logan Community Mental Health Service. His case manager advised that Mr Smith had been regularly attending his weekly appointments and his case was recently reviewed by the consultant psychiatrist and it was decided no change in his treatment or medication was needed.

Conversely, if the family contend that there was an obvious high risk that was not being adequately managed and/or the deceased was only very recently discharged from in-patient care or refused admission, a review by an independent mental health specialist may be warranted. For example:

Mr Smith was diagnosed with schizophrenia five years before his death. In the intervening period he had numerous in-patient admissions, the last, nine days before his death.

The psychiatrist who authorised Mr Smith's discharge from the Logan Hospital Mental Health Unit provided a report explaining the basis of the decision with reference to a risk assessment screening tool and clinical observations. He further explained the patient was referred to the Logan Community Mental Health Service and steps were taken to ensure there was continuity of care as a result of the CMHS case manager meeting with the patient before discharge and arranging home visits in the week following.

The decision to discharge Mr Smith and the care provided since has been reviewed by an independent psychiatrist who has advised that both were in accordance with accepted professional standards and the statutory principle of providing the least intrusive manner of care consistent with good treatment. That expert has reported that precisely predicting the risk of suicide is not possible in all cases and there is no basis to criticise the care provided to Mr Smith, despite the very sad outcome.

A similar approach should be taken to health care related deaths when the ailment is a physical illness, injury or disease. If there is any basis to consider the care was inadequate it should, at first instance, be reviewed by a doctor from the Clinical Forensic Medicine Unit. Depending upon that doctor's view, an independent specialist might then be briefed. In either case, if there is to be criticism of the treating team included in the findings, they should be asked to respond and their response included in the summary.

It is not necessarily the role of a coroner to always resolve disputes among medical witnesses. It is matter for the judgement of the coroner how far they should go in any case.

On occasions the members of the treating team will continue to assert their treatment was appropriate, despite independent reviewers coming to the opposite conclusion. Both versions can be included in the findings. The more serious the alleged departure from accepted standards and the more closely it is allegedly connected with the death, the more intensively it needs to be investigated. Indeed, inquests are frequently held for that purpose.

In other cases however, it is quite acceptable for the various versions to be included in chamber findings together with an account of any remedial action that has been taken, including the fact that a referral to the Health Ombudsman has been made.

Provide procedural fairness

Care should be taken to ensure any person or organisation that is the subject of adverse comment in the narrative findings has been given an opportunity to respond to the allegations. If this has not been done by the investigator, the task can either be detailed back to enable the person in question to be interviewed or re-interviewed, or the coroner can write to the person or organisation advising what he is considering finding and inviting a response. The coroner's findings should include some discussion of the coroner's assessment of that response.

Find manner of death

Queensland coroners do not sit with juries; hence there are no coroners' verdicts of the old English style: death by misadventure, accident, justifiable homicide, etc. However, it is still important to ensure the manner of death in broad terms is clearly found. Many mechanisms of death could equally be the result of a homicide, an accident or a suicide - drug overdoses, fall from a height, or even a motor vehicle crash are examples. Coroners should ensure they categorise all deaths in this way, or explicitly say so in those rare cases when the evidence does not allow them to make a finding in relation to this aspect of the death. Official statistics on manner of death are drawn from coroners' findings and are used to frame public health and safety policy and focus research. Both endeavours can be undermined if coroners fail to do their duty in this regard.

After the narrative describing the circumstances of the death and giving reasons for your finding of how the person died, it is appropriate to conclude with something like one of the following:-

I find Ms Smith died of natural causes.

I find that Ms Smith intentionally took her own life while adversely affected by illicit drugs and suffering from mental illness.

While I have found that Ms Smith intentionally took the illicit drugs that ended her life, I am unable to determine whether she did so with the intention of killing herself.

I find that Ms Smith was deliberately killed by Mr Smith. He was charged with her murder and sentenced to life imprisonment.

Be sensitive to the impact of language

A coroner should consider how the facts can be accurately recited in the least offensive manner: for example, '*the body was significantly affected by post mortem changes*' is probably less distressing than '*the body was grossly decomposed and infested with maggots*'. Similarly, the dead person's name should be used throughout the findings and use of the term '*the deceased*' should be avoided. When the deceased person is a child, the use of their first name only may be appropriate after first commencing the findings with both names.

8.13 Balancing confidentiality of child protection information

Legislation

Coroners Act
Child Protection Act
Section 189

The Child Protection Act contains stringent confidentiality provisions aimed at preventing the identification of a child as a child in care or the subject of a child safety investigation or as a child harmed or at risk of harm by a member of their family. These provisions also extend to protect the identity of people who make a child protection notification, as well as information obtained by child safety officers in the performance of their duties. These provisions operate, subject to limited exceptions, to prevent the recipient of this information from disclosing it. Strictly applied, these restrictions could be seen to impinge on the transparency and rigour of the coronial process.

Inquest and chamber findings should not include confidential information obtained from Department of Communities, Child Safety and Disability Services unless that information is necessary to support and make sense of the coroner's findings and recommendations.

Care must be taken to ensure findings do not include information that identifies or could lead to the identification of any other child, for example a

sibling or relative of the deceased child, as a child in care or the subject of a child safety investigation or as a child harmed or at risk of harm by a member of their family.

Coroners contemplating a public interest release of chamber findings about the death of a child in care should turn their minds to redacting content that may impinge on the confidentiality of child protection information before the findings are released to a broader audience.