

State Coroner's Guidelines 2013 Outline

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

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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

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Assistance of Aboriginal and Torres Strait Islander Legal Service

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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

2.9 Access to coronial information

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- In principle
- In practice

2.10 Application for inquest and review of reportable death or inquest decision or findings

- Legislation

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- In principle
- In practice
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- What is a disability?

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Legislation
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Form1B
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4.2 Release to the family's funeral director from the place of death

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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

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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

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Legislation

In principle

In practice

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In principle

In practice

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Legislation
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In principle
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5.2 Preliminary investigations, issue of cause of death certificates

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5.3 When should an autopsy be ordered?

Legislation
In principle
In practice

5.4 What type of autopsy should be ordered?

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In principle
In practice
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In principle
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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

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Autopsy notices and autopsy certificates
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In principle
In practice
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Guidelines to pathologists regarding autopsy reports

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Legislation
In principle
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Legislation

In principle
In practice
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What is an organ?
What is a whole organ?
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6.1 Introduction

6.2 Release of bodies for burial or cremation

Legislation
In principle
In practice
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Chapter 7 - Investigations

7.1 Introduction

7.2 How should deaths generally be investigated?

Legislation
In principle
In practice
Which deaths must be investigated?
Which deaths must not be investigated or further investigated?
Deaths outside Queensland
Indigenous burial remains
Authorisation of cause of death certificate where autopsy not necessary
Stillbirths
Direction to stop investigation
Investigation and case management strategies

- 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

- Introduction
- Legislation
- In principle
- In practice

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

- Aim of the guidelines
- Reportable deaths and property
- Obligations of investigating officers
- Exhibits
- Safekeeping
- Legislation
- Review of decision about whether death is reportable
- Reopening non-inquest investigations

Chapter 8 - Findings

8.1 Legislation

- In principle
- In practice

8.2 The identity of the deceased

- Visual
- Fingerprints
- Dental identification
- DNA
- Circumstantial identification

8.3 How the person died

8.4 When the person died

8.5 Where the person died

8.6 What caused the person to die

8.7 Confirming draft findings and no inquest decision

8.8 No findings of criminal or civil liability

8.9 Burden and standard of proof

- Presumption against suicide

8.10 The making of comments – preventative recommendations

8.11 Dissemination of findings

8.12 Drafting ‘chamber findings’

- Include all pertinent details
- Complete the picture
- Social circumstances
- Basis of non-visual identification
- Medical or mental health history and treatment

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 principle
In practice
Balancing confidentiality of child protection information

9.9 Leave to appear

Legislation
In principle
In practice
Legislation
In principle
In practice
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Standard of proof
Practical considerations
Family participation

9.11 Power to compel witnesses

Legislation
In principle
In practice

9.12 Inquest findings and comments

Findings
The making of comments – preventive recommendations
Legislation
In principle
In practice
Informing preventative recommendations
Framing strong recommendations
Responses to coronial recommendations
Dissemination of findings and comments
No findings of criminal or civil liability

9.13 Management of s. 48 referrals

Legislation
In principle
In practice
Submissions on and statements about section 48 referrals

9.14 Review of inquest findings and reopening inquests

Legislation
In principle
In practice

Chapter 10 - Access to coronial information

10.1 Introduction

Legislation

10.2 Access to investigation documents for other than research purposes

In principle

In practice

What are 'investigation documents'?

Coronial documents

Investigation documents

Documents that can not be accessed

Coronial consent

Who has sufficient interest in an investigation document?

Journalists and media organisations

Authors, television producers, film makers etc

Proof of applicant's identity

When can access be given in the public interest?

When should conditions be placed on access?

Redaction and de-identification

When can access be refused or postponed?

Timing of access

Access to sensitive or distressing investigation documents

Suicide notes

Photographs and audio-visual footage

10.3 Application of RTI to coronial information

10.4 Access to non-documentary physical evidence

10.5 Access to inquest exhibits

10.6 Access to records of pre-inquest conferences and inquests

10.7 Responding to subpoenas

10.8 Access for research purposes

In principle

In practice

Who is a genuine researcher?

What is genuine research?

When can investigation documents be released for research purposes?

10.9 Access for tissue banking purposes

10.10 Access by the Children's Commissioner

Chapter 11 – Memoranda of Understanding

11.1 Introduction

Legislation

In principle

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)