State Coroner's Guidelines 2013 Outline

QUEENSLAND COURTS

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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)

State Coroner’s Guidelines 2013

Chapter 1

Introduction and the scope of the coroner’s role

1.1 Introduction

In order to ensure best practice and consistency in the coronial system the state coroner is obliged by s.14(1)(b) of the *Coroners Act 2003* to issue guidelines to local coroners stipulating matters to be taken into account when the discretions vested in them are being exercised. Guidelines may also be issued to any persons carrying out a function under the Coroners Act – s. 14(4).

When investigating a death, a coroner must comply with the guidelines and any direction issued to the coroner to the greatest practicable extent – s. 14(5).

These are those guidelines. They are intended to assist coroners to discharge their responsibilities. They will undoubtedly change over time and comments or suggestions from those working in or with the coronial system are always welcome.

The office of coroner is ancient and its development fascinating. It can be traced at least to 1194, although the role has obviously changed extensively in the intervening years. For those interested in this history the references below will assist. It is important to note, however, that unlike the position in say, NSW, the common law is expressly overridden by s. 104 of the Coroners Act which is in effect a codification of the law. The Coroners Act creates the jurisdiction and governs the powers and duties of coroners.

The *Coroners Act 2003* emphasizes:

- the desirability of a more consistent, efficient and transparent coronial system
- the right of family members to be involved in coronial investigations
- the need for coroners to seek to contribute proactively to a safer and more just community.

The Act seeks to facilitate the attainment of these objectives through various mechanisms including the appointment of a state coroner with power to issue guidelines and give directions to local coroners; an obligation on coroners to consult with and inform family members about key decisions; greater emphasis on coroners making preventative recommendations; and the centralisation of data collection.

The primary focus of coronial investigations is not whether someone should be held criminally or civilly liable for a death, although that may be an eventual outcome in some cases. Rather, more effort will be devoted to identifying the root cause of the incident that precipitated the death with a view to analysing systemic failures that contributed to the death and designing remedial responses.

The rigour, diligence and thoroughness with which coroners scrutinize unexpected deaths are a vindication of the value of life. Commitment to a just outcome and a meticulous approach to its pursuit are essential, but do not ensure success because coroners need to try to balance and reconcile competing interests. For example, the resolution of forensic questions must be tempered with reference to deeply held personal, religious and cultural beliefs that may come to the fore in times of tragedy: sometimes a coroner will forgo seeking to establish all of the facts relevant to understanding the circumstances of a death if there is no basis to suspect a serious wrong has occurred and the family of the deceased believe further investigation would be unduly intrusive. The coronial counsellors can assist mediate these and other issues with family members.

The identification of avoidable risks and recommendations designed to ameliorate them provides an opportunity for something positive to come from calamity. However, when analysing current practice and designing preventative recommendations the tendency to extrapolate from the single incident under investigation without sufficient regard to the frequency with which good outcomes are secured by the status quo must be avoided. Recommendations must have a sound evidentiary basis. The section on inquests contains suggestions about how this might be achieved.

The coronial system is inter-disciplinary: it depends on the cooperation and expertise of professionals from numerous agencies and organisations. That a coroner can not have personal knowledge of all matters relevant to a coronial investigation was elegantly explained 140 years ago by the great novelist George Eliot who wrote:-

> *'In my opinion,' said Lydgate, 'legal training only makes a man more incompetent in questions that require knowledge of another kind….A lawyer is no better than an old woman at a post mortem examination. How is he to know the action of a poison?'*
>
> *'You are aware I suppose, that it is not the coroner's business to conduct the post mortem, but only to take the evidence of the medical witness?' said Mr Chrichely, with some scorn.*
>
> *'Who is often as ignorant as the coroner himself,' said Lydgate.*[1]

However the coroner is at the centre: he or she is primarily responsible for ensuring the other participants play their parts appropriately. Hopefully these guidelines will assist coroners to do that.

Above all, coroners must ensure that familiarity with the processes of death investigation does not lead to their forgetting that for most people, involvement in the coronial system is a uniquely distressing experience. Compassion and patience in all dealings with those affected by the deaths investigated is essential.

1.2 The scope of the coroner's role

In principle

The role of a coroner is to:

- supervise the investigation
- direct the inquiry to ensure all necessary evidence is gathered
- preside over an inquest
- make the findings required by the Act and any appropriate preventative comments.

In practice

A coroner is in control of a death investigation from the time a death is reported under s. 7 until the coroner stops investigating the death and makes the necessary findings. While the investigative steps may be undertaken by police officers, pathologists or other forensic experts, they are acting as the coroner's agents and are subject to the coroner's direction.

[1] Eliot G, *Middlemarch*, ch 16

In an *inter partes* matter, it is the parties' role to determine the scope of any pre-trial inquiries, what witnesses are called and what information is put before the judicial officer who remains aloof from that part of the proceedings and adjudicates upon the evidence put forward by the parties after having regard to their submissions.

In an investigation and/or inquest commenced when a death is reported under the Coroners Act there is no such separation of function. The coroner identifies the issues to be investigated and the means by which that should happen. The coroner determines whether an inquest will be held, who will be given leave to appear and what witnesses will give evidence. It is appropriate for the coroner to consult on these issues with the family member and other parties who may have an interest in the inquiry. However, it is the coroner who is principally responsible for directing the course of the investigation and/or inquest and for ensuring the gathering of all information necessary for a thorough examination of the cause of death and of the means by which the likelihood of similar deaths can be reduced. It is the coroner on whom the Act places the responsibility of making the findings set out in s. 45.

When one considers that a coroner can issue and execute search warrants, instruct police on what inquiries should be made, require witnesses to answer even incriminating questions, obtain reports from experts of their choosing, is not bound by the rules of evidence, there can be no doubt the role is very different from that discharged by a magistrate adjudicating in civil litigation or criminal charges. It is essential the different purposes this system is designed to achieve are vigorously pursued and the different role the coroner plays is recognised and acted upon.

Even though a coroner can no longer commit a person to trial, as was authorised by earlier Acts, it would be disingenuous to suggest the criminal justice system and the coronial system are completely separate and discrete. Indeed the Act makes specific provisions for coroners to refer information to prosecutors - see s. 48. Similarly, although the Act in s. 45(5) and s. 46(3) prohibits a coroner from purporting to determine questions of civil liability, it is common for litigants to seek evidence for use in such proceedings via the coronial process. Approaches coroners might utilise to reduce the likelihood of their proceedings becoming focussed on issues that should better be contested in other proceedings are discussed in chapters 7 and 9 which deal with investigations and inquests. However, in some cases complete separation or compartmentalisation of the coronial, civil and criminal aspects of a death investigation is not possible or desirable. Coroners are required to find 'how' the person died; a question that is often central to civil or criminal proceedings. Evidence discovered by coroners will often be crucial to civil or criminal cases. This overlap should not discourage coroners from discharging their statutory duties.

Summary

Coroners need to be involved in determining what issues should be investigated and how they should be pursued, guided by the experts with whom they collaborate. The focus is on establishing as far as is reasonably possible, the circumstances of the person's death and considering whether changes could reduce the likelihood of similar deaths or to otherwise contribute to public safety or improvements in the administration of justice.

1.3 Further reading

Jervis on Coroners 12th ed

Halsbury's Laws of England Vol 9(2) (2006 Reissue), paras [903]-[904]

Knight, B. (1999) *History of the Medieval English Coroner System*. http://www.Britannia.com/history/coroner1.html

McKeough J, *"Origins of the Coronial Jurisdiction"* (1983)6 UNSWLJ 191

Freckleton I & Ranson D, *Death Investigations and the Coroner's Inquest* Oxford UP, Melbourne, 2006, pp 35ff.

State Coroner's Guidelines 2013

Chapter 2

The rights and interests of family members

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.

[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.

State Coroner's Guidelines 2013

Chapter 3

Reporting deaths

3.1 Introduction

The objectives of the Coroners Act can only be met if coroners receive timely notification of the deaths they are charged to investigate. Efforts to ensure a death is properly identified as reportable and referred to the coroner for consideration ensure the opportunity for appropriate investigation, including autopsy where one is warranted, is not lost and the coroner's ability to investigate the cause and circumstances of a person's death is not compromised.

This Chapter explains the various categories of reportable death with a view to helping identify when a death is reportable and provides guidance about how the obligation to report a death can be met. It also explains the circumstances in which the coroner's jurisdiction to investigate a suspected death is triggered.

3.2 What is a reportable death?

Legislation

Coroners Act
Section 8

In principle

Deaths where the causes are uncertain, are violent (including deaths that are the result of any trauma) or suspicious, or are otherwise untoward or occur in particular circumstances that warrant receiving special attention must be reported to a coroner for scrutiny.

In practice

In common with all modern coronial systems, the Act draws a distinction between deaths that result from the effect of natural disease and/or old age and those where the cause is uncertain, violent, and/or suspicious or occurs in circumstances where the state has accepted greater responsibility for the welfare of the deceased. These are *reportable deaths* pursuant to sections 8, 9, 10 and 10AA.

It is important a clearly articulated and recorded decision is made in relation to this issue as soon as possible after a coroner is made aware of a death. This is because unless a decision is made that the death is reportable, a coroner has no right to exercise any of the powers under the Act.[1] Indeed the intrusion into the grief of the family and the interference in how they might otherwise choose to respond to the death would be reprehensible.[2]

[1] The Act allows a coroner to exercise powers when undertaking a preliminary investigation to determine whether a death is reportable – see Schedule definition of *investigate*
[2] For judicial comment on the need to avoid unwarranted involvement in non "reportable deaths" see R V Price (1884) 12 Q.B.D. 247 at 248

Apparently reportable deaths

In practice, whether a death enters the coronial system is dependent upon whether a doctor is able to issue a cause of death certificate pursuant to section 30(1) of the *Births Deaths and Marriages Registration Act 2003.* A doctor may do so if, as a result of attending upon the deceased when the person was alive, examining the body after death, or considering other information such as medical records etc, the doctor is *able to form an opinion as to the probable cause of death.* Issuing a certificate may enable the death to be registered under that Act without the involvement of a coroner.

The authority to issue a cause of death certificate is limited by s. 26(5) of the *Coroners Act 2003* which provides that a cause of death certificate must not be issued if it *appears to the doctor to be a reportable death, unless a coroner advises the doctor that the death is not a reportable death.* A coroner can do so if, on being apprised of the circumstances, the coroner comes to the view that the death is not a *reportable death* and accepts that the doctor has sufficient basis for the proposed diagnosis. Coroners should ask the doctor to provide a copy of the certificate so the doctor's consultation with the coroner about the death can be recorded in the Coroners Case Management System (CCMS) and staff can respond to any subsequent enquiries about whether the death was reported.

Given s. 11A of the Act now provides for a review of such decisions as to reportability by the State Coroner (or the District Court if the State Coroner made the decision), the reasons for making that decision, in anything that is not otherwise straightforward, should be recorded by the coroner either in the form of a file note, or on a Form 1A and noted in CCMS.

For deaths in hospitals, it is recommended that where it is initially unclear if the death is reportable, the body should remain in the hospital mortuary until the situation has been clarified with the coroner. Only when the coroner decides the death is reportable and requires an investigation, (and this will usually be after a review of the medical information, possibly with assistance from a forensic pathologist or forensic medical officer), should the body be transferred to a mortuary for an autopsy. It is accepted that outside of greater Brisbane, such decisions may have some practical problems due to transport logistics and the capacity of smaller facilities to hold bodies. The circumstances in which the body may be released to the family's funeral director during the coroner's preliminary investigation are dealt with in Chapter 4 *Dealing with bodies*.

Location of Death

To be reportable, deaths must satisfy the locality element of the definition which requires a connection with Queensland - see s. 8(2) - and come within one of the causal or situational categories set out in s. 8(3).

In most cases the locality requirement is unlikely to be problematic, given most deaths reported happen in Queensland.

In some cases the death may have been caused by an event that happened in Queensland e.g. a motor vehicle or aircraft crash, but the body is retrieved to a hospital interstate and the person died there.

In such cases s. 71A provides for the State Coroner to request his or her counterpart in another State to provide assistance, such as by asking for an autopsy to be conducted.

The juxtaposition of s. 11(4)(b) and 12(1), is that deaths which have sufficient Queensland connection but occur outside the state or Australia should not be investigated unless directed to do so by the State Coroner or the Attorney-General. For instance, the Australian Defence Force and the State Coroner have entered into a Memorandum of Understanding to provide coronial autopsies for defence personnel who die overseas whilst engaged in defence activities, subject to the direction of the Attorney-General.[3]

On some occasions, deaths that occur in International waters on merchant or cruise ships or in overseas locations and the body is brought back to Australia, are provided with autopsies. This can often provide some degree of confidence to bereaved families as to the cause of death where they may otherwise have considered the death was suspicious. Again any such decision must be subject to the direction of the Attorney-General.

In such cases the Coroners Court of Queensland should be contacted for advice on the procedure for applying for a direction from the Attorney-General.

It is not known who the person is

Unknown corpses can readily be divided into three categories:-

- One or a small number of bodies found in a place unconnected with habitation or occupation, for example, in a river or a shallow unmarked grave. Vagrants or joggers as well as the victims of suicide or homicide are examples of these types of corpses. These bodies may be completely unidentified at the time of discovery and may require exhaustive investigation as foul play may be involved or at least reasonably suspected.

- A body found in a usual place of habitation about which there is a sound basis for asserting an identity but little proof in the legal sense. This can often be overcome by tracking down relatives who can give visual identification evidence, or resort may be had to fingerprints or dental records. Once this matter is resolved, and unless the death falls under one of the other reportable death headings in s. 8(3), the case can be finalised by the coroner either accepting a cause of death certificate if satisfied the death is from

[3] See Chapter 11 Memoranda of Understanding

natural causes or authorising an autopsy (external if that is sufficient) and making the findings required by s. 45.

- Multiple fatality disasters – these will almost always require an exhaustive inquiry which will, among other things, allow identification of the victims to occur via various means including DNA analysis if necessary.

In all cases identification is important for a variety of reasons including:-

- social and emotional responses
- legal ramifications - criminal and civil liability and/or succession issues may be at stake
- public health issues
- public safety considerations when mass deaths occur in transport or engineering disasters, etc.[4]

For discussion concerning the various methods which can assist with establishing identity see section 8.2 of these guidelines.

The Form1A should not be used to report these deaths.

Violent or otherwise unnatural deaths

Violent deaths, together with those involving lesser degrees of trauma, fall within the spectrum of unnatural deaths and, generally, are readily identifiable.

Traditionally, *unnatural* deaths are defined as those due to accident, suicide or homicide. Section 8(3) clarifies that the concept includes a death at any time from an injury that directly caused the death, for example, a subdural haematoma sustained in a mechanical fall, or contributed to the death and without which the person would not have died, for example, a death from complications of traumatic injuries sustained in a motor vehicle accident years previously. Such deaths contrast with those due to *natural causes* such as heart attack, cancer, stroke or infectious illness.

Infectious disease deaths

Deaths from infectious conditions warrant special mention. Where the condition was acquired through ordinary exposure to the infecting organism in its natural state in the environment the death is a generally natural causes death and not reportable. This holds for clinically suspected or confirmed diagnoses of communicable infectious diseases like influenza and whooping cough, zoonotic viruses such as Hendra virus or Australian bat lyssavirus or from foodborne illnesses e.g. listeria or salmonella. These natural causes infectious deaths are more appropriately the focus of public health responses. However, the circumstances in which an infectious

[4] For a discussion of the need for identification and the scientific means by which it can be achieved see Mason J K, *Forensic Medicine for Lawyers*, Butterworths, London, 4th edn, 2001 at p47

condition was acquired or managed may make the death reportable as the examples below demonstrate:

1. A man with chronic lung disease dies from community acquired pneumonia. Provided there is no suggestion of inadequate or delayed treatment and the death is not a death in care, this is regarded as a natural causes death and is not reportable.

2. A woman undergoes surgery and dies from complications of a treatment resistant hospital acquired infection. She acquired the condition which caused her death only because she was receiving health care. Consequently the death is reportable via a Form 1A.

3. A child's death from meningococcal disease is generally considered a natural causes death and not reportable, unless there was a failure by medical personnel to diagnose the signs and symptoms of the disease, in which case the death is reportable as a potentially health care related death

The reportability of deaths from Legionnaires' disease illustrates some artificiality about the coronial management of infectious disease deaths. The confirmed Legionnaires' death of an immunocompromised hospital patient who contracted the disease from the hospital's contaminated hot water system has been deemed reportable as a health care related death because the condition was acquired as an unexpected consequence of receiving health care. However, the death of a person who acquired the condition in other than a health care context is generally considered a natural causes death and not reportable, for example, the death of an avid gardener who contracted the disease from exposure to potting mix and compost, or that of an office worker who acquired the infection from the air conditioning system at his place of employment. One might argue there are potential systemic issues warranting coronial scrutiny of the circumstances in which infectious diseases are acquired in a non-health context. However, as currently drafted, the Coroners Act does not allow coroners to pursue these deaths when there is a confirmed clinical diagnosis.

Lifestyle and industrial diseases

By convention, diseases due to the longstanding effects of repeated or relatively low-level exposure to chemicals are generally not regarded as unnatural. One reason for this is that the diseases that ultimately develop often involve the complex interplay between multiple environmental and genetic factors. Diseases arising in this way include cirrhosis in chronic alcoholics, lung cancer in smokers, bacterial endocarditis in long term intravenous drug users, mesothelioma in asbestos workers, and dust-induced lung diseases in certain occupations. Such diseases are

regarded as natural, even though death from the ingestion of other drugs such as opiates etc are not when they result in immediate death.[5]

Specific causes of unnatural deaths can be divided into three broad categories:

- acute effects of or intoxication with chemicals (e.g. alcohol, drugs, poisons)
- deprivation of air, food or water (e.g. asphyxia, drowning, dehydration, starvation)
- physical factors (e.g. trauma, fire, cold, electricity, radiation)

Deaths where neglect or inadequate or delayed efforts by the person's carer to obtain treatment have, or may have, contributed to the death should be reported and arguably may be regarded as *unnatural* under the *deprivation* category.

Deaths should still be regarded as unnatural even when the causative event occurred a substantial period prior to death. In those cases there is frequently some complication that actually causes the death but if it is attributable to the initial injury the death can be said to be unnatural and therefore reportable.

Examples:

1. *An elderly person falls and fractures her femur. While in hospital she develops pneumonia and dies. It is unlikely she would have contracted pneumonia had she not been immobilised and therefore the death can be attributed to the fall.*

2. *A heavy smoker dies of lung cancer after a lengthy illness. Although unnatural in the sense of being probably caused by smoking, such deaths are conventionally regarded as natural – and are not reportable.*

3. *A man dies from a complication of hypoxic brain damage resulting from alcoholic intoxication that occurred one year previously. The underlying causative event is unnatural and the death is reportable.*

4. *A child dies from a complication of infection, the portal for which was skull fractures sustained in a serious motor vehicle accident two years previously. The underlying causative event is unnatural and the death is reportable.*

4. *A chronic alcoholic develops cirrhosis of the liver over a number of years and dies of liver failure. He was not intoxicated at the time of death. By convention, chronic alcoholism and its complications such*

[5] See Matthews P., Foreman J., *Jervis on the Office and Duties of Coroners*, Sweet & Maxwell London, 11th edn, 1993 at p136

as cirrhosis and cardiomyopathy are regarded as natural diseases. The death is not reportable.

5. *A drug addict dies from heroin toxicity due to accidentally injecting too much heroin. The cause of death is unnatural and the death is reportable.*

6. *A drug addict acquires HIV infection from dirty needles and ultimately dies of AIDS. By convention, this cause is regarded as natural and the death is not reportable.*

7. *A long term intravenous drug user dies from bacterial endocarditis. By convention, this condition is regarded as natural disease even though it was acquired as the result of drug use. The death is not reportable.*

The conventional distinction between natural and unnatural deaths reflects the distinction adopted by the World Health Organization in ICD-10[6] between natural and 'external' causes. The Australian Bureau of Statistics uses ICD-10 to classify causes of death entered on death certificates.

Deaths due to the combined effects of natural and unnatural causes may be more problematic. The test should be whether an unnatural cause has contributed significantly to the occurrence of death.

Examples:

1. *An independent 90-year-old woman with severe osteoporosis turns over in bed and fractures the neck of femur. Despite optimal treatment, she dies in hospital four days later from pneumonia. If osteoporosis is the predominant underlying cause of the fracture, the death should be regarded as natural and is not reportable.*

2. *A 90-year-old woman with severe osteoporosis sustains a significant fall on some steps and fractures the neck of femur. Despite optimal treatment, she dies four days later in hospital from pneumonia. In this example, the fall should be given greater significance and the death regarded as unnatural and hence reportable.*

Deaths in some unusual situations may be difficult to classify as natural or unnatural. As with pneumonia complicating a fractured femur, the immediate cause of death may be natural and yet the underlying event initiating the train of events leading to death may be unnatural.

Examples:

1. *An elderly overweight person with a history of heart disease dies suddenly from a presumed pulmonary embolus two weeks after flying to Australia from Europe. There are sufficient predisposing natural*

[6] International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, WHO 1992, Volume 1, Chapters XIX and XX

factors operating independently of the flight to regard the death as natural. Assuming that a treating doctor can make the diagnosis, a medical certificate of the cause of death could be issued. However, as the death is borderline it would seem to be caught by s. 26(5)(a) – a death that may 'appear' to be reportable and so it should be referred to a coroner on a Form 1A.

2. *A young woman who is pregnant dies suddenly from a presumed pulmonary embolus two weeks after flying to Australia from Europe. The death is likely to be reported to the coroner because no doctor is in a position to form an opinion as to the probable cause of death. However, if a treating doctor could form such an opinion, it is debatable as to whether the death is reportable, given that pregnancy can predispose to deep vein thrombosis of the legs and pulmonary embolism. If such a death is reported, the coroner should consider whether arguably unnatural factors such as dehydration and immobility during the long flight may have contributed significantly to the occurrence of death. Again this death would best be referred to a coroner on a Form 1A as an apparently reportable death or as a reportable death, if the doctor considered no further investigation was warranted.*

In these difficult situations, coroners should seek the advice of a forensic pathologist or Clinical Forensic Medicine Unit (CFMU) doctor before making a decision the death is a reportable death. There may be no right or wrong answer in these borderline cases where reasonable minds might *differ, but the reasons for making a decision as to its reportability should* be recorded.

These deaths should always be reported directly to police. The only exceptions are mechanical fall-related deaths which should be reported by the Form 1A process.

Suspicious circumstances

The term 'suspicious' is not defined and given its wide scope is not straightforward in the coronial context. Many suspicious deaths will also be reportable under the 'violent and unnatural' head of jurisdiction. Deaths that are not reported under that category but otherwise appear unnatural should be reported as suspicious, unless the coroner who is consulted can be strongly persuaded that neither the actions nor inaction of a third party contributed to the death.

Although usage varies, deaths in 'suspicious circumstances' are essentially those where homicide is either suspected or cannot be excluded, at least in the initial phases of the police investigation.

Frequently it is clear the death is unnatural (e.g. drowning, drug overdose), but unclear whether another person has been involved. Occasionally, it is initially unclear whether the death is from natural or unnatural causes – and if the latter, whether another person was involved.

Example:

A man is found dead at home covered in blood. Although the premises are secure and undisturbed, police (rightly) treat the death as suspicious. Medical records later reveal that he suffered from a natural disease (e.g. cirrhosis, lung cancer, peptic ulcer) that could cause coughing/vomiting copious amounts of blood and rapid death or a post mortem CT scan found a ruptured aortic abdominal aneurysm.

In these and similar instances, the coroner, having discussed the circumstances with police and relevant doctors, has several options, depending on the extent to which the coroner is satisfied that neither the actions nor inaction of a third party contributed to the death, and that the cause of death can be sufficiently identified:

- regard the death as **not** reportable and authorise a doctor to issue a cause of death certificate pursuant to s. 26(5)(a) with the decision in a file note and in the CCMS.

- order an external examination to exclude significant injuries to the deceased and discuss with the pathologist whether further examination is needed to establish the cause of death.

- order a partial or full autopsy of the deceased and have the matter fully investigated, with findings made under s. 45.

In practice, these deaths will always be reported directly to police.

Health care related death

Legislation

Coroners Act
Section 10AA

It is perhaps a unique characteristic of hospitals and other health care facilities that people frequently die in them without there being any reason to suspect that anything has ‘gone wrong’. For this reason, death in a hospital or nursing home is less likely to attract the same degree of scrutiny by external agencies as would occur if the death happened in another setting. However, the relatives of a patient who dies may feel that the cause of death has not been adequately explained to them or they may suspect that it could have been avoided with better care. There is evidence that such suspicions may have some foundation.[7] There is also

[7]. Research undertaken by the Cwth Department of Human Services and Health in 1994, the *Quality in Australian Health Care Study*, found that 16.6% of all admissions in the sample were associated with an ‘adverse event’, 51% of which were preventable and 4.1% of which resulted in death. Extrapolated nationally, this represented 14,000 avoidable deaths.

evidence that many of these deaths are not reported to coroners[8] which, if accepted, suggests that coroners need to be proactive in encouraging the health care sector to be better informed as to the obligation to report such deaths. Part of that message must be that the reporting of a death to a coroner does not imply that the treating doctor has done anything wrong.

There is no evidence that numerous avoidable deaths are being deliberately hidden from coroners; indeed in view of the number of different people involved in the care of patients in large hospitals that would require a fairly complex conspiracy.

However, the Queensland Public Hospitals Commission of Inquiry into the well documented events occurring at Bundaberg Hospital has shown, with only one of the deaths reported to a coroner, that increased vigilance is necessary.

The person in the best position to know whether the death was avoidable will often be the person whose failing may have led to the death, or a supervisor or colleague of that person. In such cases obvious sensitivities and risk management issues arise. Hospitals and other health care facilities need to be encouraged to see the reporting of such deaths as part of their accountability and quality assurance mechanisms rather than an attack on the professionalism of their staff. In short, it is an opportunity to identify 'system problems' that may have caused or contributed to death – and might, if not identified, do so again in the future.

As a result of the Queensland Public Hospitals Commission of Inquiry (the Davies Report) an expansion of the definition of what are reportable 'health care related' deaths, combined with introducing stricter standards for review of adverse incidents within both the public and private hospitals,[9] has meant more hospital deaths are being reported or referred to the coroner for independent review.

The concept of health care related death now captures not only deaths resulting from the provision of health care but also those resulting from a failure to provide health care.

Health care or a failure to provide it can be the direct cause of a person's death, for example, a surgical error or missed diagnosis, or it can contribute to the person's death meaning the person would not have died when they did but for the health care they received or had they received health care.

To be reportable, the death must be a reasonably unexpected outcome of either the health care provided or a failure to treat. In practice, this means either the health care was given with an expectation the person was

[8] See Ranson D., *How effective? How efficient? The Coroner's role in medical treatment related deaths*, Alternate Law Journal vol 23, no. 6, 1998 p.284 at p.285

[9] For example, the legislative framework for root cause analysis under the *Hospital and Health Boards Act 2011*

unlikely to die because of it, or a decision not to treat was made with an expectation the person was unlikely to die without receiving treatment.

Section 10AA imports a measure of objectivity into the concept of health care related death by making it clear the assessment of whether the death was not reasonably expected is one of an independent appropriately qualified clinician apprised of all the circumstances of the matter, rather than the perceptions of those directly involved in the person's care.

Importantly, the concept recognises considerations such as the person's state of health, the clinically accepted range of risk associated with the health care they received and the particular circumstances in which the health care was provided. For example, a 97 year old woman with multiple co-morbidities whose family, knowing she was a high surgical risk, insist on her having surgery to manage a large aortic aneurysm. Her death during the surgery or her failure to recover from it would not be reasonably unexpected in these circumstances and would not be reportable.

Some deaths associated with health procedures may be inherently reportable for other reasons. For example, many deaths due to trauma undergo surgery prior to death, and are reportable because of the trauma as violent unnatural deaths, regardless of the health procedure.

In deciding whether a death is reportable under this category, coroners should, in consultation where necessary with an independent medical practitioner (e.g. a CFMU doctor or a pathologist skilled in coronial autopsies) consider the following questions:

Did the health care cause or contribute to the death?

- Would the person have died at about the same time if the health care was not undertaken?
- Was the health care necessary for the patient's recovery, rather than optional or elective?
- Did the death result directly from the underlying aliment, disease or injury?
- Was the health care delivered with all reasonable skill and care?

If 'yes' to all - the health care didn't cause or contribute to the death.

Did failure to provide health care cause or contribute to the death?

- Given the person's condition at time health care was sought, was death more likely than not to occur i.e. would person have died at the same time anyway?
- Did the death result directly from an underlying condition?
- Was the decision not to provide health care reasonable?

If 'yes' to all – the failure to provide health care didn't cause or contribute to the death.

Was the death not reasonably expected?

- Was the condition of the patient such that death was foreseen as more likely than not to result from either the health care provided or the decision not to treat?
- Was the decision to provide health care anyway, a reasonable one in the circumstances having regard to the patient's condition including their quality of life if the health care was not given?
- Was the decision to provide the health care or not to provide it involve a clinically appropriate assessment of whether the risk of death was outweighed by the potential benefits a health care intervention could provide?
- Was the health care given with all reasonable care and skill?
- Was the decision not to provide health care reasonable?

If 'yes' to all – death was not reasonably unexpected.

If answer NO to any of the above = reportable death

Examples:

1. *An elderly man suffers rupture of an abdominal aneurysm and severe internal haemorrhage. In an effort to save his life, doctors undertake emergency surgery to repair the aneurysm, but he dies during the operation. There is no suggestion the surgery or anaesthetic was inappropriate or involved an adverse event. It is well recognised that such a condition is inevitably fatal without surgery and that there is a high mortality during attempted surgical repair of ruptured abdominal aneurysms. The death is therefore not reportable under s. 8(3)(d). The treating doctors should be encouraged to issue a cause of death certificate*.

2. *A baby is born with severe congenital heart disease. At the appropriate time during the first year of life, doctors undertake major cardiac surgery to correct the malformation of the heart and the large blood vessels, but the baby dies during the operation. There is no suggestion that the surgery or anaesthetic was inappropriate or involved an adverse event. It is well recognised that the particular congenital heart disease involved is ultimately fatal in all cases and that major cardiac surgery carries a significant mortality. The parents had been appropriately warned about these risks. The death is therefore probably not reportable under s. 8(3)(d) and the treating doctors should be encouraged to issue a cause of death certificate*.

Alternatively such deaths could be reported on a Form 1A to ascertain whether the coroner is prepared to authorise the issuing of the certificate under s. 26(5)(a).

3. *An older woman with no significant medical history undergoes an elective laparoscopic hernia repair. She develops unexpectedly*

high levels of pain post-operatively. Imaging reveals a large haematoma but no signs of bowel ischaemia. She is managed conservatively with intravenous antibiotics but her condition continues to deteriorate. She is taken back to theatre to evacuate the haematoma when it is discovered there are lacerations in the small bowel from the hernia repair. She subsequently dies from complications of sepsis. The woman would not have died but for the complications of this elective procedure and for this reason, the death is reportable under s.8(3)(d) and should be reported via Form 1A in the first instance. If the coroner is satisfied the woman was properly informed of the risks of the surgery and the surgery was undertaken with all reasonable care and skill, the coroner should authorise the issue of a cause of death certificate under s.12(2)(b).

4. *A young man with alcoholic liver disease develops bacterial peritonitis after an attempted self drainage of ascites with a needle. He is admitted to hospital for further management. Three ascitic taps are performed over the course of a week. He developed severe abdominal pain several hours after the third tap and his condition deteriorated significantly and he died the next morning. The timing and nature of his deterioration suggests it may be related to the third ascitic tap. Consequently the death is reportable under s.8(3)(d) and should be reported via Form 1A in the first instance. If after reviewing the medical records the coroner considers iatrogenic injury was likely to have occurred, then the coroner should direct the hospital to report the death to police so autopsy can explore this possibility.*

5. *A toddler presents to the emergency department in an acutely unwell state and dies in hospital a day later. Clinical investigations reveal sepsis thought to be due to an extremely rare infecting organism that carries a very high mortality rate. The child had been seen twice by a general practitioner in the week preceding the hospital admission and was diagnosed with respiratory tract infection. Although the condition which caused the child's death was known to be rare and carried a high mortality rate, the possibility of earlier diagnosis and treatment initiated by the general practitioner warrants the death being reported as a potential health care related death and should be reported via Form 1A in the first instance.*

6. *An obese woman died suddenly two days after an elective total knee replacement. Clinical investigations undertaken prior to her death revealed multiple bilateral pulmonary emboli. The death is reportable under s. .8(3)(d) because this condition is a known health care complication. However, provided the coroner is satisfied the risk of venous thromboembolism was appropriately identified and managed by the treating doctors, the coroner should authorise the issue of a cause of death certificate under s.12(2)(b).*

7. *An elderly man with severe dementia whose condition deteriorated suddenly dies after being placed on the end of life carepath. The day prior to his death, a nurse mistakenly administered more than the prescribed dosage of opiate medication through the syringe driver. Although the error was immediately rectified and the man did not die immediately, the death is reportable as a potentially health care related death and should be reported via Form 1A in the first instance to confirm the medication error did not hasten the death.*

As assessment of cases will in the first instance often be undertaken by someone who has had involvement in the treatment of the deceased (and cannot therefore be seen as entirely impartial), and doctors should be encouraged to lean towards reporting matters if they are unsure. The coroner can then seek input from an independent doctor such as a CFMU doctor or a pathologist who will undertake the autopsy if it is decided to order one.

That independent doctor may discuss the matter with the treating doctor or have access to the patient's medical records and any written report produced in accordance with a Form 25 information requirement or Form 5 requirement for extra medical evidence for autopsy if necessary. As a result of taking advice from that independent doctor, the coroner may come to the view that although the death was unexpected, there is no basis to consider that any negligence or sub-standard practice contributed to it and can then, pursuant to s. 12(2)(b)(iii), authorise the issue of a cause of death certificate.

If the treating doctors would like an autopsy, this should be conducted with the family's consent under the *Transplantation and Anatomy Act 1979*. It is not appropriate and arguably unethical for a doctor to refrain from issuing a medical certificate of the cause of death in order to secure the performance of an autopsy where a family has not consented, under the guise that the matter is a reportable death.

Health care related deaths should generally be reported via the Form 1A process in the first instance. Chapter 7.4 *Investigating health care related deaths* explains how these deaths are investigated.

Cause of death certificate has not been issued and is not likely to be issued

Deaths reported because a doctor is unavailable, unwilling or unable to issue a cause of death certificate comprise the majority of deaths reported each year to Queensland coroners.[10]

[10] For example, in 2011-12, of the total 4461 deaths reported to Queensland coroners, 40.30% were reported because the cause of death was unknown or uncertain (compared to 33.87% reported as violent or unnatural and 22.98% reported as health care-related). In 2010-11, of the total 4416 deaths reported, the breakdown was 42.07% (no cause of death certificate), 26.99% (health care related) and 25.59% (violent or unnatural).

Deaths may lack a cause of death certificate for several reasons, including:

- although death is presumed due to a natural cause, the person has not seen a doctor for years and no doctor is able to make a diagnosis.

- the person saw a doctor recently, but the condition was either minor or was not thought sufficiently advanced to cause death.

- the person died in hospital but the treating doctor either cannot or is reluctant to express an opinion as to the natural cause of death.

- the treating doctor is unavailable for some reason.

- the treating doctor does not understand the legislation and/or otherwise inappropriately refrains from issuing a cause of death certificate. For instance many doctors are still of the opinion they cannot issue a certificate if they have not treated the person in the last three months. This rule was removed when the *Births Deaths and Marriages Registration Act* 2003 commenced operation. Some doctors are not aware they do not need to have treated the deceased but can rely on the medical history and any other information which is available.

In working with police, doctors and families, coroners should strike a balance between unnecessarily investigating obviously natural deaths and missing unnatural deaths. The coronial system does not exist to investigate the finer points of known natural disease unless such inquiry can lead to systemic improvements in health care. In part, deciding how to handle deaths initially lacking a medical certificate is a question of risk management. What are the alternatives, what are the risks of each, and how can resources be most effectively deployed to manage those risks?

The options open to coroners, alone or in combination, are:-

- reassure treating doctors regarding the requirements of the coronial system.

- encourage doctors, where appropriate, to issue a cause of death certificate based on their clinical opinion as to the probable cause of death. The CFMU doctors are available to speak with treating doctors who may be uncertain about making a cause of death diagnosis.

- encourage hospital doctors to make reasonable enquiries of other regular treating doctors before they decide they can not issue a cause of death certificate for a person is not otherwise known to the hospital

- invite treating doctors who are considering competing cause of death diagnoses to submit a provisional cause of death certificate via Form 1A thus providing an opportunity for independent CFMU review to inform assessment of probable cause of death or identify where autopsy is required to clarify the cause of death.

- require medical records and/or written reports to be made available to pathologists by treating doctors by issuing a Form 5.

- request a pathologist or CFMU doctor or coronial nurse to review the records and/or reports to determine whether it is possible to form an opinion as to the probable cause of death

- order an external autopsy to exclude, so far as possible, injuries or other unnatural causes and ensure the findings are consistent with any opinion expressed as to the probable natural case of death.

- order an internal autopsy (partial or full) and conduct an investigation with a view to making findings in accordance with s. 45.

The management of apparent natural causes deaths is discussed in detail in Chapter 3.4 *Triaging apparent natural causes deaths at the initial reporting stage* and Chapter 5 *Preliminary investigations, autopsies and retained tissue*.

Death in care

Legislation

Coroners Act
Section 9

The Act makes the deaths of specific types of vulnerable people in the community (namely children in care, involuntary mental health patients and people with disabilities with high support needs who lived in funded supported accommodation arrangements) reportable to a coroner, whatever their cause of death may be. Coronial scrutiny of these deaths is warranted because the ability of these groups of people to make independent, informed decisions about their lives is subject to some form of intervention by the State. The significance of a death being reported as a death in care lies in the requirement under s.27(1)(a)(ii) of the Act for an inquest to be held when the circumstances of the death raise issues about the deceased person's care.

Deaths in care can be conveniently classified into four categories depending on whether the person:

- had a disability and who either resided in certain types of supported accommodation and/or was receiving high level support as a participant under the National Disability Insurance Scheme (the NDIS)

- was subject to treatment under the *Forensic Disability Act 2011* (the FDA)

- was subject to involuntary assessment or treatment under the *Mental Health Act 2016* (the MHA); or

- was a child in the care or under the guardianship of the State under the *Child Protection Act 1999* (the CPA).

Deaths in care are reportable irrespective of the cause of death and where the person died. A common scenario is when the person dies in hospital from apparent natural causes.

When the death is from natural causes, caused by mechanical fall-related trauma or its complications or is potentially health care related, it is appropriate for the death to be reported via Form 1A in the first instance. When the death is violent or otherwise unnatural, for example, suicide or motor vehicle trauma, it should always be reported directly to police.

Death of a person who had a disability – death in care (disability)

Not every death of a person with a disability is reportable under the Coroners Act 2003.

This category of reportable death applies only to the death of a person with a disability who was the resident of certain types of supported accommodation services - see section 9(1)(a) - and/or who was receiving high level support under an NDIS participant plan - see section 9(1)(e).

The death of a person with a disability who does not meet these specific requirements may well be reportable for another reason under the Act, for example, because they died from an unnatural cause such as airway obstruction by food bolus or drowning.
Residents of certain types of supported accommodation services – section 9(1)(a)(i)-(iii)

To trigger this reporting criterion, the person must have a disability, as defined, AND be the resident of one of the specified types of supported accommodation service.

What is a disability

Section 11 of the DSA defines a disability as a condition that is:

- attributable to an intellectual, psychiatric, cognitive, neurological, sensory or physical impairment, or a combination of impairments (or combination thereof);

- which results in a substantial reduction of the person's capacity for communication, social interaction, learning, mobility or self-care or management; and

- which also results in the person needing support.

The disability must be permanent or likely to be permanent and may be of a chronic episodic nature.

Examples of the types of conditions which would be included in the definition of disability include:

- intellectual disability;
- mental illness;
- acquired brain injury;
- cognitive deficit from a neurological condition such as a stroke; and
- multiple disabilities including a physical disability such as cerebral palsy and an intellectual disability.

Relevant supported accommodation services

It is important to note that the death of an aged care resident per se is not reportable as a death in care (disability). The deaths of aged care residents become reportable for other reasons, most commonly, because they have died from mechanical fall-related trauma or its complications.

s. 9(1)(a)(i) - 'level 3 accredited residential services' are commonly known in the community as supported accommodation hostels and are usually owned or managed by private companies or individuals as 'for-profit' businesses. These facilities are funded by the fees charged to the residents. They do not receive any funding from the State or Federal Government to provide residential services to residents.

This death in care (disability) reporting criterion applies only to residents of a supported accommodation hostel accredited to provide level 3 personal care services. This level of accreditation relates to a resident's access to supports including external support services, medication management and health care and help with clothing and hygiene management.

The Department of Housing & Public Works is responsible for the accreditation function of these level 3 facilities. The Coroners Court of Queensland maintains a list of these services with reference to the public register of residential services maintained by the regulator.[11] In practice, these hostels are concentrated in South East Queensland.

[11] https://www.business.qld.gov.au/industries/service-industries-professionals/service-industries/residential-service/definition

The operators of these supported accommodation hostels are legally obliged to report a resident's death to both the regulator and the coroner.

s. 9(1)(a)(ii(A) - residential services which are operated, or wholly or partly funded by, the State Government department responsible for administering the Disability Services Act

This category of supported accommodation service was largely relevant prior to the NDIS becoming fully operational in Queensland on 1 July in 2019. It captured a range of supported accommodation service providers including the Accommodation Support & Respite Services operated by the Queensland Government (for people with a primary diagnosis of intellectual disability) and residential services for one or more people with a disability provided by non-government agencies such as Endeavour, Cerebral Palsy League, MS Queensland, Centrecare with Government funding.

In practice, many of the clients of these services will likely have transitioned to the NDIS from 1 July 2019 meaning their deaths may be reported under section 9(1)(e), see below.

This subcategory does not include the death of a person with a disability who was living in their own home or in a residential aged care facility even when the person was receiving support services from a funded disability support service provider.

s. 9(1)(a)(iii)(B) - services that are wholly or partly funded by the department in which the *Hospital and Health Boards Act 2011* (HHBA) is administered include the following:

- long term stay wards or facilities operated by the Department of Health (the Department responsible for administering the HHBA) where people with disabilities are expected to reside on a permanent basis. The facilities for people with disabilities funded by QH presently are:
  • Halwyn, Red Hill Brisbane
  • Birribi, Rockhampton
  • Casuarina Lodge, Bayside
  • Baillie Henderson Hospital, Toowoomba
  • The Park Centre for Mental Health, Wacol
  • Charters Towers Rehabilitation Unit, Charters Towers
  • Kirwan Health Campus, Townsville

Examples of facilities which would <u>not</u> be included appear below:

- acute health care or rehabilitation facilities, such as the Head Injury Unit, Princess Alexandra Hospital, where there is a clear discharge process; and

- accredited aged care facilities operated by the Department of Health, even if there is a bed in this type of facility occupied by a younger person with a disability.

Death of a participant in the National Disability Insurance Scheme
As noted above, the NDIS became fully operational in Queensland from 1 July 2019. Section 9(1)(e) makes reportable the death of an NDIS participant not living in a private dwelling or a residential aged care facility who was entitled to or receiving high level supports funded under their NDIS plan and provided by a registered NDIS provider.

Who is an NDIS participant?
The 'access criteria' for an NDIS participant are set out at ss. 22 to 25 of the *National Disability Insurance Scheme Act 2013 (Cth)* (the NDIS Act). These access criteria include that the person must be under 65, reside in Australia, have a permanent and significant disability, and is likely to benefit from early intervention supports.

While the deaths of all NDIS participants are required to be reported to the NDIS Commission, not all of these deaths will be also reportable to the coroner as a death in care (disability). This is because the section 9(1)(e) limits the coronial reporting requirement to the most vulnerable NDIS participants, namely those people receiving high level supports in a residential environment that is not a private dwelling or a residential aged care facility.

Relevant services
For the death to be reportable as a death in care (disability) under section 9(1)(e), the participant must have been receiving or entitled to receive services from a registered NDIS service provider which fall into one or more of the following classes of supports as set out in **s. 9(1)(e)(iii)**:

(A) high intensity daily personal activities;
(B) assistance with daily life tasks in a group or shared living arrangement;
(C) specialist positive behaviour support that involves the use of a restrictive practice; or
(D) specialist disability accommodation.

In practice, this captures clients living in a supported accommodation environment who have very high support needs or extreme/complete functional impairment due to their disability affecting their ability to mobilise/self-care/self-manage.

This subcategory of death in care (disability) captures the deaths of residents of supported accommodation services that are also 'visitable sites' under the *Guardianship and Administration Act 2000*. The Community Visitor Program works closely with the Coroners Court of Queensland to maintain a current list of these sites to help in the timely identification of resident deaths as a deaths in care (disability).

The Coroners Court of Queensland will also be working closely with the NDIS Quality & Safeguards Commission to ensure the timely identification of NDIS participant deaths which meet the reporting criteria.

The following scenarios demonstrate the application of section 9(1)(e):

A 36 year old man with cerebral palsy with high physical support needs died in hospital after being admitted several days previously after an aspiration event at home the previous afternoon. He was treated for aspiration pneumonia but did not improve. After discussion with his family he was commenced on end of life cares. He lived in a share house for young people with high physical support needs as he was eligible for specialist disability accommodation under his NDIS participant plan.

A 52 year old woman with DiGeorge Syndrome died suddenly at home. She was intellectually impaired, had reduced mobility, was largely nonverbal and required full support with the activities of daily living. She received funding under the NDIS which included support under a "supported independent living arrangement" with two other co-tenants in a private dwelling rented privately under a tenancy agreement with the Department of Housing. She and her co-tenants received 24/7 support from live-in carers employed by a non-government disability support agency that was a registered NDIS provider.

These deaths are both reportable as a death in care (disability) because each deceased was funded under NDIS to receive high level support of the kind specified by section 9(1)(e) such as specialist disability accommodation and assistance with daily life tasks in a group or shared living arrangement.

A 20 year old man with Downs Syndrome died in hospital after developing pneumonia which did not respond to active treatment. He had high level support needs and was funded under the NDIS for supported independent living. He lived alone in a unit privately rented by a non-government disability support agency and received 24/7 carer support from that agency.

This man's death is reportable as a death in care (disability) because he was funded under the NDIS to receive high level support in accommodation provided by a disability support agency.

In contrast:

A 45 year old woman died from acute natural causes while visiting Brisbane with a paid carer to attend a medical appointment. She had Charcot-Marie-Tooth Syndrome which severely affected her mobility. She lived alone in her own unit. She was funded under the NDIS for specialist disability accommodation, assistive technology and equipment (including a motorised wheelchair and electric lift chairs) and support to access allied

health services), employment services and transport to participate in social and community activities.

This woman's death is not reportable as a death in care (disability) because she was not funded to receive high level supports of the kind specified in section 9(1)(e).

NDIS participants excluded from the death in care (disability) reporting requirement

Consistent with the parameters of the concept of death in care (disability) prior to 1 July 2019, it does not capture the death of an NDIS participant:

- receiving high level support in a *residential aged care facility*; or
- receiving high level support in a *private dwelling* – this exclusion is defined by reference the person having received NDIS funded high level support when they were either living alone or, in circumstances where the person's funded supports involve the provision of specialist disability accommodation or the use of a restricted practice, with one or more family members (blood relations/spouse/adoption or foster relationship/ATSI relative) in their home.

The following example demonstrates this exclusion:

A 25 year old died in hospital from complications of injuries sustained when he fell out of his wheelchair during a family outing. He was severely disabled having sustained cerebral palsy as a complication of being born prematurely, severe kyphoscolioisis and epilepsy and required full assistance with all activities of daily living. He lived in the family home with his older brother. He was funded under the NDIS for supported independent living (complex), support to attend day respite and access community-based activities and access to allied health services.

Even though this young man was funded to receive high level support, his death is not reportable as a death in care (disability) because he lived in a private dwelling with a family member (though the death is still reportable as a violent or otherwise unnatural death because he died from complications of injuries sustained in a mechanical fall from his wheelchair).

As with the first subcategory of deaths in care (disability), it can be difficult to identify when the death of a person who is an NDIS participant is reportable as a death in care. Here, the Act places an express obligation on the registered NDIS provider that was providing the relevant services to report a client's death to the coroner, even if the client died in hospital. Also as with the first category, Community Visitors will play an important role in alerting coroners to client deaths.

If a death in care is reported under this category information about the person's plan, funding, service provider, services provided and class of

supports can be confirmed by obtaining participant information from the registered service provider or the National Disability Insurance Agency (NDIA).

It can be difficult to identify when the death of a person with a disability is reportable as a death in care, especially when they die elsewhere than their place of residence. This is why the Act places an express obligation on residential service providers whose facilities fall within the death in care category to report a resident's death to the coroner, even if the resident died in hospital. Community Visitors also play an important role in alerting coroners to resident deaths. Hospital staff should always make enquiries about the deceased's residential status before they issue a cause of death certificate for a person with a disability.

Death of person who was receiving treatment under the *Forensic Disability Act 2011*

The second category of 'death in care' involves those deaths of a person who was subject to treatment under the FDA.

A forensic disability client is defined as a person who has a cognitive or intellectual disability and who is subject to a forensic order made by the Mental Health Court. The death of a forensic disability client will be a death in care if the person was being taken to or detained in the forensic disability service, being taken to or awaiting admission to an authorised mental health service, undertaking limited community treatment or absent from the forensic disability service under a temporary absence approval while accompanied by a practitioner under the FDA.

Death of a person who was subject to involuntary assessment or treatment under the *Mental Health Act 2016*

The third category of a 'death in care' involves those deaths where a person was subject to involuntary assessment or treatment under the MHA and was either being taken to or detained in an authorised mental health service, detained because of a court order, or undertaking limited community treatment.

An authorised mental health service generally means a mental health service declared under s. 495 of the MHA to be an authorised mental health service. In practice, these are gazetted health services nominated by the Director of Mental Health. Section 495 provides that the Director of Mental Health may, by gazette notice, declare a health service, or part of a health service, providing treatment and care to people who have mental illnesses, to be an authorised mental health service for the purposes of the MHA.

The MHA also provides that certain persons may be taken to an authorised mental health service for an involuntary assessment and/or treatment, or if no authorised mental health service is available, to a public hospital, until such time as the person can be transferred to an authorised mental health service.

Accordingly, a person or patient may be taken to, detained in, or be undertaking limited community treatment from or at one of the following:-

- inpatient mental health facilities including acute, medium security, high security, long term stay, and rehabilitation wards;
- private hospital inpatient mental health wards where a patient can be placed on a involuntary treatment order (for example, the Toowong Private Hospital);
- Community Care Units (where residents may live when on limited community treatment or subject to the community category of an involuntary treatment order); and
- Community Mental Health Clinics.

s. 9(1)(b)(iv) is designed to capture situations where mental health service staff are escorting involuntary patients who are on limited community treatment. For the purposes of limited community treatment, a patient may be 'in the community' any time he or she is authorised to be away from the ward (for example, walking around hospital grounds or visiting a cash machine or going shopping, etc). If a person dies while he or she is on limited community treatment and is being escorted by a mental health service staff member, that death would be a reportable death.

The Act operates such that the death of a person who immediately before the person was detained, was in the custody of the chief executive of corrective services under the *Corrective Services Act 2000* is reportable as a death in care. For example, a prisoner who is diagnosed with a mental illness and is transferred from prison to a high security psychiatric unit as a classified patient under the MHA for treatment under an involuntary treatment order will be reportable as a death in care, not a death in custody. However, because of the person's prisoner status prior to becoming a classified patient, the death should always be reported to police rather than via a Form 1A.

Death of a child under the care or guardianship of the Department

The death of a child will be a death in care if the child was:

(a) Under **s. 9(1)(c)** placed under the guardianship of the chief executive of the Department of Communities, Child Safety and Disability Services because they are awaiting adoption under the *Adoption Act 2009.*

Children who are placed for adoption are placed under the guardianship of the chief executive of the Department of Communities until such time as an adoption order is made or consent to the adoption is revoked. Children who are awaiting adoption are usually placed with approved foster carers in the carers' homes. If a child dies during this time, the carer of the child would be required to inform the Department, as well as the police, of the child's death. The carer should also inform the police that the child is under the

guardianship of the Department. The status of the child could also be confirmed by the Department.

(b) Under **s. 9(1)(d)** living away from their parents as a result of action by the Department of Communities, Child Safety and Disability Services under the CPA. This will apply if the child is:

- in the custody or guardianship of the chief executive of the Department of Communities, Child Safety and Disability Services. When a child is placed in the custody or guardianship of the chief executive the Department must find an appropriate placement for the child such as home-based care (foster, kinship and provisionally approved carers) and residential care services

- placed in care under an assessment care agreement. An assessment care agreement is an agreement between the chief executive and the child's parents for the short-term placement of the child in the care of someone other than the parents

- subject to a Child Protection Order granting custody of the child to a member of the child's family other than a parent

- subject to a Child Protection Order granting long-term guardianship of the child to a suitable person who is a member of the child's family other than a parent or another suitable person nominated by the chief executive.

s. 9(1)(d) applies to children who are placed in the care of an approved kinship carer, an approved foster carer, an entity conducting a departmental care service, a licensed care service, or other provisionally approved carer under s. 82 of the CPA). A licensed care service under the CPA means a service, operated under a licence, to provide care for children in the chief executive's custody or guardianship. A licensed care service can be a residential care service or a shared family care service. These services are usually administered by religious or charitable organisations.

Approved foster carers and kinship carers and provisionally approved carers are required to hold a certificate of approval issued by the Department. If a child dies whilst in the care of an approved carer, the carer or the Department will be able to inform police of the status of the child.

Child deaths are reported under other categories of reportable death, most commonly sudden infant deaths or other apparent natural causes deaths where a cause of death certificate is unlikely to issue, traumatic deaths eg motor vehicle accidents, suicides and accidental drug overdoses and occasionally health care related deaths. From time to time, the deceased child will be a child who was known to the

Department. The extent to which the Department's prior involvement with the child and their family is relevant to the circumstances of these deaths is considered by the coroner on a case by case basis.

Death in custody

Legislation

Coroners Act
Section 10

The investigation of deaths in police or prison custody has long been considered an important function of coroners given the vulnerability of people whose liberty is curtailed by the exercise of executive power. The Act recognises and responds to the need for public scrutiny and accountability by requiring all deaths in custody to be investigated by the State Coroner or the Deputy State Coroner and by mandating that an inquest be held into all such deaths. These requirements arose out of the extensive recommendations made in the Royal Commission into Aboriginal Deaths in Custody.

Death in custody captures the deaths of those who are at the time of their death, were actually in custody, trying to escape from custody or trying to avoid being put into custody.

Custody is defined to mean detention, whether or not by a police officer, under arrest or the authority of a court order or an Act of the State or the Commonwealth. This would clearly relate to actions of detention taken by a police officer or corrective services officer, court officers or other law enforcement personnel.

Detention in watch-houses, prisons, etc is clearly covered but the section also extends the definition by reference to the legal context that makes the physical location of the deceased irrelevant. For example, a sentenced prisoner who is taken to a doctor or a hospital for treatment is still in custody for the purposes of this Act.

Detention under the authority of an Act of the Commonwealth clearly includes the actions of the Federal Police or other federal investigatory or law enforcement bodies but also includes the detention of asylum seekers or refugees under immigration laws.

Section 27, which deals with the circumstances when a coroner must hold an inquest makes it clear that a death in custody may also include a death that is another type of reportable death, for example, a death in care or a death in the course of police operations. Although a person’s death while detained under the *Public Health Act 2005* (for example under public health emergency powers, because of a controlled notifiable condition or under a care and treatment order for a child) is a death in custody under

the Act, it is expressly excluded from the mandatory inquest requirement – see s.27(2)(b).

Death in the course of police operations

Legislation

Coroners Act
Section 8(3)(h)

This category of reportable death was included in the Coroners Act in 2009 to capture deaths occurring in the context of policing activities but which are not deaths in custody within the meaning of s.10. It captures, for example, the death of a bystander killed in the course of police attempting to apprehend a suspect or a person who dies during a routine police encounter e.g. after being pulled over by police for a traffic offence or who commits suicide while police are present conducting a welfare check. In practice, many of these deaths will be reportable under the violent or otherwise unnatural death category. However, the significance of this reporting category lies in the requirement for the death to be reported to and investigated by the State Coroner or the Deputy State Coroner. This is to ensure an appropriate level of scrutiny of the police involvement in the circumstances leading to the death. An inquest must be held into these deaths only if the coroner decides the circumstances require it.

Suspected deaths

Legislation

Coroners Act
Section 11, 45

In principle

A coroner has jurisdiction to inquire into the cause and circumstances of a suspected death though “suspected death” is not a distinct category of reportable death under section 8. The jurisdiction is triggered when there is reason to suspect a person is dead and the death was reportable under the Act. Common scenarios invoking coronial investigation include persons thought to be the victim of foul play, accident or suicide though the body has never been found, and persons seen falling from a vessel or swept away in rough seas or flood waters but search and recovery efforts were unable to recover the body.

In practice

Those cases where the circumstances indicate a person has likely died in suspicious or other known circumstances, such as the above example of a person falling from a ship at sea, in practice should be reported to the State Coroner within a short period of time.

Where a person’s whereabouts are unknown and there are justifiable fears for a person’s welfare, relatives or friends will in most cases report the

missing person to the Police. Such reports are passed on to the Missing Persons Unit within the QPS who will commence an investigation. In some cases it becomes clear suspicious circumstances exist and a full criminal investigation commences.

In over 99% of cases the missing persons are found but those who remain missing are entered on an Australian Missing Persons Register. The Queensland Police Service Operational Procedures Manual requires the Missing Persons Unit to refer these cases to the State Coroner as soon as a missing person is reasonably suspected of being dead.[12]

The OPM reporting timeframe is not always adhered to and often a report is only sent some years later. The report to the State Coroner should include the complete investigation file including a report as to the results of the police investigation into the cause and circumstance of the missing person's disappearance and suspected death. The State Coroner can then direct a Coroner to conduct an investigation, including the holding of an inquest if necessary. Depending on the circumstances of the person's disappearance, the coroner's investigation may examine issues including whether there was third party involvement and the adequacy of police or emergency services responses to the person's disappearance.

Chapter 7.5 *Investigating suspected deaths* sets out the range of considerations a coroner should take into account when investigating a suspected death.

3.3 How are deaths reported?

Legislation

Coroners Act
Section 7

In principle

The objectives of the Coroners Act can only be achieved if coroners are notified of the deaths they are charged with investigating. Consequently the Act requires <u>any</u> person who becomes aware of an apparently reportable death to report it to a police officer or coroner, unless they reasonably believe the death has already been reported.

To enable the State Coroner to discharge the role of co-ordinating and ensuring consistency in coronial practice, it is essential that all reportable deaths are reported to the Coroners Court of Queensland.

A death in custody or in the course of police operations should be reported directly to the State Coroner or Deputy State Coroner but if it is reported to a regional coroner that report should immediately be forwarded to the Coroners Court of Queensland.

[12] Section 8.5.24 *Missing person reasonably suspected of being deceased*

In practice

Depending on the category of reportable death, the obligation to report can be satisfied by:

- reporting the death directly to police – violent and otherwise unnatural deaths (other than those from mechanical falls) should always be reported to police. Police will then submit a Form 1 Police Report of Death to Coroner for the coroner's consideration.

  The Queensland Police Service has agreed all officers who are notified of reportable deaths will send a copy of the Form 1 to the coroner responsible for the region in which the death occurs. All Form 1 reports are also forwarded to the Coroners Court of Queensland. This enables the Coroners Court of Queensland to maintain the register required to be kept by s. 92 and provide input into investigations with a view to maximising state wide consistency of practice.

- reporting the death directly to the coroner via Form 1A Medical practitioner report of death to coroner – health care related deaths, deaths resulted from injuries sustained in a mechanical fall and natural causes deaths in care are generally reported using this mechanism in the first instance. The coroner's preliminary investigation will determine whether the death is reportable and if so whether it is appropriate to authorise the issue of a cause of death certificate or whether further coronial investigation including autopsy is required. The Form 1A process is discussed in detail in Chapter 7.4 *Investigating health care related deaths*.

- contacting the coroner to seek advice about whether the death is reportable – this method is most commonly used by treating doctors who are unsure about reportability and funeral directors who receive a cause of death certificate that suggests the death was reportable but not reported to a coroner.

It is not uncommon for the coroner to be notified of an apparently reportable death by the deceased person's family who may have concerns about the cause and circumstances of their loved one's death, or by another investigative entity such as the relevant health regulatory authority.

Although the Act makes failure to report a reportable death an offence, coroners have instead opted for an educative rather than punitive approach to the issue.

It is well recognised that certain reportable death categories, notably health care related deaths, are underreported by the medical profession. Research has indicated that this can be attributed to certifying doctors' lack of awareness or understanding of their coronial reporting obligations rather than any concerted effort to conceal medical malpractice or

homicide. Changes made to health sector regulation following the Queensland Public Hospitals Commission of Inquiry have certainly helped improve the identification and reporting by hospitals of health care related deaths. However, coroners are encouraged continue their proactive efforts to educate clinicians about their reporting obligations.

There is also concern about the underreporting of deaths in care of people with disabilities under s. .9(1)(a) of the Act. This is most likely because these deaths can be difficult to identify as reportable due to their reportability hingeing on the person's residential status as opposed to the circumstances of their death. For this reason, the Act was amended in 2009 to place a specific obligation on residential service providers to report the deaths of their residents even if the death may have already been reported, for example, by a hospital. This measure and efforts by the Department of Communities, Child Safety and Disability Services and the Office of Fair Trading to educate service providers appears to have improved the reporting of these deaths in recent years. This is coupled with efforts by the Coroners Court of Queensland to maintain a current list of death in care facilities which is available to police and hospital to assist in identifying these deaths.

Multiple fatalities – Form 1B and the disaster victim identification process

Incidents such as natural disasters, transport incidents, building collapses, fires and acts of terrorism involving multiple casualties pose particular problems for coroners, particularly in relation to identification of deceased persons as well as determining the cause of death. In such cases human remains may be severely burnt, disrupted, decomposed or the remains are commingled with other human or animal remains.

Positive identification is important both for legal reasons and to ensure deceased persons are returned to their families as quickly as possible for obvious social and therapeutic reasons.

In Queensland, the Coroner has the responsibility of determining identity on a legal basis. To do so a number of resources are used and the police maintain a critical coordination role as part of a multi-agency approach involving other emergency agencies and forensic specialists. The State DVI Coordinator within QPS is responsible for the coordination of the DVI process.

After the results of circumstantial, medical and scientific evidence have been compiled it becomes the responsibility of the Coroner to determine if this meets an acceptable standard of proof of identification.

Disaster Victim Identification (DVI) procedures have largely been standardised in Australia, based on Interpol procedures adopted internationally, and are contained in the *Queensland Disaster Victim Identification Standards Manual* which largely adopts and is to be read in conjunction with the *Australasian DVI Standards Manual.* It is not intended

to summarise in any detail these comprehensive manuals and they should be referred to. Copies of the Manuals can be accessed through the Office of State Coroner, as they are not available on-line. It is understood there are substantial amendments to the manuals were being made when this guideline was published, to simplify them and to better reflect current Interpol procedures.

Form1B

The initial Police Report of Death where multiple fatalities have occurred and where DVI processes are required is reported to the Coroner by Form 1B. This provides initial information concerning the incident and potential victims. An autopsy order covering all of the human remains is at this stage completed by the Coroner.

As soon as a positive identification is achieved and all associated human remains are matched then a form 1 ‘Police Report of Death to a Coroner’ is to be completed. An individual Autopsy Report may follow.

DVI Phases

The DVI process follows five (5) phases including forensic and scientific procedures at the scene, post-mortem examination, the gathering of ante-mortem information, reconciliation of this information and debriefing.

Each of these steps can be complex and time consuming but it is important this step-by-step approach is maintained. Regular liaison with next of kin is important so that unrealistic expectations of how quickly the process will take can be managed.

In the reconciliation phase the ante-mortem and post-mortem information is compared in order to effect identification of the human remains. In all cases, identification is considered on the basis of being beyond reasonable doubt. An Identification Board including specialist advisers reviews the information gathered to determine if this is sufficient. The Coroner sits on the Identification Board as an observer. Positive identification must be to the satisfaction of the Coroner. The DVI Manual suggests that where possible, identification should be based on at least one primary identifier supported by at least one other identifier.

Key identifiers include fingerprints, dental, DNA. Secondary identifiers which can be used as supportive evidence include medical (eg previous medical procedures, implants), property (eg. jewellery, documents) and photographic(visual) evidence. Visual identification may be used in some cases but experience has shown that in the majority of DVI cases this can be unreliable.

3.4 Reporting of particular deaths

Stillbirths

The coroner's power to investigate a stillbirth[13] is extremely limited. This guideline clarifies the circumstances in which this power is invoked.

Scope of coroner's jurisdiction

The Coroners Act prevents a coroner from investigating how a child came to be stillborn. The coroner can only order an autopsy to determine whether a baby was born alive.[14] If the autopsy confirms the child was stillborn, the coroner's investigation must stop.[15]

Reportability

A child who shows no sign of respiration or heartbeat or other sign of independent life at birth is stillborn[16].

A confirmed stillbirth is not reportable to the coroner. Clinicians should consult the *Queensland Maternity and Neonatal Clinical Guideline: Stillbirth care* about the non-coronial reporting requirements for these babies.[17]

A possible stillbirth is reportable if:

- the body is that of an abandoned newborn whose birth was unwitnessed by clinicians
- there is clinical disagreement or doubt about whether the child was born alive.

In these cases, the presumed 'death' is reportable so an autopsy can be performed to determine whether the child was born alive.

Recent judicial authority has confirmed pulseless electrical activity, even in the absence of respiration, is a sufficient sign of independent life.[18] Clinicians should consult the *State Coroner's Guidelines: Reporting Neonatal Deaths* when determining whether the subsequent death of a child born with limited signs of life is reportable.

Autopsy outcomes

If the autopsy confirms the child was stillborn, the coroner is limited to ordering release of the child's body for burial and in suspicious cases,

[13] Still born child is defined in the *Coroners Act 2003* by reference to the term in the *Births Deaths and Marriages Registration Act 2003*
[14] Coroners Act s19(2)
[15] Coroners Act s12(2)(c)
[16] *Births Deaths and Marriages Registration Act 2003*, Schedule 2
[17] http://www.health.qld.gov.au/qcg/documents/g_still5-0.pdf
[18] *Barrett v Coroners Court of South Australia* [2010] SASCFC 70

providing a copy of the autopsy report to investigating police. The coroner can not investigate how the child came to be stillborn.

Neonatal deaths - when and how they should be reported

Introduction

Neonatal deaths raise a number of unique challenges for coroners, namely:-

- Which should be reported?
- How should they be reported?
- Assisting grieving parents without compromising the investigation
- Informing the autopsy process in these cases.

Reportability:

While there are certain circumstances in which a neonatal death clearly is or is not reportable under the *Coroners Act 2003*, many neonates die in circumstances where the decision is not so clear cut.

Deaths not reportable to the coroner

- preterm babies born at less than 26 weeks gestation, where the death results from immaturity per se or from a recognised and appropriately treated complication of immaturity e.g. intraventricular haemorrhage, sepsis, hyaline membrane disease/respiratory distress syndrome

- babies who die as a result of severe congenital abnormality, either diagnosed antenatally with a palliative care plan in place or diagnosed postnatally and intensive care is redirected to palliation after diagnosis.

These guidelines recognise the babies born in these circumstances will generally not survive irrespective of the quality of medical care available to them. They also acknowledge the involvement of parents and caregivers in clinical decision making about the appropriateness of withholding or discontinuing active treatment. It is appropriate for a cause of death to be certified without reference to the coroner for these babies unless the parents are expressing concern about the quality of the health care or the decision making process.

Deaths reportable to the coroner via the police

Hospital staff should contact police to report:-

- a death of a baby born alive either as the result of trauma to the baby or to the mother or the foetus *in utero* e.g. assault, motor vehicle accident, fall, electrocution, drug overdose

- babies who die in suspicious circumstances e.g. smothering, suspected tampering with life support equipment or medication dosage.

These deaths should be reported to police as suspicious or violent and unnatural deaths. There is no need to contact the coroner at the time of reporting unless the police or treating team wish to clarify what action the coroner wants taken.

Deaths reportable directly to the coroner via the Form 1A process

A death should be reported to the coroner using a Form 1A if:-

- the treating team considers the death is due to potentially preventable conditions or complications arising antenatally, during the birth process or during treatment after birth (e.g. lack of timely resuscitation or subsequent neonatal care);

- a parent or caregiver expresses concerns about the mother's antenatal management, management of the labour and delivery and/or neonatal management of the child; or

- the treating clinician is not sure whether or not the death is reportable.

The Coroners Act definition of *health care related death* encompasses two broad scenarios relating to (a) the provision of health care or (b) the failure to provide health care.

Provision of health care - the Act makes reportable a death where the provision of health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would not have expected the death to occur as a result of the health care provided to the person.

Failure to provide health care - the Act also makes reportable a death where failure to provide health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would have expected health care, or a particular type of health care, to be provided to the person.

It can be difficult to determine whether a particular neonatal death comes within this definition. This is because of variables peculiar to obstetric and neonatal management including the complexity of decision making about appropriate antenatal, obstetric and neonatal interventions; diversity of opinion about whether intervention would have enhanced the child's survival prospects and limitations on the extent of a reporting paediatrician's knowledge of the circumstances in which the child was born. For example, a treating neonatologist may be given very little, if any, information about the mother's antenatal management or the delivery of a

baby retrieved from another hospital and consequently may have difficulty assessing whether the baby suffered hypoxic-ischaemic encephalopathy (HIE) because of potentially preventable events arising before or during labour and delivery.

Appendix A contains a scenario based reporting aid to guide clinicians and coroners in 'grey area' cases where clinical intervention or the failure to intervene or a decision to withhold or discontinue active treatment may be considered to have caused or contributed to the baby's death. Clinicians are strongly encouraged to discuss these and like cases with the coroner in the first instance.

The determination of whether a neonatal death is reportable may require input from members of the antenatal management and birthing team, as well as the treating paediatric intensive care team responsible for the baby's neonatal care. The Form 1A process can be used to inform this information gathering exercise. The coroner's determination may need to be informed by independent clinical opinion.

In cases where the coroner requires a Form 1A, it should be accompanied by medical records for both mother and child, with as much information as is known by the reporting clinician about the child's birth e.g. where, when and how it occurred and the lead clinician from the birthing team. The Form 1A should also report the parent or caregiver's concerns, if any, and their attitudes towards a coronial autopsy/investigation, if known.

The coroner must consider this information and make his or her determination promptly so that, if necessary, early consideration can be given to autopsy issues and an appropriate autopsy order can be issued as soon as possible.

Scene preservation

Unless the operation or positioning of medical equipment **may** have contributed to the child's death, items such as nasogastric or endotracheal tubes can be removed and lines attached to catheters or syringe drivers can be disconnected.

The sites of any injuries caused by therapy or resuscitation efforts should be marked on the child's body and noted in the chart. For more detail on what material should be preserved see the Scene preservation guidelines in Chapter 4 *Dealing with bodies*.

Parents and caregivers should then be given unrestricted access to the body of their baby, unless they are implicated in the circumstances of the death e.g. tampering with life support equipment, smothering etc.

The coroner's decision

The coroner will consult with such experts as considered necessary and advise the hospital and the family as soon as possible of whether a coronial autopsy and investigation will occur. In the meantime, after the

family have had an opportunity to be with their baby, the body can be held in the hospital mortuary.

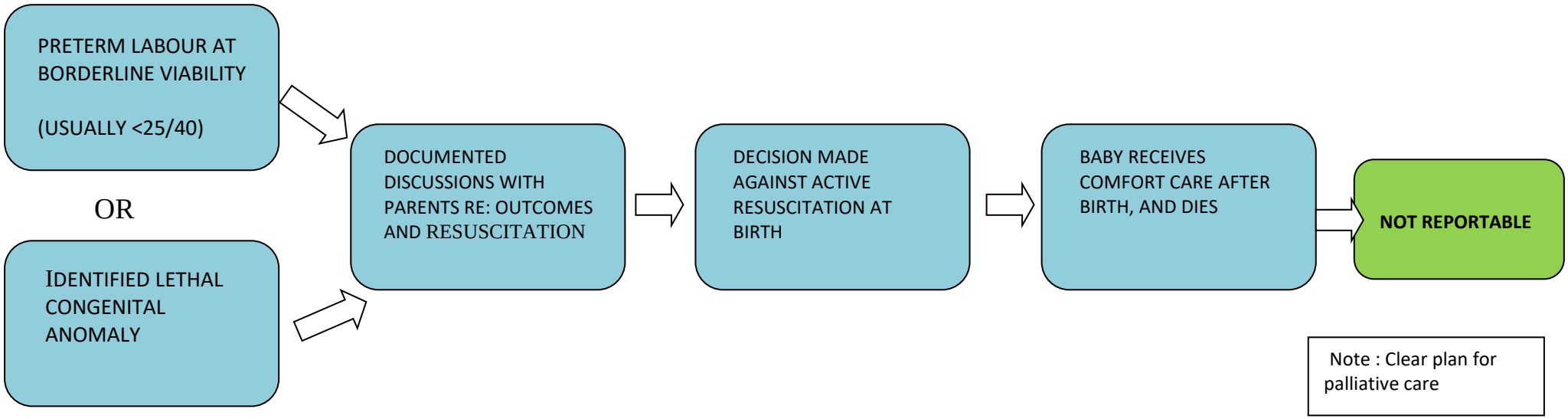
Opportunities for clinical input to the autopsy process

Given the specialist nature of infant autopsies, the forensic pathologist undertaking the autopsy is encouraged to seek collateral information from treating clinicians. The pathologist is responsible for seeking the coroner's approval for this information exchange to occur and documenting it appropriately.

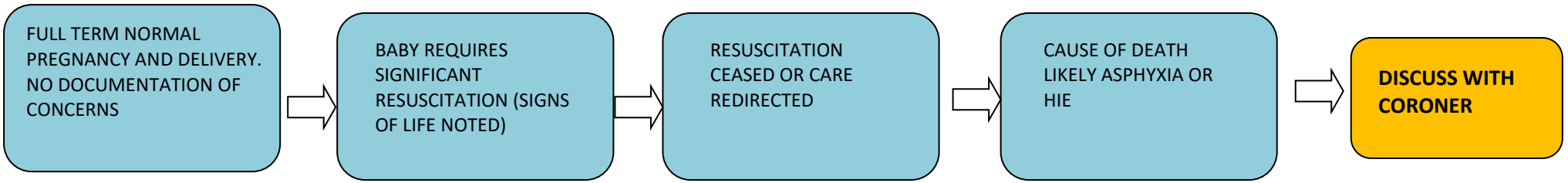
The forensic pathologist may also seek input from independent clinical sources such as an experienced paediatric anatomical pathologist or members of a non-treating hospital's perinatal mortality group.

REPORTING GUIDE FOR NEONATAL DEATHS

SCENARIO 1 – PLANNED NON-INITIATION OF RESUSCITATION

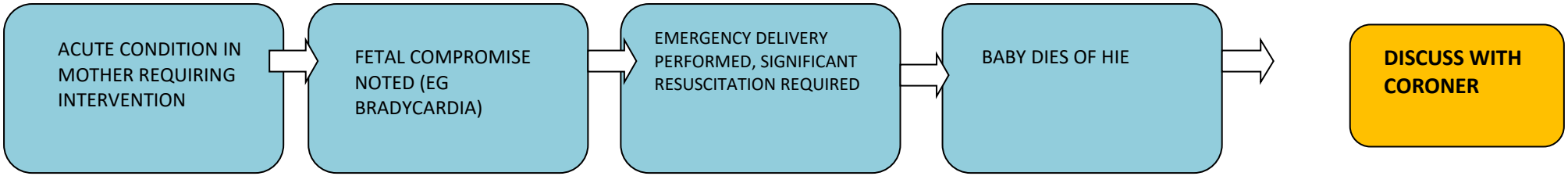


SCENARIO 2 – RESUSCITATED STILLBIRTH AFTER APPARENTLY NORMAL LABOUR



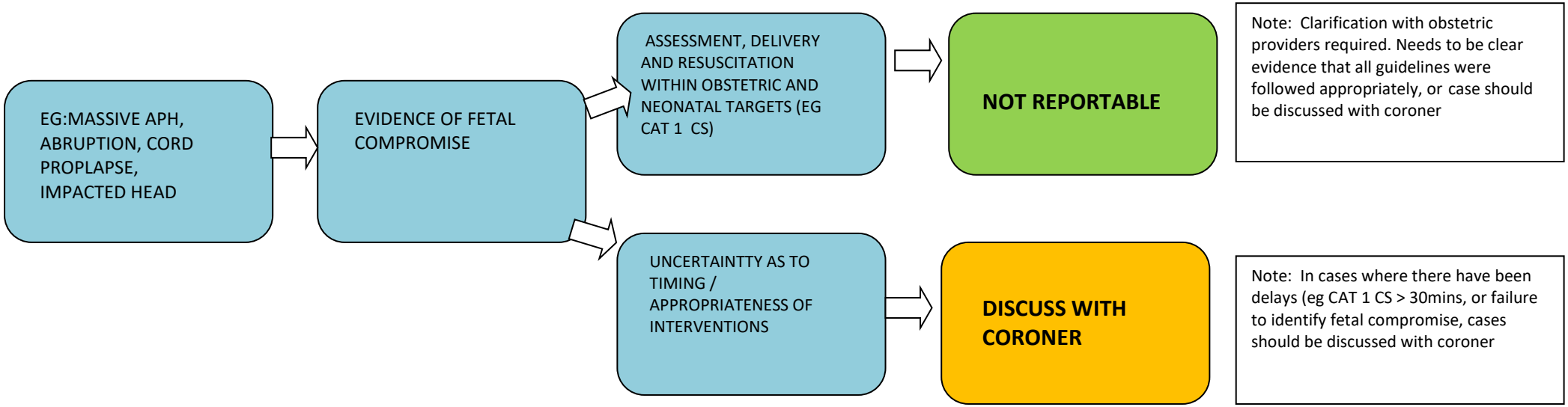
Note: needs to be discussed, neonatal care providers should not be assessing adequacy of antenatal / peripartum management

SCENARIO 3 – ACUTE MATERNAL CONDITION IN PREGNANCY



Note: Examples of maternal conditions include : MVA, seizure, (eclamptic or otherwise) DKA, overdose, trauma.
Should be discussed as care provision (or access to) may have impacted on neonatal outcome

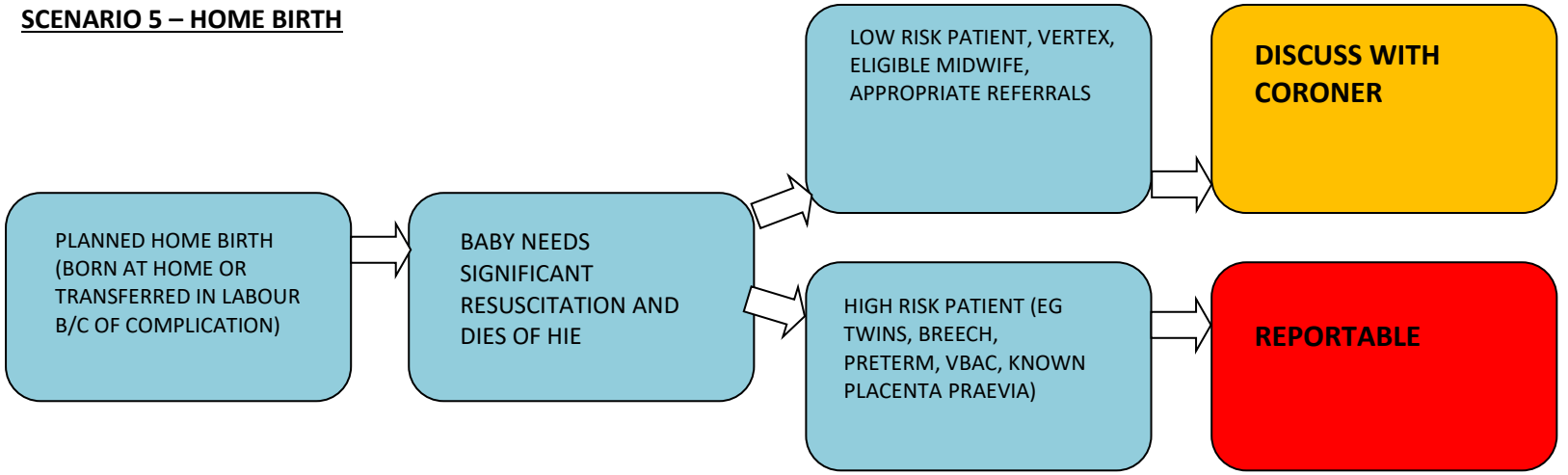
SCENARIO 4 – ACUTE COMPLICATION OF FULL TERM DELIVERY (baby resuscitated but subsequently dies)



Note: Clarification with obstetric providers required. Needs to be clear evidence that all guidelines were followed appropriately, or case should be discussed with coroner

Note: In cases where there have been delays (eg CAT 1 CS > 30mins, or failure to identify fetal compromise, cases should be discussed with coroner

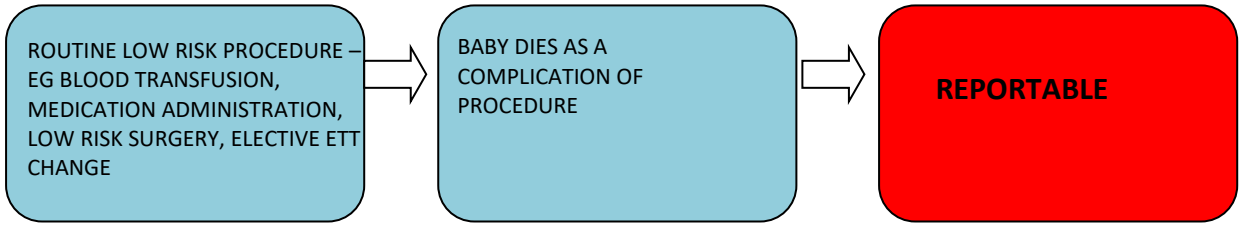
SCENARIO 5 – HOME BIRTH



Note: Care should be taken to ensure documentation is appropriate. Neonatal providers should not make decisions regarding appropriateness of home midwifery care

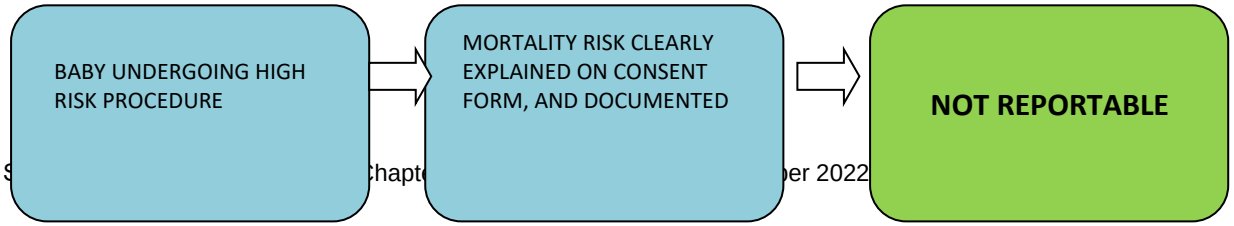
Note: Planning birth outside of accepted care guidelines makes death reportable

SCENARIO 6 – COMPLICATION OF ROUTINE NEONATAL TREATMENT



Note: Low risk surgery eg: hernia repair, ROP laser surgery in stable baby

SCENARIO 7 – HIGH RISK NEONATAL TREATMENT



Note: high risk procedure eg: NEC surgery, CDH repair, exchange transfusion in significantly unwell baby, PDA ligation in extremely preterm unwell infant
However, if known family concerns, discuss with coroner

Deaths under the *Voluntary Assisted Dying Act 2021*

From 1 January 2023, Queensland joins other Australian states in providing a process under which eligible Queenslanders can access voluntary assisted dying. The process, established under the *Voluntary Assisted Dying Act 2021*, provides an additional end of life option to a person who is dying if they meet the strict eligibility criteria under the Act.[19]

The Voluntary Assisted Dying Act amended the *Coroners Act 2003* to provide that the death of a person who has self-administered, or been administered, a voluntary assisted dying substance under that Act is not a 'reportable death' under the Coroners Act.[20] This reflects the underlying intent of the Voluntary Assisted Dying legislation which expressly provides that a person who dies under the voluntary assisted dying process does not die by suicide; rather they are taken to have died from the disease, illness or medical condition from which they suffered.[21] Nor does conduct which is authorised by the Voluntary Assisted Dying Act in connection the person's death under the process attract criminal liability.[22]

This amendment to the Coroners Act gives effect to Parliament's view that a coronial investigation for a voluntary assisted dying death would be unnecessarily intrusive for the person's family. A death that occurs under the voluntary assisted dying process is the planned and expected outcome of a person's decision to hasten their inevitable and imminent death as a result of their incurable disease, illness or medical condition.

In practice, this means that if the person's death would otherwise be reportable for another reason, section 8(5) of the Coroners Act will operate to override that reportability criterion, making the death not reportable to the coroner at all. For example, they may have died in circumstances that would otherwise make the death reportable as a death in care or a death in custody. This approach differs from that taken in Western Australia which preserves the reportability of voluntary assisted dying deaths in circumstances where the death would otherwise be reportable as a death in care.[23]

As reflected in the Explanatory Notes accompanying the Voluntary Assisted Dying Bill into Parliament, the Queensland Parliament has given effect to the Queensland Law Reform Commission's view that any suspicions surrounding the death of a person through accessing voluntary assisted dying may still be reported to the coroner for investigation.

Where there are concerns that the person's death is or may be due to the self-administration or administration of a voluntary assisted dying substance other than in accordance with the Voluntary Assisted Dying Act,

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[19] Voluntary assisted dying explained | Queensland Health
[20] *Voluntary Assisted Dying Act 2021*, section 171
[21] *Voluntary Assisted Dying Act*, section 8
[22] *Voluntary Assisted Dying Act*, section 147
[23] *Coroners Act 1996 (*WA), section 3A

the coroner can investigate the death to determine whether the death is a reportable death under the Coroners Act, and if the coroner is satisfied the death occurred in circumstances not authorised by the Voluntary Assisted Dying Act, the death will be investigated under the Coroners Act in the usual way.

Possible scenarios could include where the voluntary assisted dying substance was administered by someone other than the person or the authorised administering clinician ('unauthorised administration'); whether the person was administered the substance at a time when they no longer had decision making capacity or were alleged to have been coerced or where a voluntary assisted dying substance was used to cause the death of someone other than the person who was authorised to access voluntary assisted dying.

In practice, concerns may be brought to the coroner's attention by the Voluntary Assisted Dying Review Board, a family member or a clinician involved in the person's care. Where there are immediate concerns that the death may be suspicious, the death should be reported to police. Otherwise, the concerns are to be directed to the State Coroner in the first instance.

The State Coroner may direct a coroner to investigate a death if the State Coroner considers the death is a reportable death or the State Coroner has been directed by the Minister to have the death investigated, whether or not the death is a reportable death.[24]

The coroner's investigation to determine whether the death occurred in accordance with the Voluntary Assisted Dying Act will be informed by information including records obtained from the Voluntary Assisted Dying Review Board and clinicians involved in the voluntary assisted dying process for the person.

3.5 Triaging natural causes deaths

Apparent natural causes deaths are consistently the largest reportable death type reported to coroners. Clearly the coroner has an important role when the cause of death is genuinely unknown or uncertain. However, experience has shown that a treating doctor's unavailability or decision not to issue a cause of death certificate can and often does result in obviously natural causes deaths being reported unnecessarily.

Unless managed proactively, these deaths can place considerable strain on limited coronial resources. Unnecessary reporting of these deaths may result in:

- extra distress for family members;
- the waste of significant police time and other police resources;

[24] *Coroners Act 2003,* section 11

- the unnecessary incurring of conveyance fees paid to the government contracted funeral director; and
- a waste of time by pathologists and/or coroners.

These guidelines are aimed at reducing the number of natural causes deaths reported unnecessarily to a coroner. They also provide guidance to first response officers about how to manage the report of a sudden death at a private residence or nursing home. They are to be read in conjunction with *Chapter 5.2 Preliminary investigations, issue of cause of death certificates*, which provide guidance to forensic pathologists and coroners about the approach to be taken when considering a natural causes death reported by merely because a doctor is not available or willing to issue a cause of death certificate.

Legislation

Coroners Act
Sections 8(3)(d), 11(2)(a), 12(2)(a), 13, 26(5), definition of 'investigation'
Births, Deaths and Marriages Registration Act 2003, s. 30

When are natural causes deaths 'reportable'?

Section 8 of *Coroners Act 2003* outlines eight (8) circumstances in which a sudden death is reportable.

Natural causes deaths only need be reported if '*a cause of death certificate has not been issued, and is not likely to be issued, for the person*' - s8(3)(e).

The *Births, Deaths and Marriages Registration Act 2003* s. 30 states a doctor **must** issue a death certificate if he/she is able to form an opinion as to the **probable** cause of death and the death is not otherwise reportable under the Coroners Act e.g. the death is a violent or otherwise unnatural death. Pursuant to s. 30(4) a doctor has two (2) working days to issue the cause of death certificate.

In principle

It is important that natural causes deaths are not unnecessarily made the subject of a coronial investigation merely because the deceased person's usual treating doctor is unavailable or does not fully understand their obligations when certifying a death. The procedures described below recognise there are opportunities for police and coroners to prevent obviously natural causes deaths from entering the coronial system.

In practice

Guidelines for first response officers

Police officers who attend a sudden death either at a private residence or a nursing home, which appears to be of natural causes should make inquiries with family and/or friends as to any known medical conditions the

deceased was suffering and the identity of a doctor who may be in a position to issue a cause of death certificate.

Police officers should make reasonable enquiries to locate the treating doctor and discuss their willingness to issue a certificate for the deceased. Coronial nurses located at the Queensland Health Forensic and Scientific Services (QHFSS) mortuary in Brisbane can help officers locate treating doctors. Treating Doctors can sometimes find an approach from police inconvenient or confronting. Independent doctors from the Queensland Health Clinical Forensic Medicine Unit (CFMU) are available to assist police in their dealings with treating doctors in these cases, and can provide a helpful clinical peer 'sounding board' for treating doctors weighing up their opinion about a probable cause of death. Officers can also encourage the treating doctor to discuss the death with the Registrar or local coroner should the doctor be more reassured by doing so.

If the death is not unexpected and officers form the view a cause of death certificate is likely to issue; and the death is not otherwise reportable, the officers should advise the family the matter is not a coronial matter and the family should contact a private funeral director to make any necessary arrangements.

The family should also be advised that it will be necessary for them or their funeral director to contact the deceased person's usual treating doctor to arrange to have a cause of death certificate issued. They should be advised that if a death certificate is not forthcoming the matter will become a coroner's case.

Queensland Ambulance Service (QAS) paramedics will usually have already attended and they should be asked to issue a life extinct certificate. If this has not happened the QAS should be called to attend and confirm that the apparently deceased person does not require emergency transportation to hospital. The first response officers should ensure that a life extinct certificate has issued before they depart the scene.

Officers should be alert to the possibility that because of advancing age, infirmity, an extreme grief reaction, or poverty on occasions the surviving family member(s) may not be competent to make the necessary arrangements. In such cases it may still be necessary to contact the government contracted funeral director to move the body to its premises so that an application under the Burials Assistance Scheme can be made or more capable relatives located.

If the death for any reason appears suspicious or unnatural it should be discussed with the shift supervisor or district communications room supervisor.

The officers who attend the scene should ensure the details of their attendance are entered on QPRIME in accordance with the QPRIME user guide.

If a cause of death certificate does not issue

On occasion, even when the family indicates they had been expecting the death and/or a doctor indicates he or she will issue a cause of death certificate, one is subsequently not forthcoming.

If this occurs, the funeral director who has possession of the body and who is not authorised to prepare the body for a funeral until a death certificate is issued will contact the coroner who will direct police to treat the death as reportable. This will require police to engage the government contracted funeral director to transport the body from the family's funeral director's premises to the local government mortuary and to prepare a form 1.

The Detective Inspector, Assistant to the State Coroner, may be contacted on 07 32474603 should first response officers require any further assistance.

Guidelines for coroners – advice to treating doctors

Doctors regularly phone the coroner seeking about whether a death is reportable. Not infrequently these calls relate to apparent natural causes deaths and come from doctors who have been approached by police about issuing a certificate, or from junior hospital doctors who have been tasked with completing the paperwork.

In these cases, the doctor should be questioned carefully about the deceased's medical history, clinical management, prognosis, the event leading to the death and the doctor's level of certainty about probable cause of death. If the doctor is willing to issue a certificate and coroner is satisfied the death is not reportable, the doctor should be encouraged to contact the family to explain his or her opinion about the likely cause of death as this provides the family with a final opportunity to express any concerns about the death before the certificate is issued. A general practitioner who is willing to issue a certificate but is not sure how to write it up should be referred to a CFMU doctor for further advice.

Coroners frequently receive calls from hospital doctors about apparent natural causes deaths where the treating team is unsure about issuing a certificate. Common examples include a person not previously known to the hospital who presents in cardiac arrest and dies despite emergency resuscitation efforts, or an inpatient who dies without a confirmed clinical diagnosis.

There are many cases where efforts by hospital clinicians to obtain and consider collateral medical history information from other treating doctors and discuss the case with senior members of the treating team can inform a considered opinion as to probable cause of death, without this having to be done by the coroner. When discussing these cases, coroners should

encourage clinicians to have exhausted reasonable enquiries before they decide a certificate is unlikely to issue, and the death is reported to police. It is important for clinicians to understand that an autopsy will not automatically be ordered if an obviously natural causes death is reported to police for want of a certificate. The coronial system does not exist to investigate the nuances of a known or clinically suspected diagnosis. If the coroner is satisfied there is enough information to support the issue of a certificate, and the death is not otherwise reportable, the doctor should be encouraged to consider approaching the family about the possibility of a consented hospital autopsy if they wish to further explore the deceased's underlying condition.

Occasionally, the treating team is reluctant to issue a certificate because they are considering several possible mechanisms of death. If the coroner is satisfied the death is from natural causes and there are no health care concerns, the coroner may encourage the doctor to issue a provisional certificate and report the death via Form 1A. The involvement of forensic medicine officers from the Queensland Health Clinical Forensic Medicine Unit in reviewing these cases can assist in clarifying the most likely cause of death in these cases, without the death having to be reported to police. The option of a consented hospital autopsy should also be put to the treating team in these cases.

Triaging natural causes deaths at the preliminary investigation stage

Around 40% of the deaths reported by Form 1 are apparent natural causes deaths. Experience in Brisbane has shown how early proactive management of these reports, with assistance from pathologists, clinical nurses and forensic medicine officers, can divert a substantial number of these deaths from unnecessary autopsy and further coronial investigation.

Chapter 5.2 Preliminary investigations, issue of cause of death certificates provides guidance to coroners when deciding how to manage a natural causes death reported merely because a cause of death certificate has not issued.

State Coroner's Guidelines 2013

Chapter 4

Dealing with bodies

4.1 Introduction

Coronial involvement in the early aftermath of a person's death can be very disempowering for families. They have virtually no control over the body once the death is reported to the coroner, as the coroner takes control of the body until it is no longer needed for the investigation or the coroner stops investigating the death. Coroners can generally accommodate the therapeutic needs of grieving families to see the body or give effect to the deceased's wishes regarding organ and tissue donation without compromising the coronial investigation. It is essential for the body and the deceased person's family to be afforded dignity and respect during the early stages of the coronial process.

This Chapter provides guidance to first response officers and hospitals about when a body may be released directly to the family's funeral director. It explains how suspected indigenous burial remains should be dealt with. It explains the steps to be taken to preserve evidence when a reportable death occurs in a health care setting. It provides guidance to police and government undertakers about how bodies are to be prepared and transported for coronial purposes. Finally, it clarifies the coroner's role in relation to therapeutic viewings, administering religious or cultural rites and facilitating organ and tissue donation or sperm removal while the body remains under the coroner's control.

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

Legislation

Coroners Act
Sections 12(2), 26(1) & (2)

In principle

It is appropriate for a deceased person's body to be released directly to the family's funeral director where it is impracticable for the body to remain at the place of death pending either the issue of a cause of death certificate by a treating doctor or the outcome of a coroner's preliminary investigation.

In practice

Guideline for first response officers attending an apparent natural causes death in the community

Chapter 3.4 *Triaging apparent natural causes deaths at the initial reporting stage* provides guidance to first response officers when making enquiries to locate a treating doctor who may be willing to issue a cause of death certificate for an apparent natural causes death in the community.

If the attending officers form the view a cause of death certificate is likely to issue; and the death is not otherwise reportable, the officers should advise the

family the matter is not a coronial matter and the family should contact a private funeral director to make any necessary arrangements.

The family should also be advised that it will be necessary for them or their funeral director to contact the deceased person's usual treating doctor to arrange to have a cause of death certificate issued. They should be advised that if a death certificate is not forthcoming the matter will become a coroner's case.

Queensland Ambulance Service (QAS) paramedics will usually have already attended and they should be asked to issue a life extinct certificate. If this has not happened the QAS should be called to attend and confirm that the apparently deceased person does not require emergency transportation to hospital. The first response officers should ensure that a life extinct certificate has issued before they depart the scene.

Officers should be alert to the possibility that because of advancing age, infirmity, an extreme grief reaction, or poverty on occasions the surviving family member(s) may not be competent to make the necessary arrangements. In such cases it may still be necessary to contact the government contracted funeral director to move the body to its premises so that an application under the Burials Assistance Scheme can be made or more capable relatives located.

If the death for any reason appears suspicious or unnatural it should be discussed with the shift supervisor or district communications room supervisor.

The officers who attend the scene should ensure the details of their attendance are entered on QPRIME in accordance with the QPRIME user guide.

If a cause of death certificate does not issue

On occasion, even when the family indicates they had been expecting the death and/or a doctor indicates he or she will issue a cause of death certificate, one is subsequently not forthcoming.

If this occurs, the funeral director who has possession of the body and who is not authorised to prepare the body for a funeral until a death certificate is issued will contact the coroner who will direct police to treat the death as reportable. This will require police to engage the government contracted funeral director to transport the body from the family's funeral director's premises to the local government mortuary and to prepare a form 1.

The Detective Inspector, Assistant to the State Coroner, may be contacted on 07 3292 5900 should first response officers require any further assistance.

Guideline for coroners – arrangements for bodies when impracticable for body to remain at hospital or nursing home pending outcome of coroner's preliminary investigation

Chapter 7.4 *Investigating health care related deaths* explains the process by which doctors and nursing homes can report a death directly to the coroner without involving police. This is generally initiated by a phone call to the coroner who will decide whether the death is reportable and if so, how it is to be reported.

For those deaths reportable by Form 1A (the death is reportable but it may be appropriate for the coroner to authorise the issue of a cause of death certificate without autopsy), the body should generally remain in the hospital mortuary until the coroner completes his or her preliminary investigation. This is in case the coroner decides further coronial investigation is required and the body needs to be transported to a coronial mortuary for autopsy. However, it is not always practicable for the body to remain on site - hospital mortuaries may be at capacity from time to time and nursing homes and small hospitals generally have no storage facilities. Nursing homes often report resident deaths after the body has been released to the family's funeral director.

When directing a nursing home or hospital to report a death via Form 1A in these cases, the coroner should clarify where the body is being held and if not released already, give permission for it to be released to the family's funeral director. The coroner should ask for the funeral director's contact details to be provided with the Form 1A so the coroner's staff can notify the funeral director as soon as practicable of the coroner's involvement. This ensures the body is not buried or cremated before the coroner's preliminary investigation is completed. It also ensures the coroner is informed of the timing of the family's preferred funeral arrangements which may be affected should the coroner require the body for further investigation.

Occasionally a death reported by Form 1A will require further investigation, including autopsy. Coroners should ask nursing homes and hospitals to advise families of this possibility at the time the death is reported so families can factor this into their funeral planning. Coroners should also be proactive in ensuring families and funeral directors are kept informed of the progress of the preliminary investigation, especially if an autopsy is likely. If an autopsy is required and the family is unable or unwilling to postpone funeral arrangements, it is generally acceptable for the funeral service to proceed and for the body to be transported from the funeral home for autopsy afterwards. Before giving permission for the service to proceed, coroners should seek advice from a forensic pathologist about whether delay occasioned by accommodating a funeral could compromise the autopsy.

4.3 Dealing with possible indigenous burial remains

Legislation

Coroners Act

Sections 12(2)(a), 14(3)(b), 26(2)(a), 'indigenous burial remains', 'traditional burial site'

Aboriginal Cultural Heritage Act 2003,
'Aboriginal human remains', Part 2, division 2 ss.15, 16, 17, 18

Torres Strait Islander Cultural Heritage Act 2003,
'Torres Strait Islander human remains', Part 2 division 2 ss.15, 16, 17, 18

In principle

Burials are highly significant to Aboriginal and Torres Strait islander people and interference with burial remains is of great cultural concern to their communities. When dealing with what may be indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to minimise unnecessary disturbance of indigenous burial remains.

As soon as it is established that remains are indigenous burial remains, the coronial investigation must cease and management of the remains should be transferred to officers from the Cultural Heritage Coordination Unit of the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs and representatives of the traditional owners of the land where the remains were found.

In practice

The discovery of any skeletal remains must be reported to police in the first instance. The site is to be treated as a potential crime scene until the coroner is satisfied the death is not suspicious. The site must be secured but before it is disturbed by any forensic process, attending officers must first consider whether the remains could be indigenous burial remains. In doing so, police must have regard to section 8.5.15 of the QPS Operational Procedures Manual (OPM). The Cultural Heritage Coordination Unit has developed guidelines to assist police in identifying possible indigenous burial remains.[1] These guidelines set out a range of physical signs that may indicate a site contains indigenous human remains, for example the location of the site, its proximity to carved or scarred trees or stone arrangements, the presence of grave artefacts, how the remains are positioned and their condition.

In all cases of possible criminal activity, scene preservation and forensic examination requirements will have priority.

However, once the possibility of criminal activity is excluded and it is thought the remains could be indigenous burial remains, attending police are to contact the Cultural Heritage Coordination Unit whose officers will attend the site as a matter of priority to help investigating officers determine the antiquity and ethnicity of the remains for the coroner's consideration. Attending police retain responsibility for the site at all times and may arrange for a second forensic expert opinion (either on site or by review of digital images) if

[1] *General Information for Police: Aboriginal and Torres Strait Islander Human Remains* www.datsima.qld.gov.au/resources/atsis/people/indigenous-cultural-heritage/hr-general-info-police.pdf.

necessary. Cultural Heritage Coordination Unit officers will liaise with Aboriginal or Torres Strait Islander elders at the appropriate time during this process.

The coroner's investigation must stop once the coroner is satisfied the remains are indigenous burial remains. Sometimes this confirmation can be made without having to remove the remains from the site. However, in cases where the on-site assessment is inconclusive, it will be necessary to transport the remains to a coronial mortuary for further specialist examination. In these cases the Cultural Heritage Coordination Unit officers may continue to advise and assist police with further site examination, evidence retrieval and controlled removal of the remains. Further specialist examination and analysis of the remains may involve input from forensic osteologists or physical anthropologists.

Once the coroner is satisfied the remains are indigenous burial remains, the Cultural Heritage Coordination Unit will take responsibility for liaison and reburial with the appropriate Aboriginal or Torres Strait Islander community. This guideline is to be read in conjunction with Chapter 6.2 *Release of bodies for burial or cremation* which explains the process by which indigenous burial remains are to be released.

These guidelines have been prepared with reference to the Cultural Heritage Coordination Unit publication *The Discovery, Handling and Management of Human Remains under the Provisions of the Aboriginal Cultural Heritage Act 2003 and Torres Strait Islander Cultural Heritage Act 2003*[2]

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

This section is intended to help health professionals and first response police officers decide what steps need to be taken to preserve evidence when a health care related death has occurred in a hospital or other health care facility. Staff and police should consider the factors listed below. If in doubt about any aspect, health care staff or police should consult with a coroner or forensic pathologist.

Violent or suspicious deaths that just happen to occur in a hospital should be treated in the same way as any other violent or suspicious death.

In principle

When deciding what interference with a death scene in a health care setting should occur and what instruments, equipment and specimens should be seized, those managing the facility and the investigators must try to balance three competing priorities:

- the forensic needs of the investigation,
- the need for the hospital or health care facility to continue to treat other patients or residents, and
- the sensitivities of the family and their need to have contact with the deceased in the least distressing condition.

[2] www.datsima.qld.gov.au/resources/atsis/people/indigenous-cultural-heritage/hr-remains-guideline.pdf

The greater the likelihood that a crime has occurred or seriously deficient practice has contributed to the death, the greater the emphasis that must be given to the interests of the investigation. In these rare cases in which criminal or civil proceedings are likely, continuity of the chain of possession and strict proof of events leading to the death can justify an operating theatre or hospital ward being treated as a crime scene.

In most other cases, the needs of the facility to have free access to operating theatres etc should be given priority. In most cases, the cause of death and the factors that contributed to it can be established from witness statements, medical records and notes, instrument settings etc making the isolation of the scene unnecessary.

In all cases, the needs of the family to have contact with the deceased should be considered and the desirability of cleaning the body to make such viewing less traumatic should only be over ridden if the need to preserve evidence justifies it.

In practice

Preserving the death scene

(a) Scenes of homicides, etc resulting from an incident within a health care facility

Scenes of death that involve, or may involve homicides, suspicious deaths, suicides or accidents **resulting from an incident within the facility itself should be preserved** for examination by police in exactly the same way as if the death had occurred in the general community.

Careful scene preservation is in the best interest of the health facility. For example, thorough and independent scene examination in a suicide may deflect unjustified criticism of a psychiatric unit.

As in the community, if the patient has been removed elsewhere for treatment and dies, or is likely to die, the scene of the incident (not the scene of death) should be preserved for examination.

(b) Scenes of 'adverse health events'

Deaths from "adverse health events" are rarely of sufficient complexity to warrant preservation of the scene for examination by police or other experts. The key question is whether examination of an intact scene might help understand what happened.

In most reportable deaths that occur in health care settings, scene preservation is unnecessary and undesirable because of disruption to the health facility. For example, operating theatres in which deaths have occurred generally do ***not*** require preservation for inspection by police.

However, medical equipment at (or from) the scene must be preserved for independent examination if this may help understand the cause or circumstances of a reportable death. Medical equipment still attached to the body raises special issues and is considered next.

Preserving medical equipment attached to the body

This includes items entering the body (e.g. canulae, lines, ET and NG tubes, catheters, drains) and devices attached to these (e.g. drip bags, syringes, drain bottles and bags, urine bags).

The general rule is that medical equipment attached to the body must remain in place for the pathologist to examine as part of the autopsy whenever a deceased has been undergoing medical or surgical treatment at the time of death, regardless of the health care setting.

The reason is that, even though such items are often irrelevant to the investigation, it is difficult to predict which will be needed and in which cases. Generally, it is just as easy for items to be described, removed, examined where necessary, and discarded in the mortuary as elsewhere.

Exceptions can be made to the general rule – if removal is documented in the medical records (a sketch is useful), or in a report to the coroner and pathologist **AND** if justified by the following:

- to attempt resuscitation or other medical treatment – **this is always an over-riding priority**
- to make the body safe to handle (e.g. removal of a needle)
- to meet the request of a family member wishing to view the deceased before autopsy without sightly equipment such as an NG tube or airway, unless a problem such as incorrect positioning may have contributed to death in which case the tube should be left in place.

The following questions should be considered before removing equipment, ideally in consultation with the coroner or an independent professional (e.g. senior nurse, anaesthetist or forensic pathologist):

- could the item itself have caused or contributed to death e.g. ET tube in the oesophagus, infusion pump delivering medication incorrectly?
- what are the alternatives to complete removal e.g. defer viewing until after autopsy when the deceased may be more presentable anyway or cut an NG or ET tube just inside the body leaving the tip in situ?
- could independent examination of the equipment, either in situ or after removal, assist the investigation e.g. to document the settings, or check for faults?

Preservation of other evidence in a health care setting

(a) Preserving clothing and jewellery

Examination of clothing and sometimes jewellery can assist the pathologist and police reconstruct events e.g. by inspecting knife or bullet holes. Clothing removed to allow resuscitation should be placed in a bag accompanying the body to the mortuary. Jewellery and other valuables removed at the health facility should be documented and

returned to the family in accordance with the facility's own procedures. However, in homicides, suspicious deaths and deaths in custody, items still on the body at the time of death should be left in situ for examination in the mortuary.

(b) Preserving other non-medical items attached to the body

Items such as a noose used for self-inflicted hanging or a knife still protruding from the body should be preserved in situ wherever possible. If removed to allow medical treatment or for safety reasons, the items should be documented in the medical records and preserved separately for the police and pathologist to examine e.g. in a bag accompanying the body.

(c) Preserving trace evidence, blood stains, etc on the body

Generally, vital resuscitation attempts irretrievably contaminate any trace evidence on the body, especially on the face. Cleaning the face to allow viewing by the family is therefore usually permissible. In alleged sexual assaults, however, the genital area should not be disturbed prior to forensic examination. Consult the coroner or a forensic pathologist if in doubt.

(d) Preserving injuries

Although medical treatment is always a priority, injuries possibly due to an assault should ideally be preserved intact for the pathologist to examine. For example, examination of penetrating injuries (e.g. knife and firearm wounds) is critical to the reconstruction of events, and surgical incisions should avoid such wounds where possible.

(e) Preserving pathology samples to assist the coroner's investigation

Some pathology samples may need to be preserved for transfer to the forensic pathologist, toxicologist or other expert for separate examination. Examples include blood (or other samples) taken at the time of hospital admission as these may offer the best evidence of intoxication with alcohol, drugs or poisons at the time of an incident, and anatomical pathology specimens relevant to the autopsy such as an excised bullet wound, traumatically ruptured spleen, or placenta in a peri natal death. Admission samples should never be disposed of in cases where there is any real likelihood that the patient may die.

(f) Take blood samples when adverse reaction to anaesthetics or drugs may be involved

Deaths that may be due to an anaphylactic reaction or other form of hypersensitivity to a drug, anaesthetic or any other agent are reportable. In such cases, blood should be taken from the body for testing within 4four hours of death for tryptase and any other testing that may shed light on the cause of death. Police should therefore immediately contact the coroner to obtain consent for this to happen. The blood should then be stored in clean glass vials and refrigerated

immediately. The Form 1 Police Report of a Death to the Coroner should note the location of these samples.

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

Legislation

Coroners Act
Section 18

Hospitals and Health Boards Act 2011
Section 157

In principle

A deceased person's body is perhaps one of the most important items of evidence from a death scene.[3] While it is important for the body to be managed in way that minimises the risk of diminishing its forensic value, it must be treated with dignity at all times while being examined at the scene, prepared for transportation and transported to the mortuary.

In practice

Transportation of bodies

Bodies can only be transported to designated mortuaries by government contracted undertakers acting under direction from police or the coroner.

Attending police are required to act under the Police Powers and Responsibilities Act and section 8.4 of the Queensland Police Service Operational Procedures Manual (OPM) when attending a death scene and arranging for the body to be transported.[4]

Occasionally families may wish to observe cultural or religious rites before the body is removed from the scene. Coroners should allow this to occur for non-suspicious deaths once the scene has been forensically examined, provided the ritual does not involve physical contact with or contamination of the body. Care needs to be taken to ensure these observances do not unduly delay transportation and consequently it is reasonable to impose timeframes on when and for how long the ritual can be performed.

Government undertakers must comply with any direction given by attending police or the coroner and must observe the requirements of the commercial arrangement under which they are contracted to transport bodies for coronial purposes.

[3] Freckleton, I & Ranson, D *Death Investigation and the Coroner's Inquest* 2006, p.221
[4] See particularly section 8.4.4 Pre-mortuary procedures and removal of bodies from scene and 8.4.22 Funeral directors

Transportation of hospital records with the body

Since 2010, the Queensland Police Service has used sealed body bags to transport bodies for coronial purposes. This alleviates the need for police to escort the body to the mortuary to lodge non-suspicious deaths. It is recognised that many health and aged care facilities are moving to electronic medical record systems. Coronial mortuaries have access to the Department of Health electronic medical record system and other clinical databases. However, there are some facilities which still maintain paper-based patient/client records. When a death occurs at a hospital, it is desirable for any of the deceased's paper-based hospital records to be transported with the body. While it is preferred that the original records be made available at this time, it may not always be possible for copies to be made by the hospital before attending police leave the hospital. Consequently, it is acceptable for hospital staff to:

(a) give the paper-based medical records to attending police who will arrange for the government undertaker to deliver the records to the mortuary with the body; or
(b) if the records can not be downloaded or copied prior to the attending police officers' departure from the hospital, give the records to the government undertaker so they can be transported with the body; or
(c) if the records can not be downloaded or copied prior to the government undertaker's departure from the hospital, courier the records to the mortuary as soon as practicable.

These arrangements are consistent with the operation of section 157 of the *Hospitals and Health Boards Act 2011*.

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

In principle

It is well recognised there are significant benefits for bereaved families who have the opportunity to view their loved one's body. Viewing the body helps the bereaved start the process of mourning by satisfying themselves of the reality of the situation. In the coronial context, it also helps ameliorate the disempowering effect of the body remaining out of the family's control during the early stages of the coroner's investigation. While ensuring the integrity of the coroner's investigation is paramount, families should generally not be prevented from view the body at a coronial mortuary unless the death is suspicious or the condition of the body could place the family at risk of emotional distress or trauma.

In practice

Arrangements for formal identification viewings are dealt with in Chapter 8 of these guidelines and section 8.5.5 of the QPS OPMs.

When is a viewing not appropriate?

Viewings may not be appropriate when the body has been assessed as not visually identifiable, for example due to the extent of traumatic injury or post-mortem changes. Coronial mortuaries do not provide cosmetic reconstruction

as this is done by funeral directors for funeral home viewings. In these cases, the family is to be advised the viewing is neither possible nor recommended because of the risk of psychological injury due to the body's condition, and should be referred to their funeral director for advice about what may be possible at the funeral home.

Infection risk doesn't necessarily prevent a viewing. Advice should be sought from the case pathologist about whether and if so how this risk can be managed to facilitate a viewing.

When can a viewing be conducted?

Family requests for viewings will generally be made through coronial counsellors or hospital social workers.

Before arranging a viewing, the counsellor or social worker should first inspect the body and clarify with the case pathologist or the coroner whether the death is suspicious and whether there is a risk of infection.

It may be preferable for viewings to be conducted after the autopsy because the body's appearance will be more suitable for viewing as it will have been cleaned and carefully sutured. However, these guidelines recognise there can be reasons for the family to view the body before the autopsy is performed. Families may wish to view the body before the autopsy for religious or cultural reasons, due limited family availability to attend a viewing or before the body is transported from a local mortuary to a coronial mortuary in another region for autopsy.

There is generally no need for counsellors or hospital social workers to seek coronial permission to arrange a therapeutic viewing unless there is a family dispute about who can see the body.

Viewings will not be permitted before autopsy if the death is suspicious.

Managing family conflict

Death often exacerbates pre-existing family tensions. This can result in dispute between family members about who should be allowed to view the body. Where these disputes arise, the counsellor or social worker should seek direction from the coroner before arranging the viewing. The coroner is to have regard to the family member hierarchy established by the Coroners Act and seek advice from the counsellor or social worker about reasonable ways in which the viewing could be conducted to meet the family's competing emotional needs, for example, whether it is feasible to schedule separate viewings.

How should a viewing be conducted?

Viewings should only be conducted by coronial counsellors or hospital social workers or nurses practising in emergency, intensive care and perinatal wards. These professionals are trained to provide support to bereaved families. Viewings are not be conducted by mortuary or ward staff.

It is reasonable to impose a time limit on a viewing as families can find the process of leaving the body extremely difficult. Forty-five minutes is the recommended duration, though experience has shown many viewings do not take this long.

Children are not to attend a viewing without both an adult support person and a coronial counsellor or social worker present.

Families will generally be permitted to view, touch and hold the body, undertake memory making (such as hand and foot prints, taking locks of hair), dress the body or perform religious, cultural or social rituals that do not interfere with the body and provided the ritual is not unduly disruptive to the mortuary environment. For non-suspicious deaths, there is no need for the viewing to be supervised by police.

4.7 When can organ and tissue donation take place?

Legislation

Coroners Act
Sections 18A, 54AA

Transplantation and Anatomy Act 1979
Sections 22, 24, 25, 'tissue'

In principle

The mere fact a person's death is reportable does not preclude whole organ or tissue donation. Rather, over 50% of Australian donors are coroner's cases. Provided coroners are satisfied the retrieval won't compromise their investigation or the prosecution of any criminal charges that may be laid in respect of the death, there is no reason for coroners to withhold consent to organ and tissue retrieval. Facilitating organ and tissue donation is consistent with the coronial system's focus on respecting the wishes of the deceased and their families to the greatest extent possible, and pursuing public benefit from sudden death investigation.

In practice

The retrieval of organs and tissue for transplantation and other medical and scientific purposes is regulated by Part 3 of the *Transplantation and Anatomy Act 1979*. When a person's death is reportable under the Coroners Act, coronial consent is required before retrieval can proceed.

Whole organs - most organ donations occur when a person is declared 'brain dead' (when the brain is so badly damaged that it permanently stops functioning, usually because of bleeding in the brain, a stroke, infection or severe head injury). Organ donation may also be possible in much more limited conditions after cardiac death (after a person's heart has stopped beating). Commonly retrieved organs include the heart, lungs, liver, kidneys and pancreas. To remain viable, organs must be retrieved within up to 12 hours after the death, depending on the organ to be donated. Obviously the

retrieval must be performed in hospital and if the donor's death is reportable, before a coronial autopsy is performed.

Tissue - tissue donation may be possible after brain death or cardiac death. Commonly retrieved tissues are bone and musculoskeletal tissue, heart valve and pericardium, corneas and skin. The timeframe for tissue retrieval is within 24 hours after death, depending on the tissue to be donated. Tissue retrieval occurs mainly in major cities where tissue banks are found as regional mortuaries are not equipped to undertake tissue donation. If the donor's death is reportable and an autopsy may be necessary, this means retrieval usually occurs at the QHFSS mortuary in Brisbane.

The DonateLife website contains very useful general information about the organ and tissue donation process.[5]

Process for obtaining coronial consent for organ & tissue donation

If a potential organ donor's death is or may be reportable and an autopsy is likely, the treating intensivist or DonateLife donor coordinator will first discuss the case with the duty pathologist who will advise whether organ retrieval could compromise an autopsy. Depending on the circumstances of the death, it may be only certain organs need to be retained for forensic examination but others can be made available for donation. If the death is suspicious, input will also be sought from the investigating officer about whether organ retrieval could compromise a criminal prosecution. The treating intensivist or DonateLife donor coordinator will then contact the coroner to seek verbal consent for organ donation to proceed. Coronial consent should be given in all cases where the coroner is satisfied the retrieval will not hinder either the coronial investigation or a criminal prosecution. The coroner's consent is then documented under the *Transplantation & Anatomy Act 1979* as soon as practicable.

Forensic pathologists are available to provide on-site advice to the retrieval team during the retrieval if necessary.

If the coroner considers an autopsy is not necessary and the death is more appropriately dealt with by a Form 1A investigation, the coroner must expedite his or her consideration of the matter so as not to jeopardise organ and tissue retrieval timeframes.

Management of body following organ retrieval in hospital

Following retrieval, the body may be moved from the operating theatre to an appropriate bedspace or, if the family has already left the hospital, to the hospital mortuary without a police attendance or escort.

For non-suspicious deaths, families may spend time with the body and will generally be permitted to touch and hold the body, undertake memory making (such as hand and foot prints, taking locks of hair), dress the body or perform

[5] www.donatelife.gov.au

religious, cultural or social rituals that do not interfere with the body. There is no requirement for this to be supervised by police. However, if there is a family dispute about who may view the body, the donor coordinators and/or social workers must first consult with the coroner who will consider the situation with reference to the matters outlined in section 4.6 above. Once the family has finished spending time with the body, the body may be moved to the hospital mortuary without a police attendance or escort.

Post-retrieval viewings will not be permitted for suspicious deaths. A suspicious death is one where at the time of organ retrieval, police are investigating the death as suspicious, regardless of whether there is a known suspect or not or whether charges have been laid in respect of the death. However, in the event police are not already in attendance at the hospital, the body may be moved from the operating theatre to the hospital mortuary without a police escort. There is no need for members of the treating team or the donor coordinators who complete the donor identification to remain at the hospital pending the police attendance.

Process for obtaining coronial consent for tissue donation – donor in coronial mortuary

Amendments to the Coroners Act which came into effect on 2 November 2009 enable persons acting on behalf of prescribed tissue banks to access Forms 1 and to conduct external examinations of deceased bodies in mortuaries to assess their suitability for tissue donation on a standing or ongoing basis rather than needing to seek the consent of the investigating coroner on a case by case basis as was required before the amendments.

In order to maximise opportunities for tissue retrieval, the State Coroner has entered into arrangements under s.54AA of the Act with the Queensland Bone Bank, the Queensland Eye Bank, the Queensland Heart Valve Bank and the Queensland Skin Bank to provide tissue bank staff with access to information from the Form 1 (Police report of a death to the coroner) and perform an external examination of the body in order to assess donor suitability before the family and the coroner is approached for consent to retrieval.

Access to the Forms 1 must be in accordance with these arrangements and the examinations must comply with guidelines issued by the State Coroner under s. 18A.

These are the arrangements and guidelines under which the Queensland Health owned prescribed tissue banks (Queensland Bone Bank, Queensland Eye Bank, Queensland Heart Valve Bank and Queensland Skin Bank) and their staff or persons acting for the prescribed tissue banks including Coronial Nurse Coordinators at Queensland Health Forensic and Scientific Services and staff members of Queenslanders Donate (hereafter all referred to as ‘tissue bank staff members’ will be authorised to access Forms 1 at the QHFSS mortuary at Coopers Plains, and the Gold Coast, Nambour and Toowoomba Hospital mortuaries and undertake external examinations of the bodies of potential donors.

Arrangements for accessing forms 1

Tissue bank staff members may access the front page of all Forms 1 to ascertain the type of death and the date of birth of the deceased. In cases where the Form 1 indicates the death is suspicious or is a death in custody or the deceased is less than two years old, no further inspection of the Form 1 is authorised without the consent of the investigating coroner.

In all other cases the form can be inspected to ascertain the other matters set out in s. 54AA(1)(c)-(f), namely a brief description of the circumstances of the death; the deceased person's previous medical information; and the name and contact details of the deceased person's available next of kin.

Tissue bank staff members may access the Forms 1 from AUSLAB or from police or mortuary staff when the body is lodged at the mortuary or from the coroner's office.

State Coroner's guidelines for external examination of potential tissue donors

In cases where, as a result of inspecting the relevant Form 1, a tissue bank staff member concludes the deceased person may be a suitable tissue donor and the staff member wishes to undertake an external examination of the body to further asses its suitability, the staff member must comply with the following guidelines:

Prior to the examination

1. The Australian Organ Donor Register must be checked to confirm the deceased did not object to donating tissue.
2. The deceased must meet the basic donor selection criteria of the prescribed tissue bank (e.g. time since death, age).
3. Agreement must be obtained from the case pathologist or on-call pathologist.
4. The deceased must have been formally identified, unless visual identification is imminent and may provide an opportunity to seek family consent.
5. The identity of the deceased must be confirmed by comparing the details on the mortuary tag with the case documentation.

During the examination

6. The dignity of the deceased person must be respected and maintained.
7. Interference with the body must be kept to a minimum.
8. The body should not be altered in any way or undergo any invasive process.
9. Items attached to the body (e.g. a noose, IV lines) must not be altered or removed without the pathologist's approval.

Immediately after the examination

10. The examination details must be recorded on a Queensland Health approved form, highlighting any abnormalities, especially any of forensic or coronial relevance.

11. A copy of the completed form should be placed in the autopsy file straight away.
12. If abnormalities are found, these should be discussed with the pathologist and agreement obtained that donation can proceed before seeking next of kin consent.

The coroner will be approached for written consent under the *Transplantation & Anatomy Act 1979* in appropriate cases after senior available next of kin consent has been obtained. Depending on autopsy scheduling, the retrieval may take place before or at the end of the autopsy. There is no reason for a coroner to withhold consent for tissue retrieval once satisfied the retrieval will not compromise the coronial investigation or any criminal prosecution.

Documentation of organ and tissue retrieval

Any abnormalities or other significant issues identified during organ or tissue retrieval will be documented for the case pathologist, who will convey this information to the coroner and include it in the autopsy report.

4.8 Removal of sperm and associated procedures for in-vitro fertilisation (IVF)

In principle

Coroners do not have currently have power to order sperm removal for non-coronial purposes. The posthumous removal of sperm, a testis or other tissue and the removal of blood for IVF testing can occur without court approval under Part 3 of the *Transplantation and Anatomy Act 1979*.[6]

Coroners and forensic pathologists will help facilitate sperm removals performed by IVF organisations under Part 3 without delay.

Coronial consent to the removal of the tissue is required where a death is a reportable death. This may be given orally and if so given must be confirmed in writing within seven days. [7]

In practice

Sperm and testes must be removed from a deceased person and processing commenced within 24 hours of death to remain viable for IVF.

This guideline adopts the QHFSS procedures for managing IVF sperm retrieval from a deceased person whose body is under the coroner's control.[8]

The coroner must be notified of a person's intention to apply for authorisation for sperm removal for IVF.

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[6] Re Cresswell [2018] QSC 142 https://www.sclqld.org.au/caselaw/QSC/2018/142
[7] *Transplantation and Anatomy Act 1979*, s.24
[8] https://www.health.qld.gov.au/healthsupport/businesses/forensic-and-scientific-services/forensic-services/death-autopsies/sperm-retrieval

Pending authorisation the coroner and forensic pathologist should action any lawful, reasonable and non-invasive interim measures recommended by the nominated IVF organisation to prolong sperm viability. Given the extremely short timeframe in which these applications must be dealt with, it is hard to imagine a situation where the autopsy could not be delayed to accommodate sperm removal.

Once sperm removal is authorised, the coroner and forensic pathologist must make appropriate arrangements to enable the IVF organisation to carry out the order without delay and in a way that doesn't compromise forensic examination of the body. A record of the coroner's consent should be saved to the coronial file.

State Coroner's Guidelines 2013

Chapter 5

Preliminary investigations, autopsies and retained tissue

5.1 Introduction

Autopsies are a vitally important aspect of coronial investigations. They can assist to identify the deceased, contribute information about the circumstances of the death and establish the cause of death. They are however, invasive, costly and potentially harmful. Accordingly, autopsies should be limited to the extent necessary to enable the coroner to make the findings required by s. 45 of the Coroners Act. In the case of deaths that are only reportable because a death certificate has not been issued the coroner should only order an autopsy if the coroner reasonably believes that no death certificate will be issued. The views of a family member should always be sought and considered before ordering an internal autopsy.

This Chapter also looks at steps that should be taken to ascertain whether a death is in fact reportable before ordering an autopsy including, if necessary, having a pathologist review the case with a view to issuing a cause of death certificate.

5.2 Preliminary investigations, issue of cause of death certificates

Legislation

Coroners Act
Sections 11, 11AA, 12, 13, 26, Schedule 2 Dictionary - investigation

Births, Deaths and Marriages Registration Act
Section 30

In principle

Preliminary examinations for deaths reported by initial police report

The Coroners Act authorises a range of largely non-invasive preliminary procedures to be undertaken promptly after police report the death to the coroner in writing under s 7(4) of the Act in order to enhance the efficiency and quality of the coronial process.

The preliminary examination process may include visual examination and post-mortem imaging of the body, taking and testing blood and other samples and collating information about the person's medical history. These procedures will generally be performed by forensic pathologists or other clinical coronial personnel under the supervision of a forensic pathologist. Information obtained from the preliminary examination may inform timely decision making by coroners about the extent to which further coronial investigation including autopsy is necessary, and/or improve the quality of testing through prompt sampling or testing.

In principle

Issue of cause of death certificates for natural causes deaths

Medical practitioners have a legal obligation to issue a cause of death certificate if they can 'form an opinion as to the probable cause of death'. When considering that issue the doctor may have regard to information gleaned as a result of examining the deceased person's body and/or information about the deceased person's medical history and the circumstances of their death.

Forensic pathologists, as a result of their having undertaken numerous autopsies may be better placed than other medical practitioners to form an opinion as to a probable cause of death after examining the deceased person's body and/or reviewing their medical records and considering the circumstances of the death as set out in the Form 1.

By having regard to this information, pathologists may be in a position to issue a cause of death certificate in relation to deaths that appear to be the result of natural causes and have only been reported because no other doctor can identify probable cause of death.

Experience shows in some months as many as 40% of reported deaths may ultimately receive a cause of death certificate and therefore not require any coronial investigation.

It is important that natural causes deaths are not unnecessarily made the subject of a coronial investigation merely because the deceased person's usual treating doctor is not available or does not fully understand their obligations in relation to the issuing of a cause of death certificate. The procedures described below are designed to avoid this happening by authorising pathologists to conduct a preliminary examination to determine whether they are able to issue a death certificate. The procedures also contemplate that in some instances it may be appropriate for the coroner to accept a death certificate even after an autopsy order has been issued.

In practice

Guidelines for examiners - preliminary examinations

For coronial purposes, preliminary examination procedures can commence as soon as police have submitted a written report of the death to the coroner. Section 11AA of the Coroners Act does not authorise the preliminary examination of bodies before police have reported the death in writing to a coroner, which will generally by way of a Form 1 registered with the Coroners Court.

Specifically, preliminary examinations may not be performed while police are endeavouring to obtain cause of death certificates for apparent natural causes deaths under the pre-registration triaging processes set out in the QPS Operational Procedures Manual. This is to ensure coronial resources, particularly pathologists, coronial nurses, mortuary assistants are applied only to deaths that have been formally reported to the coroner.

The preliminary examination process is designed to optimise post-mortem testing through timely taking of samples as post-mortem changes during the interval between death and sample collection can significantly affect the interpretation of test results. For this reason, coroners and coronial registrars need to be aware that sampling and/or testing can be particularly time-sensitive and may need to be undertaken in advance of both the Form 1 and the autopsy, ideally within 6-12 hours of death. Examples include:

- blood for tryptase in anaphylaxis
- blood for drugs affected by post-mortem redistribution
- samples for sensitive bacteria such as Meningococcus
- vitreous for glucose; and
- CT scans for arterial gas in maternal and diving deaths before obscured by decomposition.

Accordingly, in an urgent and exceptional case, a coroner may inform the pathologist that these procedures can be carried out after the death is reported to the coroner in writing (e.g. by email) but before the Form 1 is lodged; for example, a suspected homicide occurring over a weekend. In most cases of this nature the procedures would form part of an order for an internal autopsy examination.

The following doctors are approved as "examiners" under section 11AA(4) of the Coroners Act to perform preliminary examinations:

- Forensic pathologists employed by Health Support Queensland and credentialed to perform coronial autopsies
- Medical registrars working under the supervision of forensic pathologists
- Pathologists contracted by the Department of Justice & Attorney-General and credentialed to perform coronial autopsies

The following clinical personnel are considered to be "suitably qualified" under section 11AA(4) to perform preliminary examinations under the general supervision of an examiner:

- Registered Nurses employed by Health Support Queensland as a coronial nurse
- Mortuary assistants who are trained and qualified to a sufficient standard, as advised by the Managing Scientist in charge of Coronial Services
- Doctors employed and credentialed by Health Support Queensland as a forensic physician, forensic medical officer, or government medical officer
- Radiographers and Licensed Operators in the field of medical imaging
- Forensic odontologists credentialed by Health Support Queensland
- Police officers trained and qualified in the taking of fingerprints

Invasive preliminary examinations for deaths in custody, suspicious deaths and child deaths may only be undertaken by a suitably qualified person with the express approval and supervision of an examiner.

While section 11AA(3) of the Coroners Act sets out the range of procedures authorised for a preliminary examination, not all procedures will be necessary in every case. For example, whereas the taking of blood samples will form a routine part of a preliminary examination, vitreous humour will generally only be taken when an adequate femoral blood sample cannot be obtained for toxicology testing or when it is needed for specific biochemical testing. In short, the scope of the preliminary examination will be considered by the examiner on a case by case basis. Bodies will only be fingerprinted when required for formal identification purposes. In a few instances, sampling, imaging or other procedures may be undertaken as part of preliminary examinations solely to reduce the post-mortem deterioration that would occur if delayed until an autopsy; the results of these may only become available some days later.

Section 11AA(5) requires examiners to consider whether the family may be distressed by the preliminary examination, especially invasive sampling. Examiners must also take into account known cultural traditions and spiritual beliefs. The Form 1 may assist because, if the family has not raised any concerns about an internal autopsy, it may be reasonable to assume that preliminary examinations would likewise not raise concerns. On the other hand, if the family has raised concerns about an autopsy, examiners should consider carefully whether to proceed with invasive sampling and seek assistance from coronial counsellors or coronial nurses, who should support families to understand the preliminary examinations proposed. The examiner must consider the feedback provided and whenever practicable take this into account before preliminary examinations are undertaken.

Section 11AA(6) requires examiners to prepare a written preliminary examination report as soon as practicable and give this to a coroner. Such reports are confidential and must only be provided to coroners or the Coroners Court. In the report an examiner may adopt written material provided by suitably qualified persons or by those performing tests or examinations, e.g. nurses, toxicologists, radiologists or odontologists.

In cases where it is initially uncertain whether a cause of death certificate can be issued or what type of autopsy should be performed, it is intended that coroners will have regard to the preliminary examination report before issuing an autopsy order. A preliminary examination report must be contained in an email or other writing with a heading to that effect and contain a summary of the following:

(i) any additional information obtained or considered (including the medical and circumstantial history);
(ii) any imaging, sampling, testing or other procedures undertaken;
(iii) the results or findings of imaging, sampling, testing or other procedures unless these are not available and will be included in the autopsy report; and
(iv) the likely medical cause of death (if available) (or a recommendation as to the type of autopsy to perform).

In some cases it will be clear from the outset that a preliminary examination will not assist the coroner in deciding whether the death is reportable or

deciding the type of autopsy order, e.g. homicides requiring CT scans and access to medical records. In those cases, a separate preliminary examination report is not needed and the results of such examinations should be included in the autopsy report.

Guidelines for examiners – preliminary examination of apparent natural causes deaths reported to coroner or coronial registrar

The preliminary examination process is a crucial part of the initial stages of the investigation of an apparent natural causes death reported to the coroner only because a cause of death certificate has not been issued – section 8(3)(e). In many cases, the preliminary examination will yield sufficient information to support the issue of a cause of death certificate, whether by the person's treating doctor or by the pathologist.

Because the family will be aware the death is being treated as a coroner's case, it is important to involve them before any final decisions are made to exclude the death from the coronial processes. Therefore, if a probable cause of death can be established, the pathologist should request a coronial nurse or a coronial counsellor to contact the family to ascertain if they have concerns about the circumstances of the death or for some other reason want an internal autopsy to be undertaken.

The results of this consideration and consultation should be conveyed to the coroner or coronial registrar to whom the death has been reported. If the coroner or coronial registrar considers no further investigation is needed they should accept a cause of death certificate and the family be advised to arrange for their funeral director to collect the body.

If the pathologist considers further scene, eyewitness accounts or medical records might assist in reaching a conclusion as to the probable cause of death, the pathologist should email or telephone the Coroners Court registry with a request that this information be sought. Consultation with the family and liaison with the coroner or coronial registrar will be put on hold until this extra material is received and considered.

If the family raises concerns or if the pathologist is unable to determine a probable cause of death within two business days the pathologist should seek further direction from the coroner or coronial registrar.

Guidelines for coroners and coronial registrars – preliminary examination of apparent natural causes deaths

In all cases of deaths that appear to be of natural causes and only reported to a coroner or coronial registrar because the deceased person's usual treating doctor has not issued a cause of death certificate, before proceeding to issue any autopsy order, the coroner or coronial registrar should ensure all options for identifying the probable cause of death and issuing a death certificate are explored.

Where the body has not yet been transported to the mortuary where the autopsy would be performed, the coroner or coronial registrar should consult with an appropriate pathologist (either the local pathologist or if unavailable,

the duty pathologist at Forensic and Scientific Services or the Chief Forensic Pathologist) to ascertain whether they can issue or facilitate the issue of a cause of death certificate. The body should not be transported until these enquiries have been made.

Where the body has been transported to the mortuary where the autopsy would be performed, a preliminary examination will be performed under section 11AA.

If the pathologist advises that:

- the probable cause of death can be identified
- a counsellor or coronial nurse has confirmed the family of the deceased person has not raised any concerns warranting investigation by the coroner,

the coroner or coronial registrar should accept a cause of death certificate unless there is some other aspect of the matter that warrants further investigation by the coroner and enlivens the coroner's jurisdiction.

If a cause of death certificate is issued, a copy must be provided to the Coroners Court registry and the coronial file should be closed noting the death was determined to be not reportable. A copy of the cause of death certificate should be placed on the file.

Guidelines for coroners and coronial registrars – where a doctor issues a cause of death certificate after an autopsy order is made

Occasionally a coroner or coronial registrar may issue an autopsy order for a deceased person but in the meantime the person's treating doctor has issued a death certificate or the pathologist indicates they are prepared to issue a death certificate.

In these cases, it is permissible for the coroner or coronial registrar to accept the death certificate. However, the family must be involved before any final decision is made. The coroner or coronial registrar should request a coronial counsellor or coronial nurse to contact the family to ascertain if they have concerns about the circumstances of the death The results of this consideration and consultation should be conveyed to the coroner or coronial registrar to make a decision about whether the autopsy should proceed or whether a death certificate should be accepted.

When the coroner or coronial registrar accepts the certificate, it must be endorsed appropriately. On the bottom left hand side of the certificate there is a question 'Is this death reportable under the Coroners Act?' Tick the middle box, *'*No. Coroner has advised death not reportable*.'* Once the death certificate is accepted the coroner or coronial registrar ceases to have control of the body under s. 26(2)(b) and the body can be released to the family.

5.3 When should an autopsy be ordered?

Legislation

Coroners Act
Section 19

In principle

An autopsy should only be ordered if the coroner considers the death is probably reportable, except when the death of a neonate is involved, in which case an autopsy may be ordered to determine if the baby was stillborn.

Whenever a coroner proposes to investigate a reportable death, some level of autopsy must be ordered if the death is reported before the body is buried or cremated.

In practice

Autopsies may be divided into two classes based on their purpose - a hospital autopsy or a coronial autopsy.

A hospital or clinical autopsy is undertaken for educational or research purposes; to allow clinicians to better understand the issues relating to the pathology or epidemiology of diseases and their diagnosis. It is not connected and has no relevance to the coronial system. These examinations can only take place with the consent of the family of the deceased. Refusal to grant such consent should not result in a coroner being asked to authorise an autopsy if the death would not otherwise be investigated by the coroner.

A coronial autopsy can:

- confirm or determine the identity of the deceased
- identify injuries and diseases that may have contributed to the death
- determine the effect of medical treatment on the deceased
- assist in the evaluation of the manner of the death
- re-assure carers that their action or inaction did not contribute to the death
- maintain public confidence in relation to deaths that occur in custody
- establish the cause of death.[1]

Therefore, whenever any of these questions are in issue, will need to be proven in future court proceedings or are relevant to recommendations aimed at reducing the likelihood of future similar deaths, a forensic autopsy should be ordered pursuant to s. 19 if that is what is required to provide sufficient information to address these matters and there are no countervailing considerations such as concerns by relatives or risks of infection to mortuary workers.

In some cases, only when a coroner has been informed of the pathologist's conclusions as to the cause of death can they decide the course an investigation should take. However, in other cases the results of the scene examination and witness accounts will be relevant to the decision about the extent of the autopsy to be ordered. If that information enables all suspicions or concerns as to cause of death to be resolved there may not be sufficient reason to order an internal autopsy.

[1] Ranson D, *The autopsy* in *The inquest handbook*, Selby H. (ed), Federation Press, 1998, p107 and the Royal College of Pathologists of Australia, *Position Statement – Autopsy and the use of tissue removed at autopsy*, in *The medical journal of Australia*, Vol 160 4 April 1994

In other categories of cases, information gathered by investigators can assist the pathologist determine what tests should be made to clarify uncertain results.

It is essential therefore that all available information be shared with the coroner, the pathologist and the investigators as soon as possible so that the three strands of the inquiry – the pathological, the scene examination and witness interrogation - can be integrated.

Unless a coroner decides the death is not reportable or considers no further investigation of a death is necessary and authorises the issuing of a death certificate pursuant under s. 12(2)(b) the coroner must order a doctor to perform some form of autopsy.

The decision not to order any autopsy has the effect of ending the coronial process. That must happen if the initial investigation shows that the body is Indigenous burial remains or the State Coroner directs that the investigation cease. It may happen if the coroner decides that despite the death being reportable, an autopsy is not needed to establish the deceased person's identity and is otherwise unnecessary and the coroner is prepared to authorise a doctor to issue a cause of death certificate - see s. 12(2) and the section in Chapter 3 dealing with deaths reported by Form 1A.

However only in rare cases of sudden, violent or unexpected death should a coroner decide at the outset that no further investigation is warranted.[2] If there is any reasonable doubt about the medical cause of death or the circumstances which led to the death, some form of autopsy should be ordered.

If the probable cause of death can be established and there is no likelihood of evidence relevant to the manner of death being obtained by an internal autopsy but there are other reasons for investigating the death, for example, public safety concerns, public health issues or matters relevant to the functioning of the criminal justice system are in issue, the investigation can continue by the coroner ordering an external examination of the body.

If the scene examination and witness accounts provide sufficient evidence to establish the cause and circumstances of death to the required standard, an external examination, perhaps augmented with the results of toxicology tests and/or x-rays may be all that is required to confirm no inquest is necessary and the findings required by s. 45(2) can then be made and the file closed.[3]

The types of autopsy that might be ordered are discussed in more detail below.

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[2] For example, if an elderly person falls in their home and dies subsequently in hospital, after a conversation with the treating doctor a coroner might authorise the issuing of a death certificate.

[3] For example, on arrival at the scene, police find the deceased clasping a hand gun and bleeding profusely from a wound to the head. Witnesses at the scene say that the deceased was depressed, threatened suicide and produced a gun and shot himself before anyone could intervene. Close relatives not present give evidence consistent with these claims. A doctor who examines the body confirms an entry and exit wound consistent with a gunshot injury. A suicide note is shown to be in the deceased's handwriting.

5.4 What type of autopsy should be ordered?

Legislation

Coroners Act
Sections 19, 22, 23, 23A

In principle

The least intrusive examination that will resolve the issues in doubt should be ordered. In particular, internal examinations of the body should be limited to those cases in which the findings required by s. 45(2) can not safely be made without access to information that can only be obtained in this manner.

In practice

The Act gives formal recognition to the power of coroners to order different types of post mortem examinations and tests and requires the order to stipulate what type of autopsy is to be undertaken. As discussed above, in many cases a full three cavity internal examination will not be necessary to enable the findings required by s. 45 to be made. When all of the information readily available from the scene examination and the accounts of witnesses are considered it may be that sufficient evidence will be available to make the necessary findings with only an external examination or an external examination and a partial internal examination.[4] However, when the death may result in a criminal charge in which the cause of death is needed to be proven, a full autopsy will usually be necessary.

Additionally, or in the alternative, various tests may assist in addressing the questions the coronial process must seek to resolve. For example, a CT scan or x-ray might confirm the deceased did not suffer any internal trauma injuries.

Understandably, some coroners feel ill-equipped to decide in some cases what type of autopsy should be ordered. It is advisable to discuss these issues with the pathologists from Forensic and Scientific Services or another pathologist with experience in forensic matters who can give advice to coroners about tests that can be undertaken and the information those tests will provide.

Obtaining extra medical evidence for autopsy

When the deceased has had medical treatment prior to dying, it is important that information gathered during that treatment be made available to the doctor who will undertake any autopsy. Where the deceased person dies in a medical facility, police will usually obtain copies of the medical records when they attend the scene of death and the medical records will accompany the body to the mortuary. Even though medical records are protected by the confidentiality provisions of the *Health Services Act 1991* there is an exception in s. 62P which allows records to be provided to police acting on behalf of the coroner.

[4] While massive loss of blood at the scene may suggest violence, when coupled with a history of severe peptic ulcers and an absence of any other evidence of violence, a pathologist may be willing with the coroner's authorisation to issue a cause of death citing a ruptured ulcer as the cause of death without needing to perform an internal autopsy.

In areas where the sealed body bag process is operating, police no longer accompany the body and any medical records to the mortuary with the government undertaker. In these cases, it is acceptable for the medical records to be provided to the government undertaker for transportation with the body.

Where the records haven't been obtained by police or where additional information is required, the coroner can make an order under s. 22 using a Form 5 to require the medical records of the patient be provided to the pathologist undertaking the autopsy, together, if necessary, with a report from the treating clinicians summarising the history of the initial diagnosis and its basis and detailing the treatment given to the patient, including all drugs administered and the results of any test ordered while the patient was alive. The order can also require doctors to express an opinion as to the cause of death and their reasoning.

Note also that s. 22 empowers a coroner to order a doctor who treated the deceased person to attend the autopsy. This could help inform the pathologist undertaking the autopsy of the information gathered before death and make it easier to explain things discovered during autopsy. Obviously this has the potential to be fairly disruptive for the hospital concerned and should therefore be reserved for those cases in which it is really necessary, for example, peri-operative deaths, other adverse medical events and/or homicides in which attempts to save the life of the deceased person precipitated complex interventions.

Autopsy testing - toxicology

Section 23 authorises the coroner to order that particular tests be conducted by the pathologist performing the autopsy. The tests include any which may reasonably assist the coroner to make the necessary findings.

In addition, under s. 23(3), the pathologist is authorised to perform any test consistent with the type of autopsy ordered if the pathologist considers it necessary for the investigation. Section 23(5) confirms the pathologist may collect blood or urine no matter what type of autopsy is ordered.

Accordingly, where an internal autopsy is ordered, there is no restriction on the tests the pathologist may perform as long as the test is considered by the pathologist to be necessary for the investigation **and** is consistent with the type of autopsy ordered by the coroner.

Determining which samples should be taken for toxicology testing is complicated. Decisions about the number of samples, the source of them and whether they should be taken and analysed, or taken and stored pending the completion of the autopsy will often depend on information not known when the autopsy is ordered and an understanding of esoteric issues such as post mortem re-distribution and the effects of decomposition on drug concentrations.

Therefore, where an internal autopsy is ordered, unless a coroner has information that is not on the Form 1 and which could indicate a particular

drug or poison should be tested for, it is probably better to allow the pathologist to determine what sampling and testing should be undertaken. Where an internal autopsy order is made, the coroner need not give any further instruction about what testing should be performed. However there are exceptions to this. The coroner may, based on previous experience, consider that a particular sample (e.g. vitreous) is crucial to an investigation, and may want to order at least the retention of this sample. Secondly, as noted above, an order for a limited autopsy (e.g. chest) may not authorise sampling of another part of the body. Again, this can be addressed by appropriate completion of the Form 2.

However, the coroner will need to give specific instructions to sample vitreous humour if an 'external only' order for autopsy is made. An external order does not necessarily authorise the collection of vitreous humour from the eyeball because the eyeball may be damaged and therefore could be considered inconsistent with an external examination.

If an 'external only' order is proposed it can be useful to sample vitreous in some cases as it is less prone to decomposition than blood. The Form 2 allows the coroner to specify the testing of blood or urine or other samples. If in doubt the coroner should consult with the pathologist by telephone.

In making decisions about toxicological testing, pathologists should have regard to guidelines the chief forensic pathologist and the State Coroner have settled. These guidelines appear in Attachment 5A at the end of this chapter.

When an internal autopsy is ordered the pathologist will have regard to those guidelines and sample accordingly. If a partial internal autopsy is ordered and the pathologist considers samples should be taken from other parts of the body, the pathologist will contact the coroner, who if persuaded such sampling is necessary should extend the order. Similarly, if an external autopsy is ordered and the pathologist is of the view the sampling of vitreous is necessary but hasn't been specifically ordered by the coroner, the pathologist will contact the coroner to discuss the possible extension of the order.

Because the opportunity to take samples is for all practical purposes lost once the body is released, pathologists will often take samples that upon completion of the autopsy and/or further inquiries, may not need analysing to establish the cause of death.

For this reason, in many cases pathologists will take samples but store them unless the coroner, for good reason, specifically stipulates particular samples should be analysed. The autopsy order should be marked accordingly. However, in many cases, it may not be clear until several weeks or even months after an autopsy (e.g. after certain other test results have become available) that toxicology samples do, in fact, need to be tested.

Of course, as always, if any uncertainty exists the coroner should discuss the issues of concern with the pathologist.

Testing for infectious diseases

Section 23A authorises a coroner to order the doctor conducting the autopsy to also test for various infectious diseases that are notifiable under the *Public Health Act 2005.* The order can be made in response to an application, most likely from a public health official or a person in contact with the deceased who fears infection, or on the coroner's own initiative. Such an order should be made whenever there is a basis to suspect the deceased might have had one of the diseases in question or where a person has been exposed to bodily fluids.

DNA testing for identification purposes

DNA testing is a complex process that can take weeks or even months to complete. The testing may have to be repeated because profiles developed from post mortem samples and reference material, vary in quality.

In most cases circumstantial evidence will enable bodies to be released avoiding the delay that relying on DNA involves. In these cases scientists at Forensic and Scientific Services will not continue with development of DNA profiles but the coroner should consider whether a bone sample should be kept as a safeguard to enable a DNA profile to be developed in the future should the need arise.

Where adequate profiles cannot be developed for comparison purposes, it is not necessary for the scientist to prepare a full statement setting out their reasons. It is sufficient for the scientist to send the coroner an email to that effect.

Genetic testing

Sometimes the autopsy will not show a clear explanation for death and the pathologist may suggest genetic testing be ordered by the coroner to confirm or eliminate a potential diagnosis. For example, a person may have died of an abnormal heart rhythm possibly caused by long QT syndrome. Genetic testing of the deceased person may show positive genetic test results for long QT syndrome in which case the cause of death can be established with certainty. However, a negative genetic test result does not necessarily exclude the possibility of the deceased having the syndrome. Genetic testing is expensive and is not necessarily conclusive. Therefore any requests by pathologists for orders to undertake genetic testing should be discussed with the State Coroner before the order is made.

In all cases where there may be an underlying genetic cause it is important the deceased person's living relatives are advised as quickly as possible and referred for appropriate diagnosis and treatment. The coronial counsellors and coronial nurses at Forensic and Scientific Services facilitate this contact and referral.

5.5 Limiting internal autopsies

In principle

Internal autopsies are invasive. They inevitably result in major alteration of the deceased person's body which the family may regard as mutilation or

desecration. They are expensive and expose those undertaking them to numerous occupational health and safety risks. It is unethical in my view to authorise an internal autopsy unless it is necessary to enable the investigating coroner to make the findings required by s. 45(2). Accordingly, coroners should avoid ordering internal autopsies where this would not compromise the investigation. A three cavity autopsy order should not be a default response to a reportable death; rather, it should only be done for a good cause or clear benefit.

If an invasive autopsy is unavoidable, every effort should be made to minimise any adverse impact on families.

In practice

Guidelines for coroners - autopsy orders

When considering the type of autopsy to order, a coroner should have regard to all of the clinical history, scene evidence and eyewitness accounts. If these are inadequately recorded on the Form 1 the decision about the type of autopsy to be ordered should be postponed while this information is sought from the investigating police officer.

When considering the type of autopsy to order in relation to a death that appears to be the result of natural causes, a coroner should first satisfy themselves that all avenues for issuing a cause of death certificate are explored. In these cases, the Form 2 should include a request that the pathologist conduct a preliminary investigation to determine whether the pathologist can form an opinion as to the probable cause of death before proceeding to conduct any autopsy order made in the alternative – see section 5.2 *'*Preliminary investigations, issue of cause of death certificates*'*.

When considering the type of autopsy to order in relation to a violent or unnatural death, a coroner should consider whether the circumstances of the death including the evidence obtained from eye witnesses and/or the scene enable the making of findings required by s. 45(2). In these cases the coroner should order an external examination and the taking of blood and ideally urine samples for toxicology. Only if the pathologist, police or a person with an interest in the case raises the possibility of a contribution by a person or event not evident in the information already to hand, should an internal autopsy be ordered. Even then, the invasiveness should be minimised, where possible, by the ordering of a partial internal examination.

An exception to this approach may be those cases where a prosecution is likely, for example for dangerous driving causing death. In such cases it may be necessary to order an internal examination to exclude other contributions to the death to the higher standard of proof.

In summary, depending on circumstances, reported deaths should undergo step-by-step assessment, first considering a cause of death certificate, then external or partial examination, and a full autopsy only if needed. In some cases, an external examination may be a precursor to a full autopsy. A review of medical records, radiography and toxicology are frequently useful.

Examples

If a person who has made previous attempts to take their own life and/or who has suffered a suicide triggering event such as a relationship breakdown is found hanging in their locked residence and a suicide note proven to be in the deceased person's handwriting is also found, an external examination and toxicology will usually suffice to enable a coroner to make a finding of suicide as 'how the person died' and hanging for 'what caused the person to die'. The identity of the deceased and the time and place of the death will usually be able to be deduced from witness accounts.

If the passenger in a motor vehicle died of identifiable traumatic injuries after the motor vehicle collided with another vehicle, it is not necessary to order a full internal examination to determine the precise cause of death. An external examination and CT scan would ordinarily enable the cause of death to be determined with sufficient certainty to enable the coroner to make findings.

However, if the deceased person was driving the vehicle it may be necessary to order a full or partial internal autopsy to determine whether the driver was suffering from a medical condition which may have contributed to the accident.

If a person with no known medical history of heart disease was seen to collapse during or after exercise after clutching their chest it may be possible to identify the cause of death by first ordering an external examination and CT scan or a partial (chest only) examination.

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

Legislation

Coroners Act
Section 19

Family concerns

In principle

Before ordering an internal examination, a coroner should always consider whether, having regard to any cultural traditions and/or spiritual beliefs of the family of the deceased, an internal examination is likely to cause distress and must also consider any concerns raised by a family member whose views have been sought.

If those concerns are over-ridden and an internal examination is ordered, the order and reasons for the decision must be provided to the person who raised the concerns.

In practice

The cultural and religious diversity of the Queensland population means that attitudes to death and dealing with the body of the deceased may vary widely. The Act requires these sensitivities be borne in mind when the principle

objectives of the Act - the ascertainment of the cause and circumstances of sudden, suspicious or unnatural deaths - are being pursued.

It might seem, in some cases, to not be possible to reconcile the requirement to consider the views of the family with the obligation to ascertain the cause of death. If an autopsy is essential for the latter how can the former be given any weight if the family are vehemently opposed to an autopsy being undertaken? However, once it is accepted the requirement in s. 19(5) is only that the concerns of the family be 'considered' the problem diminishes.

The requirement the family's views be considered does not mandate those views always determine the matter or indeed that any particular weight be given to them.[5] Those views should be taken into account along with the other issues which bear upon the decision as to whether, and to what extent, an autopsy is required.

If an internal autopsy is required because there is a basis to suspect foul play, the relatives' spiritual beliefs that an autopsy desecrates the body can not be allowed to hinder the criminal investigation. However, the same views could justify a coroner deciding not to order an internal autopsy if the probable cause of death is known but an internal autopsy might give greater understanding of the pathology of the processes that led to death. Alternatively, the views of the family might lead a coroner to order a more limited internal examination than if there were no family objections, provided the coroner can still be satisfied about the issues that must be found to the required standard.

There have been no Supreme Court challenges to orders made by coroners for an internal autopsy under the Coroners Act. However, Freckelton and Ranson usefully digest a number of cases in which coroners' orders for internal autopsies in other states have been challenged and upheld despite family objections and other cases where the family's objection has been upheld.[6] The thrust of those decisions appears to be if there is no basis to suspect foul play or anything untoward and the objection is based on religious or cultural beliefs, the objection will usually be upheld. When the objection is based on humanist sensibilities, it is given less weight.

If a family member has raised concerns about an internal examination, the coroner should usually seek the assistance of a counsellor from Forensic and Scientific Services to liaise with that person to explore whether the provision of more information about the proposed procedures can alleviate the concerns. Counsellors will also explain that in some cases it may not be possible to identify a cause of death unless an internal autopsy is conducted in which case the cause of death will be 'undetermined'.

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[5] Rathbone v Abel [1965] ALR 545 at 549 per Barwick CJ, *"to have regard to " does not necessarily mean that the Board was bound to make a specific finding as to each of the matters, nor was it bound to give any particular weight to any of them*

[6] See Freckelton I. & Ranson D. , Death investigation and the coroner's inquest, Oxford University Press 2006, 376 - 382

If the coroner decides despite continuing objection, an internal examination is necessary, the coroner must give a copy of the order for autopsy and written reasons for it to the family member who raised the concern.

In order to give affect to the rights of family members to participate in the making of coronial decisions, it will usually be necessary for the autopsy to be postponed for 24 hrs to give the family member objector an opportunity to seek a review under the *Judicial Review Act 1990* if a coroner has overridden an objection to an internal autopsy. In these circumstances the autopsy order should direct the pathologist undertaking the order to contact the coroner issuing the order before commencing the autopsy to check whether a review application has been lodged. Of course, as this suggestion is only an administrative arrangement, it can be modified if the circumstances of a particular case require more immediate action.

Guidelines for police - obtaining the views of family members

The Form 1 requires police reporting the death to nominate a 'family member' who will be the point of contact for the coronial investigation. The Form also requires police to obtain the views of the family member concerning autopsy when gathering other information the form requires.

The term 'family member' is defined in the dictionary of the Act to mean the closest relative reasonably available. The definition creates a hierarchy of relationships – spouse, adult child, parent, etc. The relative highest on the list who is available must be nominated as the family member and consulted about autopsy. It is crucial police take this role seriously as the coroner relies on this information when ordering the autopsy and progressing the investigation.

The police officer should explain that in some cases the coroner may wish to order an internal examination of the deceased person's body. The examination will be carried out by a specialist medical practitioner and the body will be treated with respect and dignity throughout. It may help to describe an autopsy as akin to a surgical operation designed to ascertain the cause of death.

Family members should be assured the body will only be dissected to the extent necessary to enable the coroner to make the necessary findings and it will be reinstated so in most cases, it will not be apparent at the funeral an autopsy has been conducted.

The officer should explain to the family member the coroner is required to take their views into account but if the coroner believes an internal autopsy is necessary one may be ordered even though the family member has expressed concerns. In such a case the family member will be contacted by a coronial counsellor who will explain the coroner's decision to the family member and advise them of their entitlement to have the decision reviewed in court.

Officers should be aware they are not seeking to establish whether the family member consents, approves, opposes, or objects to an internal autopsy.

Rather, they are seeking to establish whether the family member has any concerns about such a procedure.

The 'Coronial Investigations and the Police Response' brochure should be provided to the family. This brochure contains more detailed information about what an autopsy involves and it may assist police in explaining the autopsy process to the family member.

What if family members are in disagreement?

Occasionally, family members of equal priority in the family member hierarchy will disagree on the level of autopsy that should be ordered. Please refer to Chapter 2 –'The rights and interests of family members' for advice on how this should be handled.

What if the deceased has not been identified?

It is only necessary for a coroner to have regard to family concerns about an internal examination if it is 'practicable' to do so. In my view this means if the deceased has not been able to be identified reasonably promptly, it is appropriate to proceed to order an autopsy without waiting for the family of the deceased person to be identified and their views sought. Indeed, information gathered during an autopsy examination is often crucial in establishing identity especially in cases where the deceased cannot be visually identified.

What if family members are suspects?

Similarly, it may not be appropriate to seek the views of the family member if they or a close associate is suspected of being responsible for the death. In my view, it is not 'practicable' to seek the family member's views if this could undermine the investigation of 'how' the person died by alerting a potential witness that the investigators suspect they may have been responsible for the death.

Therefore, if the death appears suspicious, the coroner should consult with the investigators before asking the coronial counsellors to liaise with the family member to try to more precisely establish and/or assuage concerns about an internal autopsy that have been indicated on the Form 1. If the investigator indicates disclosure to the family member of the basis on which an internal autopsy is thought necessary could undermine the investigation of the death, I am of the view that brings the case within the exception obviating consideration of family concerns.

Others who may be exposed to risk

In principle

Section 19(5)(b) also requires coroners ordering an internal examination to consider concerns raised by a 'person with sufficient interest*'.* Those transporting the body and involved in the examination could clearly come within this category if those activities involved particular risk of harm. When a coroner is considering ordering an internal autopsy, the concerns of pathologists or others regarding the health risks posed by the procedure should be given due weight.

The forensic benefit of the information sought to be gained by internal examination should be balanced against the risk of obtaining it.

In practice

The performance of autopsies and mortuary work generally is potentially hazardous. The risks include cuts from knives, exposure to chemicals, back injuries, falls, electrocution, psychological trauma and, perhaps above all, the risk of infection. This places special obligations on all those connected with coroners' autopsies to ensure they are performed with appropriate precautions and for clearly defined and sound reasons. Mostly these issues must be addressed by those responsible for workplace health and safety in the facility in question. However, when an autopsy poses a particularly high risk because of some condition of the body, those in jeopardy are entitled to raise their concerns with the coroner considering ordering an internal autopsy to seek to negotiate a compromise that meets the coroner's needs while minimising the risk and to receive reasons if the coroner decides to order the autopsy despite those objections.

All autopsies should be regarded as potentially infectious and performed by trained personnel in appropriately equipped mortuaries observing standard infection control procedures. As an additional precaution, cases with known or high risk of particular infections should be autopsied in specialised facilities.

Examples of infections meriting additional precautions include HIV, hepatitis B and C, meningococcal meningitis or septicaemia, tuberculosis, Creutzfeldt - Jakob disease (CJD), and SARS. CJD presents a special problem because the organism is not killed by normal disinfectants. Examples of high-risk cases include drug addicts, those with multiple tattoos, prostitutes, atypical lung infections and certain types of dementia (where CJD is possible). Certain severe infections (e.g. anthrax, plague), if known or suspected, should not undergo autopsy outside 'containment' facilities which are not available in Queensland.

In potentially infectious cases, every effort should be made to avoid, or to limit the extent of, an internal examination of the body, especially where the only reason for it is the initial lack of certainty about cause of death as soon as it has occurred. Often, delaying a decision about an autopsy until additional medical information can be obtained, or until laboratory results from tests taken before the patient died are available (e.g. to confirm meningococcal meningitis) can obviate the need for one. If an examination is needed to confirm the diagnosis, its extent can be minimised – for example, the removal of the brain for neuropathology in suspected CJD, the taking of lung samples for appropriate testing in suspected SARS or the taking of blood for toxicology screening in suspected drug addiction deaths. Of course, even these limited procedures can be hazardous and should only be performed for good reason.

In complex situations involving potentially hazardous autopsies, coroners should consult with the Chief Health Officer or Chief Forensic Pathologist at Forensic and Scientific Services. If concerns can not be resolved the State Coroner should be involved in the discussion.

5.7 Who should conduct an autopsy?

Legislation

Coroners Act
Sections 14 and 19

In principle

Decisions concerning who undertakes an autopsy should be informed by the following considerations:

- The expertise of the person authorised to undertake an autopsy should be commensurate with the complexity of the questions in issue.
- The higher the standard of proof the information sought to be gathered via autopsy will need to satisfy, the greater the need for expert qualifications in the person performing the autopsy.
- It is desirable an autopsy be undertaken in the locality where the death occurs to obviate the need for the body to be removed from the vicinity of the family, but this needs to be balanced with the need for specialist staff and mortuary facilities available only in large centres.

In practice

It has long been the practice in Queensland for autopsies to be undertaken by doctors ranging in expertise in this field from general practitioners to forensic pathologists.

This work can involve the making of complex judgements based on subtle qualitative assessments that may be interrelated to other observations and test results. Accordingly it is not knowledge that can be quickly or simply acquired in total, although aspects of it may be readily gained while under the supervision of a specialist in the field.

The Royal Commission into Aboriginal Deaths in Custody examined over one hundred internal autopsy reports and had them critiqued by eminent forensic pathologists. It concluded:

> 'While the services of a non-specialist pathologist may yield adequate results, the expectation that a general practitioner is qualified to undertake such exacting work and provide satisfactory and reliable results is both unfair and unfounded.'[7]

In descending order of expertise the hierarchy of practitioners who might undertake autopsies can be divided into the following four categories:

- Forensic pathologists hold specialist qualifications in forensic pathology and/or have undergone additional supervised practice in this discipline.
- Anatomical and general pathologists hold specialist qualifications in these disciplines.
- Pathology registrars are doctors undertaking training as pathologists at an accredited laboratory who work under supervision of specialist pathologists.

[7] E. Johnson, *National Report of the RCADIC*, AGPS, Canberra, 1991, vol. 1, p.127

- Doctors with expertise in injury examination are practitioners who through practice as government medical officers (GMOs) or medical superintendents with experience in emergency medicine, are expert in examining the victims of accidents and reporting on the likely cause and effect of injuries.

Specialist pathologists are medical practitioners who have undergone five years supervised training in an accredited laboratory and passed a number of examinations to attain Fellowship of the Royal College of Pathologists of Australasia (FRCPA) or an overseas qualification such as FRCPath recognised as equivalent.

Around Australia reliance on expert witnesses is increasing, as are challenges to the credentials and credibility of such witnesses. A court or tribunal will always want put before it the best opinion evidence available, although the extent to which this might be pursued will vary having regard to the significance of the evidence and challenges to it by other evidence.

In an inquest, if the cause of death is in doubt or there are competing views on the issue, or it is likely the issue may need to be proven in future criminal proceedings, it is essential the best evidence reasonably available is presented. This is most likely to come from a forensic pathologist or other specialist pathologist experienced in coronial work whose qualifications and credentials are more likely to result in the court being accurately informed and the opinion evidence withstanding challenges from other experts.

However, it is not necessary, practical or reasonable to have all autopsies undertaken by such specialists, particularly if that would require the body to be transported long distances. The distress caused to the family and the cost to the state occasioned by removing the body should only occur if the services of a forensic pathologist or a specialist pathologist are needed to resolve the issues in question. In many cases an external examination by a practitioner with expertise in examining injuries when coupled with toxicology test results and the information gathered by police from the scene will suffice and can be undertaken locally.

In general, forensic pathologists may perform both standard and complex categories of autopsy, while other specialist pathologists are restricted to standard cases. However, only a small number of forensic pathologists have the specialist expertise required for complex paediatric cases.

Increases in specialist pathologists available to undertake autopsies and rejection of the notion that invasive autopsies should be undertaken in all coronial cases, mean that doctors who are not pathologists should be restricted to undertaking external examinations of deceased in straightforward accidents, suicides and natural deaths. These criteria should be read in conjunction with Section 5.4 ‘What type of autopsy should be ordered?’ As noted above, doctors performing such examinations may be Government Medical Officers, emergency physicians or others with suitable skills. A list of such doctors willing to perform external examinations is maintained by the Coroners Court of Queensland. It is recommended the performance of

external examinations by non-pathologists be supervised by the Chief Forensic Pathologist or delegate.

Advice on distinguishing and managing particular types of autopsies should be sought from the State Coroner, Chief Forensic Pathologist or a forensic pathologist on call.

5.8 Who may be present at an autopsy?

Legislation

Coroners Act
Section 21

In principle

The coroner and the police officer investigating the death are entitled to attend the autopsy. Anyone with sufficient interest should also be permitted to attend and observe the autopsy.

The Act envisages the attendance of people for training purposes but this should not happen on an ad hoc basis. Rather, a person wishing to attend an autopsy for this purpose should be referred to the State Coroner who will liaise with the Chief Forensic Pathologist to ensure such requests are handled in a consistent and defensible manner.

In practice

The principal investigator should usually attend the autopsy if the death is suspicious. They will often be able to provide the pathologist with valuable information that has been gathered from the crime scene that can easily be mis-communicated if passed to the pathologist through other officers. It is essential the pathologist note any additional information received from the investigator if it is at all relevant to the pathologist's findings.

Occasionally, family members or suspects in homicide matters contest the validity of the processes used during an internal autopsy. This can be avoided if a medical practitioner, who is a representative of those parties, is permitted to attend and observe the autopsy. It is preferable such parties observe the first autopsy and thus avoid the need for a second autopsy if they dispute the findings of the first. The consent of the pathologist undertaking the autopsy should be sought and the views of the family member should also be considered before a coroner authorises a third party to attend an autopsy – see s. 21(4).

5.9 Notifying families of autopsy results

The Form 2, autopsy order, allows the coroner to tick a box at paragraph 6 authorising counsellors, the doctor who conducted the autopsy or police officers to inform the family of the autopsy results. It is highly desirable this authority be given in almost all cases as the autopsy report may take months to be finalised and the family needs to know the result as soon as possible.

The only exception is where the Form 1 indicates the death is suspicious. Unfortunately, family members are in many cases the perpetrators of murders and police may want to interview them before they have the benefit of knowing what was discovered at autopsy. It is important coroners do not unwittingly negatively impact on a criminal investigation by releasing information without considering its impact. In these cases the paragraph 6 of the Form 2 should be amended to provide that no information should be released without consulting the investigator.

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

Autopsy notices and autopsy certificates

Legislation

Coroners Act
Sections 21 and 24A

In principle

Section 24A(3) of the Coroners Act requires a doctor who has undertaken an autopsy and who has determined the cause of death to complete an autopsy certificate – Form 30. This enables the cause of death to be entered onto the Register of Births Deaths and Marriages which is usually a prerequisite for life insurance payouts, etc. If the pathologist is unable to determine the cause of death pending the receipt of test results an autopsy notice - Form 29 - is issued. This enables the death to be registered only.

The level of certainty autopsying doctors need when considering whether to issue a Form 30 is no higher than that applied by a doctor issuing a cause of death certificate for a non reportable death, i.e. they need to be able to form an opinion as to the probable cause of death.

In practice

Guidelines for pathologists regarding autopsy certificates

Following consultation with the Chief Forensic Pathologist, I have issued the following guidelines to pathologists undertaking coronial autopsies.

Whenever doctors who have conducted an autopsy can identify the probable cause of death, they should complete a Form 30 and send it to the Registrar, Births, Deaths and Marriages and copy it to the coroner who ordered the autopsy.

If subsequent investigations or test results cause the issuing doctor to conclude another cause of death is more likely, the doctor should issue an amended Form 30.

Doctor's notice to coroner after autopsy – Form 3

Immediately following the autopsy, the doctor performing the autopsy must complete a Form 3 and provide it to the coroner. The Form 3 records the fact

the autopsy has taken place and gives advice about tissue and prescribed tissue kept after the autopsy (refer to Section 12 'Retention of tissue, whole organs, foetuses and body parts and prescribed tissue' below). The form also advises whether the body is required for further examination or testing; whether identification is settled and whether there is a cremation or infection risk.

The Form 3 also contains a section where the pathologist is able to provide a summary of their main macroscopic findings. These initial conclusions may well be of assistance to coroners considering what further investigation is necessary and would be highly relevant to inquiries being conducted by other bodies such as hospital mortality and morbidity committees or a hospital root cause analysis team. In most cases it would seem appropriate for a coroner to conclude such bodies have 'sufficient interest' to receive the Form 3 upon application. In the past, those reviews have often not been informed by formally reported autopsy findings as the report is usually not received until three to six months after the death.

The form also enables the pathologist to recommend to the coroner further investigative steps at paragraph 11. In the past, pathologists have been alive to issues warranting investigation but these have not usually been communicated until the autopsy report is received. By that time, circumstances may have changed that make it difficult to obtain information, for example, hospital staff may have often moved on. I therefore recommend, in future, you carefully scrutinise paragraph 11 to ascertain whether the pathologist recommends statements be obtained from treating doctors or reports obtained from independent experts. You will note there's also provision for the pathologist to identify the issues which should be explored via those mechanisms.

Autopsy reports

Legislation

Coroners Act
Section 25

Guidelines to pathologists regarding autopsy reports

Autopsy reports must be in the prescribed Form 8 that is current at the time the report is prepared. The reports should always make clear any extraneous factual underpinning and the source of that information, for example, conversations with police or treating doctors.

Consent of the coroner who ordered the autopsy should always be obtained before seeking input from anybody other than a pathologist colleague or other forensic scientist.

The Form 8 includes a 'Summary and Interpretation' section that should alert the coroner to any unusual findings or the need for further investigation. It should be completed in all cases to assist the coroner's understanding of the autopsy findings.

In straightforward cases, the pathologist may provide the coroner with an autopsy report containing only demographic details, the type of autopsy and tests performed, the Summary and Interpretation and pathologist's opinion as to the cause of death. However, pathologists should retain in the case file details of the examination and testing performed in case these are required at a later stage. The Chief Forensic Pathologist is encouraged to develop guidelines to facilitate this practice.

Autopsy findings should never be disseminated orally or in writing without the coroner's consent. The autopsy order will usually authorise counsellors or others to advise family members of the autopsy findings.

If requested, the pathologist must provide a copy of an autopsy or test report to the investigating police officer – s. 25(2). If requested by the chief executive of Queensland Health or the chief executive of the Department of Justice and Attorney-General, the pathologist must provide a copy of an autopsy or test report to a public or health service employee or executive nominated by the relevant chief executive – s. 25(4).

5.11 Performing a further autopsy

Legislation

Coroners Act
Section 19

In principle

The Act authorises the undertaking of second or successive autopsies but repeated examination of the body should only be ordered for good reason.

In practice

Occasionally, after the initial autopsy has been undertaken, either the coroner - as a result of receiving further information, or the family of the deceased - as a result of the natural suspicions that arise in some coroners' cases, will query the accuracy of the findings of the first autopsy.

In these circumstances, the coroner can ask the original pathologist to undertake a further autopsy or authorise another pathologist to do so.

When the family requests a second autopsy, they usually also request a pathologist they have retained to undertake the procedure. Provided the coroner is satisfied the nominated pathologist is appropriately qualified an autopsy order can be directed to that pathologist. It is advisable to make the consent to ordering a second autopsy conditional on the pathologist providing the coroner with a copy of the autopsy report as soon as reasonably practicable.

It is also highly desirable to liaise with the pathologist who undertook the first autopsy so that if another pathologist is to undertake the second autopsy the two doctors can discuss the case. Usually the first pathologist will attend the second autopsy and make tissue samples available to the second pathologist.

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

Legislation

Coroners Act
Section 24

In principle

This section seeks to ensure 'prescribed tissue' - whole organs, foetuses or 'identifiable body parts' - is not retained unless the coroner is persuaded it is necessary for the purposes of the investigation and the family has been informed before the body is released.

To ensure that even if these requirements are satisfied a collection of retained organs does not accumulate through oversight, the need for continuing retention must be reviewed every six months.

When such retained tissue is no longer needed for forensic purposes, it must be disposed of in accordance with the family's wishes.

The provisions do not define 'whole organ' or 'identifiable body parts' or indicate what regard, if any, should be had to any concerns the family might express. These guidelines seek to address those issues.

In practice

The Act as passed put safeguards around the unnecessary retention of whole organs and foetuses but those safeguards were in some respects unclear. For example, s. 24(4) prohibited a coroner from ordering the release of the body unless satisfied retention was necessary and the family had been advised, but it gave the coroner no explicit power to order the organ be returned to the body. That anomaly has been addressed – see s. 24(5) – but the extension of the protection to 'identifiable body parts' has focussed attention on definitional issues.

Around the world there has been reaction against the unnecessary retention of organs and other tissues after autopsy. The Australian Health Ministers Advisory Council and Conference in 2002 adopted a National Code of Ethical Autopsy Practice which sought to respond to these concerns and retention rates have reduced significantly. Queensland Health is working with the Coroners Court of Queensland to maintain this trend. Local coroners can play their part in this reform by insisting prescribed tissue is not retained unnecessarily.

Definitional difficulties –what tissue is caught?

What is an organ?

It is surprisingly difficult to precisely and exhaustively define what is meant by 'organ'. The discipline of human anatomy has developed since ancient times, resulting in a largely arbitrary intellectual construct delineating numerous individual organs and recognisable body parts - approximately 6000 named

structures are listed in the index of Gray's Anatomy. The large, discrete, well-recognised organs such as the heart, brain and eyes are clearly included. However, more problematic are the dispersed organs, e.g. the skin, digestive organ, lymphatic system, including numerous lymph nodes – and named structures within whole organs, e.g. the aortic valve - and small organs or structures only a few millimetres across, e.g. the four parathyroid glands.

Small anatomical structures, such as lymph nodes, that are technically part of a large dispersed organ, such as the lymphatic system, should therefore not be regarded individually as a whole organ and need not be treated as prescribed tissue.

In some situations, it may be impossible to treat small structures as prescribed tissue simply because they are so inconspicuous the pathologist might unknowingly include them in a sample of another tissue, e.g. parathyroid gland, lymph node. Accordingly, it would be impractical for these small structures to be treated as prescribed tissue.

Having regard to the purpose of the provision, I have concluded it is only necessary to treat as prescribed tissue those organs readily identifiable as discrete entities and not just a part of a system. The attached schedule identifies those which in my view enliven the provision and those which don't.

What is a whole organ?

A literal application of the provision could mean if a pathologist took all but a small sliver of an organ, the safeguards would not be activated because the whole of the organ had not been retained. I am of the view the intent of the regime should not be circumvented in this manner. Conversely, it was not the intention of the legislature that the provision be activated if samples of, say, heart tissue are taken for testing and the balance returned to the body at the completion of the autopsy.

It is therefore necessary to settle upon some proportion of an organ as satisfying the criterion. I am of the view that greater than 50% by weight is a practical and defensible delineating measure.

What is an identifiable body part?

Anatomists and forensic pathologists can identify and name almost every aspect of every organ, all vessels of the vascular system, the ligaments, fascia and other connective tissue, etc.

Large complex organs, especially the brain, spinal cord and heart, incorporate numerous recognisable structures, either as a part or extension of their substance e.g. brain stem, pituitary gland, cervical cord, papillary muscle. In my view, components of whole organs, if retained on their own, should not be regarded as 'identifiable body parts', as this appears not to have been the purpose of amending the section 24 regime in November 2009. Not only do the Explanatory Notes to Clause 23 of the *Coroners and Other Acts Amendment Bill 2009* make no reference to seeking to cover the retention of organ components, but also indicate the intention was to ensure the regime covered additional tissues that are 'commonly removed' and, by implication,

are likely to raise families' concerns, citing 'hands and jaws' as examples. Section 24 of the Act gives similar examples – 'limb, digit or jaw'.

Having regard to the need to interpret the Act in the manner most likely to give effect to its intent, and the impracticality of applying s. 24 to every piece of retained tissue a pathologist can name, I have concluded its application be limited to those parts identifiable by a reasonably educated layperson, untrained in anatomy, that are not parts of other organs.

Attachment 5C gives examples.

What is a foetus?

Foetus includes a stillborn baby examined for the purpose of determining whether it was born alive, a foetus found within its mother, and an embryo.

Informing the coroner

A pathologist who conducts an autopsy and removes prescribed tissue they consider should be retained for further testing will inform the coroner of the reasons for the proposal as soon as possible after the autopsy is completed by way of the Form 3. In some cases the pathologist will have identified prescribed tissue they consider should be retained before the autopsy is performed. In these cases the coroner's authorisation may be sought before the autopsy. The Form 3 will still need to record details about the prescribed tissue sought to be retained by the pathologist.

The coroner needs to be satisfied the retention of the tissue is necessary for the effective investigation of the death rather than just the professional interest or development of the doctor. If the cause and circumstances of the death are already established with sufficient clarity, retention will rarely be justified and the coroner should order the return of the prescribed tissue to the body prior to its release.

The coroner's decision about the retention of prescribed tissue must be recorded in Section B of the Form 3. Section B should be completed by the coroner in all cases where prescribed tissue is sought to be retained by the pathologist including those cases where retention of prescribed tissue is authorised prior to autopsy.

Body parts such as a limb, digit or jaw are not ordinarily removed during an autopsy. The coroner should be informed about proposed removal and proposed retention of body parts before they are removed so the coroner can decide whether this is necessary while the body is still intact.

In cases where the body is not identified it may sometimes be necessary to remove the jaw and/or teeth to aid dental comparison and identification. The coroner should still be informed of the removal even though it will be impractical to contact the family member as the identity of the deceased is unknown.

Informing the family member

If the coroner is persuaded retention is probably necessary, the coroner should request a coronial counsellor to seek the views of the family member, unless to do so might compromise the investigation by conveying information to a witness before investigators have interviewed that witness. The views of the investigating officer should be sought if this seems a likely possibility. I consider this proviso is permissible on the basis the obligation to notify the family is conditional upon it being 'practicable' to do so.

If the family objects to the prescribed tissue being retained and acknowledges the failure to retain the tissue for further testing might prevent the precise cause of death being established, the coroner should consider whether such precision is necessary. If there is sufficient evidence otherwise available to satisfy the coroner the death is from natural causes and there is no basis to conclude any third party or wrongful act was involved in the death, the coroner might conclude such extra information retention and testing might provide is unnecessary.

Disposal of prescribed tissue

The entity holding the tissue must dispose of it having regard to the wishes expressed to the coroner by the family member when the retention was authorised. Therefore, if a decision is made to retain prescribed tissue, the coroner must be informed of the family member's wishes as to what is done with it when it is no longer required for testing. The coronial counsellor who seeks the family member's views regarding the retention will also ascertain this information and should relay this to the coroner.

In some cases, the family may not be ready to decide about disposal at the time of autopsy. If so, the coronial counsellor will advise the coroner a decision on disposal has been deferred and will follow this up with the family later. This should be sufficient to allow release of the body.

All orders for release of bodies are entered into the Coroners Case Management System (CCMS). If prescribed tissue has been retained, this must be noted in the Autopsy Screen in CCMS. The Coroners Court of Queensland will run monthly reports showing those matters where such tissue has been retained for six months and inform the local coroners of such matters requesting confirmation that the tissue should be retained or released. This will ensure compliance with s. 24(6) which requires coroners to consider at six monthly intervals whether prescribed tissue is still required for the purposes of the investigation. When the continued retention of prescribed tissue is reviewed in accordance with s. 24(6), the reason for on-going retention should be recorded on the file.

However, in those case where the family has indicated they want the prescribed tissue returned to them for interment, coroners should closely monitor retention of prescribed tissue so it can be released as soon as possible. Usually organs will only need to be kept for a few weeks to enable them to be 'fixed' and samples taken. In some particularly contentious cases a suspect might want to have testing undertaken by an independent pathologist who might want to take their own tissue sample. This is a matter that must be

negotiated with the case pathologist on a case by case basis, balancing the need to preserve evidence and the interests of other parties to review the case pathologist's findings with the right of the family to have their loved one's organs returned as soon as possible.

Section 24(6) gives the coroner the power to order disposal of prescribed tissue at any stage in the investigation of the death having considered whether the tissue is still needed for the investigation itself or for future proceedings, e.g. murder trial, death in custody inquest. Indeed, the coroner has a responsibility to ensure prescribed tissue is kept for no longer than is strictly necessary. To achieve this, the coroner may wish to establish administrative arrangements, for example, by authorising disposal as soon as the autopsy report is received, or by asking pathologists to advise when examination of the prescribed tissue is complete. In deciding when to authorise disposal of prescribed tissue, coroners should consult with the pathologist, but bear in mind the pathologist's view may ultimately need to be over-ridden because other factors are also important, especially the family's views, and the likelihood and potential value of subsequent re-examination.

It should be borne in mind some types of tissue may, in the process of testing, be converted entirely to 'specimen tissue' as defined under the *Transplantation and Anatomy Act 1979* and must therefore be kept indefinitely in accordance with s. 24(7). Examples include the eye, the brain stem and parts of the spinal cord.

Summary

- Prescribed tissue should only be retained for testing, examination or evidentiary purposes if the coroner is persuaded the retention is necessary for the investigation of the death.
- When considering whether tissue is a whole organ or an identifiable body part, coroners should have regard to the attached schedule.
- Family members must be consulted in relation to these issues if possible and if to do so would not risk compromising the investigation.
- If not satisfied retention is necessary for the investigation of death, the coroner should order return of the prescribed tissue to the body prior to its release.
- If prescribed tissue is retained, the coroner should monitor its testing so what is not needed to be kept can be returned to the family as soon as possible.

Paternity testing

Tissue taken at autopsy can't be released or destroyed without the consent of a coroner. Usually this happens at the conclusion of the coronial investigation. Occasionally, family members seek access to such samples for DNA testing with a view to confirming paternity of a child presumed to be of the deceased person.

As cited above s. 24(9) provides the tissue must be released to 'a family member' if the family member 'wishes to test, or use the tissue for a lawful purpose'.

The term family member is defined by reference to a descending hierarchy of relationships – spouse, adult child, parent, etc. In my view that means a parent of a deceased man is not entitled to the tissue to test the paternity of a putative grandchild if the deceased was in a spousal relationship with the child's mother or any other person at the time of his death.

Attachment 5A

Guidelines for coroners and pathologists: toxicology samples at autopsy

Samples for toxicology should be kept in the following deaths:

- Homicides and suspicious deaths
- Deaths in custody and during, or as a result of, police operations
- Suicides and accidents (including passengers)
- All cases of suspected deliberate and accidental intoxication by medical and illicit drugs, carbon monoxide, cyanide, and other poisons
- Negative autopsies (including sudden deaths in infancy – "SUDI")
- Deaths in a health care setting, including analyses for toxic, therapeutic and sub-therapeutic levels of drugs
- Natural deaths where reactions to drugs or herbal medicines are possible
- Cases undergoing external examination only – samples for toxicology should generally be taken and at least placed on hold

In many cases, however, samples should simply be placed on hold in Forensic Toxicology pending resolution of the autopsy investigation or further discussions with the coroner. The aim of these guidelines is to ensure that sufficient samples are retained and are available, not to promote excessive or unnecessary analysis.

The guidelines also include measures to address the issue of post-mortem drug redistribution which can cause spurious increases in drug levels in post-mortem blood samples. This affects drugs that are concentrated to high levels in particular tissues during life (e.g. liver) and then leak out into nearby blood after death.

Unless specifically ordered by the coroner, toxicology samples are not needed in straightforward natural deaths with a clear cause of death and no contribution from medication. Useful samples may be unobtainable in some cases (e.g. skeletal remains, advanced decomposition, disruptive injuries). In certain circumstances, the coroner may agree that samples need not be kept (e.g. selected disasters).

If in doubt, advice on how to proceed should be sought from a forensic toxicologist, forensic pathologist or forensic medical officer, depending on the expertise needed.

Dedicated forensic toxicology tubes (10ml) should be used for most liquid samples (see table) as the fluoride-oxalate reduces post-sampling fermentation, which can otherwise occur, even in relatively "clean" samples such as urine.

Type	Samples	Guidelines
Blood	3 x 10ml in fluoride oxalate tube (1 x 10ml in plain tube in cases of suspected fluoride poisoning)	All cases requiring toxicology, if available. To minimise post-mortem drug redistribution, blood should be taken promptly from the femoral vessels, ideally the femoral vein. Avoid "milking" the vessels if possible. Only if blood is not obtainable from femoral vessels (e.g. in infants, severe bleeding, decomposition) should other sites be used and in these cases the reason should be recorded. The actual sampling site utilised must always be noted. Without this information, the toxicology results may be uninterpretable.
Blood	1 x 5ml in EDTA tube – submit for biochemistry to Pathology Qld	Cases of suspected poisoning with anti-cholinesterase pesticides (seek advice on details)
Urine	1 x 10ml in fluoride oxalate tube	All cases requiring toxicology, if available
Admission samples	All blood (& urine) samples that the clinical laboratory can provide	In deaths that occur after admission to hospital, post-mortem samples will not reflect alcohol and drug levels at the time of an incident. Samples from the time of admission should therefore be sought.
Blood in health care deaths	All blood (& urine) samples that the clinical laboratory can provide	In deaths where the administration of drugs may be involved, it may be necessary to ask toxicologists to analyse samples from different times during admission.
Vitreous humour from eyeballs	Whatever is obtainable without damaging eyeballs, typically about 5ml in a fluoride oxalate tube (Disfigurement should be avoided by restoring the shape of the eyeball by injecting water.)	So far as practicable, vitreous should be sampled in all cases requiring toxicology and at least placed on hold. Vitreous is less prone than blood to decomposition, alcoholic fermentation and drug redistribution. In some cases, use of vitreous for glucose and other clinical biochemistry may take precedence.
Head hair	Pencil-thick tuft of plucked head hair about 3-5 cm long in click-seal plastic bag or other small plain container	Cases in which previous exposure/usage is a significant issue (e.g. therapeutic and illicit drugs, heavy metals) – seek advice from toxicologist as validated testing is not readily available in Australia (as at Feb 2012).
Kidney, head hair, nails	Head hair as above Others – seek advice	In suspected heavy metal poisoning, these samples should be considered – seek advice about details
Lung	One lobe of a lung "triple bagged" with minimal headspace (Note: one lobe does not amount to a "whole organ")	All cases (except carbon monoxide poisoning) in which toxicity of volatiles or gases may be involved (e.g. solvents, butane, propane, spray paint, petrol, glue, helium, nitrous oxide)
Stomach contents	50-250 ml in plain container (Measure and record total stomach contents volume.)	Cases where the route of ingestion, or the amount remaining in the stomach may be significant issues. Also cases where an oral poison is suspected but may not be detectable in blood (e.g. corrosives, pesticides, heavy metals). Seek advice if in doubt.
Nasal swabs	Plain swabs from both nostrils	Cases where nasal inhalation or snorting of cocaine, heroin or other drugs is a possibility

Type	Samples	Guidelines
Liver	2 x 50 grams in a plain container	Cases where blood is unobtainable, or where an extra sample type may provide a cross-check if post-mortem redistribution is possible
Bile	1 x 10ml in fluoride oxalate tube	Sampling bile may be useful in possible opioid toxicity to distinguish acute and chronic use – see footnote[8]
Skeletal muscle	2 x 50 grams in a plain container	Cases where blood and liver are unobtainable
Injection site	Skin & subcutaneous tissue (about 3 cm cube in plain container)	Cases where route of administration is an issue, or to check for drugs that break down in blood (e.g. heroin)
Bite site	Bite site, regional lymph node, blood, urine, etc	In suspected bites by snakes, spiders etc, seek advice about suitable samples and where to send them
Medical equipment	E.g. morphine infusion pump if this may be implicated in the death	Should be submitted intact for examination and analysis in the toxicology laboratory – seek advice
Syringes	Syringes in cases of suspected illicit drug use are **not** recommended	The toxicology laboratory does **not** analyse syringes in cases of illicit drug use unless there are exceptionally good reasons. Prior consultation is required.

[8] "Biliary total morphine concentrations are significantly higher in delayed deaths, persons using very high doses and in persons using heroin regularly. There are, however, few data in the literature to support any strong conclusions made from biliary concentrations…" on page 252 in *The Forensic Pharmacology of Drugs of Abuse*, OH Drummer, Arnold publishing 2001.

Attachment 5B

Doctors approved as examiners under sections 11AA and 14 of the *Coroners Act 2003*

The following doctors are approved as "examiners" and may perform "preliminary examinations":

- Forensic pathologists employed by Health Support Queensland and credentialed to perform coronial autopsies
- Medical registrars working under the supervision of forensic pathologists
- Specialist pathologists contracted by the Department of Justice and Attorney-General and credentialed to perform coronial autopsies

Doctors approved by the State Coroner to conduct particular types of autopsy under section 14 of the *Coroners Act 2003*

To perform coronial autopsies in Queensland, specialist pathologists must have appropriate qualifications and training. Based on these, the Health Support Queensland Credentialing Committee has determined scopes of clinical practice for different types of autopsies.

Specialist pathologists employed by Forensic and Scientific Services, within Health Support Queensland, hold full scope of clinical practice across all types of coronial autopsy.

Medical registrars and other trainees may perform all types of coronial autopsy but only under the supervision of a specialist pathologist, based on their stage of training.

Specialist pathologists contracted by the Department of Justice and Attorney-General do not hold full scope of practice. For Dr David Williams, this excludes complex autopsies on children. Dr Boris Terry and Dr Max Stewart hold scope limited to coronial autopsies that are not complex, i.e. straightforward natural deaths, accidents and suicides.

A specialist forensic pathologist from another Australian State or Territory may be approved by the State Coroner to perform any type of autopsy in a particular case, such as where the family has requested a further autopsy.

Types of coronial autopsy

Autopsies limited to external examinations are usually of low complexity.

Complex coronial autopsies in subjects over 14 years of age

- Homicides and suspicious deaths
- Other deaths where criminal charges possible, e.g. hit-and-run accidents
- Complex accidents, e.g. industrial and mining deaths, SCUBA diving deaths
- Deaths in custody, in police operations and in care
- Complex natural deaths, e.g. sudden unexpected deaths in young adults

- Healthcare related deaths, including all maternal deaths
- Deaths requiring specialised identification, including skeletal remains
- Deaths requiring Disaster Victim Identification (DVI) procedures
- Deaths involving complex poisoning (e.g. agricultural chemicals, snake bites)

Complex coronial autopsies in children aged 14 years or under

- All complex categories for adults as above
- Sudden unexpected deaths in infancy
- Accidental drowning
- Neonatal and perinatal deaths

Attachment 5C

Anatomical structures that are prescribed tissue and those that are not

Distinctions between prescribed and non-prescribed tissues may be difficult. The attachment is not intended to be exhaustive but provides examples of anatomical structures that pathologists commonly seek to retain.

Prescribed tissue		**NOT prescribed tissue**	
Definitions	**Examples**	**Definitions**	**Examples**
What is an organ? *"organs that are readily identifiable as discrete entities"* **What is a whole organ?** *"greater than 50% by weight is a practical and defensible delineating measure"*	Brain Spinal cord Eye Heart Lung Liver Spleen Kidney Ovary or testis A group of organs removed and retained *en bloc* (e.g. neck or pelvic organs)	**What is not an organ?** *"Small anatomical structures … that are … part of a large dispersed organ [or system] … should … not be regarded individually as a whole organ."* **What is not a whole organ?** *"samples of … tissue … taken for testing, and the balance [of the organ] returned to the body"*	Gastrointestinal tract (eg tongue, pharynx, stomach) Larynx, trachea or bronchi Blood vessels Lymph nodes Endocrine system (eg adrenals, parathyroids) Ureters, bladder, prostate or urethra Portions of an organ that weigh less than 50% of the whole organ
What is an "*identifiable body part*"? *"those parts that are identifiable by a reasonably educated layperson, untrained in anatomy, that are not parts of other organs"*	Arm or leg Finger or toe Upper or lower jaw Tooth or teeth Long bone Identifiable part of the skull, spine or chest wall	**What is not an "*identifiable body part*"?** Parts that are **not** *"identifiable by a … layperson"* or *"parts of other organs"* *"components of whole organs, if retained on their own, should not be regarded as 'identifiable body parts'"*	Brain stem Cerebellum Individual brain nuclei Pituitary Cervical cord Papillary muscle Heart valve Coronary artery
What is a foetus? *"Foetus …or an embryo"* [examined either in its own right or as part of a maternal autopsy]	Stillborn baby *"examined [to determine] whether it was born alive"* Foetus Embryo	**What is not a "foetus"?**	Small tissue samples taken for testing with the balance of the organ(s) returned to the body of the foetus or mother

State Coroner's Guidelines 2013

Chapter 6

Release of bodies for burial or cremation

6.1 Introduction

Timely release of a deceased person's 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.

This Chapter sets out the matters a coroner must take into account before ordering the release of the body. It provides guidance about how to manage competing claims for possession of the body. It also deals with the matters a coroner must consider before giving permission for the body to be cremated.

6.2 Release of bodies for burial or cremation

Legislation

Coroners Act
Sections 24, 26, Schedule 2 Dictionary

In principle

A coroner should order the release of a body that has been sufficiently identified as soon as the coroner is satisfied its retention is no longer necessary for the investigation of the death.

Before ordering the release, the coroner must consider whether it is still necessary for retained tissue to be kept for the investigation.

There are very limited circumstances in which a coroner can order the release of a body that has not been sufficiently identified.

It is important for coroners to have regard to cultural and religious considerations when considering the timing of a body's release.

If a coroner is satisfied the body is indigenous burial remains, the coroner must order the release of the body to the Minister responsible for the *Aboriginal Cultural Heritage Act 2003* and the *Torres Strait Islander Heritage Act 2003*, as soon as practicable.

In practice

Section 12(2) sets out the circumstances in which a coroner must stop an investigation. These include matters where the body is determined to be indigenous burial remains or that of a still born child or where the State Coroner has directed the investigation be stopped. In these cases, and in those where an autopsy has been conducted and the body is no longer required for the investigation, the coroner should order release of the body as soon as practicable.

Consideration of request for release order

The family's nominated funeral director must submit a request for release (Form 14A), together with an application for permission to cremate where this

is the family's chosen method of disposal. These forms are also used by funeral directors who are authorised to conduct burials and cremations under the *Burials Assistance Act 1965*. Infrequently, applications are made directly by family members or other persons.

The management of applications for permission to cremate is dealt with in section 4 below.

Is the body no longer required for the investigation?

The crucial issue when considering a Form 14 request is whether releasing the body could impact on the coroner's ability to make the findings required under s. 45(2). This rationale underpins the prohibition under s. 26(4) on releasing a body if the deceased's identity has not been established.

The coroner should first review paragraphs 8 and 9 of Section A of the Form 3 (Doctor's Notice to Coroner after Autopsy). These sections require the pathologist who conducted the autopsy to advise the coroner whether they have completed an autopsy certificate or autopsy notice and whether the body is ready for release, more specifically whether (a) any tissue donation is complete; (b) the examination of the body is complete; (c) all retained tissue has been returned to the body and (d) whether the body has been formally identified.

Section 26(4) permits the release of an unidentified body in circumstances where the coroner believes it is necessary to bury the body. This is a carryover from the repealed *Coroners Act 1958*. While in practice this occurs infrequently, it may be appropriate in circumstances where a body has been stored at the mortuary for many years and the coroner is satisfied the person died from natural causes.

Retained tissue

Chapter 5 of these guidelines deals with the circumstances in which a coroner may decide it is necessary to retain tissue, whole organs, foetuses or body parts.

In cases where retained tissue has not been returned to the body, the coroner must consider whether the tissue is still needed for the investigation e.g. to enable the completion of testing or for subsequent re-examination for future proceedings e.g. inquest or criminal proceedings. In doing so, the coroner should have reference to the pathologist's advice about why it is necessary to retain the tissue and how long the tissue is expected to be required. This will usually be set out in Section A of the Form 3, but in some circumstances may require further discussion with the pathologist. If the coroner is satisfied of the need for continued tissue retention, the coroner must also be satisfied that where practicable, the family has been informed of the tissue retention. The coroner should also consider the family's wishes in relation to disposal of the retained tissue e.g. strong preference for the tissue to be returned to the body, as this may impact on the timing of the coroner's release order. In most cases, the coronial counsellor will have canvassed this issue with the family when seeking their views about the tissue retention.

If the coroner is not satisfied the tissue retention is necessary for the investigation of the death, the coroner should order return of the tissue to the body prior to its release.

Consideration of who is seeking the release order

The Act does not prescribe the persons to whom a body may be released.

In practice, the funeral director's request will generally identify the person on whose behalf the release is sought. Generally, this will be a family member, but not necessarily the family member who is mentioned in the Form 1 ('the nominated family member'). In the vast majority of cases the family is acting collectively in arranging the funeral. However, occasionally the family is in dispute about who is entitled to make the funeral arrangements. The release of the body to someone other than the nominated family member can exacerbate the dispute.

There are some factual situations that are suggestive of a family dispute and these cases warrant some form of vetting before the body is released to someone other than the nominated family member. The following is a non-exhaustive list of circumstances in which further vetting should be undertaken:

- the coronial file contains evidence of a family dispute e.g. in the Form 1 summary or advice from the coronial counsellor
- the release request is made by the wife/husband of the deceased but it is clear from the file there is a de facto spouse
- the application is made by an estranged de facto spouse
- the application is made by adult children or another family member who live in a different area to the deceased person and the nominated family member
- the deceased person is indigenous and the applicant lives in a difference community to the deceased person and the nominated family member.

Before ordering the release, it is prudent to check whether the applicant is a nominated family member. If the applicant is not a nominated family member, the coroner's clerk should make enquires to ascertain the relationship between the applicant and the nominated family member, e.g. the funeral director should be asked to confirm whether the applicant is making funeral arrangements on behalf of the family more generally, or if he or she is acting alone. If this confirmation is not forthcoming and the relationship is not otherwise apparent from the coronial file, the coroner should direct that contact be made with the nominated family member to confirm they are aware of, and/or have no concerns about the body being released to the applicant. The coroner's clerk should refer the outcomes of his or her enquiries to the coroner for consideration and decision.

The management of competing claims for possession of the body is dealt with in section 3 below.

Applicant for release is person who is, or may be, criminally responsible for the death

There is presently no restriction at law on the right of a person who may have caused a deceased person's death to make decisions about disposal of the deceased person's body if they are entitled at common law to do so.

There has been little judicial consideration of this issue. The possibility that a disputant may have been implicated in the death was not a relevant consideration in either of the two recent cases where this issue has arisen.[1]

The Queensland Government is currently considering recommendations made by the Queensland Law Reform Commission to prohibit a person who is charged or convicted of the murder or manslaughter of a deceased person from exercising the right to control the disposal of the deceased person's body.

Unless and until the Government legislates on this issue, a coroner who receives a release request from a person who is suspected of having caused the death should consider taking steps to locate other family members who are willing and able to make arrangements for disposal of the body. Only if no other family member can be found, should the coroner order release of the body to the initial applicant in these circumstances.

Lawful disposal

Burial as defined in the dictionary of the Act includes cremation or other lawful disposal, either in Queensland or elsewhere. This means the coroner can only release a body for disposal by lawful means.

In the vast majority of cases, the release request will be for a funeral director to collect the body from the mortuary for a traditional burial or cremation. There may be cases where a family member seeks to collect and transport the body themselves in order to minimise conveyance costs. In these cases, the person should be asked for clarification of their intentions regarding disposal of the body and if other than a traditional burial or cremation, they should be directed to contact the relevant local authority for advice about any state or local laws regarding disposal of human remains. The person should also be encouraged to contact the coronial counsellors who can facilitate advice about suitable arrangements and any necessary precautions e.g. infection control measures, for transporting the body.

A coroner should not order the release of a body if he or she is concerned about the lawfulness of the proposed method of disposal. In these rare cases, the coroner should engage the assistance of the coronial counsellors to clarify the person's intentions and to assist the person seeking release to obtain appropriate advice about lawful disposal options.

Infectious disease risk

The order for release (Form 14) requires the coroner to indicate whether the deceased person presents an infection risk to persons transporting the body.

[1] *Joseph v Dunn* (2007) 35 WAR 94; *AB v CD* [2007] NSWSC 1474

The coroner should review paragraph 7 in section A of the Form 3 for information about the deceased person's infection risk status.

Cultural and religious considerations

Coroners should always be mindful of cultural and religious considerations when considering a release request. For example, Jewish, Islamic, Taoist – Buddhist, Hmong and indigenous beliefs entail the need for speedy burial of the deceased.[2] In the vast majority of cases, the coroner will have already considered these issues in the context of objections to autopsy and tissue retention. Coronial counsellors should ensure the coroner is made aware of any cultural or religious issues that may impact on the timing of release and coroners should prioritise their consideration of the release request in these cases.

Release of body of deceased foreign national

Coroners should always ensure timely and open communication with the family of a deceased foreign national about the timing of, and arrangements for, the release of their loved one's body. The coroner should engage the assistance of foreign consulates or embassies if there are difficulties communicating with the deceased person's family.

Release of indigenous burial remains

Chapter 4.2 of these guidelines deals with how coroners should handle suspected indigenous burial remains.

In cases where the remains have been transported to Forensic and Scientific Services for testing and are subsequently determined to be indigenous burial remains, the coroner's investigation must stop. The coroner must then order release of the remains to the Minister responsible for the *Aboriginal Cultural Heritage Act 2003* and the *Torres Strait Islander Heritage Act 2003* as soon as practicable. Currently, that is the Minister for Aboriginal and Torres Strait Islander and Multicultural Affairs. Form 12 (Order for release of traditional burial remains) is to be used for this purpose.

Testing of human remains in criminal proceedings

The coronial inquest into the death of Daniel Morcombe examined circumstances in which the prosecution and defence failed to reach agreement on the identity of the deceased, which resulted in the remains being held for an extended period before they were returned to Daniel's family for burial. One of the recommendations made by the State Coroner at the close of the inquest was that a time limit should be imposed on testing of the remains for the purpose of the criminal proceeding.

As a result, an amendment has been made to the Criminal Code to insert a new section 590ASA which deals specifically with the viewing or examination of the remains of a deceased person that is original evidence disclosed by the prosecution in the context of a criminal proceeding. Under this section, the prosecution may (on request or by direction from the court) allow the viewing or examination of the body of a deceased person. This may only occur by specified persons and in certain circumstances, including subject to conditions considered appropriate to protect the integrity of the body and ensure the release of the body for burial under the Coroners Act is not unnecessarily delayed.

In appropriate circumstances and having regard to the best interests of the deceased person's family, Coroners should liaise with relevant agencies, including counsellors from Forensic and Scientific Services (should they be involved in the case and have an existing relationship with the family), the Queensland Police Service and Office of the Director of Prosecutions, with a view to ensuring that families are informed where the prosecution or court permits the viewing or examination of the body in these circumstances. This will help to ensure that families are given an assurance that the body will continue to be treated with dignity and respect and are made aware of arrangements for testing, including supervision and conditions.

6.3 Management of competing claims for release of the body

The Coroners Act does not expressly empower a coroner to make a decision about who is entitled to control the disposal of a deceased person's body once it is released. To date, the suggestion a coroner may have an implied power to do so because he or she is obliged to order release of the body for burial as soon as reasonably practicable has not been tested in Queensland, though this was questioned but not resolved by the Supreme Court in the 2012 matter of *Kontavainis-Hay v Hutton & Welch*[3]. In that matter, Douglas J indicated a preliminary view the decision was a matter for the Supreme Court, not the coroner.

In contrast, the Victorian Court of Appeal has held:

[2] Freckleton, I & Ranson, D, *Death Investigation and the Coroner's Inquest* (2006), p.372
[3] (Unreported, Supreme Court of Queensland, Douglas J, 12 November 2012)

> *…Nevertheless, we are in no doubt that the Coroner does have the power to decide those questions if and when they arise. The duty to issue "as soon as reasonably possible' a certificate permitting one or other form of disposal of the body carries with it, by necessary implication, the power to decide questions as to where and by whom the disposal will be carried out. The existence of the implied power is essential to the effective discharge of the Coroner's functions. Moreover, to deny the coroner this implied power and require the issue to be litigated elsewhere would only prolong and exacerbate the distress which inevitably attends any such dispute*.[4]

In Queensland, there is presently no statutory hierarchy of persons with the duty and the right to dispose of a deceased person's body. Subject to the operation of the *Cremations Act 2003* (discussed in section 4 below), disputes about the right to control disposal of a deceased person's body are determined by the application of common law principles.

The common law gives priority to the executor of the deceased person's estate or, if there is no will, to those in order of priority for applying for letters of administration (as set out in the *Uniform Civil Procedure Rules 1999*[5]*).* In cases where there is a dispute between two or more equally entitled persons, the court will often give significant weight to the practicalities of disposal without unreasonable delay and may also take account of other considerations including:

- the deceased person's wishes,
- religious, cultural or spiritual factors;
- where the deceased lived and for how long prior to death,
- the strength of the deceased's association with particular people and places;
- the wishes of the deceased's children;
- the convenience of family members in visiting the deceased's final resting place;
- the closeness of the claimants' relationship with the deceased; and
- the '*sensitivity of the feelings of the various relatives and others who might have a claim to bury the deceased*'.[6]

As at the time of issuing these guidelines, only eight cases involving disputes of this kind have been decided by the Supreme Court of Queensland over the last 25 years.[7]

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[4] *Gilliott v Woodlands* [2006] VSCA 46 at [20]; relied upon in *Ugle v Bowra & O'Dea & Anor* [2007] WASC 82

[5] See Rule 610. It should be noted that a spouse for this purpose means a person who at the time of the deceased's death – (a) was the deceased's husband or wife; or (b) had been the deceased's de facto partner for a continuous period of at least 2 years ending on the deceased's death. This applies despite the *Acts Interpretation Act 1954*, section 32DA(6).

[6] See *Smith v Tamworth City Council* (1997) 41 NSLR 680. See also *Jones v Dodd* (1999) 73 SASR 328 at 336-7 [51]-[56] where Perry J opined '..*the proper approach in cases such as this is to have regard to the practical circumstances, which will vary considerably between cases, and the need to have regard to the sensitivity of the feelings of the various relatives and others who might have a claim to bury the deceased, bearing in mind also any religious, cultural or spiritual matters which might touch upon the question. In my opinion, proper respect and decency compel the courts to have some regard to what Martin J there refers to as 'spiritual or cultural values', even if the evidence as to the relevance of such considerations in a particular case may be conflicting. This is not to say that the Court should have regard to expressions of pure emotion or arbitrary expressions of preference.*

The Queensland Law Reform Commission's report '*A Review of the Law in Relation to Final Disposal of a Deceased Person's Body*' contains a detailed discussion of the law in this regard.[8] Its recommendations include a proposal to establish a legislative scheme to determine who is entitled to make decisions about the disposal of a deceased person's body – the proposed scheme involves a statutory hierarchy and retains the Supreme Court's jurisdiction to resolve disputes. The Queensland Government is currently considering these recommendations.

In principle

The approach to be taken where there is no executor and there is a dispute between competing family members was outlined by Byrne J in *Threfall v Threfall & Anor* [2009] VSC 283. The coroner should first determine who has priority in terms of entitlement to a grant of letters of administration. The body should be released to that person unless the circumstances show this is not appropriate. The coroner should make a practical decision having regard to the competing relationships of the claimants and to any social, cultural and practical considerations and also having regard to the requirement the body be disposed of without unnecessary delay.

In practice

From time to time, a coroner will be made aware of a dispute among family members about how and where a deceased person's body is to be disposed of. For example, disputes can arise between estranged parents of a deceased child or between a subsequent spouse and children from a previous relationship. This situation can culminate in the coroner receiving more than one release request in relation to a deceased person.

Pending resolution by a higher court of the issue whether the coroner has implied power to resolve disputes about the disposal of the body, the coroner should make an administrative decision based on the principles outlined above. Before doing so, the coroner should refer the competing claimants to mediation to see if agreement can be reached. The Coronial Counselling Service may be able to assist in appropriate cases. If the coronial counsellors are unable to facilitate agreement, then the claimants should be given information about other dispute resolution options available to them, such as the Dispute Resolution Centre, or where the deceased person is indigenous, ATSILS or a relevant Community Justice Group. The coroner should be advised of the outcome of mediation but should not be advised about the issues discussed during mediation.

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[7] *Re Dempsey* (Unreported, Supreme Court of Queensland, Ambrose J, 7 August 1987); *Reid v Crimp* [2004] QCS 304; *Doherty v Doherty* [2006] 2 Qd R 257; *Savage v Nakachi* (Unreported, Supreme Court of Queensland, Byrne SJA, 10 March 2009); *Liston v Pierpoint* (Unreported, Supreme Court of Queensland, Douglas J, 15 July 2009); *Re Schubert* (Unreported, Supreme Court of Queensland, Byrne SJA, 5 November 2010); *Frith v Schubert & Anor* [2010] QSC 444 (26 November 2010); *Kontavainis- Hay v Hutton & Welch* (Unreported, Supreme Court of Queensland, Douglas J, 12 November 2012); *Laing v Laing* [2014] QSC 194; *Logan v Waho* (Unreported, Supreme Court of Queensland, Wilson J, 4 December 2014)

[8] QLRC, *A Review of the Law in Relation to Final Disposal of a Deceased Person's Body* (2011) www.qlrc.qld.gov.au/reports/r69.pdf

If a mediated agreement is not achieved, the coroner should proceed to make an administrative decision about the release of the body. The coroner should seek submissions from each of the claimants and then give written reasons why the coroner intends to release the body to one claimant over another. The competing claimants should be allowed time to approach the Supreme Court for an urgent order before the body is actually released in accordance with the coroner's administrative decision.

6.4 Issue of permission for cremation

Legislation

Cremations Act
Sections 5, 6, 8, 9, 10,12

In principle

A coroner, who orders the release of a body for cremation, may only give permission for the body to be cremated if satisfied the body does not pose a cremation risk and there are no known objections to the cremation.

In practice

The *Cremations Act 2003* operates to ensure the body of a person whose death is reportable is not cremated without discovery and also to reduce the incidence of harm to crematorium workers from cremation risks, such as cardiac pacemakers. The Cremations Act facilitates this by preventing a body from being cremated unless permission is given by a coroner or an independent doctor.

When a request is made to a coroner for release of a body for cremation, the request must be accompanied by a Cremations Act Form 1 (Application for Permission to Cremate).

A copy of the application and the coroner's permission to cremate must be kept on the coronial file.

Standing of applicant

When considering a cremation application, the coroner should satisfy himself or herself of the applicant's standing to make the application. Under s. 6 of the Cremations Act, the application can only be made by or on behalf of the deceased person's close relative (spouse, adult child or parent), personal representative or another adult who has a satisfactory reason for making the application. If the applicant's relationship to the deceased person is unclear, the coroner should take steps to clarify this e.g. by seeking written confirmation from the funeral director or reviewing information contained in the coronial file.

Cremation risk

The coroner must also be satisfied the body does not pose a cremation risk. The pathologist who performed the autopsy is required to advise the coroner whether there is a pacemaker, radioactive implant or other implanted device in the body that would pose a cremation risk. This notification is made in

paragraph 6 of section A of the Form 3 (Doctor's Notice to Coroner after Autopsy). The coroner should not give permission if the pathologist is unable to confirm the absence of a cremation risk.

Known objections to cremation

Unless the deceased person has left signed instructions that he or she be cremated, a coroner must not authorise cremation if the coroner is aware of objections by a close relative or the personal representative to the cremation. There is no positive obligation on the coroner to make enquiries in this regard. In practice, family objections to the method of disposal are likely to arise in the context of a dispute about who the body is to be released to – concerns of which the coroner will most likely already be aware.

Coroner likely to receive benefit from death

A coroner must not issue a permission to cremate in respect of a person from whom the coroner or the coroner's spouse may receive a benefit such as a distribution from the person's estate or a payment

State Coroner's Guidelines 2013

Chapter 7

Investigations

7.1 Introduction

The Act bestows broad powers of inquiry on coroners that enable them to investigate deaths creatively in order to make findings or comments about the death. Over the past decade, coroners have increasingly applied a proactive case management approach to ensure they conduct appropriately thorough and efficient investigations.

This Chapter explains which deaths must be investigated and clarifies those which may not. It outlines general case management strategies coroners may consider when investigating a death and explains how certain categories of reportable death should be investigated. It encourages coroners to proactively consider potential referral issues. Finally, it explains how investigation outcomes can be reviewed.

7.2 How should deaths generally be investigated?

Legislation

Coroners Act
Sections 11, 11A, 12, 13, 14(5), 15, 16, 48 'investigation'

Police Powers and Responsibilities Act
Part 5 (ss.596-602)

In principle

Section 45 stipulates the findings that must be made in relation to all reported deaths. The scope of a coroner's inquiry under s. 45 is extensive and is not confined to evidence directly related to the matters listed in s. 45(2).[1]

The scope of inquiry that is appropriate in this jurisdiction was well summarised by the 2003 review of coronial practice in the United Kingdom. After listing the findings of fact similar to those referred to in s. 45(2) of our Act the committee went on to say:

> *Other issues to be covered should be the immediate circumstances in which the death was discovered, the events leading up to it and the actions of any individuals involved in those events, any relevant aspect of the deceased persons circumstances, situation, or history, any management or regulatory systems relevant to the protection of the dead person or others facing comparable risks, and the role of any emergency services that were or might have been summoned to the situation*[2]

Coroners should bring a proactive case management approach to their investigations to secure the evidence needed to support their findings or comments and to ensure relevant issues are identified and investigated appropriately and in a timely way. Coroners should carefully assess the extent of investigation warranted by the circumstances of each death so finite coronial resources are applied strategically. Any

[1] *Atkinson v Morrow* [2005] QSC 092 and *Queensland Fire & Rescue Authority v Fall* [1998] 2 Qd R 162 at 170, affirmed in *Doomadgee & Anor v Clements & Ors* [2005] QSC 357
[2] *Death certification and investigation in England, Wales and Northern Ireland, The report of a fundamental review,* (the Luce report) The Home Office, London, 2003, p98

temptation to assume the death is from a pre-determined cause must be resisted until the cause of death and the circumstances of it have been established.

In practice

Which deaths must be investigated?

A coroner must, and may only, investigate a reportable death – s. 11(2). Chapter 3 *Reporting deaths* explains the various categories of reportable death. The coroner may not investigate the death if it is being investigated by another coroner.

By virtue of the definition of 'investigation', coroners may exercise their powers under the Act to conduct a preliminary examination to determine whether a death is reportable. While the Act does not prevent a coroner from ordering an autopsy as part of his or her preliminary examination, coroners should have regard to the steps set out in Chapter 5 *Preliminary examinations, autopsies and retained tissue* and Chapter 7.3 *Investigating health care related deaths* when assessing whether a death is reportable.

The coroner's decision about whether or not a death is reportable is reviewable under s. 11A by the State Coroner or the District Court (if the investigating coroner was the State Coroner). This review mechanism is discussed in Chapter 3 *Reporting deaths*.

Chapters 3 *Reporting deaths* and 7.5 *Investigating suspected deaths* explain the coroner's jurisdiction to investigate suspected deaths.

Only the State Coroner or the Deputy State Coroner can investigate a death in custody or a death in the course of or as a result of police operations – s11(7). Chapter 7.3 Investigating deaths in custody details how these deaths are investigated.

Which deaths must not be investigated or further investigated?

Deaths outside Queensland

A coroner can not investigate a death that occurred outside Queensland but which has a sufficient Queensland connection unless directed to do so by either the State Coroner or the Attorney-General – ss.11(4)(b) and s.12(1). The circumstances in which these directions are given in practice are discussed in Chapter 3 *Reporting deaths*.[3]

If a coroner investigating one of these deaths becomes aware the death has been reported to a non-Queensland coroner, the coroner's investigation must stop unless the Attorney-General's direction is for the coroner's investigation to continue – s12(2)(e). The coroner must provide his or her investigation outcomes to the relevant non-Queensland coroner.

Indigenous burial remains

A coroner's investigation must stop as soon as it is established that remains are indigenous burial remains – s12(2)(a). Chapter 4 *Dealing with bodies* explains how suspected indigenous burial remains should be dealt with.[4]

[3] See section 3.1.2 Location of Death
[4] See section 4.2 Dealing with possible indigenous burial remains

Authorisation of cause of death certificate where autopsy not necessary

Section 12(2)(b) enables a coroner to authorise the issue of a cause of death certificate for a reportable death in circumstances where the coroner's investigation shows an autopsy is not necessary. The coroner's investigation must stop once the coroner authorises the certificate – s12(2)(b). In practice, these deaths are reported via the Form 1A Medical Practitioner Report of a Death to the Coroner or directly by funeral directors without involving the police. Chapter 7.3 *Investigating health care related deaths* details how deaths reported this way are investigated.

Stillbirths

The coroner's power to investigate a stillbirth is extremely limited. The Act prevents a coroner from investigating how a child came to be stillborn. The coroner can only order an autopsy to determine whether a baby was born alive. If the autopsy confirms the child was stillborn, the coroner's investigation must stop – s. 12(2)(c). Chapter 3.3.1 *Stillbirths* clarifies the circumstances in which the coroner's power to investigate a stillbirth is invoked.

At the time these guidelines were published, the Government was giving consideration to extending the coroner's jurisdiction to investigate intrapartum stillbirths.

Direction to stop investigation

The State Coroner can direct a coroner to stop an investigation. Such a direction is appropriate in circumstances where the State Coroner considers the death has already been adequately investigated and there is sufficient evidence to support the making of findings without further investigation.

Investigation and case management strategies

The Act gives coroners power to direct all necessary inquires be undertaken by the police or other agencies investigating a death, including the issuing of search warrants, requiring statements and the production of documents and the undertaking of tests and examinations etc. In some respects the powers of a coroner exceed that of a police officer investigating a crime: for example there is no need to suspect that evidence of a crime will be found in order to ground a warrant to search premises and a potential witness can not refuse to answer questions during the investigation unless they have a reasonable excuse for doing so.

Initial investigations

In the majority of cases there will be no inquest, but even if there is, flaws and inadequacies in the initial response to the notification of the death may not be able to be overcome. All investigations must commence from the premise that they are potential homicide cases. It is essential therefore that from the outset the scene is properly secured and examined and all appropriate inquiries, including concerns raised by the family member or other witnesses are canvassed thoroughly. While investigators naturally must resist making assumptions that the death was self inflicted, arose from natural causes, or was an accident, in many cases this will be readily established after initial inquiries and the investigation can then focus on whether any systemic issues require addressing. However, until that position is reached, the inquiry should continue with all of the rigour and safeguards that apply in a murder investigation.

It is important that from the outset coroners maintain oversight of investigations to ensure that all relevant aspects of the death are effectively investigated. Back tracking to recover evidence passed over is costly and frequently unsuccessful. Police will obtain all evidence required to complete the Form 1. The Coroner will then decide what level of autopsy is necessary and, after considering the results of the autopsy, what further investigation is necessary.

Proactive investigation and case management

The length of coronial investigations is a common cause of complaint. Whereas under the previous system coroners tended to be the passive recipients of investigation reports, under the current system coroners have increasingly applied proactive investigation and case management strategies to their investigations. Coroners should constantly strive to progress their investigations as expeditiously as possible. Not only is coronial performance scrutinised against formal reporting benchmarks,[5] but more importantly delays in finalising investigations can exacerbate a family's grief.

Early identification of issues enables investigations to be progressed more efficiently. Most investigations can be progressed without having to wait for the final autopsy or investigations report. Key milestones at which investigation issues become apparent include receipt of:

- the Form 1 or supplementary Forms 1
- the Form 3 Pathologist's report to coroner after autopsy
- family concerns[6]
- preliminary clinical or mental health review reports
- witness statements
- final autopsy and investigation reports
- outcomes of other administrative or non-coronial proceedings relating to the death, for example, disciplinary investigations or criminal proceedings.

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 in a timely fashion.

As discussed in Chapter 2 *The rights and interests of families*, 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.

[5] The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services. Coronial performance is measured by reference to a clearance rate (finalisations/lodgements) and a backlog indicator (the percentage of matters more than 24 months old). The national standard for coroners' courts is that no lodgments pending completion are to be more than 24 months old.
[6] See also Chapter 2 The rights and interests of families, section 2.7 (Management of family concerns about the death)

Investigation reports

Depending on the circumstances of the death, the coroner is assisted by police (including the QPS Forensic Crash Unit) and other specialist investigative agencies such as the Australian Transport Safety Bureau, Civil Aviation Authority, Department of Transport and Main Roads (for rail fatalities), Maritime Safety Queensland (for marine fatalities), Office of Fair and Safe Work Queensland (for workplace or electrical fatalities) and the Department of Natural Resources and Mines (for mining, quarrying, petroleum and gas and explosives fatalities). The coroner's investigation is informed by investigation reports from these agencies.

Each of these agencies have procedures which if followed properly should result in an adequate investigation. However, as the circumstances which are likely to be the subject of coronial inquiry are so diverse it is impossible for those procedures to cover every eventuality and therefore coroners and their counsel assisting must be vigilant in ensuring all necessary sources of information which may bear on the coronial function are accessed. For example, on occasions some of the regulatory agencies mentioned focus their investigations only on whether a prosecution is warranted and do not necessarily extend their examination of the circumstances of the death to identifying changes to law or practice that could prevent similar deaths recurring in the future. Similarly, these investigators might not be familiar with the power under the Act to require witnesses at an inquest to answer even incriminating questions and accordingly they may not appreciate how this procedure could further an investigation. As investigations involving these agencies tend to be complex and lengthy, it is advisable for the coroner to meet regularly with the investigators to ensure the investigation is progressing and focussed, and to ensure issues outside the scope of the other agency's remit are investigated by other means.

Less complex deaths, such as those from natural causes or straightforward violent or unnatural deaths, rarely warrant a full police investigation. In these cases, the coroner should turn his or her mind early in the investigation to the extent to which further police involvement is warranted and either direct no further police investigation at that stage or issue a direction tasking only specified further investigation.

Experience has shown that inquiries into health care related deaths are better made by the coroner without further police involvement, unless a criminal offence may have been committed.

Deaths in custody are a subset of those matters which must always be exhaustively examined and accordingly the comments below relating to the investigation of those deaths are equally apposite to the investigation of other suspicious deaths.

Obtaining statements

It is important to acknowledge that participation in a coronial investigation can be equally stressful and costly for those involved in the events leading to a reportable death. For this reason and to expedite investigations, coroners should endeavour whenever possible to particularise the issues they want covered in statements or be specific about the documents or other items they require under s16 of the Act.

Non-compliance with a requirement under s16 is an offence, unless the person has a reasonable excuse. The Act specifically recognises the privilege of protection against

self-incrimination as a reasonable excuse for this purpose. However, other common law privileges such a legal professional privilege may be claimed in response to a s.16 requirement. The State Coroner's ruling in the inquest into the death of Saxon Bird provides a useful overview of the application of legal professional privilege in the Coroners Court. In that matter, the State Coroner held that litigation privilege has no application to communications made in contemplation of or in furtherance of participation in an inquest and that advice privilege can apply to a client seeking advice as to what evidence he or she should give to an inquest.

Obtaining expert reports

The coroner may seek help from any person who he or she considers can inform the investigation.

Coroners are routinely assisted by forensic medicine officers from the Queensland Health Clinical Forensic Medicine Unit and mental health clinicians from the Queensland Health Directorate of Mental Health who review investigation material and provide preliminary opinions about the adequacy of clinical and mental health treatment. Chapter 7.*4 Investigating health care related deaths* explains how to use these resources. The forensic medicine officers can also provide opinions about the effects of alcohol and other drugs and injury interpretation.

The complexity of the circumstances of some deaths will require specialist clinical or technical expertise to assist in resolving the issues to be determined by the inquiry. If this expertise can not be obtained through QPS or other involved investigative agency, the investigating coroner may seek State Coroner approval to obtain an independent expert report. Coroners are to use the template Request to obtain expert report for this approval.

Coroners should ensure experts are appropriately briefed about the circumstances of the death and the issues about which opinion is sought. Experts should be provided with copies of all relevant investigation documents and any known relevant family concerns so they can be considered and addressed by the expert.

Referral to other investigative agencies

Suspected commission of an offence

Section 48(2) obliges a coroner who as a result of information obtained while investigating a *reasonably suspects* a person has *committed an offence* to give the information to the appropriate prosecuting authority. The information can not include information compelled under s39(2).

'*Committed an offence'* is taken to mean there is admissible evidence that could prove the necessary elements to the criminal standard. That would include the evidence necessary to rebut any defence reasonably raised by the evidence.

The use of the term '*reasonable suspicion'* is analogous to the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence but not necessarily well founded or factually correct and be a suspicion that

a reasonable person acting without passion or prejudice might hold. As a result, a relatively low level of certainty is needed to satisfy the test.

The management of a potential s. 48(2) referral is detailed in Chapter 9 *Inquests*.

Official misconduct or police misconduct

Section 48(3) gives coroners discretion to refer information about official misconduct or police misconduct to the Crime and Corruption Commission. There is no statutory threshold for these referrals.

Professional or occupational conduct issues

Section 48(4) gives coroners discretion to refer information about a person's professional or occupational conduct to a relevant regulatory body if the coroner reasonably believes the information may warrant inquiry or action by that body. The referrals most commonly made under 48(4) relate to professional conduct by registered health practitioners.

In the interests of natural justice, coroners should always give the subject of a potential referral under s. 48(4) an opportunity to respond to the basis on which the coroner proposes to make the referral.

When a referral is made to a regulatory body under s. 48(4), and the coroner has sufficient evidence to make findings, the investigation may be finalised without waiting for the outcome of the referral. The fact and basis of the referral should be noted in the findings. The coroner can always reopen the investigation and amend the findings at a later stage once informed of the outcome of the referral.

Referral of issues not relevant to coronial investigation

From time to time the coroner's investigation will identify issues that although not relevant to the cause or circumstances of the death, are more appropriately referred to another investigative agency, for example, health quality concerns that warrant investigation by 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.

Referrals can be made at any time during a coronial investigation.

The impact of criminal proceedings

Although the Act prevents a coroner from holding or continuing an inquest when a person has been charged with an offence in relation to the death,[7] it does not prevent the coroner from continuing their investigation (other than by inquest), for example, the investigation of potential systemic issues can be continued while waiting for the outcome of a prosecution.

Although technically there is nothing to stop a coroner who has sufficient evidence to make findings from finalising an investigation before a prosecution relating to the death is completed, coroners should generally keep the investigation open until the prosecution outcome is known so this information can be reflected in the findings. The

[7] Section 29 (When inquest must not be held or continued)

investigation may then be finalised without waiting for the appeal period to expire. If the conviction is successfully appealed, the coroner can reopen the investigation and amend the findings accordingly. This approach is consistent with that taken in other Australian coronial jurisdictions.

7.3 How should deaths in custody be investigated?

Legislation

Coroners Act
Sections 10, 14

See also: QPS Operational Procedures Manual (S.1.17)

In principle

Deaths in custody warrant particular attention because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained. Further, a thorough and impartial investigation is in the best interests of the custodial or police officers involved.

Elliot Johnson QC wrote in the National Report of the RCADIC:-

> *A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of the duties. Justice requires that both the individual interest of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.*[8]

In the Commission's Interim Report, Commissioner Muirhead wrote:-

> *The situation demands the most thorough investigation of facts and circumstances by skilled investigators who hopefully may be regarded as impartial, autopsies performed by expert pathologists followed by thorough coronial inquires conducted by legally trained Coroners under modern legislation which enables such Coroners to make remedial recommendations.*[9]

In practice

All '*deaths in custody*' must undergo an inquest. Note the extended definition given to that term by s. 10.

Correctional Centre Deaths

Experience demonstrates that some prison deaths that appear to be suicides are in fact murders. Police intelligence indicates that there are groups of prisoners whose familiarity with investigative techniques has equipped them with the knowledge to

[8] E. Johnson, *National Report*, AGPS, Canberra, 1991, vol.1, p.109
[9] J. H. Muirhead, *Interim Report*, AGPS, Canberra, 1988, p.58

confound inquiries by constructing false alibis and interfering with crime scenes. Investigators must be alert to the possibility of these ploys even when death initially presents as suicide. No presumption of self inflicted death or natural causes should distract an investigator from conducting an exhaustive inquiry.

All deaths in correctional centres are undertaken by officers from the QPS Corrective Services Investigation Unit (the CSIU). In consultation with the State Coroner the Inspector in charge of the CSIU has settled a standard form investigation report that will be used in these cases. Further it has been agreed that all investigations will be completed within 6 months of the date of death unless delays are unavoidable.

Additionally, the Office of the Chief Inspector (OCI), Queensland Corrective Services (QCS); may appoint independent external inspectors to investigate the death. This is not a requirement but is usually done if the death appears to be other than by natural causes or apparently relates to a systemic failure within a correctional centre. Experience has demonstrated that these reports are generally thorough and useful to the coronial investigation. The investigators appointed by the QCS OCI will often more thoroughly examine the influence of systemic issues in the death than will the investigating police officer. Counsel Assisting should therefore ensure that the OCI report and all supporting documentation (especially records of interviews conducted by the OCI investigators) is obtained and, usually, tendered at the inquest. Consideration should be given to calling one of the OCI investigators if it becomes evident to Counsel Assisting that their findings or recommendations are not likely to be accepted by the individual prison (in the case of a privately run correctional centre such as AGCC) or the QCS.

Natural Causes deaths

A growing and ageing prison population has resulted in the increased incidence of deaths in correctional centres due to natural causes. That the death is a result of natural causes should only, of course, be made once a careful initial investigation discounts the possibility of foul play or suicide.

In such cases (as with all deaths in correctional centres) the CSIU investigator must obtain all medical records relating to the deceased from both the QCS file and from any external hospital or medical practitioner involved in the provision of relevant treatment. These should be provided at first instance to the pathologist conducting the post mortem examination and then delivered to Counsel Assisting.

The primary investigative task in apparent “natural cause” correctional centre deaths will relate to the adequacy of the medical treatment afforded to the deceased while in custody. The treatment must be compared and contrasted to the treatment a non-incarcerated member of the community with an equivalent medical condition could reasonably expect. After receipt of the autopsy report Counsel Assisting should refer the investigation material to an appropriate medical practitioner and seek an assessment of the adequacy of the medical care provided to the deceased while in custody. In nearly all cases the initial referral should be made to the Clinical and Forensic Medicine Unit of Queensland Health (CFMU). Counsel Assisting should ensure that all relevant medical records have been obtained and seek the advice of the CFMU practitioner in this regard.

The extent to which further investigation is required in relation to the adequacy of care will usually be guided by the advice of the CFMU practitioner.

Deaths involving police

The OSC is bound by a tripartite memorandum of understanding (MOU) with the QPS and Crime and Corruption Commission (CCC) relating to the investigation of deaths arising from police related incidents. A copy of the MOU can be found in Chapter 11.

All deaths in police custody or that occur during a police operation will be undertaken by officers from the Ethical Standards Command of the QPS and overviewed by officers from the CCC. The exception to this would be the rare case in which the CCC exercises its power to assume control of the investigation.

As a matter of geographical practicality police related deaths in remote locations will be investigated initially by local police officers. Every effort should be made, through consultation with the QPS, to ensure that ESC investigators are urgently sent to the scene of the death. Where officers from another agency within the QPS must be assigned to conduct the investigation prior to the arrival of ESC officers (for instance, because evidence may be lost prior to the arrival of the ESC officers) the Coroner should request that the principal investigating officer be as independent as possible from the police officers apparently involved in the death. The coronial findings and extensive subsequent litigation relating to the death of *Mulrunji* set out the actual and perceived prejudice that can otherwise arise.

In most cases a full internal autopsy should be undertaken by a forensic pathologist. The pathologist should be provided with all information gathered from the scene and any witnesses that is available at the time the autopsy is undertaken. If, during the course of the investigation, evidence is uncovered that contradicts or is inconsistent with the information available when the autopsy was undertaken that information should be conveyed to the pathologist and he/she should be asked to provide a further report indicating whether the new information provides any basis to vary the conclusion of the earlier report.

All deaths in custody

In all cases investigations should extend beyond the immediate cause of death and whether it occurred as a result of criminal behaviour. It should commence with a consideration of the circumstances under which the deceased came to be in custody and the legality of that detention. The general care, treatment and supervision of the deceased should be scrutinised and a determination made as to whether custodial officers complied with their common law duty of care and all departmental policies and procedures and whether these were best suited to preserving the prisoner's welfare. Only by ensuring the investigation has such a broad focus as to identify systemic failures will a Coroner be given a sufficient evidentiary basis to discharge his/her obligation to devise preventative recommendations.

In cases where preventative recommendations are made by another investigating agency prior to the inquest Counsel Assisting should investigate the extent to which the recommendations have already been accepted and implemented. This should be done by requesting a statement from a suitable representative of the department or agency which is the subject of the recommendation. The Coroner should consider

seeking such a statement in the scope drafted by Counsel Assisting pursuant to a requirement set out in a Form 25.

7.4 Investigating health care related deaths

Deaths in a health care setting can raise novel challenges:

They can raise complex clinical issues and prompt a variety of clinical opinion:

- They can invoke a range of investigative responses, in addition to that of the coroner because there are a number of other bodies obliged to investigate concerns about medical treatment.

- Most police investigators are ill-equipped to undertake the investigation of these deaths without detailed instruction.

- Medical charts should mean the preservation of evidence is not as problematic as in other cases. However, the frequent inadequacy of those records and the propensity of medical practitioners to move between hospitals, states or even countries can make the gathering of evidence more difficult.

- Because so many people die in hospital, requiring clinicians to provide detailed statements about all of them would impose an unreasonable burden and potentially impede the treatment of the living.

This section is intended to guide:

- the coroner's timely consideration of what information is required to properly investigate a health care related death
- the extent to which the coroner should investigate the death
- the coroner's assessment of what aspects of the circumstances leading to the death warrant referral to another investigative entity.

Legislation

Coroners Act
Sections 9, 10AA, 12, 45

Health Ombudsman Act 2013 (health service complaints, health practitioner discipline)
https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthOmbA13.pdf

Health Practitioner Regulation National Law Act 2009 (health practitioner regulation and discipline)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HealthPracRNA09.pdf

Hospital and Health Boards Act 2011, Parts 6 & 9 (quality assurance committees, root cause analysis and health service investigations)
http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/H/HHNA11.pdf

When is a death potentially 'health care related'?

Chapter 3 discusses this category of reportable death in some detail.

To recap briefly, the Coroners Act definition of *health care related death* encompasses two broad scenarios relating to (a) the provision of health care or (b) the failure to provide health care. The definition of 'health care' is broad and encompasses primary health care provision by general practitioners, medical specialists, non-medical health practitioners and paramedics outside the hospital system, as well as emergency, medical, surgical and mental health care provided within a hospital context.

Provision of health care

The Act makes reportable a death where the provision of health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would not have expected the death to occur as a result of the health care provided to the person.

Failure to provide health care

The Act also makes reportable a death where failure to provide health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would have expected health care, or a particular type of health care, to be provided to the person.

'Death in care' investigations can often also involve consideration of the adequacy of health care provision to the deceased person, particularly when the person was a person with a disability or the subject of involuntary mental health treatment.

How can health care related deaths be reported?

Health care related deaths are reported by police using a Form 1, by hospitals on a Form 1A or by funeral directors who usually call and then fax a cause of death certificate about which they have concerns.

The majority of health care related deaths and many deaths in care are reported by hospitals, using a Form 1A. This may be preceded by a telephone discussion with the coroner about the death. Form 1As can also be generated through a hospital's internal mortality review processes.

Less frequently, a hospital will report a death to police without speaking with the coroner first – this can occur when there has been a clear-cut adverse outcome such as a surgical mishap in the operating theatre.

The Form 1A process facilitates the exercise of a coroner's power under s. 12(2)(b) of the Coroners Act to authorise the issue of a death certificate in cases where the coroner is satisfied that although the death is reportable neither an autopsy nor any further coronial investigation is necessary.

Occasionally health care related deaths are reported directly to the coroner by funeral directors. This happens when the doctor they engage to issue the cremation permission identifies the death as potentially reportable. In these cases, the funeral director submits a copy of the death certificate. Using this information, the coroner's office identifies the treating doctor/hospital and obtains the medical records for review. If satisfied the death is reportable the coroner should require the hospital to submit a

Form 1A so the demographic details and the information necessary to enable the coroner to determine whether the matter is reportable and/or warrants investigation.

Management of deaths reported via a Form 1A

CFMU review

A Form 1A will be accompanied by the death certificate and varying amounts of hospital documentation. This documentation can range from a medical or discharge summary to extracts from, or the complete, hospital records.

On receiving a Form 1A, the coroner should consider whether additional documentation is required to enable a proper consideration of the death e.g. further documentation from the hospital where the death occurred; records from another hospital where the deceased received prior treatment; records from the deceased's treating general practitioner or specialist or nursing home records.

It is recommended the coroner's review of a Form 1A be informed by a review of the medical records and death certificate by an independent doctor from the Queensland Health Clinical Forensic Medicine Unit (CFMU). The CFMU employs forensic medicine doctors whose role includes the provision of clinical advice to coroners. The CFMU review assists in the identification of any issues warranting further investigation whether by the provision and review of further medical information from a treating doctor, hospital or nursing home, or by proceeding to autopsy. This process also provides an opportunity for constructive feedback to the certifying doctor about the appropriateness of the death certificate.

When providing the Form 1A to CFMU for review, the coroner should highlight any known family concerns for specific consideration by the reviewing doctor. Sometimes the circumstances of the death may warrant discussion with the family to clarify their concerns – this can be managed by the coroner directly or with the assistance of a coronial counsellor or where appropriate, by the reviewing CFMU doctor.

The CFMU doctor may speak with the treating doctor or other members of the treating team to clarify aspects of the deceased's treatment or to clarify the certifying doctor's rationale for the stated cause of death. This can sometimes result in the reporting doctor issuing a revised cause of death certificate.

The CFMU doctor will generally provide a written response summarising the deceased's treatment, documenting the outcomes of any discussions had with the treating team and advising whether there are any concerns about the treatment provided to the deceased person. These concerns may be alleviated through the provision, and further CFMU review, of additional medical information, or the concerns may be sufficient to require further coronial investigation.

In cases where additional medical information is sought, the coroner's office should keep the family's funeral director informed of the coroner's progress in reviewing the death. This ensures the family's funeral arrangements are not unduly inconvenienced wherever possible.

On occasions, family members may be pressing for a funeral to proceed, either because the death has been reported late after funeral arrangements have been made, or because people have come from overseas, etc. In such cases the coroner can consider allowing the body to be transported to the funeral home where the ceremony will take place on receiving an undertaking the funeral director will retain possession of the body and deliver it to the mortuary if an autopsy becomes necessary. The body can't be lawfully buried or cremated without there being a valid cause of death certificate in the funeral director's possession, so the risk of proceeding in this way is slight.

CFMU review identifies no health care concerns

If the CFMU doctor considers there are no health care issues warranting further investigation, the coroner should authorise the death certificate and complete Section B of the Form 1A advising that no further investigation is required. It is helpful for a copy of the CFMU advice to be provided with this documentation when it is transmitted back to the reporting doctor/hospital for their records. Section 45(3) of the Coroners Act obviates the making of findings in these cases.

In cases where the family is known to have concerns, it can be helpful to provide a copy of the CFMU advice to the family also. This information can give families reassurance their concerns have been actively considered and the coroner's decision not to investigate those concerns any further has been informed by independent clinical opinion.

CFMU review identifies health care concerns

In cases where the CFMU identifies treatment concerns the coroner considers warrants further coronial investigation, the coroner should:

- not authorise the death certificate
- complete Section B of the Form 1A to indicate the death requires further investigation, including autopsy, and direct the reporting doctor/hospital to report the death to police who will complete a Form 1
- provide a copy of the Form 1A and CFMU advice to the pathologist, with a copy to the coronial counsellors, to notify them of the death and highlight the specific issues of concern – this helps inform the pathologist's assessment of the extent of autopsy required to investigate those issues
- advise the QPS Coronial Support Unit of the decision to require the death to be reported as a Form 1, and provide them with a copy of the Form 1A to assist in this process
- arrange for the coroner's staff to inform the family's funeral director of the coroner's decision.

Autopsy decision making

When the death is reported to police, the medical records are generally sent to the mortuary with the body. Coupled with CFMU advice (where the death was initially

reported as a Form 1A), this informs the pathologist's assessment of the extent of examination required to establish the cause of death and/or examine specific treatment concerns. It is often helpful for the coroner to discuss the case with the pathologist before an autopsy order is issued. In some cases, an external examination +/- toxicology and review of the medical records will be sufficient; others will warrant some degree of internal examination.

In some cases, the family may have already communicated specific concerns about the deceased's health care, either directly to the coroner's office or during discussion with the coronial counsellors. It is advisable to provide the pathologist with any information about the family's known concerns prior to autopsy as this may also inform autopsy decision making.

Sometimes families have concerns about the deceased's health care but equally strong concerns about autopsy. A coronial counsellor should be involved in these cases to help explain to the family the coroner's rationale for autopsy and the possible implications for further investigation of health care concerns by not proceeding with an autopsy.

Timely investigation

The efficient management of health care related death investigations hinges on identifying issues of concern early and gathering relevant information for further timely investigation of those issues.

Given the time it can take for an autopsy report to be finalised, the coroner should actively consider the following possible lines of inquiry once in receipt of the Form 3 containing the pathologist's macroscopic autopsy findings if the pathologist, the CFMU or the family have raised concerns about the treatment:

Deaths involving non-psychiatric treatment issues

- obtaining a general statement from the most appropriate senior treating clinician/s outlining the deceased's medical history, presenting symptoms, assessment, diagnosis and management

- obtaining the deceased's consultation and/or prescription history from Medicare

- obtaining a list of all clinical personnel involved in the deceased's treatment – the Queensland hospital workforce is highly mobile, so it is advisable to identify all members of the treating team as soon as possible in cases where some or all of them may be required to provide statements about their involvement in the deceased person's care

- in cases where there has been an identified 'adverse event' – obtaining statements from key members of the treating team outlining their qualifications and experience, their involvement in the deceased's treatment and more specifically, the adverse event; their version/observations of the adverse event and their thoughts about whether anything could have been done differently to prevent the adverse outcome

- obtaining copies of any relevant clinical policies, guidelines or pathways in place at the time of the death and a statement from the relevant clinical director about the extent to which the relevant policy, guideline or pathway was followed in relation to the deceased's treatment

- giving the hospital an opportunity to respond to the family's documented concerns

- requiring the hospital to provide a copy of the final root cause analysis report and/or the outcomes of any other clinical incident review or internal mortality review process undertaken in respect of the treatment provided to the deceased – as discussed in more detail below, it is helpful to issue this information requirement in the early stages of the investigation as these processes are generally commenced shortly after the death and can identify and remedy systemic issues of concern more expeditiously and effectively than a lengthy coronial investigation and inquest

- providing this additional information and the medical records to CFMU for review.

CFMU review of the medical records and additional statements or other information will assist in the identification of any issues warranting further investigation or independent expert review, pending receipt of the autopsy report.

The outcomes of the CFMU review are provided to the coroner in a formal report which should be provided to the hospital/treating clinician for response in the event it is critical of the health care provided. Natural justice requires the coroner to afford the hospital or individual practitioner in respect of whom an adverse finding or referral may be made, an opportunity to respond to any criticism of their management of the deceased person before that finding or referral is made.

The Department of Health Patient Safety Unit may also be able to provide the coroner with advice about the number and outcomes of clinical incident reviews undertaken across public health services into similar incidents.

The coroner should consider releasing a copy of the CFMU report to the family at an appropriate time, accompanied with advice about what action is proposed to be taken in respect of any concerns identified in the report.

Deaths involving paramedic response issues

- requesting the Medical Director, Queensland Ambulance Service to conduct a root cause analysis or clinical audit review of the paramedic response and provide a report on the outcomes of that review process

Deaths involving mental health treatment issues

Coroners should consider whether the treatment provided to deceased persons was adequate or whether further investigation and/or specialist review is necessary. If a review is required it will generally need to be undertaken by an independent psychiatrist.

If the review raises significant concerns about the quality of the mental health care, the coroner should consider taking the following steps:

- obtaining a statement from the most appropriate senior treating mental health clinician outlining the nature of the deceased's mental health condition, how this mental health condition was being managed, the date and nature of the deceased's last contact with the Mental Health Service and the basis of any assessment of the risk of the deceased self harming at that time

- obtaining the deceased's consultation and/or prescription history from Medicare

- obtaining a list of all key clinical personnel involved in the deceased's in-patient or out-patient treatment

- obtaining copies of any relevant clinical policies, guidelines or pathways in place at the time of the death and a statement from the relevant clinical director about the extent to which the relevant policy, guideline or pathway was followed in relation to the deceased's mental health treatment

- giving the hospital an opportunity to respond to the concerns raised in the review

- requiring the hospital to provide a copy of the final root cause analysis report and/or the outcomes of any other clinical incident review or internal mortality review process undertaken in respect of the treatment provided to the deceased.

Independent expert reviews

The CFMU report and formal responses to it or the 'Mental Health Advice to Coroner' will inform the coroner's assessment of whether further independent expert review is required. The State Coroner's approval is required before an expert is briefed to provide an opinion. The Office of the State Coroner can provide assistance in identifying an appropriate expert. All relevant investigation material, including the autopsy report, should be provided to the expert for review. The outcomes of independent expert review will inform the coroner's decision about whether an inquest is warranted.

After an independent specialist has provided a report, it will usually be appropriate to provide any of the treating clinicians whose practice has been criticised to respond to these criticisms.

Informing inquest recommendations

Once the coroner decides to hold an inquest, it is recommended that early consideration be given to possible recommendations, with a view to inviting input from relevant health care sector stakeholders for examination during the inquest.

Depending on the circumstances of the death, the coroner may consider approaching the following entities for their views on possible recommendations:

- relevant medical specialist colleges
- relevant regulatory authority e.g. health practitioner registration board or the Therapeutic Goods Administration
- relevant health industry representative bodies e.g. Australian Medical Association
- Patient Safety Service, Department of Health
- Office of the Chief Psychiatrist, Department of Health
- Drugs of Dependency Unit, Department of Health
- Private Health Regulatory Unit, Office of the Chief Health Officer, Department of Health
- Queensland Maternal and Perinatal Quality Council
- Queensland Paediatric Quality Council
- Australian Commission on Safety and Quality in Health Care.

It is preferable that this response gathering process is commenced prior to the inquest to allow sufficient time for all parties to consider the responses, and for arrangements to be made for relevant witnesses to give evidence.

Death review processes in Queensland hospitals

Prior to 1 July 2014, all Queensland hospitals were required by the former Health Quality and Complaints Commission Review of hospital-related deaths standard to ensure all hospital-related deaths were reviewed. This included all deaths that occur:

- in a public hospital, licensed private hospital or day hospital
- in public or private emergency departments, pre-admission clinics and outpatient clinics
- within 30 days of being discharged, or attending a hospital for clinical care.

The HQCC standard mandated the implementation of review processes incorporating:

1. review of all deaths by the relevant clinical team within two weeks of the death
2. independent peer review and/or mortality review committee within eight weeks of the death in circumstances where there is a concern/complaint about the deceased person's care OR a root cause analysis is commissioned OR multiple clinical units were involved in the deceased person's care
3. external review by the coroner, QPS, HQCC or other relevant entity.

The level 2 review process was intended to identify opportunities and make recommendations for improving the safety and quality of patient care.

The HQCC Review of death standards (and other HQCC standards) ceased to have effect from 1 July 2014 when the *Health Quality and Complaints Commission Act 2006* was repealed by the *Health Ombudsman Act 2013* and has not been replaced with a specific directive. The National Safety and Quality Health Service Standards, Standard 1 *Governance for safety and quality in health service organisations* requires implementation of an incident management and investigation system (criterion 1.14). In the absence of a specific directive, it is hoped this will be incentive enough for Queensland hospitals and day procedure services to continue implementing local

death review policies (which were built on the repealed HQCC standard) in order to continue meeting accreditation requirements.[10]

It is recommended the coroner routinely issue an information requirement for the outcomes of an internal mortality review as this information can inform consideration of whether further clinical review (by CFMU or an independent expert) or other investigation is warranted.

Clinical incident management in public health facilities

The Department of Health has a Clinical Incident Management System that guides reporting and review of '*any event or circumstance which had actually or could potentially lead to unintended and/or unnecessary mental or physical harm to the patient*'.

When an unexpected patient death occurs, it is reported in PRIME CI (a state wide clinical incident reporting information system). The incident is classified by reference to a Severity Assessment Code (SAC) – death which is not reasonably expected by the treating clinicians, patient or family as an outcome of heath care is rated SAC1. This rating determines how the incident will be analysed.

A SAC1 incident should trigger a root cause analysis (RCA). This is a quality improvement technique that examines the contributory factors that led to the adverse outcome. It is a systemic analysis of what happened and why and is designed to make recommendations to prevent it from happening again, rather than to apportion blame or determine liability or investigate an individual clinician's professional competence.

The RCA process is governed by a statutory framework under the *Hospital and Health Boards Act 2011* (Part 6) and the Hospital and Health Boards Regulation 2012 (Part 6). An RCA is mandatory for a range of reportable events including the following death scenarios - maternal death associated with labour or delivery; death associated with the incorrect medication management; death associated with an intravascular gas embolism; death resulting from the wrong procedure being performed or a procedure being performed on the wrong part of a person's body; death associated with a haemolytic blood transfusion reaction resulting from the wrong blood type being used during a blood transfusion; suspected suicide of a person receiving inpatient health care; and any other death not reasonably expected to be the outcome of health services provided to the person. These reportable events generally correspond with the list of National Sentinel Events.

An RCA may be performed in respect of the suspected suicide of a person with a mental illness who is under the care of a provider of community mental health services – the commissioning authority retains discretion about the method of analysis of these deaths, after consultation with the relevant mental health mortality review committee.

[10] The NSQHS Standards developed by the Australian Commission on Safety and Quality in Health Care provide a nationally consistent statement of the level of care consumers should be able to expect from health services. They are designed to drive the implementation and use of safety and quality systems and improve the quality of health service provision in Australia. All hospitals and day procedure services are required to be accredited the NSQHS standards (www.safetyandquality.gov.au)

The RCA process involves the appointment of an RCA team comprising members who were not directly involved in the incident. The information provided to, and generated by it is protected by statutory privilege.[11] However, the coroner is permitted to be told, on request by the coroner, when an RCA has commenced or is stopped and to be provided with a copy of the final RCA report. The coroner is generally not provided with a copy of the complete RCA documentation (comprising a commissioning authority report, chain of events document, contributory factors diagram and final report). The final report will present a description of the reportable event, causal statements and associated recommendations, outcome measures and measure dates. It may also include discussion of any 'lessons learned', namely other unrelated opportunities for safety improvement. The Government is currently considering changes to the RCA legislation to expand the scope of RCA documentation that can be provided to a coroner.

There are also statutory protections for both RCA team members and individuals who provide information to an RCA team. They can not be compelled to produce a document or information or give evidence relating to their involvement in the RCA process or relating to any document provided to, or generated by that process.[12]

Human Error and Patient Safety (HEAPS) is an alternative analysis method used for deaths where an RCA is either not appropriate or is not required. This process guides a systemic analysis by frontline health care workers and their line manager of the factors that may have contributed to the adverse event which caused the death. The majority of clinical incidents are reviewed using this process.

It is recommended the coroner routinely issue an information requirement for the outcome of a clinical incident review (final root cause analysis report or HEAPS analysis) undertaken in respect of a health care related death. These processes can take several weeks or months to produce an outcome, but that outcome can alleviate the need for a lengthy coronial investigation or inquest if the coroner is satisfied the review has adequately identified issues of concern and made recommendations which are being implemented. The relevant senior person in a health service district should also be required to produce a statement detailing what has been done in response to the review recommendations.

For more information about clinical incident management, contact the Department of Health Patient Safety Unit via http://www.health.qld.gov.au/psu/

Clinical incident management in private health facilities

Private health facilities are accredited and licensed under the *Private Health Facilities Act 1999*. The regulatory scheme is administered by the Private Health Regulatory Unit within the Department of Health. www.health.qld.gov.au/privatehealth

Private hospitals also make use of the RCA process but past experience has demonstrated the private hospital sectors tends to review clinical incidents through gazetted quality assurance committees (which can have the protection of statutory privilege under the *Hospital and Health Boards Act 2011*) or through locally

[11] See *Hospital and Health Boards Act 2011*, Part 6 Div 2, Subdiv 5
[12] Ibid, Part 6, Div 2, Subdiv 6

implemented clinical incident management processes such as the Mater Hospital's Clinical Incident System Analysis.

Referral to another investigative agency

There can be a range of investigative responses to a health care related death, in addition to the coronial investigation:

- internal clinical incident or mortality reviews by the hospital
- root cause analysis conducted under the *Hospital and Health Boards Act 2011* (Part 6) or the *Ambulance Service Act 1991* (Part 4A)
- assessment, investigation ,conciliation and/or possible disciplinary action by the Health Ombudsman
- possible regulatory action under the *Health Practitioners Regulation National Law Act 2009*
- a clinical review or health service investigation instigated by the Department of Health Director-General under the *Hospital and Health Boards Act 2011*
- assessment, investigation by the Commonwealth Office of Aged Care Quality and Compliance (in relation to health management in a licensed aged care facility)
- an ethical standards investigation by Department of Health or the Department of Community Safety (QAS)
- investigation of suspected official misconduct by the Crime and Corruption Commission
- a criminal investigation by Queensland Police Service.

When investigating a health care related death, the coroner should ascertain whether the death is or is likely to be subject to one or more of these investigative processes and ensure the relevant entity is aware of the coronial investigation.

Office of the Health Ombudsman (OHO)

The OHO is Queensland's health service complaints agency. It is an independent statutory body whose role is to manage complaints about health services and health service providers, including private and public health care facilities, ambulance service, mental health services, community health services, medical centres, pharmacies, aged care facilities and individual registered and unregistered health practitioners.

From 1 July 2014, the OHO took over the health care complaint responsibilities of the former Health Quality and Complaints Commission (HQCC), and assumed certain responsibilities from the Australian Health Practitioner Regulatory Agency for the discipline of registered health practitioners against whom serious allegations have been made.[13]

The standard-setting function and some quality monitoring functions of the former HQCC were discontinued from 1 July 2014. While the Health Ombudsman's key functions relate to health complaint management, he/she also has a role in identifying

[13] http://www.oho.qld.gov.au/

and reporting on systemic health service issues, including matters relating to the quality of health services.

The OHO complaints management process involves:

- an attempt to resolve the complaint through early local resolution
- assessment– this involves obtaining advice from an independent clinician in order to determine what if any further action is required. As the CFMU review delivers more timely and comprehensive advice than the OHO assessment process, it is the preferred first step for determining what clinical or systemic issues may have caused or contributed to the death
- conciliation – this is a privileged process that may result in a financial settlement
- referral to another regulatory body such as the Australian Health Practitioner Regulatory Agency[14] or relevant licensing body
- formal investigation – this is undertaken in more complex matters involving an adverse health outcome and/or potentially raise broader systemic issues e.g. treatment by more than one hospital is under scrutiny, particularly when there is strong media, political or public interest in the incident. An OHO investigation often involves interviewing witnesses, obtaining formal expert clinical opinions and making formal recommendations for improvement. When investigating a complaint, the Health Ombudsman has access to clinical advice from independent advisory committees and panels
- taking immediate action against the health provider.

There will be some health care related deaths where the role of the coroner and the Health Ombudsman converge. It is important for the coroner to consider whether the death raises issues that may be more appropriately investigated by the OHO and to liaise with senior OHO officers early to ascertain whether and if so how the OHO should be involved in the matter. It is important to bear in mind the investigation of health care related deaths forms only part of the OHO's much broader remit and its investigative resources are limited.

Chapter 11 discusses the protocol between the State Coroner and the Health Ombudsman which sets out arrangements aimed at timely notification of matters, co-ordination of concurrent investigations and information sharing between the OSC and OHO.

It is important to remember the primary purpose of the health practitioner regulatory scheme is protective, not punitive. It is focussed on protecting the public and maintaining professional standards.

The coroner should consider contact with/referral to the Health Ombudsman in the following circumstances:

- there is significant media/political focus on the circumstances of the death – as soon as possible, the coroner should request a meeting with senior OHO

[14] AHPRA is the entity responsible for supporting 14 national health practitioner boards responsible for regulating the health professions- Aboriginal and Torres Straight Islander health practitioners, Chinese medicine practitioners, chiropractors, dentists and allied oral health practitioners, general and specialist medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists (www.ahpra.gov.au).

officers to discuss allocation of lead agency responsibility for investigating the death

- the preliminary CFMU review identifies a potential systemic issue – a systemic issue is a problem due to issues inherent in the overall system (whether a specific unit, department, hospital or the broader health care system) rather than due to individual factors such as clinician performance. Examples of systemic issues encountered by coroners include issues relating to clinical handover; communication; documentation; recognition of patient deterioration; end of life planning; co-ordination of care; inter-hospital co-ordination; training; staffing levels; lack or adequacy of clinical guidelines/protocols, etc; work environment and availability of equipment. The coroner should request a meeting with senior OHO officers to discuss the issue and determine whether it is more appropriately referred to OHO for further investigation

- the family complains about aspects of the deceased's care that are unrelated to the cause of death e.g. clinician interaction with the family – these issues can be referred to OHO for assessment at any stage of the coronial investigation

- it is known the family intends to or has made a complaint to the OHO (or the former HQCC or AHPRA) – the coroner should consider issuing an information requirement for the outcomes of the assessment of the complaint, as this information (together with the complaint file) will inform the coroner's decision about whether further coronial investigation is warranted.

- the coroner is concerned that death may be part of a pattern of adverse outcomes in relation to a particular health provider – the coroner should request a meeting with senior OHO officer to ascertain whether OHO is aware of a number of similar deaths and to discuss how the OHO can assist the coroner's investigation i.e. assume lead agency responsibility or provide specific assistance to the coroner's investigation

- the circumstances of the death raise serious concerns about the competence or professional conduct of one or more individual health practitioners.

  For example, the CFMU review may identify professional conduct that warrants referral under s. 48(4) of the Coroners Act to the Health Ombudsman for further investigation and possible disciplinary action. The threshold for the exercise of this discretion is quite low – the coroner may do so if information obtained by the investigation might cause the relevant professional regulatory body to enquire into, or take steps in relation to a person's conduct in the profession.

  When considering whether a referral is warranted, the coroner should:

  - note whether the CFMU review has identified an instance of 'notifiable conduct' – this concept captures practice that significantly departs from accepted professional standards. It also captures a practitioner who is impaired, practised while affected by drugs or alcohol or who engaged in sexual misconduct. It is conduct that is the subject of mandatory notification by any registered health practitioner, who in the course of practising their

profession (including a CFMU doctor), forms a reasonable belief that another registered health practitioner has behaved in a way that constitutes notifiable conduct. In cases where CFMU has identified a clinician's conduct is so deficient it meets the mandatory notification threshold, the coroner should immediately refer the matter to the Health Ombudsman, with advice to the affected practitioner about the basis on which the referral is made and advice to CFMU that the referral has been made

- otherwise, provide the clinician who may be referred an opportunity to respond to the issues identified in the CFMU report.

- issue an information requirement to the OHO to determine whether the practitioner has been the subject of previous complaints or investigations about their competence

- where it is known a complaint has been made to the Health Ombudsman (or the former HQCC or AHPRA) about the practitioner, issue an information requirement to the relevant entity for advice about the outcome of the assessment or investigation of that complaint and/or copies of the assessment/investigation documents

- consider whether the practitioner's response demonstrates an appropriate degree of insight into their professional conduct and/or evidence they have reflected and made changes to the way they now practise

- consider whether a preliminary discussion with a senior OHO officer may assist in determining whether the conduct in question meets the threshold for disciplinary action.

The coroner can make a referral to the Health Ombudsman at any time during the investigation.

In matters where the coroner decides to make a formal referral to the Health Ombudsman for further action, the coroner may be in a position to finalise his or her investigation noting the referral has been made, without waiting for the OHO assessment and/or investigation to be completed.[15] The coroner should provide a copy of his/her findings to the OHO with a request for formal advice of the outcomes of the OHO process in due course. This will enable the coroner to assess whether the findings require amendment to reflect those outcomes.

In matters where the coroner declines to make a disciplinary referral, it is advisable the findings include some discussion of the basis for this decision.

[15] The *Health Ombudsman Act 2013* requires investigations to be completed within 12 months of the decision to commence the investigation, but may be extended in 3-monthly periods. The Health Ombudsman must report publicly on investigations that taken more than 12 months, and must refer an investigation that takes longer than two years to the relevant Parliamentary Commission for review.

Australian Health Practitioner Regulatory Agency (AHPRA)

AHPRA is the entity responsible for supporting 14 national health practitioner boards responsible for regulating the health professions.[16]

Amongst other functions, AHPRA assesses notifications made about a registered health practitioner or student and on behalf of the relevant board, manages investigations into the professional conduct, performance or health of registered health practitioners. Investigations can result in the relevant board proceeding with disciplinary action ranging from counselling, caution, reprimand, voluntary undertakings, imposition of conditions on registration, suspension of registration and deregistration.

Prior to 1 July 2014, AHPRA was responsible for investigating serious allegations against Queensland registered health practitioners. However, since then the Health Ombudsman has taken responsibility for these matters. That said, APHRA has continuing ***registration*** and ***health monitoring*** jurisdiction in respect of Queensland registrants. As noted above, the Health Ombudsman can refer a complaint to AHPRA for further action

While referrals under s.48(4) of the Coroners Act relating to an individual health practitioners can now only be made to the Health Ombudsman, there may be circumstances in which the coroner's investigation may be informed by information held by AHPRA in respect of the practitioner (eg, registration, health impairment or previous complaint outcomes). An information requirement will be required to obtain this information from AHPRA.

Office of Aged Care Quality & Compliance

The OACQC is a Commonwealth agency that administers the Aged Care Complaints scheme (www.health.gov.au/oacqc). The scheme manages complaints about government subsidised aged care services including residential aged care, Commonwealth funded Home and Community Care, community aged care packages, extended aged care at home packages and extended aged care at home – dementia packages.

When investigating a death that raises concerns about the care provided to a nursing home resident, the coroner should consider contact with/referral to OACQC in the following circumstances:

- the family has raised concerns about the care provided to the deceased which is not related to the cause of death – the coroner can refer these issues to OACQC at any stage in the investigation.
- it is known the family intends to make or has already made a complaint to OACQC – the coroner should issue an information requirement for the outcomes of OACQC's assessment/investigation of the complaint and/or the

[16] The regulated professions are Aboriginal and Torres Straight Islander health practitioners, Chinese medicine practitioners, chiropractors, dentists and allied oral health practitioners, general and specialist medical practitioners, medical radiation practitioners, nurses and midwives, occupational therapists, optometrists, osteopaths, pharmacists, physiotherapists, podiatrists and psychologists (www.ahpra.gov.au).

OACQC investigation documents as this information may assist in determining whether further coronial investigation is necessary.
- the CFMU report identifies issues of concern about the provision of care to an aged care resident – the coroner should give the relevant facility or clinician an opportunity to respond to those concerns, before referring the matter to OACQC.

The coroner can make a referral to OACQC at any time during the investigation.

In matters where the coroner decides to make a formal referral to OACQC for assessment, the coroner may be in a position to finalise the investigation noting the referral has been made, without waiting for the OACQC assessment/investigation to be completed. The coroner should provide a copy of the findings to OACQC with a request for formal advice of the outcomes of the OACQC assessment/investigation in due course. This will enable the coroner to assess whether the findings require amendment to reflect those outcomes.

Clinical review or health service investigation

The Director General, Queensland Health can appoint clinical reviewers or health service investigators to undertake an investigation into any matter relating to the management, administration or delivery of public health services. These reviews and investigations can result in recommendations aimed at improving the safety and quality, administration, management or delivery of public sector health services.

In matters where the coroner is aware Queensland Health has or is undertaking a clinical review or a health service investigation into a health care related death, it is advisable the coroner issues an information requirement for the outcomes of the investigation and the departmental or government response to its recommendations. The statutory duty of confidentiality that applies to clinical reviewers and health service investigators does not apply to the disclosure of information required under the *Coroners Act 2003*.[17]

Official misconduct investigations

In matters where the death is the subject of an official misconduct investigation, that investigation may or may not raise issues of relevance to the coronial investigation.

The coroner should ensure the investigating entity is aware of the coronial investigation and keeps the coroner informed of the progress of its investigation.

Conclusions

It is the coroner's responsibility to investigate the cause of the death and how it occurred. In most health care related deaths input from independent medical practitioners will be necessary.

If these matters can be established by a paper based investigation, the matter need not proceed to inquest even if the investigation establishes sub standard health care has contributed to the death – it is not the role of the coroner to adjudicate upon the

[17] See *Hospital and Health Boards Act 2011*, Part 6 Div 3 & Part 9

standard of medical care. The coroner should make findings and refer concerns about the quality of the health care to the appropriate regulatory body.

However, if the cause of death or how it came about can not be established by the investigation, an inquest may be necessary.

An inquest may also be warranted to advance public health or safety and/or to reduce the chances of similar deaths occurring in future. However, if the health service district or private hospital has acknowledged the problems and taken steps to address them, there may be little left on which to focus the coroner's prevention function.

7.5 Investigating domestic and family violence related deaths

Specialist assistance is available to support the role of coroners in their investigation of domestic and family violence related deaths through the Domestic and Family Violence Death Review Unit (DFVDRU). For a significant proportion of these types of deaths there have been key predictors of a heightened risk of harm as well as missed opportunities for intervention prior to the death. There are also often similar themes, issues and identifiable risk factors that recur in many of these deaths which is why there is a benefit to a systematic review process. [18]

The implementation of this unit aligns Queensland with other jurisdictions who have dedicated positions focused specifically on preventing future deaths. This section is intended to guide:

- the identification and classification of domestic and family violence related deaths;
- the coroner's consideration of information that may be required to effectively investigate a domestic and family violence related death; and
- the resources available to coroners to assist with their investigations of these types of deaths.

Legislation

Coroners Act 2003

Domestic and Family Violence Protection Act 2012 s. 8, 13, 12, 19, 20.

https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2012/12AC005.pdf

When is a death potentially domestic and family violence related?

Domestic and family violence encompasses a range of threatening or abusive behaviour designed to control another person within an intimate partner or family relationship. This includes physically, emotionally, psychologically or economically

[18] The connection between domestic and family violence and homicide, the extent of the problem and the characteristics of deadly relationships were discussed in the former State Coroner's findings of the inquest into the deaths of Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers (http://www.courts.qld.gov.au/__data/assets/pdf_file/0007/154537/cif-gold-coast-murder-suicide-20120621.pdf)

abusive behaviour that is used to control or dominate another party and causes this person to fear for their safety or wellbeing or that of someone else.

For the purposes of a coronial investigation the following criteria is used to define a 'domestic and family violence related death':

(a) homicides or murder suicides which have occurred within the context of an intimate partner, family or informal care relationship as defined by the *Domestic and Family Violence Protection Act 2012;*

(b) 'bystander' homicides such as a person who may have been killed intervening in a domestic dispute or a new partner who is killed by their current partner's former abusive spouse;

(c) child deaths where there was a history of domestic violence between the child's parents/caregivers and the child dies as a result of an intentionally harmful act of one of the parents or care givers or an intimate partner of one;

(d) suicides of a victim or perpetrator of domestic and family violence in which there is a clear link between the suicide and history of domestic and family violence, such as an incident of violence within close proximity to the death.

These criteria are not exhaustive. The context and circumstances of a death, even when it does not meet the criteria outlined above, may still support a finding that the death was domestic or family violence related.

The Domestic and Family Violence Death Review Unit

The expertise of DFVDRU is available to assist and inform coronial investigations whenever it becomes evidence that a death may have occurred within the context of domestic and family violence. It does so by providing coroners with access to specialist expertise to examine a range of factors including the circumstances of the death, prior interaction with support services, potential points of intervention as well as the nature and history of the relationship between the victim and perpetrator. The unit also assists with the identification of any systemic shortcomings and in the formulation of preventative recommendations for those matters that proceed to inquest.

Coroners are encouraged to seek advice and assistance from the unit as soon as it becomes evident that the death may have occurred within the context of domestic and family violence.

Understandably, the review process differs for individual cases dependent on the complexity of issues involved and the level of information available. Although most cases are referred to the unit at the initial stages of investigation, on occasion it may not be immediately apparent that a death is domestic and family violence related but the connection may emerge as the coroner's investigation progresses.

The primary role of the DFVDRU is to provide advice and assistance to coroners in their investigation of these types of deaths. However the unit is also responsible for the monitoring and identification of any patterns or trends in relation to domestic and family violence related deaths.

This information is invaluable in developing an evidence base to inform future coronial investigations but is also used in the development of strategic policy and practice responses to domestic and family violence across government departments and non-government services. Consequently referral and liaison with the unit by coroners, counsel assisting and other staff is strongly encouraged when a death is suspected to relate to domestic and family violence.

Management of the investigation of domestic and family violence related deaths

Upon initial notification and assessment of a suspected domestic and family violence related death, the DFVDRU will arrange for the QPS Coronial Support Unit to provide preliminary details regarding the death and any history of domestic and family violence between the victim and/or the perpetrator.

Dependent upon the availability and extent of these records a preliminary review will be conducted advising the coroner of the relationship of the death to domestic and family violence, any initial issues and proposed avenues for investigation; including where necessary, obtaining additional records from different agencies.

For a significant proportion of homicides that occur within an intimate partner or family relationship, there may be no prior contact with police in relation to domestic and family violence. A lack of police records however, should not be considered a reliable indicator that there was no abuse in the relationship. It is often the case that victims will access help and support from family or friends, health agencies or other services, as opposed to seeking assistance through the criminal justice system.

In recognition of this, and to assist the coroner in gathering relevant information, the Queensland Police Service Operational Procedures Manual contains provisions to guide police investigations of domestic and family violence related deaths (Section 8.5.23). This may include, but not be limited to, the following information:

- Previous history of domestic or family violence between the victim and perpetrator and/ or with their former partners;
- Status of the relationship at the time of the death;
- History of suicide threats or attempts;
- Drug and/or alcohol abuse or any known mental health issues;
- Factors related to the incident such as separation, new partner, financial problems, custody issues or an upcoming court appearance;
- History of stalking or obsessive behaviour; or
- Previous threats to kill (including against children or other family members).

Witness statements and other records obtained during police investigations are invaluable in providing contextual information regarding the history of the relationship between the victim and the perpetrator. Because of this the brief of evidence is

required for all domestic and family violence related homicides and it is preferable that this be routinely requested at the committal stage.

Once there is sufficient information available, the DFVDRU will provide an interim report to assist coroners in the identification of any issues warranting further investigation. After all relevant records have been received; the DFVDRU will provide a final file review covering the context and circumstances of the case as it relates to domestic and family violence. This information can subsequently be used to inform a coroner's consideration as to whether it may be within the public interest to hold an inquest or the circumstances of the case are such that they wish to proceed to making their findings.

The Centre for Domestic and Family Violence Research

The Centre for Domestic and Family Violence Research (CDFVR), Central Queensland University has been funded to provide external expert assistance to the Office of the State Coroner in the investigation of domestic and family violence related deaths.

Under this agreement an investigating coroner, or nominated representative, may provide the CDFVR with discussion papers and de-identified case material, pose questions for consideration and seek that the CDFVR provide one of the following:

- advice and assistance on the identification of relevant service providers or recognised experts;
- provide general advice in the form of a short report (e.g. types of services available within the service system); or
- provide information and advice on emerging trends or issues of relevance to the prevention of domestic and family violence related deaths and within the context of improving systemic responses to domestic and family violence.

This work is intended to compliment, not duplicate, the work of the DFVDRU, and as such decisions around accessing support from the CDFVR should be made in consultation with the Principal Researcher and Coordinator of the DFVDRU.

7.6 Investigating 'child protection' deaths

From time to time, coroners will investigate the death of a child whose life circumstances raise concerns about the family's previous or ongoing contact with the child protection system, or suggest missed opportunity for protective intervention which may have prevented the child's death. While some of these deaths may occur in the context of domestic homicide, others may not be the result of interpersonal violence but arise out of neglect, challenging behaviours or intentional self-harm. Regardless of whether or not the child was subject to formal intervention under the *Child Protection Act 1999* at the time of their death, there is considerable value in informing coronial investigations of this nature with systemic review expertise as the coroner has an important external oversight function in relation to these deaths.

This section outlines the information and specialist resources, including the expertise of the DVFVRU, available to assist coroners in the investigation of these types of deaths.

Legislation

Coroners Act ss. 8, 9

Child Protection Act 1999 s. 159P, 246AA, 246D, 246H
https://www.legislation.qld.gov.au/LEGISLTN/CURRENT/C/ChildProtectA99.pdf

Adoption Act 2009
https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2009/09AC029.pdf

Family and Child Commission Act 2014
https://www.legislation.qld.gov.au/LEGISLTN/ACTS/2014/14AC027.pdf

When is the death of a child potentially a "child protection" death?

Thankfully, these deaths number few among the variety of child deaths reported to coroners for investigation, and of those reported to date, only a very small proportion have raised issues of concern in terms of the State's involvement with the child and their family.

Child deaths 'in care'

The most clear cut cases are those reported as a 'death in care' under section 9(1)(d) of the *Coroners Act 2003* because when the child died, he or she was subject to a formal intervention under the Child Protection 1999.[19] In practice, this captures deaths which occur when action by the Department of Communities Child Safety and Disability Services results in the child being:

- in the custody or guardianship of the chief executive of the DCCSDS. When a child is placed in the custody or guardianship of the chief executive the Department must find an appropriate placement for the child such as home-based care (foster, kinship and provisionally approved carers) and residential care services;

- placed in care under an assessment care agreement. An assessment care agreement is an agreement between the chief executive and the child's parents for the short term placement of the child in the care of someone other than the parents;

- subject to a child protection order granting custody of the child to a member of the child's family other than a parent; or

- subject to a child protection order granting long-term guardianship of the child to a suitable person who is a member of the child's family other than a parent or another suitable person nominated by the chief executive.

While these interventions are often actioned to protect the child from risk of harm, they can also be used to facilitate a child's medical treatment, for example, when a

[19] See State Coroner Guidelines Chapter 3 Reporting deaths

chronically or critically ill child from a remote community needs treatment that can only be delivered a tertiary facility many thousands of kilometres from the child's home and family.

It is important to acknowledge that the Coroners Act operates to require the reporting of all child deaths "in care", even if the death was an expected natural causes death, for example, terminal illness, or has occurred in circumstances completely unrelated to the reason for which they were placed "in care", for example, from injures sustained in a motor vehicle accident where the driver of the other care was at fault. These deaths generally do not raise systemic child protection issues warranting extensive coronial investigation.

However, child deaths "in care" involving interpersonal violence, neglect, suicide, accident or the tragic outcomes of reckless or challenging behaviours may warrant close examination of the appropriateness of the action taken (or not) by the State in relation to the child and his or her family.

The significance of a death being reported as a "death in care" is that an inquest must be held if the circumstances of the case raise issues about the care that was provided to the deceased person. Examples of child protection issues examined in previous child death "in care" inquests include the appropriateness of the child's placement and case management, supervision by carers and communication with and within the child protection system.

Other reportable child deaths

Child deaths are also reported under other categories of "reportable death" under the Act, most commonly sudden unexpected infant deaths or other apparent natural causes deaths where the cause of death is unknown, traumatic deaths, for example, motor vehicle accidents, suicides and accidental drug overdoses, and occasionally health care related deaths. From time to time, the deceased child will be a child who was known to the child protection system. The extent to which the State's prior involvement with the child and their family may relevant to the circumstances of these deaths is considered by the coroner on a case by case basis.

In some cases, the circumstances of the child's death will raise questions about whether the child should have been subject to formal child protection intervention at the time of their death, and will require a careful examination of whether there were missed opportunities for this to have occurred and if so, whether earlier or different intervention or departmental involvement with the child's family may have prevented the child's death. These deaths can often reveal broader systemic deficiencies in the sense of gaps or blockages between various government and non-government agencies (health, housing, education, child protection, police) engaged with the child's family in the lead up to the death.

Information available to inform the coroner's "child protection" death investigation

Child death review outcomes

Queensland's child protection system has been the subject of a number of independent investigations and inquiries since the Queensland Ombudsman highlighted historical system failures in the Brooke Brennan Report[20] and the Baby Kate Report[21] and the then Crime and Misconduct Commission report *Protecting Children: an inquiry into abuse of children in foster care*.[22] Recommendations from these inquiries resulted in significant changes to the previous system of internal child protection death reviews conducted by the then Department of Families, including the establishment of the multidisciplinary Child Death Care Review Committee to provide independent and external oversight of departmental reviews of child deaths.[23] This system was changed again following recommendations made by the Child Protection Commission of Inquiry[24] which resulted in new child death review processes being implemented from 1 July 2014.

When investigating a death that raises potential child protection issues, coroners should routinely have regard to child death review outcomes as this review process examines case management decisions and actions taken in respect of notifications made about the deceased child and his or her family, with a view to identifying deficiencies in existing practices and procedures and making recommendations to address them. The outcomes of the child death review process can often assist in resolving or at least narrowing the issues for coronial investigation.

For deaths prior to 1 July 2014, the following reports were routinely provided to the coroner by the relevant review entity:

- the department's child death case review report – the department previously conducted a review of all deaths of a child known to the department in the last three years of the child's life; and
- the Child Death Case Review Committee report – the former CDCRC examined the adequacy of the departmental reviews and the appropriateness of the department report recommendations.

From 1 July 2014, the child death review process was changed to require:

- departmental review of a child death where the child was known to the department within 12 months of their death – a specialist internal investigation team has been established to perform this function on behalf of the child safety chief executive; and
- oversight of departmental review by an independent multidisciplinary child death case review panel formed by the Minister responsible for administering the *Child Protection Act 1999*.[25]

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[20] http://www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/brooke_brennan_report.pdf

[21] ww.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/OMB-3281%20Baby%20Kate%20Report.pdf

[22] http://www.communities.qld.gov.au/childsafety/about-us/publications/protecting-children-an-inquiry-into-abuse-of-children-in-foster-care

[23] www.cdcrc.qld.gov.au

[24] http://www.childprotectioninquiry.qld.gov.au/publications; http://www.justice.qld.gov.au/corporate/justice-initiatives/carmody-report-recommendations

[25] See *Child Protection Act 1999*, Chapter 7A Child death and other case reviews

These reports will be routinely provided to the investigating coroner via the State Coroner.[26]

To date these reports have generally been quite comprehensive, produced to the coroner in a timely fashion and helpful in informing the coroner's consideration about whether there are issues warranting further investigation or response from the department. Coronial investigations and inquests benefit significantly from the child death review process as it uses specialist child protection expertise not otherwise readily available to coroners to identify child safety service shortcomings and propose recommendations to address those shortcomings. This can assist coroners greatly in narrowing the coronial investigation issues, progressing the coronial investigation in a timely way and informing consideration of reasonable, workable coronial recommendations in the very few child protection deaths that proceed to inquest.

Coroners should routinely seek information from the department about the status of its implementation of child death case review recommendations as this information can be very influential in a coroner's determination of whether there is a need to proceed to inquest in respect of any child safety system deficiencies identified by the coronial investigation.

While reports generated under the current child death review system will only relate to the case management of children known to the department within 12 months of their death, the Child Protection Act enables the Minister to require an investigation of departmental involvement with the deceased child or the family outside of this time frame.[27] If the coronial investigation identifies issues relating to the department's involvement with the child or the child's family beyond the 12 month time frame, the coroner may consider writing to the Minister seeking his or her co-operation in requiring a child death review for the relevant period.

Other departmental information

In the event the child death review outcomes do not adequately address issues arising in the coronial investigation, the coroner may consider issuing formal information requirements for information including:

- the child's departmental case file
- the outcomes of any other conducted in respect of the child or another member of the child's family or household, for example, if the child had previously suffered serious physical injury while known to the department or another child from the same family or household was the subject of a review conducted under the Child Protection Act
- statements from relevant departmental or service provider personnel addressing specific questions about the case management decisions and action taken in respect of the child
- relevant departmental policies and procedures

[26] See *Child Protection Act 1999*, s.246H
[27] See *Child Protection Act 1999*, s.246B(3)

- statement from the most appropriate senior departmental officer about the extent to which the child death review recommendations have been implemented.

Expert review

Depending on the circumstances of the child's death, the coroner may also consider obtaining an independent expert review of the child's management. State Coroner approval is required before an expert review can be commissioned.

Senior Advisor (Child Protection), Domestic and Family Violence Death Review Unit

The Senior Advisor (Child Protection) role is situated within the Domestic and Family Violence Death Review Unit to provide specialist advice and assistance to coroners in relation to child protection systems, policies and practices. This role also has responsibility for the provision of assistance with the identification of systemic shortcomings and the formulation of preventative recommendations for those matters that proceed to inquest.

The primary focus of this role is to ensure that all relevant issues pertaining to the child's death are considered, with a focus on the involvement of the DCCSDS both during and prior to the one year departmental review period. The case management process aligns with those for the investigation of domestic and family violence related deaths outlined in section 7.5 of these guidelines, and is designed to facilitate access to information about the family's prior contact with the department, police other government agencies and/or non-government organisations prior to the child's death.

Coroners are encouraged to seek advice and assistance from the unit as soon as it becomes evident the death may raise systemic child protection issues.

7.7 Investigating suspected deaths

Introduction

A finding of death or declaration of presumed death serves not only the emotional needs of a missing person's family but is a practical necessity for matters including estate administration and life insurance and superannuation claims. The Coroners Act has substantially narrowed the coroner's jurisdiction to investigate a missing person's disappearance. Previously the police, a missing person's family or another sufficiently interested person could request the coroner to investigate the cause and circumstances of the disappearance of a person who had been missing for more than 12 months.[28] However, the coroner's missing persons jurisdiction is now limited to only those matters where there is reason to suspect a person is dead and the death was reportable under the Act.

[28] See repealed *Coroners Act 1958*, s.10 – the coroner had jurisdiction to inquire into the cause and circumstances of the person's disappearance and all matters likely to reveal whether the person was alive or dead and the person's whereabouts at the time of the inquiry.

This chapter sets out the range of considerations a coroner should take into account when investigating a suspected death.

Legislation

Coroners Act
Sections 11, 14, 45

In principle

A suspected death is one in which a person is missing but no body is located – living or dead. A coroner can only investigate a suspected death upon direction from the State Coroner who must either suspect the person has died in circumstances that make the death reportable, or because the Attorney-General has directed that the suspected death be investigated. The general principle is that if the person has not been seen or heard from by those who might be expected to have seen or heard from him or her and due inquiries have been made that have produced no positive results, the circumstantial evidence may be sufficient to enable a finding of death to be made.[29] When making such a finding, care needs to be taken there is sufficient evidence to exclude the possibility of the missing person having assumed another identity.

In practice

Common scenarios invoking coronial investigation include persons thought to be the victim of foul play, accident or suicide though the body has never been found, and persons seen falling from a vessel or swept away in rough seas or flood waters but search and recovery efforts were unable to recover the body.

As explained in Chapter 3, missing persons are generally first reported to the QPS Missing Persons Unit. The QPS Operational Procedures Manual requires the Missing Persons Unit to refer these cases to the State Coroner as soon as a missing person is reasonably suspected of being dead.[30] The police report to the State Coroner should include the complete investigation file including a report as to the results of the police investigation into the cause and circumstance of the person's disappearance and suspected death. The State Coroner can then direct a coroner to conduct an investigation, including the holding of an inquest if necessary. The coroner is required, if possible, to find whether or not a death in fact happened and if so, to the extent possible, the usual findings required under s. 45(2).

The circumstances of suspected deaths vary greatly and can pose quite challenging issues for coroners. For example, if a person who is known not to be able to swim is seen washed from rocks by large waves while fishing and whose body has not been found after a week of search and recovery efforts, it may reasonably be concluded the person is dead. In such a case, a coroner can find accordingly and the death can be registered.

However, in other cases, such a conclusion may not be so readily drawn. For example, if there is some basis to suspect that the missing person may have had reason to 'disappear' or at least relocate in order to leave behind some trouble or unhappiness,

[29] For a useful discussion of presumption of death principles see *Riggs v Registrar of Births, Deaths and Marriages & Ors* [2010] QSC 481 (24 December 2010) per Martin J at [10]-[12]
[30] Section 8.5.24 *Missing person reasonably suspected of being deceased*

it may be unsafe to conclude he or she has died. In these cases the coroner must consider whether all reasonable inquiries have been made and whether it is more likely than not that those inquiries would have disclosed some evidence of the missing person's continued existence were they not dead.

Depending on the circumstances of the disappearance, checks with the Australian Taxation Office, Centrelink, Medicare, financial institutions, interstate Registries of Births Deaths and Marriages, Australian or overseas police services and immigration authorities can be useful. Evidence from family, friends, treating doctors, work colleagues, business or other associates can assist in exploring whether the missing person's life and character immediately before his or her disappearance was consistent with that of a person likely to stage a disappearance and create a false identity. However, a coroner has to be satisfied the missing person has not assumed another identity and that negative results to these checks are sufficient to conclude the person is dead. If the death is to be registered in Queensland, the coroner also needs evidence that the person died here.

The risks posed by these cases were highlighted in a New South Wales matter where the coroner found the man had drowned when his runabout was found floating, damaged and empty in a coastal waterway. Three years later the deceased was located, alive and well and charged with insurance fraud.

Many suspected death investigations will yield sufficient information for a coroner to make chamber findings. However, some disappearances may warrant an inquest to test evidence about matters including the missing person's last known movements, their state of physical or mental health immediately before the disappearance, potential third party involvement in the person's abduction and death or the opinions of survival or other relevant experts. The circumstances of the suspected death may also raise broader systemic issues such as the adequacy of police or emergency services responses to the person's disappearance that may appropriately be the subject of coronial comment.

From time to time there will be cases where despite exhaustive investigations there may still be insufficient evidence for the coroner to make a definitive finding about whether a person has died. As distressing as this may be for the person's family, 'hedge bet' findings to the effect '*I presume X to have drowned after being dragged out to sea by a strong tidal current but should he be found alive then his present whereabouts are unknown*' should be resisted.

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

Aim of the guidelines

To provide guidance and advice to police officers in relation to the disposal of property taken into possession during the investigation of a reportable death.

The guidelines are aimed at;

- minimising the number of requests to coroners for approval to dispose of property, and
- problems and costs associated with the storage of property at police establishments, and
- returning property not needed for the investigation to the rightful owner as expeditiously as possible.

Reportable deaths and property

Section 8 of *Coroners Act 2003* outlines eight circumstances in which a sudden death is reportable. Officers should refer to the OPMs chapter 8 - Coronial Matters for details.

Section 794 of the *Police Powers and Responsibilities Act 2000* places a duty on a police officer to help a coroner in the investigation of a reportable death, including complying with all reasonable directions. Accordingly, the Queensland Police Service is responsible for conducting investigations into reportable deaths on behalf of a coroner.

Often these investigations result in police officers taking possession of property associated with a deceased person. Such property is taken possession of by a police officer for two primary reasons:

- it seized for the purpose of the investigation, (either criminal or coronial), or
- it is taken for safe keeping.

Obligations of investigating officers

Exhibits

Section 59 of the *Coroners Act 2003* provides that police officers who take possession of property for the purpose of the investigation of a reportable death (which includes suspicious deaths) are not to dispose of the property without the permission of the investigating coroner. Directions as to the disposal of the property will usually be given by the coroner checking a box on the bottom of page 2 of the relevant findings forms (i.e. 20A, 20B, 20C, 28A and 28B).

The investigating coroner will consider authorising the earlier release of property if:

- it is dangerous to retain, e.g. explosives, unstable chemicals etc;
- it is cost prohibitive to store e.g. motor vehicles, aircraft, vessels etc
- its retention may impact on the livelihood of others – e.g. business operating equipment; or
- the next-of-kin or rightful owner requests its return because of its monetary value, sentimental value or practical urgent use – e.g. baby clothing, computers, mobile phones etc which may contain important information necessary to finalise financial affairs and/or conduct funeral arrangement.

When such property is involved, at the completion of any examination or testing, officers must submit a supplementary Form 1 to the coroner seeking permission to dispose of the property in accordance with established procedures. Such supplementary Form 1 should clearly outline what is proposed to be done with the property and the basis for the proposal.

Safekeeping

The disposal of property taken possession for safekeeping can be more problematic as often the significance of the item to an investigation can be overlooked and the property returned to the owner risking its evidentiary value. Accordingly, only property clearly of no value to the investigation is to be returned or disposed of without referral to a coroner. If an officer is in any doubt the property is to be retained.

The following items may be disposed of by police assisting at mortuaries where retention is no longer required for the investigation of the death:

- A noose used by the deceased in causing their own death; and
- A helmet worn by the deceased at the time of their death.

This should only occur after the items has been examined by the forensic pathologist, photographed and recorded within the relevant QPS register.

Examples of circumstances where property can be disposed of without referral to a coroner may include;

- Clothing, personal items (wallet etc) located at non-suspicious death scenes in a public place or not their usual place of residence
- Jewellery found on a deceased
- Personal/valuable items where deceased was located at place of residence but residence may not be able to be secured, other persons reside at residence or other persons appear to have access to the residence.
- Keys taken to secure a residence or enable police to re-enter if necessary for inquiries.
- Mobile phones/address books/documents taken possession of to assist inquiries to locate Next of Kin (apart from probative value in certain cases i.e. suicide, motor vehicle accident).[31]
- Personal items may be seized for safekeeping where it becomes immediately apparent a dispute exists between NOK and there is the potential to release property to the wrong person without further inquiries being conducted.
- Property of itinerants or tourists where property is taken possession of for safekeeping due to lack of any alternate secure storage for the items.

If for any reason the attending officer is unsure, the matter should be discussed with the District Duty Officer or Shift Supervisor.

The officers who dispose of property should ensure the details are entered on QPRIME occurrence.

The Detective Inspector, Assistant to the State Coroner, may be contacted on 07 32474603.

[31] Particular attention should be paid to the preservation of any document or recording that purports to state the testamentary intentions of a deceased person – see s 18 *Evidence Act 1981*

Review of investigation outcomes

Legislation

Coroners Act
Sections 11A, 50B

The 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 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 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.

Review of decision about whether death is reportable

The Act was amended in 2009 to create a right for a person dissatisfied with a coroner's decision about whether a death is reportable to apply for an order as to whether it is a reportable death. The application is made to the State Coroner or if the State Coroner made the original decision, to the District Court.

When considering an application under s. 11A, the State Coroner may seek additional information or opinion about the death.

Reopening non-inquest investigations

The Act was amended in 2009 to enable a non-inquest investigation to be reopened by the State Coroner or the investigating coroner acting on his or her own initiative, or by the investigating coroner at the State Coroner's direction – s. 50B.

An investigation can be reopened if the State Coroner or the investigating coroner considers:

- the circumstances of the death warrant further investigation; or
- new evidence casts doubt on the findings.

The State Coroner can also reopen or direct another coroner to reopen an investigation if he or she considers the investigating coroner's findings could not reasonably be supported by the evidence.

In practice, s. 50B is activated when the coroner or the State Coroner is considering representations from a family dissatisfied with the findings or new evidence that comes to light at a later date.

When responding to a representation to have the investigation reopened, the coroner should ensure he or she provides clear reasons for any decision not reopen the investigation or to limit the reopening to specific issues.

If the coroner reopens an investigation and undertakes further investigation, he or she must assess the extent to which the original findings require amendment and if so, issue amended findings.

State Coroner's Guidelines 2013

Chapter 8

Findings

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 to 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

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[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 indentify 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/0/475BC02643DB45E DCA25750B000E38A4/$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

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[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 Court[12] described the presumption as "*no more than a presumption of fact, based upon common sense and common experience*". The New South Wales Court of Appeal[13] 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:

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[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 in appropriate 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 heath 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.

State Coroner's Guidelines 2013

Chapter 9

Inquests

9.1 Introduction

An inquest is the coroner's "public face", an open and transparent inquiry that scrutinises the events leading to a reportable death and provides an opportunity for coroners to make comments that can be powerful catalysts for broad systemic reform. Despite the common misconception that all reportable deaths proceed to inquest, inquests are held only into a small percentage of the total number of reportable deaths reported to Queensland coroners each year.

This Chapter explains when inquests should be held and the matters a coroner should take into account when considering whether to hold an inquest, either on his or her own initiative or in response to an application for an inquest to be held. It outlines the inquest process and strategies for managing the preparation for, and conduct of, an inquest. It provides an overview of the role of counsel assisting and the basis on which leave to appear is granted. It explains the standard of proof applicable in the Coroners Court and how incriminating evidence and potential referrals under s48 are dealt with. It provides guidance about the making of inquest findings and comments. Finally, it outlines the avenues by which a coroner's decision not to hold an inquest or the coroner's inquest findings can be reviewed and how inquests can be re-opened.

9.2 When should an inquest be held?

Legislation

Coroners Act
Sections 27, 28, 29, 33, 45(2)

In principle

An inquest **must** be held whenever:-

- there is a death in custody
- the circumstances of a death that happened in the course of or as a result of police operations raises issues that warrant the holding of an inquest
- a death in care raises issues about that care
- the Attorney General directs an inquest be held
- the District Court upholds an appeal against the decision of a coroner not to hold an inquest
- the State Coroner directs one be held.

An inquest should be held whenever there is reasonable doubt about the cause or circumstances of the death or it is in the public interest to do so.

An inquest must not be held, or must be postponed if already commenced, when someone is charged with a criminal offence in connection with the death.

In practice

Mandatory inquests

The mandatory inquest categories are generally clear cut except the death as a result of police operations and "*death in care*" categories. Chapter 3 *Reporting deaths* explains these categories of reportable death.[1]

Deaths as a result of police operations

The Act mandates an inquest for these deaths only if the coroner considers the circumstances of the death warrant an inquest. In practice, an inquest should be held when the death raises concerns about the police involvement in the event leading to the death and/or highlights inadequacies in police policy and operational procedures.

Deaths in care

This category of reportable death recognises the vulnerability of persons who meet the death in care criteria because of their disability, youth or mental health status. The coroner's investigation should focus on whether the welfare of the deceased was being properly attended to by those who have been charged with supplementing the deceased's ability to care for him or herself. If there is any evidence that sub-optimal care contributed to the death or that a different approach to caring for the deceased may have avoided the death, an inquest should be held.

Discretion to hold an inquest

The discretion to hold an inquest should be exercised with reference to the purposes of the Act and with regard to the superior fact finding characteristics of an inquest compared to the fault attributing role of criminal and civil trials. The wide scope of the coroner's inquiry as outlined in Chapter 7 *Investigations* should also be considered as should a family's right to know the circumstances of their relative's demise. It may be entirely appropriate to hold an inquest even if the medical cause of death can be established without one and no family member is insisting on one being held.

Factors for consideration when assessing whether an inquest should be held include, but are by no means limited to, the following:

- can all of the findings required by s45(2) be made without an inquest? Are chambers findings sufficient? If not, why not? Is an inquest likely to assist?

- Is there such uncertainly or conflict of evidence so as to justify the use of the judicial forensic process?

- are there suspicious circumstances that have not been resolved or resulted in criminal charges?

[1] See sections 3.1.8 (deaths in care) and 3.1.10 (deaths as a result of police operations)

The interplay between the criminal and coronial processes is far from clear in some cases. In theory, inquests should not be used as quasi-committals but in practice it can be more difficult to maintain a discrete and complete distinction.

In a small number of cases there is a suspicion the death may be the result of a crime but the police are unable to gather sufficient evidence to charge the suspect. Usually, in those cases the police request the coroner to convene an inquest so the versions can be better tested or witnesses who have refused to cooperate with the police can be required to give an account. Compelled answers, even if incriminating, are only inadmissible against the witness who gives them; they can be used against co-accused or others.

Establishing criminal liability frequently largely depends on proving precisely how the death occurred which is also what a coroner is obliged to find. While it is clearly inappropriate for a coroner to determine whether charges should be laid, it is entirely reasonable for the coroner to establish with some precision how the death occurred. For example, whether the driving that caused the death amounts to dangerous driving is purely a criminal law question; however, the speed of the vehicle, what precipitated the crash etc are questions a coroner should answer.

In cases where family members believe someone is criminally responsible for the death and no charges have been laid, inquests are commonly requested. Unless a coroner can demonstrate the suspicions are baseless the request will usually be granted. As the determination of criminal culpability is the motivation for the inquest, it is essential that the coroner gives reasons if he/se concludes no referral to the DPP is warranted.

If there is evidence that the death might have been intentionally caused by another person it is difficult to see how a coroner could discharge his or her duties under the Act without fully investigating that via an inquest if that is what is needed to clarify how the death occurred.

- is there a need to exclude the involvement of a third party procuring or failing to prevent an apparent death form self-harm?

- did an apparent failure by an individual to discharge a legal/moral duty allow an otherwise preventable death to occur, for example, by permitting abuse or neglect or failing to seek medical attention?

- did an apparent failure by a public official or agency to adequately discharge its responsibilities allow an otherwise preventable death to occur?

- is there a likelihood that an inquest will uncover important systemic defects or risks not already known about?

- are there issues of public health and safety and/or controversy that should be investigated by way of an inquest to allay public concern?

- did the incident result in multiple fatalities?

- is the identity of the person in control of the vehicle, vessel or craft involved in a fatality in question?

- does the death when grouped with others that have occurred in similar circumstances indicate there may be an unexpected increase in danger in a particular location, area, family, industry or activity?

- has the family requested an inquest and provided cogent reasons for one to be held?

- is it likely an inquest would address or allay reasonable fears or suspicions held by the family?

- do the circumstances of the death raise issues of public health and safety that have not been adequately addressed by other processes or proceedings?

- is it likely preventative recommendations would be made if an inquest was held?

- have previous inquests dealt with similar deaths and made recommendations for reform that have not been adopted?

- is there potential for publicity from an inquest to generate fresh useful evidence?

- as a matter of fairness to persons involved in the event leading to the death, should they be given a public opportunity to address adverse publicity or potential coronial criticism?

In decisions arising from applications made pursuant to s.30(6) the District Court has agreed that[2]:

- relief should be granted rarely or sparingly, and that regard should be had to the specialist nature of the Office of the State Coroner, including resourcing issues

- the phrase "in the public interest" involves a discretionary value judgement of the kind identified in *O'Sullivan v Farrer* (1989) 168 CLR 210.

[2] *Gentner v Barnes* [2009] QDC 307; *Lockwood v Barnes* [2011] QDC 084

In each case the District Court has considered evidence not available to the State Coroner when the decision under review was made.

There is also judicial recognition that, in assessing whether there is a public interest in the holding of an inquest, regard can be had to other forensic avenues by which the circumstances surrounding a death might be investigated or examined. In *Dupois v Barnes* [2012] QDC 306 it was found that the Health Quality and Complaints Commission would be a more appropriate forum in which to examine allegations of medical malpractice which had been made on the basis of the observations of a lay person.

9.3 The right to request an inquest

Legislation

Coroners Act
Section 30

In principle

Any person has a right to request an inquest be held, to receive reasons if the investigating coroner declines and to appeal that decision to the State Coroner and/or the District Court. Significant weight should be given to requests for inquest made by someone with a legal or other real interest in the investigation.

A response must be given to such requests within 6 months, unless the coroner requires longer to obtain relevant information, for example additional witness statements or an independent expert report, to inform his or her decision.

In practice

In most cases it is apparent from the Form 1 Police report of a death to the coroner and the autopsy results that the investigation will not need to proceed to inquest, and that subject to some straightforward inquiries being made, the final autopsy report being received and the family confirming they have no concerns that warrant further coronial investigation, chamber findings can be done.

Families will routinely be given 14 days notice of a coroner's intention to finalise an investigation without an inquest. This can prompt an application under s30.

It is not uncommon for a family's request for an inquest to be based on the misapprehension that an inquest is held into every reportable death.

Giving appropriate weight to requests for inquests requires the balancing of considerations that are difficult to reconcile.

If the coroner considers that the findings required by s45 can be made without an inquest and the criteria outlined in section 9.2 above do not indicate an

inquest is called for, the obligation to husband resources appropriately suggests that a request for an inquest which is not based on any new evidence should usually be refused. Further, in some cases, an inquest can provide a forum for publicising baseless but damaging allegations against individuals or institutions.

On the other hand, if after providing the family member or other interested party with a detailed explanation of why the coroner considers that an inquest is not warranted, the requester continues to insist, the following factors may support a decision to hold an inquest:

- an important purpose of the coronial system is the maintenance of public confidence in public health and safety and the justice system. An unwillingness to conduct an inquest in the face of persistent demands by a person with a real interest in the death may be counter-productive to this goal.

- the savings achieved by not holding an inquest could well be off set by the time and resources consumed by participating in an appeal to the District Court.

- an appeal to the District Court involves the risk that the Court, which will have little opportunity to develop a detailed appreciation of the function and practice of the coronial system, may in reaching its decision in a particular case make a ruling or comment that will significantly limit the discretion of coroners to determine which cases should be subject to inquest.

9.4 Communicating decisions to hold/not hold an inquest

In principle

All individuals and agencies with a real interest in the death should be advised of the decision as to whether an inquest will be held. Family members should be given reason for the decision and advised of the right to seek a review of a decision not to convene an inquest by the State Coroner or the District Court**.**

In practice

The decision as to whether an inquest will be held should be recorded on Form 26. If the decision is not to hold an inquest the form should set out detailed reasons for the decision.

The Form 26 should be sent to:-

- the Office of the State Coroner
- the Queensland Police Service
- any other investigative agency that has provided reports to the coroner or conducted an investigation into the death in discharge of its statutory

duty, for example, the Office of Fair and Safe Work Queensland or the Mining Safety Inspectorate.
- the senior family member
- any other party who has made submissions to the coroner concerning the holding of an inquest.

The form sent to the family should be under cover of a letter that provides sufficient details of the evidence to enable the basis of the decision to be fully appreciated and should advise the family member of their right under s30 to have the decision reviewed by the State Coroner or the District Court.

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

In principle

In short, the role of Counsel Assisting at inquest is to impartially and fairly present the evidence to the coroner, identify issues for examination, call and examine witnesses, explore the range of possibilities open on the available evidence, explore possible options for preventative recommendations and make submissions about the findings and comments open to the coroner. Coroners may ask Counsel Assisting to assist in the preparation of findings by providing a summary of the evidence, outline of relevant legislation and case law. However, it remains the coroner's responsibility to weight the evidence and make appropriate findings and comments.

Chapter 2 *The rights and interests of families* discusses the role of Counsel Assisting at inquests when the family is not represented.[3]

Freckleton and Ranson's *Death Investigation and the Coroner's Inquest* contains a useful discussion of the role of counsel assisting.[4]

In practice

Each coroner is supported by in-house lawyers whose role is to assist the coroner to manage complex investigations and inquests and appear as Counsel Assisting at inquest.

However, if it is anticipated that an inquest may be complex, protracted or contentious, it may be desirable to brief external counsel. An application for approval funding for the briefing of external counsel should be made to the State Coroner setting out reasons, an estimate of the duration of the matter and an indication whether any particular counsel is preferred.

9.6 Notification of inquests

Legislation

Coroners Act

[3] See section 2.11.4 (Role of Counsel Assisting when family not separately represented)
[4] See p.p.564-5

Sections 32, 34(2) & (3)

In principle

All people with a legitimate interest in an inquest must be notified of the date, time and place it will commence. There must also be a general public notice of the commencement date published in the newspaper.

In practice

Inquest notice

A notice giving details of the commencement of all inquests should be published in the *Courier- Mail* at least 14 days prior to the commencement of the inquest or pre-hearing conference. Although it is not mandatory to do so, it is desirable for the inquest notice to be published prior to the pre-inquest conference.

The inquest notice must outline the issues proposed to be examined at the inquest. It is important for the issues to be articulated in sufficient detail to indicate the scope of the inquest. The notice is prepared by Counsel Assisting and settled by the coroner.

This information is also published on the Office of the State Coroner website.

Balancing confidentiality of child protection information

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.

For an inquest into the death of a child in care under s9(1)(d), it is appropriate for the pre-inquest and inquest notice to name the deceased child. Where the circumstances of the child's death raise issues about their care arrangements, the notice is to include references to the fact that the child was in care within the meaning of section 9(1)(d) and that the actions of Child Safety Services are being examined by the inquest.

Additional notification

Additionally, written notice of the commencement date should be given to the senior family member and the inquest should not commence unless the coroner is satisfied that the family member has been notified.

If the deceased person is an Aboriginal or a Torres Strait Islander person, notice of the commencement should also be given to the local Aboriginal and Torres

Strait Islander Legal Service unless another legal practitioner has indicated that he/she is acting on behalf of the family or the family has indicated that they don't intend to be represented at the inquest.

Counsel Assisting must ensure any person who is potentially the subject of adverse findings and/or a s48 referral is given notice of this possibility, with the recommendation that he or she seek legal advice about their participation in the inquest.

9.7 Preparing for an inquest

Timely identification of inquest issues and witness and proper preparation is essential to the efficient conduct of an inquest.

Prior to the pre-inquest conference, Counsel Assisting should prepare a proposed issues and witness list for the coroner's consideration. Once settled by the coroner, the proposed issues and witness list and the brief of evidence should be provided to the family and any other person who has indicated an intention to seek leave to appear at the inquest.

It is appropriate for Counsel Assisting and the coroner to meet with the family prior to the inquest being notified, if the family requests it. This meeting should canvas the inquest process and explain the scope of the inquest. It is important that neither the coroner nor Counsel Assisting express any view about the evidence. While it is appropriate for Counsel Assisting to meet with the family in the lead up to and during the inquest, the coroner should not participate in these meetings.

It is appropriate for Counsel Assisting to liaise frequently with the coroner in the lead up to the inquest as this ensures relevant evidence is gathered prior to the hearing to enable proper examination of all relevant issues at the hearing.

9.8 Pre inquest conferences

Legislation

Coroners Act
Section 34

In principle

Pre-hearing conferences should usually be convened before inquests unless there is a reason not to do so. Although not mandatory, pre-inquest conferences assist greatly in ensuring a focussed and efficient inquest.

In practice

The following matters are routinely dealt with at the pre-inquest conference:

- Counsel Assisting opens the evidence, tenders the brief of evidence and discusses previously circulated issues and witness lists

- applications for leave to appear and limited leave to appear are determined

- those granted leave to appear should be invited to make submissions regarding proposed issues and/or witnesses either at the pre-inquest conference or in writing within 14 days

- Counsel Assisting raises any outstanding material, for example witness statements, expert reports etc and timetables set for the production of this material, followed up with a Form 25

- Counsel Assisting makes submission as to venue and the need for a view and the coroner makes appropriate rulings

- submissions about the making of non-publication orders under s41 of the Act are heard and determined

It is preferable that applications for leave to appear and challenges to the scope of the inquiry etc be determined prior to the hearing commencing so that if any party wishes to challenge that ruling or persuades the court that more time is needed to consider matters the witnesses will not have needlessly been summoned to attend a hearing that will then not proceed. This also assists with estimations as to the likely duration of the proceedings and the settling of the witness list. Two days to a week is long enough for most inquests.

If the inquest is to proceed on the day it is set to commence it is important for the parties to be given timely access to the brief of evidence. A pre-hearing conference enables the coroner to authorise the release of the investigations documents to parties granted leave to appear and to impose conditions on access and stress with the parties the seriousness of any breach of such an order.[5]

Although not bound by the rules of evidence, coroners are obliged to ensure that the principles of procedural fairness are applied.[6] One consequence of this is that if evidence adverse to any party is led, that party must be given an opportunity to respond. If the leading of such evidence has not been anticipated and the party whose conduct is criticised has not been involved from the outset of the inquest it will be necessary to adjourn the inquest and allow that party time to obtain representation and familiarise him/herself with all of the evidence that has been given. At a pre-hearing conference counsel assisting can outline the issues that will arise during the a hearing and if any party affected by that evidence has not sought leave to appear a direction can be given by the coroner that they be contacted and invited to seek such leave

[5] See s55(2) The maximum penalty is 100 penalty units or 2 yrs imprisonment
[6] *Harmsworth v State Coroner* [1989] VR989 at 994. For discussion see Freckelton, I in the *The Inquest Handbook*, Selby H. (ed), Federation Rules, Sydney, 1998

from the outset or for so much of the proceedings as may be relevant to their interests.

Pre-hearing conferences also provide a convenient forum for the exchange of expert witness reports. Arrangements can be made for these witnesses to meet and discuss their competing views with a view to isolating any points of substantial difference; often this may result in agreement among these experts on all but a few salient points.

Balancing confidentiality of child protection information

For inquests into a death in care under s9(1)(d), it is appropriate for the child's name to be used during the pre-inquest conference and the inquest hearing. However, coroners are to give consideration to making a non-publication order under s41 of the Act to ensure the child's name is not reported in the media.

9.9 Leave to appear

Legislation

Coroners Act
Section 36

In principle

All parties with sufficient interest should be given leave to appear. The Act was amended in 2009 to clarify the standing of public interest interveners who have specialist expertise in matters on which the coroner may make comments under s46.

In practice

The Act does not define 'sufficient interest'. In *Barci v Heffey*[7], Beach J held that standing was a question of fact to be determined after a consideration of the circumstances surrounding the death. His Honour identified that following persons as having sufficient interest:

- persons closely related to the deceased - in this regard, s36 specifically recognises family members as having sufficient interest to appear at an inquest

- Any person whose actions may have caused or contributed to the death, where there is a reasonable prospect that the coroner may make a finding or comment adverse to that person's interest.

  Employers, treating doctors, supervisors, professional accreditation bodies, government welfare agencies and regulatory agencies are examples of parties that may not be directly implicated in the death but who may have sufficient interest to be given leave to appear and be heard on an issue affecting them before any finding is made.

[7] Unreported Supreme Court of Victoria, 1 February 1995)

It is appropriate to discuss this question with counsel assisting before the pre-trail conference is convened so that parties can be invited to attend the pre-hearing conference to hear the issues that are likely to be raised during the inquest outlined by the counsel assisting. They can then seek leave to appear if they wish. Some parties may only have an interest in some of the issues that will be canvassed at the hearing and may therefore be granted leave only to the extent necessary for them to protect those interests.

Those given leave to appear have a right to examine witnesses and make submissions, unless they have been granted leave to appear as a public interest intervener under s36(2), in which case, the right of appearance is limited to examining witnesses only with the leave of the coroner and making submissions only on those matters on which the coroner ma make comments under s36.

9.10 Scope and conduct of an inquest

Legislation

Coroners Act
Sections 31, 35, 37, 38, 40, 41, 42, 43, 44

In principle

In inquest is bound by the principles of natural justice and procedural fairness. Although coroners are not bound by the rules of evidence or procedure, the guiding principles regarding admissibility of evidence will be relevance and fairness only.[8]

It well established that "*the scope of inquiry under section 45 is extensive and is not confined to evidence directly relevant to the matters listed in section 45(2)*".[9]

Despite the breadth of the scope of a coroner's inquiry under sections 45 and 46, the coroner may only rely on evidence that is relevant to, and logically probative of, matters within the scope of coronial inquiry, as defined by sections 45(2) and 46(1).[10] In *Doomadgee v Clements*, Muir J stated the test as follows[11]:

> ..the decision must be based upon material which tends to logically show the existence or non-existence of facts relevant to the issue to be determined, or to show the likelihood or unlikelihood of the occurrence of some future event the occurrence of which would be relevant.

[8] *Annetts v McCann* (supra)
[9] *Doomadgee v Clements* [2006] 2 Qd R 352 at 360 [28], citing *Atkinson v Morrow & Anor* (ibid) and *Queensland Fire & Rescue Authority v Hall* [1988] 2 Qd R 162 at 170
[10] *Doomadgee v Clements* at 361 [35]
[11] ibid

In *R v Doogan* (2005) 157 ACTR 1, Higgins CJ, Crispin and Bennett JJ stated the point at which the coroner's line of inquiry is drawn as follows:[12]

> A line must be drawn at some point beyond which, even if relevant, factors which come to light will be considered too remote from the event to be regarded as causative. The point where such a line is to be drawn must be determined not by the application of some concrete rule, but by what is described as the "common sense" test of causation affirmed by the High Court of Australia in *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506; 99 ALR 423. The application of that test will obviously depend upon the circumstances of the case and, in the context of a coronial inquiry, it may be influenced by the limited scope of the inquiry, which as we have mentioned, does not extend to the resolution of collateral issues relating to compensation or the attribution of blame.

It is important to acknowledge inquests can be stressful for not only the family but also witnesses. Participation in an inquest can be costly and those costs are not recoverable. For these reasons, it is essential that Counsel Assisting and the coroner ensure the inquest is conducted as expeditiously and efficiently as possible.

An inquest is the public facet of the coronial process. An inquest should generally be held in open court unless there is a good reason for the proceedings or part of them to be closed. Coroners should consider alternative strategies such as the use of non-publication orders or excluding persons from the court to manage the giving of sensitive evidence or vulnerable witnesses.

In practice

Evidence

The Court of Appeal considered the practical application of the power granted by the liberally worded section 37(1) in *Commissioner of Police Service v Clements*[13]

> *While the Coroners Court is not bound by the rules of evidence, the touchstone of the evidence and submissions it may receive must be relevant to the matters the Coroner is empowered to investigate, the questions on which he or she must make findings and the matters on which he or she may comment.*

The admissibility of evidence will, therefore, hinge on the scope of an inquest. In practice, arguments over the admissibility of individual documents are usually resolved by admitting them as an exhibit. This emphasises the importance, discussed earlier, of Counsel Assisting clearly identifying the relevant issues for investigation at the pre-inquest conference. Any disagreement as to the proper scope of the inquest should be settled prior to the commencement of the inquest through, if necessary, the convening of further pre-inquest conferences.

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[12] At 9-10 [29] – [30]
[13] [2006] 1 Qd R 210

In *Goldsborough v Bentley*[14] McMurdo J considered the scope ss45 and 46 in the context of admissibility of evidence and the scope of inquests. This case arose from an inquest into the drowning death of a tourist in a waterhole located within a privately operated tourist facility. In that inquest the Northern Coroner sought to investigate the reasoning behind the decision of Workplace Health and Safety Queensland ("WHSQ") not to prosecute the owner/operator. WHSQ sought declarative relief on the basis that the scope of the coroner's intended investigation was *ultra vires.* His Honour applied the reasoning of Muir J (as he then was) in *Doomadgee v Clements*[15]in determining that:

- The scope of s45 is extensive;
- There is no justification for construing s46 as being qualified by s3 (i.e. it is not the case that any comment must be directed only at preventing deaths from similar causes to the death under review);
- s46, being remedial in nature, should be construed liberally;
- The decision of an agency not to prosecute, although unconnected to the cause of death, does have a connection to the death in this case and relates to the administration of justice;
- A decision not to prosecute is something that '*…would appear to have potential relevance for a comment which the coroner might make under the power conferred by s46(1).*";
- The limitation contained in s46(3) does not prevent coronial comment on a decision not to prosecute; and
- The principle that courts should disassociate themselves from the administrative decision to prosecute is not relevant to the investigative, evidence gathering function of a coroner.

Standard of proof

The particulars a Coroner must if possible find under s45 need only be made to the civil standard but on the sliding *Briginshaw* scale.[16] That may well result in different standards 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 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.

The paragraph above was specifically contemplated by the Court of Appeal[17] with apparent approval. The Court went on to state:

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[14] [2014] QSC 141
[15] [2006] 2 Qd R 352
[16] *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
[17] *Hurley v Clements & Ors* [2009] QCA 167 at 11

> *Two things must be kept in mind here. First, as Lord Lane CJ said in* R v South London Coroner; ex parte Thompson*, in a passage referred to with evident approval by Toohey J in* Annetts v McCann*:*
>
> *…an inquest is a fact finding exercise and not a method of apportioning guilt … In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish facts. It is an inquisitorial process, a process of investigation quite unlike a trial where the prosecutor accuses and the accused defends, the judge holding the balance or the ring, whichever metaphor one chooses to use.*
>
> *Secondly, the application of the sliding scale of satisfaction test explained in* Briginshaw v Briginshaw *does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not."*

Preventative recommendations on the other hand, do not of themselves negatively impact upon any individual or organization and a Coroner need therefore only act judicially – not perversely or capriciously – when determining the level of satisfaction required to support conclusions on which they are based.[18]

Practical considerations

Counsel Assisting plays a pivotal role in ensuring the smooth conduct of an inquest. It is recommended that Counsel Assisting confer daily with the coroner to discuss the evidence to be called and any issues or applications likely to arise.

A witness schedule should be distributed to the parties well prior to the inquest commencing and all summons issued within the required timeframes. It is preferable to call the minimum number of witnesses needed to resolve the issues to be examined by the inquest.

While it is desirable for all oral evidence to be heard in one sitting, there may be occasions when it would be advantageous to schedule a break between brackets of evidence if it is foreseen that factual evidence may be required before more expert opinion is obtained.

There is no need to have witness statements read into the record, as the brief of evidence will already have been tendered. Witnesses should be given their statements in court and asked questions about them. Consideration may be given to the appropriateness of 'stopwatch' orders or concurrent evidence. It

[18] For discussion of these issues see Freckelton I., *Inquest Law* in *The Inquest Handbook*, Selby H.(ed), Federation Press, Sydney, 1998 at p9

is generally appropriate and efficient for independent experts and policy witnesses to sit in on the examination of relevant witnesses so they can comment efficiently on those witnesses' evidence.

Invariably some witnesses involved in the events leading to the death will have been significantly traumatised. Counsel Assisting should explore a range of options to assist vulnerable witnesses to give evidence. This may involve obtaining reports from treating doctors about the extent to which the experience of giving evidence may affect the witness' physical or mental health and ways in which that impact can be minimised, for example, giving evidence in closed court or using a screen or arranging for family members to hear the evidence from outside the court.

Coroners have power to make non-publication orders in respect of information arising from a pre-inquest conference or inquest. The circumstances in which these orders may be appropriate include when the inquest relates to confidential child safety information, the information could identify a minor or publication of the information could prejudice ongoing police investigations into the death.

It is helpful for Counsel Assisting to confer with the coroner about the submission he or she proposes to make, in the final days of the inquest. Counsel Assisting's submissions should foreshadow any adverse findings or comments, preventative recommendations or s48 referrals open to the coroner.

Generally oral submissions should be made at the close of the oral evidence. However, in complex and lengthy matters, it may be necessary to adjourn the inquest for submissions to give parties access to the transcript in order to make written submissions.

Submissions are not evidence but only the opinions of lawyers or parties. For this reason, and in order to protect the legitimate interests of the parties, submissions should be tendered so coroners can make use of non-publication orders and refrain from releasing written submissions until after the findings have been published.

Family participation

Chapter 2 *The rights and interests of families* details the ways in which families can participate in inquests, even if they do not seek leave to appear.[19]

9.11 Power to compel witnesses

Legislation

Coroners Act
Section 39

[19] Section 2.11 (Involvement in inquests)

In principle

Consistent with the inquisitorial nature of the coronal jurisdiction, the Act expressly abrogates the common law privilege of protection against self-incrimination and enables coroners to compel a witness to give self-incriminating answers. However, it does so at the cost of preventing evidence given under direction or evidence derived from it being used against the witness in any other proceeding. Before issuing a direction under s39, coroners must be satisfied it is in the public interest for a direction to be given.

The power to compel incriminating answers is designed to ensure a coroner gets all information relevant to finding how the person died and what caused the death. Such information must not be included in a referral to the DPP under s48 (discussed below).

Freckelton and Ranson's *Death Investigation and the Coroner's Inquest* provides a useful discussion of this issue.[20]

In practice

Section 39 allows a coroner at an inquest to require a person to give oral evidence that would tend to incriminate the witness. The coroner can only do this if the coroner is satisfied that it is in the public interest for the witness to do so.

The evidence is not admissible against the witness in any other proceeding other than a proceeding for perjury. Nor is derivative evidence (namely any information, document or other evidence obtained as a direct or indirect result of the evidence given by the witness). Compelled answers, even if incriminating, are only inadmissible against the witness who gives them; they can be used against co-accused or others.

Factors which may help divine what is in the "public interest" in the context of an inquest are discussed above.

Issuing a direction pursuant to section 39 can potentially have serious ramifications for the course of an investigation. A direction should only be made if the coroner is satisfied that there is a reasonable apprehension a witness may incriminate him or herself. Experience shows that counsel will sometimes seek a s.39 direction for their client in the absence of reasonable grounds due to an overly conservative approach.

9.12 Inquest findings and comments

Findings

Chapter 8 *Findings* details the considerations coroners must take into account when making findings.

[20] See pp.578-585

The making of comments – preventive recommendations

Legislation

Coroners Act
Section 46

In principle

The coroner's power to make preventative recommendations is a powerful tool for furthering the death prevention objectives of the Act. As acknowledged by Freckleton and Ranson,[21]

> *coroners' comments and recommendations can be of profound importance to manufacturers, distributors, industrial entities, health institutions, government instrumentalities and many others. They are frequently publicised extensively by the media and can result in considerable embarrassment and financial disadvantage for those who are the subject of them*.

The coroner can only make comments if an inquest is held but can not hold an inquest for the sole purpose of making preventative recommendations.

Section 46(1) empowers coroners to comment, whenever appropriate, on any anything connected with the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Recent Queensland authority supports a broader than direct connection between any matter on which comment is made and the death under investigation.[22]

The power to comment under section 46 is ancillary to, not independent of, the coroner's power and obligation to make findings under section 45(2).[23] Section 46 does not make coroners '*roving Royal Commissioners empowered to make findings and recommendations in respect of the matters described in paragraphs (a), (b) and (c) of section 46*' – any matter on which comment is made must relate to one or more of those of matters and must be connected with the death.[24]

In order to properly achieve the Act's death prevention objectives, preventative recommendations must be realistic and workable. Consequently it is vital that Counsel Assisting and coroners give careful consideration to possible recommendations well prior to the inquest commencing and ensure the inquest is informed by input and evidence from agencies that may be required to implement those recommendations.

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[21] *Death Investigation and the Coroner's Inquest*, p.662
[22] *Doomadgee v Clements* (supra) at 360 [29] & [33]; affirmed in *Thales Australia Limited v The Coroners Court & Ors* [2011] VSC 133
[23] *Harmsworth v The State Coroner* (supra) at 996; *R v Doogan* (supra) at 6, 7, 9-10; *Doomadgee v Clements* (supra) at 360 [28]; *Walter Mining Pty Ltd v Hennessy* [2010] 1 Qd R 593 at 597
[24] at 360 [28]-[29]

In practice

Informing preventative recommendations

Once the coroner decides to hold an inquest, early consideration should be given to possible recommendations, with a view to inviting input from relevant agencies for examination during the inquest. This will ensure that agencies to whom possible recommendations may be directed are identified and given an opportunity to participate in the inquest, either by seeking leave to appear or providing information or written submissions about the practicality of any proposals under consideration.

Depending on the circumstances of the death, consideration should be given to seeking input from relevant government agencies, statutory authorities, regulatory authorities, professional or industry representative bodies or public interest groups.

The National Coroners Information System[25] is another valuable resource for coroners when considering whether and how systemic issues have been dealt with by other coronial jurisdictions.

It is preferable that this response gathering process is commenced prior to the inquest to allow sufficient time for all parties to consider the responses, and for arrangements to be made for relevant witnesses to give evidence. Parties should be actively encouraged to suggest areas where the coroner may consider making recommendations.

It is desirable for experts to be given an opportunity to comment on the appropriateness of proposed recommendations either before or during their evidence at inquest. There may be merit in other witnesses being examined about the workability of the proposals under consideration. It may also be necessary to call agency representatives to give evidence.

Counsel Assisting's submissions should address possible comments open to the coroner so the family and other parties have an opportunity to respond to those proposals.

Framing strong recommendations[26]

The most effective recommendations are arguably those which involve low implementation effort but achieve high impact.

When framing a recommendation, coroner should consider the ways in which and how likely the recommendation could fail. Clearly, input from agencies who will be required to consider whether and if so how the recommendation can be implemented is pivotal to this exercise.

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[25] www.ncis.org.au/

[26] These comments draw on a presentation given to the Australia Pacific Coroners Society Conference 2011 by Dr Jill-Ann Farmer, Queensland Health Patient Safety and Clinical Improvement Service: *Fluoride for Recommendations: making them strong so they don't decay!* *www.courts.qld.gov.au/__data/assets/pdf_file/0009/163791/osc-asia-pacific-conference-15-farmer-jillann.pd*

For example, a general recommendation that "*all maternity units should ensure there are clear guidelines and instructions for midwives as to when to refer to obstetricians*" could fail for reasons including implementation of different guidelines in different maternity units, guidelines not being readily accessible or known to the staff who need to apply them and staff forgetting or ignoring the detail of the guidelines. A more effective alternative of achieving the intended outcome would be for the recommendation to *require Queensland Health facilities to implement a standardised clinical pathway that is used by all staff in the documentation of intrapartum care*.

Ideally, coroners' recommendations should make clear the intended objective and allow the agency to which they are directed some flexibility to assess how best to achieve that objective. For example, rather than recommending that there be mandatory inspections of residential rental properties with decks of a certain age, the recommendation may be more appropriately framed to direct that consideration be given to legislative amendment to ensure rental properties meet the standards required under the legislation governing residential tenancies, and that this exercise incorporate a cost-benefit analysis of a mandatory inspection model and consultation with relevant industry stakeholders.

Responses to coronial recommendations

Although the Act does not require the Government to respond to coronial recommendations, the Government has implemented an administrative arrangement whereby government agencies are required to report publicly on their response to recommendations directed to them. This process was implemented in 2008 in response to the Queensland Ombudsman's Coronial Recommendations Project Report which identified the need for a coordinated system for ensuring appropriate action was taken by public sector agencies in response to coronial recommendations.[27] The agency responses are tabled in Parliament annually by the Attorney-General and accessible on the Department of Justice and Attorney-General website.[28]

Dissemination of findings and comments

Chapter 8 *Findings* explains how inquest findings and comments are to be disseminated.

No findings of criminal or civil liability

Chapter 8 *Findings* explains the prohibition on coroners' findings and comments making an explicit statement reflecting on a person's guilt or liability.[29]

[27] www.ombudsman.qld.gov.au/Portals/0/docs/Publications/Inv_reports/Coronial_Recommendations_Project.pdf
[28] www.justice.qld.gov.au
[29] Section 8.8 (No findings of criminal or civil liability)

9.13 Management of s. 48 referrals

Legislation

Coroners Act
Section 48

In principle

For at least the 137 years prior to the commencement of the Coroners Act 2003[30], coroners in Queensland presided over inquests at which submissions were made about whether people should be committed for trial and coroners gave reasons as to why, or why not, that was to happen. If a person was committed for trial, Crown prosecutors determined whether an indictment would be presented.

One of the most significant changes made by the 2003 Act was to abolish the coroner's committal power and replace it with an obligation for coroners to given information to the Director for Public Prosecutions or other prosecuting authority in the coroner reasonably suspects an offence has been committed.

The Act obliges referral of a suspected offence and gives coroner discretion to refer official misconduct, police misconduct or professional conduct issues to the relevant regulatory authority for further investigation. Coroners should ensure a person who may be the subject of a possible referral is given an opportunity to be heard before the referral is made.

The referral mechanism reflects a shift to a coronial regime in which prevention of future deaths is central and coroners are unable to find that a person is or may be guilty of an offence.

In practice

Chapter 7 *Investigations* discusses the application of s48 to non-inquest investigations.[31]

Submissions on and statements about section 48 referrals

The effect of section 45(5) is that the coroner must not include in his or her description of the particulars of the death required by section 45(2) statements that a person is or may be guilty of a criminal offence. Similarly, when a coroner is making comments under section 46, no such statement can be made.

However, referral under section 48 is another and discrete function of a coroner who has investigated a death. It imposes a duty on the Coroner to refer information to the DPP in certain circumstances, whether or not an inquest has been held. There is in section 48 no limitation similar to that

[30] *An Act to abolish Coroners' juries and to empower Justices of the Peace to hold inquests* was passed in 1866. s8 provided a coroner or JP who held an inquest could commit a person for trial for homicide. However it is likely that colonial coroners acting under the common law were already doing that from when the first was appointed in 1819.
[31] Section 7.2

contained in section 45(5). Indeed, it would be internally inconsistent and contradictory to do so.

If a coroner gathers information during an investigation that concludes with findings on the papers - that is, without an inquest being convened - and he or she concludes a s48 referral is mandated, the coroner is encouraged to give the subject of such a referral the right to be heard. It follows then that submissions should be heard on a possible referral pursuant to section 48 where an inquest is concerned. Coronial proceedings should be as open and transparent as reasonably possible. There is a presumption they will be held in open court. It would be contrary to these principles to require the section 48 function that arises and is triggered during an inquest to be hived off from the inquest and dealt with in private.

Further, that approach would offend against the obligation to give any person who might be adversely affected by a coroner's decision the right to be heard before such a step is taken.

On the basis of the same principles of openness and transparency espoused above it is appropriate and proper that the decision on whether a referral has been made under section 48, and the basis for it, be set out clearly at the conclusion of the findings. Being informed that the coroner intends referring the material to prosecutorial or disciplinary bodies for further consideration, and if not why not, is an essential part of a coroner's function. Bereaved family members and members of the public expect at the end of the inquest to know what happens next. If the answer is "nothing", they will want to know why.

Although this approach involves a risk to reputation, that can be ameliorated by the coroner making clear the low threshold on which the obligation to refer arises and referring to the role of the DPP in determining whether charges should be brought.

It follows that the right to make submissions would be confined to Counsel Assisting and counsel for the person or organisation subject to possible referral.

9.14 Review of inquest findings and reopening inquests

Legislation

Coroners Act
Sections 50 & 50A

In principle

The Act establishes mechanisms for administrative review of inquest outcomes including a right to review inquest findings or to re-open an inquest. These 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.

In practice

Section 50 provides for the reopening of inquests either on application to the State Coroner or District Court.

A person may apply to the District Court even if an unsuccessful application based on the same or substantially the same grounds has been made to the State Coroner. A person may not apply to the State Coroner if an unsuccessful application based on the same or substantially the same grounds has already been made to the District Court.

The State Coroner may set aside the finding if satisfied:

- new evidence casts doubt on the finding; or
- the finding was not correctly recorded.

If the finding is set aside the State Coroner can reopen the inquest to re-examine the finding or hold a new inquest (or direct another coroner to do either of these things).

The District Court may set aside the finding if satisfied:

- new evidence casts doubt on the finding; or
- the finding was not correctly recorded; or
- there was no evidence to support the finding; or
- the finding could not be reasonably supported by the evidence.

If the finding is set aside the District Court may order the State Coroner to re-open the inquest to re-examine the finding or hold a new inquest (or direct another coroner to do either of these things).

In a reopened or new inquest conducted pursuant to section 50 the Coroner may accept any of the evidence given, or findings made, at the earlier inquest as being correct.

There is no statutory right to review coronial comments.

The Act was amended in 2009 to allow the coroner who held an inquest, or the State Coroner, to reopen an inquest, or hold a new inquest, on his or her own initiative. Section 50A provides that the State Coroner has the same powers as he or she would have on receipt of an application under section 50 without it being necessary for such an application to first be made. In acting this way on his or her own initiative the State Coroner's power to reopen or hold a new inquest is extended so that it can be exercised if such further inquiry is thought to be in the "public interest". In that sense regard can be had to the earlier guidelines relating to the public interest test embedded in section 28.

State Coroner's Guidelines 2013

Chapter 10

Access to coronial information

10.1 Introduction

Information generated by and obtained during a coronial investigation can be highly sensitive or distressing, yet timely and appropriate release of coronial information can be therapeutic for the deceased person's family or important for other investigative, systemic review, legal or financial processes running concurrently in respect of the death. Coronial information can usefully inform medical, scientific or other research which in turn assists the coronial system to prevent future deaths. Carefully considered public release of coronial information can help protect public health and safety and can also properly inform fair and accurate reporting of inquest proceedings.

This Chapter sets out the considerations a coroner must take into account before releasing coronial information. It provides guidance about how to manage requests for access to sensitive and potentially distressing material. It deals with the process by which researcher applications are managed. It briefly explains other standing access arrangements established by the Act. It also clarifies the application of the Right to Information and Information Privacy schemes to coronial information.

In this guideline, the concept of coronial information encompasses both documentary items gathered during a coronial investigation and information derived from those documents.

Legislation

Coroners Act
Section 17(4) & (5), 38, 52-59, 62

Acts Interpretation Act
Section 36, definition of 'document'

Recording of Evidence Act and Recording of Evidence Regulation
Sections 5B (Act) and sections .4, 6, 7 (Regulation)

Right to Information Act
Sections 4, 11, Schedule 1 (Documents to which this Act does not apply) s. 8

10.2 Access to investigation documents for other than research purposes

In principle

Determining whether access should be granted to investigation documents requires the consideration and balancing of competing interests - the privacy of the deceased and his or her family members; the openness and transparency of official processes; and the potential benefits to public health and safety.

Independence, openness and transparency are hallmark features of the coronial process. However, information coming to light during a coronial

investigation is often confidential, personal, highly sensitive or distressing. Coroners should conduct their investigations in a way that appropriately and sensitively manages the needs of those with a legitimate interest in the information arising from an investigation but carefully guards against exciting or satisfying mere personal or public curiosity.

The determination of whether someone has sufficient interest in a document requires consideration of their connection with the deceased person or the circumstances of the death, the particular purpose for which access is sought and the document's relevance to that purpose. For example a deceased person's spouse may need access to an autopsy report to process a life insurance claim and a person injured in the fatal event may also need it to assist their claim against the deceased person's estate.

The deceased's family will generally be entitled to access coronial information at appropriate stages during an investigation.

Other persons given or eligible for leave to appear at an inquest should be given access to coronial information during the investigation, subject to appropriate conditions, so they can participate effectively in the coroner's investigation.

Access will generally be given to others deemed to have sufficient interest, during an investigation and subject to appropriate conditions, when it will facilitate other investigative, systemic review, or legal processes relating to the death that may in turn inform the coroner's investigation, or will assist in administering the deceased's personal affairs or alleviating hardship to the deceased's family or other affected parties. In these cases, access will be limited to only those documents the coroner considers relevant to the particular purpose for which access is sought.

Otherwise access will generally not be given until an investigation is finalised.

Journalists and media organisations will generally not be given access to documents from investigations that do not proceed to inquest, but may be given to access documentary inquest exhibits where it is considered necessary to properly inform fair and accurate reporting or public scrutiny of inquest proceedings. Notwithstanding this, it may still be appropriate for a coroner to communicate limited information about a death by issuing a public statement.

Coroners should be proactive in releasing coronial information to public officials or entities with public health and safety responsibilities where to do so is in the public interest and would further the objects of the Act.

In practice

Part 3, Division 4 of the Act establishes criteria and processes for the release of documents prepared specifically for, or obtained during a coronial investigation (**investigation documents**). In general, coronial consent is required and may be given subject to appropriate conditions, or refused in the

public interest. Coroners are prevented from releasing certain types of highly sensitive information. The coroner must be satisfied that the person has "sufficient interest" in the document sought, unless it is released to a "genuine researcher".

Documents other than those prepared specifically for a coronial investigation may still be accessible from the entity that created them under other access to information schemes such as Right to Information (RTI).

The access regime under Part 3, Division 4 of the Act applies to the management of requests to access investigation documents at any stage during a coronial investigation or inquest, and after an investigation or inquest has been finalised.

Because the regime applies specifically to access requests, it is not considered to limit the coroner's ability to release investigation documents, on his or her initiative, for example, for the purpose of an investigation or inquest. The coroner may consider it necessary to provide investigation documents to an independent expert for review and opinion[1] or for response by a person whose actions may have caused or contributed to the death. In preparation for inquest, the coroner will routinely release investigation documents to persons given or eligible for leave to appear as part of the inquest brief of evidence.

The release of documents for purposes connected with the investigation or inquest should always be made subject to the condition that they can only be used for coronial purposes and may not be disseminated for any other purpose without the coroner's authorisation.

The Act was amended in August 2013 to expand coroners' powers to release investigation documents and non-inquest findings in the public interest – see ss. 46A and 54(3)(b)[2] These changes support proactive information release which furthers the general death prevention objectives of the Act, for example, immediate release of information to the Office of Fair Trading about a death resulting from a product defect may prevent future deaths by prompting an urgent product recall or ban. The changes recognise the family's right to have their views considered whenever practicable when the coroner is contemplating a public interest release.

What are 'investigation documents'?

The Acts Interpretation Act definition of 'document' is such that documentary material captured by Part 3, Division 4 includes not only written documents but also audio-visual or other electronic data from which sounds, images, writing or messages are capable of being produced or reproduced.

[1] The coroner may make, or arrange for, any examination, inspection, report or test that the coroner considers is necessary for the investigation – s13(2) of the Act

[2] See Chapter 8 – Findings for a discussion (section 8.11) about the publication of non-inquest or "chamber" findings

Part 3, Division 4 of the Act distinguishes between documents prepared specifically for a coronial investigation ("*coronial document***"**) and other documents generated for a purpose other than the coronial investigation but obtained under the Act to inform the coronial investigation (other types of "*investigation document***"**).

It is important that coroners properly characterise documents for release purposes as specific release considerations apply to different document types, as explained below.

Coronial documents

These are documents prepared specifically for a coroner's investigation or inquest. Coronial documents commonly include the pathologist's preliminary advice to the coroner, autopsy reports and toxicology certificates, police photographs of the death scene, police reports to the coroner, witness statements, independent reports commissioned by the coroner or on behalf of another person specifically to inform a coronial investigation or inquest, and the coroner's findings.

The recording or transcript of an inquest is not a coronial document. Access to records of coronial proceedings is dealt with in section 10.6 below.

The significance of this characterisation is that:

- coronial documents can generally only be released under Part 3, Division 4 of the Act and not under the Right to Information scheme **while an investigation is on foot**

- coronial consent is not required if access is necessary for a police investigation or prosecution of an offence relating to a death

- coroners may postpone giving access to coronial documents if disclosure of the information they contain would not be in the public interest.

Investigation documents

The broader concept of 'investigation document' includes:

- documents obtained by a coroner under section 17 of the Act (***confidential document***) by virtue of other statutory provisions which permit disclosure to a court of information otherwise protected by a statutory duty of confidentiality, for example, a document kept under the *Child Protection Act 1999* containing information that would otherwise identify or identify a person as a notifier of harm or risk of harm. This category of investigation documents also includes documents containing confidential information that was disclosed to the coroner under the *Child Protection Act 1999*, s.159P and the *Public Health Act 200*5, ss.56 (environmental health events) or 86 (notifiable conditions).

The significance of this characterisation is that these documents, to the extent they contain confidential information, cannot be released by the coroner under Part 3, Division 4 of the Act. Instead, the coroner must make his or her release decision having regard to the constraints of the statutory provision under which the confidential information was disclosed to the coroner. For example, section 17(4) of the Act limits the coroner to disclosing confidential information obtained under section 17 only for a purpose connected with the coroner's investigation, for example, to obtain an independent expert opinion or to enable persons given leave to appear at an inquest to prepare for the inquest. The coroner could not release the document to a person's legal representative for use in non-coronial proceedings.

- documents prepared or obtained by a police officer for the investigation of an offence relating to the death (**police document**). Coroners routinely obtain a brief of evidence from QPS or the Director of Public Prosecutions (DPP) where a person has been charged with, or consideration was given to charging a person with, or prosecuting a person for, an offence relating to the death.

  The significance of this characterisation is relevant to release by the State Coroner of these documents for research purposes or to the Family and Child Commissioner.

- any other documents connected with the investigation obtained by the coroner under the Act – in practice, these are documents generated for a purpose other than the coronial investigation but which have been obtained by the coroner under the Act. Given the breadth of the coroner's power to inquire into a person's death, this category can cover an exceedingly wide range of documentary material. Common examples include suicide notes, CCTV footage, SMS or email messages, telephone recordings, medical records, Medicare and prescription history records, departmental records, internal policy and procedure documents and the outcomes of internal incident reporting and review processes (e.g. clinical incident reviews or safety analyses) or other investigative processes (e.g. workplace health and safety, health regulatory authority, ATSB investigation reports)

- child death case review reports prepared under Chapter 7A of the *Child Protection Act 1999* and given to the State Coroner under s.246H of that Act

- a report prepared by the Ombudsman relating to a person's death and given to the State Coroner under s.57A of the *Ombudsman's Act 2001*.

  The latter three categories of investigation documents are subject only to the general coronial consent requirement discussed below.

Documents that can not be accessed

Section 52 of the Act prevents a coroner from giving access to investigation documents to the extent they contain certain types of highly sensitive information. Broadly this prohibition relates to information:

- subject to legal professional privilege – in practice, this really only relates to counsel assisting's legal advice to the coroner as legal professional privilege in respect of external documents obtained under the Act will generally have been waived by the act of providing the document to the coroner for the investigation or inquest. (It is a reasonable excuse not to comply with a coroner's information requirement under s.16 of the Act if the document sought is subject to a valid claim of legal professional privilege.)

- likely to prejudice a fair trial, the investigation of an alleged offence or the effectiveness of law enforcement or public security measures

- likely to lead to the identification of a confidential source of information for law enforcement purposes or to endanger a person's life or safety

- likely to facilitate a person's escape from custody

- about a living or dead person's personal affairs except where the information is relevant to a matter about which a coroner can make findings, whether or not the coroner has made the findings.

  The breadth of the coroner's power to inquire into a person's death can result in the coroner receiving all sorts of sensitive information about a person's private life, for example, their sexual orientation, personal proclivities, infectious disease status, criminal history or events leading to a relationship breakdown or loss of employment. The extent to which this information is relevant to a finding about the death will depend on the circumstances of the death, for example, it may explain a person's state of mind immediately before they took their own life but may have little bearing on a person's death as a passenger in a motor vehicle accident.

  This general prohibition does not prevent a coroner releasing test results to the person who applied for infectious or notifiable condition testing under s.23A of the Act.

- compelled under another Act, for example, under the *Crime and Corruption Commission Act 2001, Coal Mining Safety and Health Act 1999*.

Interviews given by police officers under direction by the Commissioner of Police under section 4.9 of the *Police Service Administration Act 1990* are not caught by this prohibition.[3]

- that is restricted information connected with an investigation or inquiry conducted under the *Transport (Rail Safety) Act 2010* given to the coroner under s.238 of that Act or its predecessor provision, the repealed s.239AC of the *Transport Infrastructure Act 1994*.

It is important that coroners carefully consider whether a document contains information caught by this prohibition, and if persuaded to grant access to the document in part, must ensure the document is appropriately redacted to obliterate this information.

It is possible for documents safeguarded from release under s.52 to still be accessible from the entity that prepared them through other access to information schemes such as Right to Information. For this reason, coroners are to pass on any access request denied under s.52 to the relevant entity and alert it to any concerns the coroner has about how release of the document could affect the coronial investigation.

The interplay between ss.17 and 52 was considered by the Deputy Chief Magistrate in the third inquest into death of Mulrunji,[4] who found there was nothing in either section to exclude the operation of s52 in relation to section 17. Rather, he considered section 52 qualified the access the coroner may give to confidential information under s17(4). However, the more general issue of whether s52 impacts on the release of investigation documents for investigation and inquest purposes was not addressed in this case, as it was held the documents to which access was sought did not fall within the prohibition under s52(1)(d).

I consider section 52 should not be construed to prevent a coroner, on his or her initiative, releasing investigation documents for a purpose connected with an investigation or inquest, especially as part of an inquest brief of evidence. The rationale for this interpretation is as follows:

- an Act should be interpreted so as to give effect to its purpose wherever possible
- the Act requires coroners to investigate or hold an inquest in certain circumstances[5]
- coroners are obliged to give procedural fairness[6]
- to withhold information in his or her possession from a person directly interested in a coronial investigation or who is given or eligible for leave to appear at an inquest risks denying procedural fairness[7]

[3] Ruling of Deputy Chief Magistrate Hine in the third inquest into the death of Mulrunji, 26 February 2010
[4] ibid
[5] ss.11(Deaths to be investigated), 12 (Deaths not to be investigated or further investigated), 27 (When an inquest must be held), 28 (When an inquest may be held)
[6] Annetts v McCann [1990] HCA 57; (1990) 170 CLR 596 (20 December 1990)
[7] Musumeci v Attorney General of NSW & Anor [2003] NSWCA 77 (8 May 2003)

- s52 is contained in a division of Part 3 that is separate to those relating to investigations and inquests
- the purpose of the Act can be achieved while affording interested persons procedural fairness if s52 is contrasted so as not to related to dissemination of investigation documents to interested persons for use in an investigation or inquest.

Coronial consent

An investigation document can only be accessed for non-research purposes with a coroner's consent – s.54(2). The only exception relates to access by or through a police officer to a coronial document for the purpose of a police investigation or prosecution of an offence relating to a death.

Before giving consent, a coroner must turn his or her mind to matters including whether the applicant has sufficient interest in the document or whether it is in the public interest for the document to be accessed, the extent to which the document contains information that cannot be released, the desirability of placing conditions on access and whether it is in the public interest for the document not to be released at that time or indeed at all.

Consent is generally given by the investigating coroner, but can be given by another coroner or the registrar acting under the State Coroner's delegation, if the investigating coroner is not available.

Who has sufficient interest in an investigation document?

A coroner can only authorise access if he or she is satisfied the person seeking to access to a document has sufficient interest in it – s54(3).

The Act does not define sufficient interest. However, relevant case law suggests following matters can be relevant to the determination of sufficient interest, having regard to the circumstances of the death:

- the applicant's connection with the deceased person - in practice, this involves an assessment of any familial, personal or other relationship that may have existed between the applicant and the deceased person and the directness of that relationship.

- the nature of the applicant's involvement in the events leading to the death

- the purpose for which access is sought and the relevance of the document to that particular purpose - the authorities are clear that the applicant's interest in the document must be more substantial than mere curiosity, newsworthiness or some other trivial interest. Sufficient interest is something more particular than a general public interest.

Applying these considerations, the following categories of applicant will generally be regarded as having sufficient interest in an investigation document:

- the deceased's family members – as discussed in Chapter 2 *The rights and interests of families*, Parliament clearly intended that families be given access to a broader range of coronial information under the Act than was made available to them under the previous system. This is why family members are specifically recognised as having sufficient interest under s.54. The family is generally entitled to know as much as possible about the circumstances of their loved one's death. Quite apart from meeting a family's emotional needs, timely release of coronial information to family members can alleviate hardship by helping to expedite financial or other legal processes running concurrently in respect of the death, for example life insurance or superannuation claims and estate administration.

  Coroners must also give careful consideration to the impact of information release on known family tensions, for example, between a current and former spouse or between estranged parents. While coroners should be vigilant about a family's desire to prevent another family member 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. Coronial counsellors can provide valuable assistance to coroners in working with family members to resolve these tensions in difficult family dynamics.

- any person or entity whose actions may have caused or contributed to the death, particularly when it is possible the coroner may make an adverse finding about that person

- a person who was materially involved in the events leading to the death

- any person given or eligible for leave to appear at an inquest

- an investigative entity whose statutory function enables or requires it to inquire into the death, for example, Office of Fair and Safe Work Queensland, ATSB, health regulatory authority, Crime and Corruption Commission, Office of Aged Care and Quality Compliance

- an entity responsible for service provision to the deceased person during life seeking access to coronial information to inform internal quality assurance processes, for example, a hospital seeking a copy of the autopsy report to inform a clinical incident or mortality review

- the deceased's personal representative

- an insurer, superannuation fund or workers compensation entity considering a claim in respect of the death or the incident in which the death occurred - coroners should only give access to those documents considered relevant to the particular claim and are encouraged to require these applicants to demonstrate the relevance of the information they seek to the matters to be assessed when considering the claim.

- a person's legal representative in respect of criminal or civil proceedings relating to the death

- a health practitioner or health service advising a family member about possible genetic predisposition to the condition that caused the death

- a public official or regulatory entity with public health or safety responsibilities, for example, Chief Health Officer, Therapeutic Good Administration, Australian Health Safety and Quality Commission, Office of Fair Trading, Civil Aviation Safety Authority.

Journalists and media organisations

Some reportable deaths and inquests attract considerable media attention.

Coroners frequently receive media requests for information about a death. When a request is made regarding a named deceased person, then provided the deceased has been formally identified and the family notified of the death, it is appropriate for the coroner to release information confirming the deceased person's name, that the death has been reported to the coroner for investigation and when the death was reported.

Journalists and media organisations are not considered to have sufficient interest in investigation documents arising from an investigation that does not proceed to inquest.[8]

The issue of media access to inquest exhibits is discussed below.

Authors, television producers, film makers etc

From time to time, coroners will receive requests for access to investigation documents to inform the development of, or be used in a feature article, book, television show or other film production about the deceased person or the incident in which the death occurred. When considering these applications, coroners should carefully consider the objective of the proposed publication or production – is the objective to raise public awareness about preventable death or merely to provide public entertainment?

The coroner should seek the family's views whenever practicable, and consult the State Coroner before consenting to release of investigation documents in these cases.

[8] *Mirror Newspapers Ltd v Waller* (1985) 1 NSWLR 1

Proof of applicant's identity

Documents can be released to family members nominated or mentioned in the Form 1 Police Report of Death to a Coroner or Form 1A Medical Practitioner Report of Death to Coroner, without requiring further proof of identity.

Otherwise, the applicant should be required to provide proof of identity, for example a driver's licence and if relevant, proof of their relationship to the deceased person, for example birth or marriage certificate. It is acceptable for this documentation to be submitted electronically.

When can access be given in the public interest?

Consistent with the general death prevention objective of the Act, the Act was amended in August 2013 to enable coroners to give access to investigation documents in the public interest – see s.54(3)(b). This change allows coroners to release information proactively, including by way of a public statement, or in response to an application under s.54.

Circumstances in which it would be appropriate for a coroner to make proactive public interest release include where the information will inform death prevention initiatives, raise public awareness, correct public misinformation or inform profession or industry-specific regulators. For example, where a product defect or adverse medication reaction has been proven to have caused the death, or conversely was initially thought to have caused the death but subsequent investigations have confirmed this was not the case. Another example would be to clarify the cause of death where autopsy has confirmed a natural causes death in a case initially reported by the media as suspicious.

Applicants may satisfy the public interest criterion by demonstrating how use of the information sought will contribute to the various objectives outlined above.

It is well established that satisfying mere public curiosity or prurient interest does not equate to public interest.

Coroners are required to consider the family's views whenever practicable when considering a public interest release and should consult the State Coroner before issuing any public statement in these cases.

When should conditions be placed on access?

Coroners have power to place conditions on a person's access to an investigation document if considered necessary to protect the interests of justice, the public or a particular person. Failure to comply with these conditions is an offence under the Act – s55.

Given the confidential, sensitive and often distressing nature of coronial information, it is highly desirable that coroners always consider placing

reasonable limitations on the use a person can make of a document released to them under the Act.

Coroners are encouraged to make any document released for the purpose of enabling effective participation in an investigation or inquest subject to the standard condition that the documents may only be used for coronial purposes (i.e. to obtain advice, opinion or instructions for participation in the investigation or inquest) and may not be disseminated to anyone for any other purpose without the coroner's authorisation. Unless there are specific statutory confidentiality obligations attaching to information contained in those documents, then documents released as part of an inquest brief of evidence will generally not be redacted or otherwise de-identified.

When crafting appropriate release conditions, coroners should turn their minds to matters including the nature of the document itself, the specific purpose for which access is sought, who is likely to gain access to it when used for that purpose, and the extent to which its contents could cause distress to either the applicant or another person, and appropriate strategies to minimise that distress. For example, the coroner may consent to a family member having access to an autopsy report or a suicide note if they agree to receive the document through a treating doctor or counsellor who can explain the document to them and support their reaction to it. A further example is where a person seeks access to a document in order to produce it in evidence in a non-coronial proceeding and the coroner allows a copy of the document to be provided directly to the relevant court or tribunal.

It is advisable that document release for non-coronial purposes always be made subject to a condition that the document's use be limited to the particular purpose for it was sought.

Redaction and de-identification

Before a document is released, care must be taken to ensure it is appropriately redacted to obliterate:

- any information caught by s.52 of the Act
- confidential information
- information considered irrelevant to the scope of the applicant's access request
- where considered necessary, identifying information.

When can access be refused or postponed?

To the extent that a document contains information captured by s. 52 of the Act, access will not be given to that information.

A person who is not considered to have sufficient interest in an investigation document will not be given access to it, unless the coroner is otherwise satisfied it is in the public interest to give access to the document.

Notwithstanding that a person may have sufficient interest, a coroner can still refuse to allow access to an investigation document if he or she considers it

would not be in the public interest for the information it contains to be disclosed. This requires the coroner weigh up all other relevant interests. The coroner also has power to postpone the release of coronial documents – s. 56 of the Act.

The determination of whether disclosure of coronial information would be inimical to the public interest should be made having regard to the particular circumstances of the death and the nature of the document to which access is sought and the information it contains. Relevant considerations could include but are not limited to:

- the interests of justice
- risks to public health and safety
- the risk of damage to a person's personal or professional reputation.

In practice, it would be appropriate for a coroner to refuse access when to do so at that time, or at all could compromise the coroner's investigation or another legal proceeding or investigative process relating to the death. A coroner may be similarly minded in relation to documents that contain defamatory information or unsubstantiated allegations of criminal behaviour or professional misconduct. A further example might be where the document contains information that could trigger copycat suicidal behaviour.

Timing of access

Coroners are encouraged to regularly keep families and others with a direct interest in the outcome of an investigation informed of the progress of the investigation, unless to do so risks compromising the investigation. This can prompt requests to access investigation documents as and when they become available to the coroner.

Careful consideration should be given to the timing of release of coronial documents during an investigation. Release of information at appropriate stages during an investigation enables effective participation in the investigation and often addresses family concerns much more effectively than if documents are released in piecemeal fashion. Impact on the coroner's investigation strategy is also an appropriate consideration.

Access to documents containing words of testamentary intention

The *Succession Act 1981*, section 18 has the potential effect of classifying a very broad range of communications by a deceased person as an effective will. It enables the Supreme Court of Queensland to admit a document to probate if satisfied the document embodies the deceased's person's testamentary intentions, even though the document does not comply with formal requirement for executing, altering or revoking a will. The Court can only exercise this broad dispensing power if satisfied the person intended the document to constitute their will or an alteration to or revocation of it.

Section 18 applies to any information, whether in writing or other form of recording including video or voice recordings or unsent text messages on smart phones.

Individuals who intentionally take their own life often leave behind communications, whether in writing or video recorded or posted on social media applications, touching on issues including what they want to happen to their body and how they want their personal belongings dealt with and by whom.

Suicide notes have been declared as a valid will in Queensland.[9]

For this reason, it is very important for coroners to actively turn their minds to the potential effect of section 18 of the Succession Act when considering requests for access to investigation documents that may assist in the administration of the deceased person's estate. Early access to documents potentially evidencing the deceased person's testamentary intention can greatly assist in the timely and efficient administration of their estate. Importantly, it could potentially avoid the time and expense of an unnecessary application for letters of administration on intestacy.

Coroners are encouraged to authorise early access by applicants involved in the administration of the deceased person's estate to, at the very least, a copy of these communications bearing in mind the original will be required should a probate application be necessary.

Access to sensitive or distressing investigation documents

Suicide notes and audio-visual footage of a death are amongst the most personal and distressing items obtained by coroners. However coroners should resist adopting an overly paternalistic attitude when assessing potential risk of psychological harm from exposure to these items.

Suicide notes

Suicide notes, electronic messages and other documents evidencing a person's intention to take their own life are routinely seized by investigating police for the coroner's consideration. Consequently they are both investigation documents and physical evidence under the Act.

These documents often contain final messages to family members, friends or other persons. These messages can range from expressions of love, friendship and gratitude to declarations of abject despair and hopelessness to outpourings of anger, accusation, blame and hate. They often canvass intensely personal information and sometimes contain admissions or denials of guilt.

A person to whom a suicide note or message is directed will generally be considered to have sufficient interest in the document. To the extent the

[9] *Sadleir v Kahler* [2018] QSC 067; *Re Nichols; Nichol v Nichol & Anor* [2017] QSC 220

document contains information about another person, that person may also be considered to have sufficient interest in that information.

The very nature of the content of these documents means they require careful scrutiny to identify information captured by s.52.

When giving access to these documents, coroners should consider the extent to which disclosure of information they contain may cause the distress to the applicant or to another person, and appropriate strategies to minimise this distress. These strategies may include partial release or conditions requiring release through a counsellor or treating doctor or the undertakings not to communicate the document's contents to specified persons e.g. the deceased's non-adult children. Coronial counsellors can provide valuable assistance to coroners considering these matters.

If the coroner refuses access to a note, he or she should consider whether instead a general description of its contents may satisfy the applicant's needs. For example, a letter advising the note contains nothing more than a brief farewell and expression of thanks and love to a spouse may alleviate an applicant's concern that the note contained an admission of guilt by the deceased about having sexually abused the applicant as a child.

Because these documents are also physical evidence, they must be dealt with under Part 3, Division 5 of the Act once the coroner is satisfied they are no longer required for coronial or other legal proceedings. The original documents will generally be returned to the person to whom the note was directed or it that is unclear, to the deceased's personal representative, unless the coroner considers it would not be desirable to do so, for example if the note is contaminated by bodily fluids or a toxic substance.

Photographs and audio-visual footage

The incident in which a person is fatally injured or dies is sometimes captured in audio-video footage e.g. telephone recording, CCTV footage, bystanders' mobile phones or media coverage of an event. A person who commits suicide may film their own death. This footage is routinely seized by investigating police for the coroner's consideration. The death scene is also routinely photographed and/or videoed by police and the photographs provided to the coroner.

This information will routinely form part of a brief of evidence for an inquest and consequently will be released to persons given or eligible for leave to appear.

It is appropriate for photographs and audio-visual footage of the death or death scene to be provided to an entity that is also investigating the death e.g. Office of Safe and Work Queensland, or for the purpose of other legal or financial processes concerning the death.

Given the highly distressing and graphic content of these items, a coroner who contemplates giving access to these items for purposes other than

informing another investigative or legal process should seek advice from a coronial counsellor or treating doctor about the likelihood of psychological harm to the applicant or another person, and appropriate access strategies to minimise this risk.

10.3 Application of RTI to coronial information

Right to Information schemes provide a right to access government information, unless on balance, it is contrary to the public interest to release the information. Information Privacy schemes give individuals a right to access and amend their own personal information.

Right to Information, and to a much lesser extent Information Privacy schemes can provide an alternative means of access to investigation documents, particularly those held by a government agency.

Coronial documents are generally not accessible under Right to Information while an investigation is on foot. However, copies of coronial documents given to a government agency under the Coroners Act may be accessible under a Right to Information application directed to that agency before the coronial investigation is finalised.

It is not uncommon for investigation documents like the deceased's medical or departmental records to be accessed through a Right to Information application to the source government agency.

Applications are often made under Right to Information for access to closed coronial investigation files. These applications can result in the release of documents other than investigation documents, for example, correspondence and file notes.

10.4 Access to non-documentary physical evidence

Physical evidence covers anything seized by police for a coronial investigation or inquest, any exhibits tendered at an inquest or any other property that comes into the possession of the coroner or investigating officer. Naturally this includes both documentary items and non-documentary items.

While access to documentary items is dealt with under Part 3, Division 4, the Act does not establish a corresponding access regime for non-documentary items that have not been tendered as inquest exhibits. There is currently only a requirement that until physical evidence is dealt with under Part 3, Division 5, a coroner must allow the item's owner to access it for inspection, or copying purposes unless it is impracticable or unreasonable to do so – s.62.

In practice, a coroner should provide reasonable access to non-documentary items, on request by persons given or eligible for leave to appear at an inquest into the death for purposes that will inform the efficient conduct of an investigation or inquest, for example, to enable a party's expert to examine the item.

10.5 Access to inquest exhibits

The Act was amended in August 2013 to establish a specific access regime for inquest exhibits.

This regime ensures access to documentary exhibits is dealt with under Part 3, Division 4 and establishes a consistent approach to managing access to non-documentary exhibits ("physical evidence exhibits"), meaning the coroner's consent is required and access may be given if the applicant demonstrates sufficient interest in the exhibit or that access to it would be in the public interest.

These changes recognise the family's right to be consulted and have their views considered, to the extent practicable, when the coroner is contemplating giving access in the public interest.

The changes do not affect a police officer's ability to access or give access to an exhibit without the coroner's consent if the exhibit is necessary for the investigation or prosecution of an offence relating to the death.

When considering whether a person has sufficient interest in an inquest exhibit, regard must be had to the principle of open justice which does not create a right of access to court documents, but favours allowing a non-party to access any non-confidential document or thing that has been admitted into evidence in an open court proceeding, unless there is a good reason to refuse access. Further, there is authority that media organisations have an interest in accessing an exhibit if it is necessary to properly inform fair and accurate reporting and public scrutiny of court proceedings.

Circumstances in which it would be appropriate to refuse non-party access to an inquest exhibit could include where the exhibit relates to evidence given in closed court or contains information which would not otherwise be released under the Act e.g. under sections 17, 52 or 56 or the exhibit is contaminated by bodily fluids or toxic substances or is in some way inherently unsafe.

10.6 Access to records of pre-inquest conferences and inquests

Section 38 of the Act requires inquest proceedings to be recorded under the *Recording of Evidence Act 1962* and the *Recording of Evidence Regulation 2008*. The recording of a pre-inquest conference is a matter for the presiding coroner's discretion.

Access to records of coronial proceedings is regulated by section 38(3) of the Act and the Recording of Evidence Act and Regulation. In practice, to the extent the record is not subject to a non-publication order made under s.41 of the Act, the record is available either electronically or in transcribed form to anyone who requests and pays for access to it. Eligibility for fee waiver is dealt with in the Recording of Evidence Regulation. Only the Director-General's delegate can waive fees on hardship grounds. Coroners have no

power to waive fees or provide free copies of transcripts to persons given leave to appear at an inquest.

10.7 Responding to subpoenas

From time to time, coroners are served with subpoenas requiring them to provide their complete investigation file or specified documents. While there is a view that it is an abuse of process to issue a subpoena to a coroner, coroners are encouraged to co-operate with the conduct of other legal proceedings, having regard to the law under which the subpoena was issued and the operation of Part 3, Division 4.

10.8 Access for research purposes

In principle

The scholarly investigation of reportable deaths is vitally important to improving public health and safety. The coronial system is an important source of information for researchers and in turn research analyses are essential in assisting the coronial system to prevent future deaths.

In practice

Applications for access to investigation documents for research purposes are considered under s.53 of the Act. Access for research purposes can only by authorised by the State Coroner, who must be satisfied the applicant is a genuine researcher and the document sought is reasonably necessary for the research. There are limited circumstances in which this authorisation can be given while an investigation is on foot. The State Coroner's authorisation can be given for specified types of documents for either a defined period or on an ongoing basis, and can be made subject to conditions.

The genuine research access regime does not permit release of confidential documents and is subject to the release prohibitions under s.52. The State Coroner can refuse access in the public interest.

Documents released under this mechanism must be de-identified unless the State Coroner considers the person's identity is necessary for the research to be effective and the benefit of the research outweighs the need to protect an individual's privacy.

The documents researchers frequently seek to access are Form 1s, police or other investigation reports, autopsy and toxicology reports, witness statements and coroners' findings.

Who is a genuine researcher?

The Act recognises three categories of researcher, namely:

- public health researchers who have been given access to health information under the *Public Health Act 2005*

- members of quality assurance committees established under the *Hospital and Health Boards Act 2011* e.g. Queensland Maternal and Perinatal Quality Council, Queensland Paediatric Quality Council
- another person conducting genuine research.

What is genuine research?

The Act does not define 'genuine research', so regard must be had to the usual meaning of the term. Indicators that the applicant is conducting genuine research will include the applicant's qualifications, standing and reputation in the research community, whether the applicant has obtained relevant ethical approvals, the purpose of the research and how its outcomes are intended to be published and used.

Since the Act commenced, a wide range of individuals and organisations have been recognised as genuine researchers covering diverse research activities into suicide prevention, road safety, fire fatalities, drowning deaths, scuba diving deaths, SIDS, building standards and the efficacy of the coronial system.

When can investigation documents be released for research purposes?

Access can be given while an investigation is on foot only if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in permitting access before the investigation is finalised. Otherwise access will only be given to investigation documents from closed investigations.

10.9 Access for tissue banking purposes

Section 54AA of the Act enables the State Coroner to enter into arrangements with prescribed tissue banks to provide them with timely access to information from Form 1s coroner in order to inform the donor assessment process. This mechanism is designed to maximise opportunities for tissue retrieval and recognises the timeframes for retrieving tissue for transplantation is very short (within 24 hours of death).

To date, the State Coroner has entered into arrangements with the Queensland Bone Bank, the Queensland Eye Bank, the Queensland Heart Valve Bank and the Queensland Skin Bank.

These arrangements operate in place of the general access regime under s.54 and obviate the need for consent from the investigating coroner on a case by case basis. The arrangements do not enable tissue banks to obtain a copy of the Form 1.

Chapter 4 *Dealing with bodies* explains how these arrangements work in practice.

10.10 Access by the Family and Child Commissioner

Section 54A of the Act enables the Director-General of the Department of Justice and Attorney-General to enter into an arrangement with the Family and Child Commissioner to give the Commissioner access to investigation documents to inform its child death research functions. An arrangement was entered into with the former Children's Commissioner under this provision in 2011 and has since been updated to recognise the transfer of the child death research function to the Family and Child Commission.

This arrangement operates in place of the general access regime under s.54 and obviates the need for consent from the investigating coroner on a case by case basis. Access is provided through the State Coroner and enables access while a coronial investigation is on foot. Access under this arrangement remains subject to the s.52 prohibition and the power under s.56 to refuse access in the public interest.

Documents released under this arrangement must be de-identified unless the person's identity is considered necessary for the Commissioner's child death research function.

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)