# State Coroner's Guidelines 2013 Outline

QUEENSLAND COURTS

## *Chapter 1 - Introduction and the scope of the coroner's role*

**1.1 Introduction**

**1.2 The scope of the coroner's role**

In principle
In practice
Summary

**1.3 Further reading**

## *Chapter 2 - The rights and interests of family members*

**2.1 Introduction**

**2.2 Deciding who is the family member**

Legislation
In principle
In practice

**2.3 Family views about autopsy and organ retention**

Legislation
In principle
In practice

**2.4 Communicating with the family**

In principle
In practice
Assistance of coronial counsellors
Assistance of Aboriginal and Torres Strait Islander Legal Service
Notification of death
Cause of death information and autopsy reports
Information about the coronial process

**2.5 Viewing the body and death scene**

**2.6 Release orders and family disputes**

**2.7 Case management and keeping families apprised**

In principle
In practice

**2.8 Management of family concerns about the death**

In principle
In practice

Relevant facilities
Death of person who was receiving treatment under the Forensic Disability Act 2011
Death of a person who was subject to involuntary assessment or treatment under the Mental Health Act 2000
Death of a child under the care or guardianship of the Department
Death in custody
Legislation
Death in the course of police operations
Legislation
Suspected deaths
Legislation
In principle
In practice

### 3.2 How are deaths reported?

Legislation
In principle
In practice
Multiple fatalities – Form 1B and the disaster victim identification process
Form1B
DVI Phases

### 3.3 Reporting of particular deaths

Stillbirths
Scope of coroner's jurisdiction
Reportability
Autopsy outcomes
Neonatal deaths - when and how they should be reported
Introduction
Reportability
Deaths not reportable to the coroner
Deaths reportable to the coroner via the police
Deaths reportable directly to the coroner via the Form 1A proces
Scene preservation
The coroner's decision
Opportunities for clinical input to the autopsy process
Reporting Guide for Neonatal Deaths

### 3.4 Triaging natural causes deaths

Legislation
When are natural causes deaths 'reportable'?
In principle
In practice
Guidelines for first response officers
If a cause of death certificate does not issue
Guidelines for coroners – advice to treating doctors
Triaging natural causes deaths at the preliminary investigation stage

## *Chapter 4 - Dealing with bodies*

### 4.1 Introduction

### 4.2 Release to the family's funeral director from the place of death

Legislation
In principle
In practice
Guideline for first response officers attending an apparent natural causes death in the community
If a cause of death certificate does not issue
Guideline for coroners – arrangements for bodies when impracticable for body to remain at hospital or nursing home pending outcome of coroner's preliminary investigation

### 4.3 Dealing with possible indigenous burial remains

Legislation
In principle
In practice

### 4.4 Preserving evidence when a health care related death occurs in a health care setting

In principle
In practice
Preserving the death scene
Preserving medical equipment attached to the body
Preservation of other evidence in a health care setting

### 4.5 How should bodies and hospital records be transported to the mortuary?

Legislation
In principle
In practice
Transportation of bodies
Transportation of hospital records with the body

### 4.6 When can families view the body prior to release from a coronial mortuary?

In principle
In practice
When is a viewing not appropriate?
When can a viewing be conducted?
Managing family conflict
How should a viewing be conducted?

### 4.7 When can organ and tissue donation take place?

## 5.5 Limiting internal autopsies

In principle
In practice
Guidelines for coroners - autopsy orders
Examples

## 5.6 Who should be consulted before an internal autopsy is ordered?

Legislation
Family concerns
In principle
In practice
Guidelines for police - obtaining the views of family members
What if family members are in disagreement?
What if the deceased has not been identified?
What if family members are suspects?
Others who may be exposed to risk
In principle
In practice

## 5.7 Who should conduct an autopsy?

Legislation
In principle
In practice

## 5.8 Who may be present at an autopsy?

Legislation
In principle
In practice

## 5.9 Notifying families of autopsy results

## 5.10 Autopsy notices, autopsy certificates, doctor's notice to coroner after autopsy and autopsy reports

Autopsy notices and autopsy certificates
Legislation
In principle
In practice
Guidelines for pathologists regarding autopsy certificates
Doctor's notice to coroner after autopsy – Form 3
Autopsy reports
Legislation
Guidelines to pathologists regarding autopsy reports

## 5.11 Performing a further autopsy

Legislation
In principle
In practice

## 5.12 Retention of tissue, whole organs, foetuses and body parts

Legislation

Initial investigations
Proactive investigation and case management
Investigation reports
Obtaining statements
Obtaining expert reports
Referral to other investigative agencies
Suspected commission of an offence
Official misconduct or police misconduct
Professional or occupational conduct issues
Referral of issues not relevant to coronial investigation
The impact of criminal proceedings

### 7.3 How should deaths in custody be investigated?

Legislation
In principle
In practice
Correctional Centre Deaths
Natural Causes deaths
Deaths involving police
All deaths in custody

7.4 Deaths in a health care related setting

Legislation
When is a death potentially ‘health care related’?
Provision of health care
Failure to provide health care
How can health care related deaths be reported?
Management of deaths reported via a Form 1A
CFMU review
CFMU review identifies no health care concerns
CFMU review identifies health care concerns
Autopsy decision making
Timely investigation
Deaths involving non-psychiatric treatment issues
Deaths involving paramedic response issues
Deaths involving mental health treatment issues
Independent expert reviews
Informing inquest recommendations
Death review processes in Queensland hospitals
Clinical incident management in QH facilities
Clinical incident management in private health facilities
Referral to another investigative agency
Health Quality and Complaints Commission (HQCC)
Australian Health Practitioner Regulatory Agency
Office of Aged Care Quality & Compliance
Clinical review or health service investigation
Official misconduct investigations
Conclusions

7.5 Investigating suspected deaths

Provide procedural fairness
Find manner of death
Be sensitive to the impact of language

**8.13 Balancing confidentiality of child protection information**

Legislation

## *Chapter 9 - Inquests*

**9.1 Introduction**

**9.2 When should an inquest be held?**

Legislation
In principle
In practice
Mandatory inquests
Deaths as a result of police operations
Deaths in care
Discretion to hold an inquest

**9.3 The right to request an inquest**

Legislation
In principle
In practice

**9.4 Communicating decisions to hold/not hold an inquest**

In principle
In practice

**9.5 The role of Counsel Assisting and seeking approval to brief external counsel**

In principle
Freckleton and Ranson's Death Investigation and the Coroner's Inquest contains a useful discussion of the role of counsel assisting
In practice

**9.6 Notification of inquests**

Legislation
In principle
In practice
Inquest notice
Balancing confidentiality of child protection information
Additional notification

**9.7 Preparing for an inquest**

**9.8 Pre inquest conferences**

Legislation

In practice
Protocol between the Australian Defence Force and the Queensland State Coroner concerning the deaths of ADF members
Investigation of death arising from police related incidents (2008)
Co-ordination of Responses to Serious Adverse Health Incidents (2011) Agreement between the Commission for Children and Young People and Child Guardian and State Coroner and Chief Executive of the Department of Justice and Attorney General (2011)
Other MOU of relevance to coronial investigations include:
Memorandum of Understanding between the Queensland Police Service and the Department of Justice and Attorney-General (2011)