State Coroner's Guidelines 2013

Chapter 11

Memoranda of Understanding

Introduction

A coronial investigation is often but one of a range of investigative responses to a reportable death. The circumstances of a death may also invoke scrutiny by Commonwealth and State entities including the Australian Transport Safety Bureau, Civil Aviation Safety Authority, Australian Defence Force, police, ombudsman, aged care and health regulatory agencies or workplace health and safety or specific industry regulators. While the focus of each entity's investigation will differ, there is often some overlap between the coroner's role and that of other investigative agencies. The State Coroner has entered into arrangements with a range of government entities to clarify their respective roles and responsibilities when investigating a reportable death.

Legislation

Coroners Act
Sections 10A, 54A, 71

In principle

It is desirable for the State Coroner to enter into arrangements with other entities whose statutory or administrative functions intersect with coronial investigations of reportable deaths. These arrangements should aim to clarify each agency's role in respect of a reportable death, rationalise investigative effort and improve co-ordination and information sharing between the coroner and that agency.

In practice

The State Coroner has entered into the following memoranda of understanding (MOU):

Protocol between the Australian Defence Force and the Queensland State Coroner concerning the deaths of ADF members

This protocol deals with the investigation of reportable deaths of ADF members in the course of the member's service irrespective of whether the death occurs within or outside Australia. It also extends to deaths incidental to or connected with a member's service, for example, by suicide or accidental drug overdose.

It recognises the ADF's power to oust the coroner's jurisdiction in certain circumstances and to undertake administrative inquiries to determine the circumstances of an ADF member's death.

The protocol establishes an ADF Liaison Officer to act as the primary point of contact between the ADF and the State Coroner. This officer co-ordinates matters including information requests, requests to de-classify information, requests to release information and secondment of ADF personnel to help an investigation.

It deals with matters including notifying reportable deaths occurring outside Australia, managing and examining the incident scene when a death occurs in

the course of a member's military duties in Australia, autopsy arrangements, communicating the findings of defence initiated inquiries, notifying inquests and managing applications for non-publication orders having regard to issues of national security.

Investigation of death arising from police related incidents (2008)

This MOU is between the Police Commissioner, State Coroner and the Crime and Misconduct Commission, now known as the Crime and Corruption Commission (CCC).[1] It establishes operational arrangements for the investigation of police related deaths. Under these arrangements, the QPS Ethical Standards Command investigates the death, subject to the CCC exercising its power to assume responsibility for the investigation. It requires consultation with the State Coroner about the allocation of appropriate police resources to these investigations. It limits media releases about these deaths to a brief description of the factual circumstances of the death and advice the matter has been reported to the State Coroner and the CCC.

Protocol between the State Coroner and the Health Ombudsman (2014)

This protocol replaces an MOU between the former Health Quality & Complaints Commission,, Australian Health Practitioner Regulatory Agency, former Office of Health Practitioner Registration Boards, State Coroner, former, Crime and Misconduct Commission, Queensland Police Service Queensland Ombudsman and former Commission for Children and Young People and Child Guardian for the co-ordination of responses to serious adverse health incidents.

From 1 July 2014, the Office of the Health Ombudsman (OHO) became the single point of entry for health service complaints in Queensland, taking over the responsibilities of the former Health Quality & Complaints Commission and assuming certain responsibilities from the Australian Health Practitioner Regulatory Agency for disciplining registered health practitioners.[2]

This protocol recognises the overlapping jurisdictions of the State Coroner and the Health Ombudsman in relation to reportable deaths. It establishes arrangements aimed at timely notification of matters, co-ordination of concurrent investigations and information sharing.

The MOU requires the Office of the State Coroner (OSC) to notify OHO as soon as practicable of any death where there are serious concerns about the quality of health care provided to the deceased. In the event OHO receives information that a death may be reportable but may not have been reported, OHO is to notify OSC without delay.

[1] The Crime and Misconduct Commission was renamed the Crime and Corruption Commission from 1 July 2014 by virtue of amendments made by the *Crime and Misconduct and Other Legislation Amendment Act 2014*.
[2] http://www.oho.qld.gov.au/

Agreement between the former Commission for Children and Young People and Child Guardian and State Coroner and Chief Executive of the Department of Justice and Attorney General (2011)

This agreement was made to facilitate the requirements of sections 10A and 54A of the Coroners Act which are designed to support the then Commissioner's child death functions under the *Commission for Children and Young People and Child Guardian Act 2000*. These functions relate to collecting, analysing and reporting on child mortality data to identify patterns and trends, conduct research and make recommendations.

The agreement establishes the process by which the CCYPCG is notified of a reportable child death, receives coronial findings, autopsy and toxicology reports and accesses other coronial investigation documents.

It requires the CCYPCG to notify the investigating coroner of any potential systemic or service delivery issue identified by its routine review of all child deaths.

The agreement also sets out the circumstances in which the CCYPCG may provide coronial investigation documents to other advisory committees, for example, the sudden unexpected death in infancy (SUDI) Advisory Committee.

From 1 July 2014, the Commissioner's child death functions transferred to the Family and Child Commissioner.[3] This agreement has since been updated to reflect the establishment of the Family and Child Commission.

Further details of these procedures are set out in chapter 10.

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)

This MOU deals with the respective roles and responsibilities of the agencies (QPS and Office of Fair and Safe Work Queensland) involved in the reporting, attendance at and investigation of workplace incidents, electrical incidents and diving incidents. Under these arrangements, QPS is the lead investigator in any workplace or electrical fatality, which by their very nature are reportable deaths. The OFSWQ investigation is limited to the extent to which the incident relates to its jurisdiction under the *Work Health and Safety Act 2011* and the *Electrical Safety Act 2002*. The MOU also establishes arrangements to ensure the investigating coroner is provided with a report for each OFSWQ investigation of a reportable death.

[3] See *Family and Child Commission Act 2014*, Part 3 (Child deaths)