State Coroner's Guidelines 2013

Chapter 2

The rights and interests of family members

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2.1 Introduction

The *Coroners Act 2003* represents the most significant reform of the coronial system in Queensland's history. One of its most important features is the explicit recognition it gives to the rights and needs of bereaved families during the coronial process.

While there is much to be said for the therapeutic benefits of the coronial process in its ability to provide answers for bereaved families and give comfort that some good may come from their loved one's death, it must be acknowledged that aspects of the process can be an equally unwelcome and distressing intrusion into a family's grief. Research has shown how families can feel disempowered by the coroner's involvement, particularly in the initial stages of the investigation when the coroner has control of the body and decisions are being made about the extent to which it needs to be forensically examined.

Most families are extremely distressed and traumatised when they first come into contact with the coronial system. They will often have had no prior experience with the State Official response to sudden, unexplained death. The way in which those involved in the coronial system interact with grieving families can either alleviate or exacerbate families' suffering.

Previously Queensland had a coronial system that treated family members as mere observers with no right to participate in decisions about their deceased relatives. There was no recognition of the differing views among cultural and religious groups with regard to the handling of dead bodies. Coroners ordered full internal autopsies in almost all cases and the family's views were not considered in the making of these orders. There was no way for families with concerns about the way their loved one's death was being investigated to have those concerns addressed.

When introducing the Coroners Bill 2002, the then Attorney-General told Parliament:

> *We have designed the new coronial system to be more sensitive and compassionate approach to families. There will be improved information and support, a greater sensitivity to different cultures and beliefs, and families will be given greater access to coronial documents during investigations*.[1]

The *Coroners Act 2003* recognises families are more that just potential witnesses. It gives them the right to have their views considered when issues arise such as the extent of autopsy and to be informed of the coroner's decision to retain organs/tissues for further investigation. They are deemed to have sufficient interest in information and documents pertaining to the investigation of their relative's death, and to be given leave to appear at an inquest into the death. They have a right to receive copies of the coroner's

[1] Hansard, 3 December 2002 at p.5220-1

findings and comments. Families' initial interactions with the coronial system are supported by coronial counsellors. Families who are dissatisfied with certain decisions made by the investigating coroner can seek a review of those decisions by the State Coroner, meaning they have access to a timely administrative review process without the delay or cost of litigation. Proactive case management of coronial investigations can bring relief to families by endeavouring to finalise official inquiries into their relative's death as expeditiously as possible.

This Chapter highlights how the rights and interests of families are recognised and supported not only legislatively but also operationally throughout the coronial process.

2.2 Deciding who is the family member

Legislation

Coroners Act
Schedule 2 Dictionary

In principle

The Coroners Act establishes a hierarchy of relationships that should be considered when it is necessary to determine whose views should be considered by the coroner, and who is entitled to receive information about the death and the investigation outcomes. Coroners and their staff should remain vigilant to the tendency for the trauma of bereavement to exacerbate pre-existing family tensions particularly when an estranged spouse, parent or child may seek to assert rights under the Act that more properly lie with another family member. In many cases, it will be entirely appropriate for the coroner to authorise information release about cause of death and the findings to more than one family member. The coronial counsellors can provide valuable assistance when negotiating volatile family dynamics and resolving dispute among equally entitled family members for the purpose of autopsy, organ/tissue retention and release decision making.

In practice

Family members are generally identified in the Form 1. The coroner's staff and the coronial counsellors use this information to identify the most senior family member according to the statutory family hierarchy for communication purposes. Often the counsellor's initial contact with a nominated family member will result in the identification of a more senior family member or provide the family with an opportunity to nominate their preferred spokesperson.

The Act was amended in 2009 to give recognition to the deceased's documented wishes as to whom should be his or her family member. These amendments also gave the coroner discretion to treat as a "family member", an adult who, immediately before the deceased person's death, had a relationship with the deceased person that the coroner considers is sufficient for being a family member. This discretion can only be exercised when there

is no person in any of the other specified categories available to act as the family member.

Unfortunately the human condition means it is not uncommon for a person's death to ignite pre-existing family disharmony or reveal a formerly secret relationship, resulting in disputes about whose views should be considered when it comes to the coroner's autopsy, organ/retention or release decision making.

When considering these disputes, coroners should first consider the nature of each person's relationship to the deceased person with reference to the 'family member' hierarchy established by the Act. Not infrequently, there will be more than one person who qualifies as the senior family member under the hierarchy, for example, an estranged husband or wife and a recent de facto spouse, or several adult children. It is prudent for the coroner to give each person an opportunity to be heard and this may entail inviting written submissions substantiating their respective claims and the closeness of their relationship with the deceased. Coronial counsellors can provide valuable assistance to coroners in working with family members to resolve these tensions in difficult family dynamics.

While coroners should be vigilant about a family's desire to prevent the coroner from considering the views of another family member or to prevent other family members from accessing information about the death, the coroner is not bound by those views. For example, it can be entirely appropriate for the surviving parent of the deceased's non-adult children from a previous relationship to be given access to cause of death information. In most cases, it is reasonable and appropriate for the coroner to give multiple family members the same degree of access to routine coronial information such as cause of death, autopsy reports and findings.

2.3 Family views about autopsy and organ retention

Legislation

Coroners Act
Sections 19, 21, 24

In principle

The Coroners Act recognises many members of the community have strong views about invasive procedures being performed on their loved one's body. It gives family members have a right to have their views considered when the coroner is making a decision about the extent of autopsy to be ordered. This does not mean families can prevent an autopsy being performed but if a coroner considers it necessary for the investigation to override the family's concerns, the coroner must give the family reasons for doing so. This enlivens the family's right to have the coroner's autopsy decision judicially reviewed.

Past autopsy practices have demonstrated the anguish to families when they later discovered their loved one's body was released without them knowing

organs had been retained.[2] Families now have a right to be informed before the body is released of the coroner's decision to retain organs or tissue for further examination, and retained organs or tissues must be disposed of according to the family's wishes once no longer required for the coroner's investigation. Coroners are required to regularly review the need for continued organ/tissue retention in every case.

Wherever practicable, the family should be consulted when the coroner is giving consideration to a third party request, for example from a treating doctor, to attend and observe the autopsy.

In practice

Attending police are required to canvass the family's attitudes to autopsy and report this information in the Form 1 Police Report of a Death to the Coroner. This information is crucial to the coroner's autopsy decision making.

In practice, a coronial counsellor will contact the family after police have reported the death to a coroner and often before the coroner has made an autopsy decision. The counsellor's initial contact with the family can assist in explaining the autopsy process, clarifying the nature of any concerns the family has about autopsy and accurately communicating this information to the coroner, and in turn often helps the family better understand the basis for the coroner's autopsy decision. It also provides an appropriately supportive mechanism for seeking the family's views about organ/tissue retention and their disposal wishes.

Chapter 5 *Preliminary investigations, autopsies and retained tissue* details how coroners are manage family concerns about autopsy or organ/tissue retention.

The fact there has been no judicial review of coroners' autopsy or organ/tissue retention decisions since the Act commenced demonstrates how the counsellors' involvement at this early stage has helped assuage family concerns about this confronting aspect of the coronial process.

2.4 Communicating with the family

In principle

The family must be must given adequate and timely information about their loved one's death in order for them to participate meaningfully in the coroner's decision making about how to respond to the death. Families of deceased persons should not be denied information about the death just because it has

[2] For example see *The Royal Liverpool Children's Inquiry Report* 30 January 2001 (www.official-documents.gov.uk/document/hc0001/hc00/0012/0012_ii.pdf), *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995* (http://webarchive.nationalarchives.gov.uk/20090811143745/http://www.bristol-inquiry.org.uk/final_report/the_report.pdf) and *Inquiry into Matters Arising from the Post Mortem and Anatomical Examination Practices of the Institute of Forensic Medicine* 17 August 2001 (http://search.records.nsw.gov.au/agencies/2163;jsessionid=A1071EACEF9E733A0B7D2B4DB613610C).

been reported to the coroner. The general principle is that families are entitled to any and all information concerning the death as soon as it is available unless there is a basis for suspecting that to release the information may compromise a criminal investigation.

Research consistently demonstrates that concerns about protecting family members from further distress by shielding them from detailed information about the circumstances of death are misplaced.[3] Careful consideration is required however to ensure that this is done in a sensitive manner and at the appropriate time. The coronial counsellors attached to Queensland Health Forensic and Scientific Services (QHFSS) can provide expert advice in relation to these issues and can act as intermediaries to facilitate the provision of potentially distressing information to family members.

In practice

Assistance of coronial counsellors

The complexities of the coronial system and the role of police can be confusing and intimidating to bereaved families. Coronial counsellors are skilled at providing information about the death in a way least likely to add to the distress of the deceased's relatives. They can also assist in seeking information from grieving families that assists the coroner's enquiries. They play an important role in demystifying the coroner's involvement by explaining the coronial process and its purpose and limitations.

Coronial counsellors are also alive to the possibility that in some cases there may be suspicions about the involvement of relatives in the death and that for this reason those relatives should be given less information than might normally be the case. The counsellors can best juggle these competing needs if they are advised of the suspicions that police have. If properly informed, the counsellors can be relied upon to maintain confidentiality of sensitive information.

Assistance of Aboriginal and Torres Strait Islander Legal Service

If the deceased is an Aborigine or a Torres Strait Islander, contact should be made with the local Indigenous legal service to arrange for a community member to accompany police to advise of the death. Such people will be better equipped to understand the more complicated family structures that exist among some Indigenous people and information they give about the coronial system may be better received or more effectively communicated to other Indigenous people than that supplied by the police. Coronial counsellors regularly engage with community members when communicating with indigenous families about autopsy and other related issues.

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[3] Eyre A., *Improving procedures and minimising distress: issues in the identification of victims following disasters*, (2002) 17(1) Australian Journal of Emergency Management 9
Dix P., *Access to the dead: the role of relatives in the aftermath of disaster* (1998) 352The Lancet

Notification of death

Police are primarily responsible for notifying the family of the death. It is essential that this is done in a sensitive manner and by someone who has adequate knowledge of the circumstances of the death. A failure to provide answers to reasonable questions at this early stage, or at least provide details of those who can give the information sought, is likely to increase the family's distress and has the potential to fuel speculations of a "cover up."

Attending police routinely provide family members with a brochure about the coronial process when they deliver the death message. Understandably many families may not be able absorb this information in the immediate aftermath of the death.

Attending police are required to canvass the family's attitudes to autopsy and report this information in the Form 1 Police Report of a Death to the Coroner. This information is crucial to the coroner's autopsy decision making.

Cause of death information and autopsy reports

The family is entitled to be given as much information as possible about the cause of death and the various steps in the coronial system. They should not be required to wait until the coroner has received the final autopsy report to be informed of the pathologist's opinion as to the cause of death and other inquiries the coroner intends to undertake.

Coronial counsellors play an important role in communicating preliminary autopsy findings to family members when the death is not suspicious. In practice, this often occurs once the post-mortem examination is completed and before the body is released. Families will also receive a copy of the Form 30 Autopsy Notice after the pathologist provides it to the investigating coroner. Coroners should generally provide a copy of the final autopsy report to family members who specifically request it unless doing so may compromise the investigation, for example, because the family member is implicated in the death. Autopsy reports are generally provided with a recommendation that families seek advice about the contents from their doctor or other health care provider. The counsellors can also assist in communicating the autopsy findings to families who may be distressed by the findings. Where appropriate, the forensic pathologist can also be made available to explain his or her findings and opinion to the family.

Information about the coronial process

Coronial counsellors routinely provide families with general information about the coronial process.

Families will also receive an initial contact letter from the investigating coroner enclosing a brochure about the coronial process.

The Office of the State Coroner website also hosts a range of useful information about the coronial process generally and specific aspects of it, for

example, what to expect at an inquest.[4] Coroners' staff should direct families to these resources whenever appropriate.

2.5 Viewing the body and death scene

The therapeutic benefits for bereaved families who have an opportunity to view their loved one's body before burial or cremation are well recognised. Chapter 4 *Dealing with bodies* explains how this important process can and should be accommodated by the coronial process without compromising the integrity of the coroner's investigation.[5]

Coronial counsellors play an important role in assisting police with formal identification viewings and preparing and supporting families who undertake this confronting task. They also play a vital role in arranging supporting families at therapeutic viewings before the body is released.

2.6 Release orders and family disputes

The coroner has control of a deceased person's body from the time the death is reported until the coroner's investigation stops or the coroner decides the body is no longer necessary for the investigation. Timely release of the body for burial or cremation is a significant step in the coronial process that can assist greatly in minimising distress to family members. The release process requires careful and expeditious consideration of the needs of the investigation, the family's wishes and the deceased's cultural or religious beliefs.

Chapter 4 *Release of bodies for burial or cremation* explains the matters a coroner must take into account before ordering the release of the body and provides guidance about how to manage competing claims for possession of the body.

2.7 Case management and keeping families apprised

In principle

Under the previous coronial system, coroners tended to be the passive recipients of investigation reports. Over the past decade, Queensland coroners have increasingly applied a proactive case management approach to their investigations. This recognises that delays in finalising coronial investigation can exacerbate a family's suffering. Coroners should constantly strive to progress their matters as expeditiously as possible and ensure families are regularly informed of the progress of the investigation into their loved one's death, unless doing so could compromise the investigation.

In practice

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

[4] www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications
[5] See specifically sections 4.3 and 4.4

in a timely fashion. Chapter 7 *Investigations* details a range of strategies coroners may consider when investigating different types of reportable deaths.

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.

2.8 Management of family concerns about the death

In principle

Coroners can access an extremely broad range of information to inform their investigations. Families can often provide very helpful information about the deceased person and should always be invited to communicate any concerns they hold about the circumstances of the death to the coroner. Coroners should carefully consider any known family concerns before they finalise their investigation and provide families with a clear indication about the extent to which the coroner considers those concerns warrant further coronial investigation and how the coroner intends to explore them.

In practice

Grief is a very individual process and while some families chose not to engage in the coronial process, others will take the opportunity to express their concerns about their loved one's death at different stages and in different ways during a coronial investigation. Some are able to articulate their concerns in the early stages of the investigation, either in discussion with the coronial counsellors or in writing in response to an invitation to do so in the initial contact letter sent to the family. Others may not do so until after the funeral or later on after receiving the autopsy report or advice the coroner intends to finalise the investigation without an inquest. Families should be encouraged to put their concerns in writing but for those who find this difficult, the coronial counsellors can help these families distil their concerns and convey them to the coroner.

Experience has shown that families can raise a range of issues that may not be relevant to the circumstances of the death. A common example is concerns about unrelated previous health care. It is important that coroners carefully consider any known family concerns and clearly identify which of them he or she considers relevant to the death. Coroners should then advise families which of those issues will be investigated and explain why others the family has raised will not. Often there will be aspects of family concerns that are more appropriately referred to another investigative agency, for example 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.

When obtaining an independent expert review, it is important for any known relevant family concerns to be provided with the investigation material for review so they can be considered and addressed by the expert.

2.9 Access to coronial information

Legislation

Coroners Act
Sections 54(1), (2), (3)

In principle

Families deal with the trauma of bereavement in different ways. Some try to understand as much as possible about their loved one's death by wanting to view investigation reports, photographs of the death scene and suicide notes.
The Coroners Act clearly intended that families be given access to a broader range of coronial information than was made available to them under the previous system. Section 54 specifically envisages the deceased's family as a category of person with 'sufficient interest' in coronial and investigation documents and family members should generally be given access to coronial information at an appropriate time, unless to do so could compromise the investigation. Care should always be taken to ensure appropriate supportive measures are offered, for example, the advice and support of a coronial counsellor, to minimise the risk of exposing family members to psychological trauma when they seek access to graphic and distressing material.

In practice

Chapter 10 *Access to coronial information* explains the access to investigation documents regime generally and details how coroners should manage requests made by family members.

The Act was amended in August 2013 to expand coroners' powers to release investigation documents and non inquest findings and to clarify when access may be given to inquest exhibits. These amendments recognise the family's rights to be consulted and have their views considered when the coroner is considering a public interest release.[6]

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

Legislation

Coroners Act
Sections 11A, 30(1) & (2) & (4), 50(1), 50A(1), 50B(1)-(4)

The Coroners 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

[6] See sections 46A and 54(3) and Chapter 8 *Findings*, section 8.11

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 3 *Reporting deaths* discusses how a coroner's decision about whether a death is reportable can be reviewed.

Chapter 7 *Investigations* discusses how non-inquest investigations can be re-opened, including on application by the family.

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.

2.11 Involvement in inquests

Legislation

Coroners Act
Section 36(1)(c)

In principle

While the Coroners Act specifically recognises family members as a category of person considered to have sufficient interest to appear at an inquest, not all families wish or have the means to do so. Consideration must always be given to ways in which families can participate meaningfully in an inquest should they wish to do so.

In practice

While Chapter 9 *Inquests* canvasses matters including the considerations a coroner should take into account when considering whether an inquest is warranted and the process by which an inquest is convened and held, it is worth flagging here those aspects where special consideration should be given to the family's rights, needs and interests during the inquest process.

Notification of coroner's decision to hold inquest

The family must always be notified of the coroner's decision to hold an inquest and the issues proposed to be investigated at inquest. This enables the family to consider and if necessary seek advice about whether they should be represented at the inquest. Counsel Assisting can play an important role in helping unrepresented families family understand the inquest process generally and explaining the intended scope of the inquest, the witnesses proposed to be called, the role of Counsel Assisting and the ways in which the family can participate should they wish to do so.

Access to brief of evidence

The family is entitled to a copy of the brief of evidence regardless of whether they are legally represented or intend to seek leave to appear at the inquest.

Access to this information prior to the inquest helps the family better understand the evidence and the issues to be explored with various witnesses. Care should be taken if the brief contains graphic images in which case it is advisable to remove these items from the brief before it is provided to the family with advice this information is available should they wish to access it.

Standing to appear at inquest

Section 36 of the Act specifically recognises family members as having sufficient interest to appear at an inquest and to examine witnesses and make submissions. It is difficult to envisage circumstances in which a coroner could reasonably reject a family member's application for leave to appear.

Role of Counsel Assisting when family not separately represented

Many families chose not to seek leave to appear, preferring instead to observe the inquest from the gallery. In these cases, Counsel Assisting should ensure he or she speaks with the family before the pre-inquest conference to give the family an opportunity to communicate any specific issues or witnesses they would like the coroner to consider. Although Counsel Assisting clearly plays no representative role in relation to the deceased's family, the role has traditionally ensured the views and concerns of unrepresented families, where relevant to the circumstances of the death, are appropriately ventilated at inquest. This can be achieved a number of ways for example, by Counsel Assisting advising the court and the parties of any specific issues the family wishes to have examined; inviting a family member to give evidence at the start of the inquest so they have an opportunity to speak to their concerns, canvassing specific questions posed by the family when examining witnesses or seeking leave for the family to approach the bench to do so themselves, or handing up the family's written submissions.

Opportunity to be heard

Families who are given leave to appear at inquest have the right to examine witnesses and make submissions. It is generally appropriate for the coroner to invite submissions from a family who does not appear provided all the parties are given an opportunity to consider and respond to them.

Recognition of deceased person in life

The coronial process is very much focused on the deceased's final moments and the events leading to the death, often at the expense of recognition of who the deceased was in life. Coroners are encouraged to invite families to provide the court with a social history for their loved one so this information can be reflected in the coroner's findings if considered appropriate.

2.12 Right to receive findings and comments

Legislation

Coroners Act
Sections.45(4)(a), 46(2)(a)

Families have a right to receive a copy of the coroner’s findings and comments. The Coroners Act requires the coroner to provide a copy to the family member who has indicated he or she will accept the findings on the family’s behalf. In practice this will be the most senior family member identified at the outset of the investigation, unless the family subsequently nominates an alternative contact person.