Guide to the 2009 amendments to the Coroner Act 2003


Duty to report deaths

Section 7(1A) imposes a duty to report deaths on those who provide residential services to people with a disability (as referred to in s9(1)(a)). The duty applies even if the death did not occur at the care facility and has been or may have been reported by someone else.

Categories of reportable deaths

Deaths resulting from police operations
A new s8(3)(h) is inserted requiring deaths that happened in the course of or as a result of police operations to be reported. This category would apply to the death of a bystander killed while police were attempting to detain a suspect.

These deaths must be reported to the State Coroner or Deputy State Coroner (s7(2)(a)) and can only be investigated by the State Coroner, Deputy State Coroner or other coroner approved by the Governor in Council to investigate the death (s11(7)). An inquest must be held unless the coroner is satisfied that an inquest is not required in the circumstances (s27(2)(iii)).

Health care related deaths
Section 8(3)(d) which required the reporting of a death that was not reasonably expected to be the outcome of a health procedure has been replaced by a new s8(3)(d) which requires the reporting of health care related deaths. Health care related death is defined in a new s10AA. The amendments clarify the circumstances in which medical deaths are reportable and make it clear that a failure to provide health care is captured.

Section 10AA(5) contains an expanded definition of ‘health care’ which is defined to mean a health procedure or any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health. The definition of ‘health procedure’ is unchanged.

Under s10AA a death is health care related if either:
(a) the health care caused or contributed to the death and immediately before the health care was provided an independent person would not have expected death to occur; or
(b) a failure to provide health care caused or contributed to the death and at the time the health care was sought an independent person would not have expected that there would be a failure to provide health care that would cause or contribute to the death occurring.

Health care causes or contributes to a person’s death if the person would not have died at that time without the health care being provided. A failure to provide health care causes or contributes to death if the person would not have died at that time if the health care had been provided. The reference to an independent person means a person qualified in the relevant area of health care who has regard to all relevant matters including the person’s state of health, the clinically accepted range of risk and the circumstances in which health care was provided or sought.
Deaths in care
Minor amendments are made to s9(1)(a) to update terminology relating to residential services provided to persons with a disability. Minor amendments are also made to s9(1)(b) in relation to deaths of persons being dealt with under the Mental Health Act 2000 to correct anomalous references.

Section 9(1)(d) is amended to ensure that the definition of death in care as it relates to children in care captures all “out of home” child protection placements under the Child Protection Act 1999 and not just children who have been placed in care by the chief executive under s82 of that Act. This would include where a child is placed under an assessment care agreement, temporary assessment order or court assessment order that does not place the child in the chief executive’s custody.

Deaths in custody
The definition of a death in custody in s10(2) is expanded to include deaths in detention under State and Commonwealth legislation (excluding the education (General Provisions) Act 2006 and the Mental Health Act). An inquest must be held for these deaths except if the person was detained under the Public Health Act 2005 (s27(2)(b)).

Violent or unnatural deaths
Section 8(5) clarifies that a death is reportable even though there may be a delay between the incident and death. For example, if a person dies many months after sustaining injuries in a motor vehicle accident.

Review of coroner’s decision about whether a death is reportable
A new s11A enables a coroner’s decision about whether or not a death is reportable to be reviewed. A person dissatisfied with a coroner’s decision may apply to the State Coroner or District Court for an order about whether the death is reportable.

State Coroner’s Guidelines
Section 14 is amended to provide that the State Coroner may issue guidelines about the types of reportable death in s8; preliminary investigations to decide whether a death is reportable; the investigation of a suspected death and any other matter relevant and desirable to ensure best practice in the coronial system.

Coroner’s powers of investigation
The amendments clarify the coroner’s jurisdiction to conduct a preliminary investigation to determine whether or not a death is reportable (see the amended definition of ‘investigation’).

Section 13 provides that the coroner may make or arrange for any examination, inspection, report or test considered necessary for the investigation. A new s13(2) clarifies that the coroner has the power to authorise a doctor or nurse to take a sample of blood for testing.

Section 16 clarifies that the coroner’s powers to compel the giving of information relevant to the investigation extends to requiring a person to give a document or anything else relevant to the investigation, for example, a statement or report.
Section 17 provides for the disclosure of confidential information at inquest if relevant legislation allows for the disclosure to a court. The provision is amended to enable disclosure during the investigation and before the inquest is convened.

A new section 17A provides protection against civil or criminal liability or liability under an administrative process (e.g. disciplinary action) for a person providing information to a coroner under s16 or s17.

**Autopsy and tissue retention**

Section 21 which provides for autopsies to be observed is replaced. The new section provides that the coroner or investigating police officer may attend as of right. If the coroner considers it appropriate a person may attend for education or training purposes if the doctor performing the autopsy consents. The coroner may also allow a person with ‘sufficient interest’ to observe an autopsy if this is appropriate and would not compromise the investigation into the death. However, the coroner must first consider any views expressed by the family and doctor performing the autopsy and give notice of the time and place where the autopsy will be conducted.

Under s22 the coroner may require medical evidence to be provided to the doctor performing the autopsy. This section is amended so that this information may be required after the autopsy has been conducted. The section is also amended to ensure that a person may send a written report or medical records to the doctor by fax or other electronic means unless the coroner requires the original to be provided.

Section 23A allows a person with ‘sufficient interest’ to apply to the coroner for an order that the doctor performing the autopsy test for an infectious or notifiable condition under the Public Health Act 2005. Under s23 the coroner may order these tests on their own initiative or on application under s23A.

The tissue retention and disposal regime in s24 is expanded to cover identifiable body parts (e.g. a jaw or hand). The amended section refers to ‘prescribed tissue’ which includes an organ, foetus or identifiable body part. The section has also been amended to provide that tissue may be released to the family for burial or for testing or some other lawful purpose.

Reflecting current practice, s24A now requires the doctor performing the autopsy to provide a copy of the autopsy notice and certificate to the coroner as well as to Births, Deaths and Marriages.

Section 25 allows autopsy reports to be given to various persons. The section is amended to confirm that a copy of an autopsy or test report must be given to the investigating police officer on request. Section 25 is also amended to provide that the doctor performing the autopsy must not give a copy of the autopsy or test report to the chief executive of the Department of Justice and Attorney-General or Queensland Health if the State Coroner decides that the report is not to be provided. The State Coroner must give reasons for this decision.

Section 96 outlines provisions of the Act which apply to a still born child. The coroner has no jurisdiction to investigate these deaths. Section 96 now provides that an autopsy report can be prepared and provided to police in those cases where the death is determined to be of a still born child at autopsy.

Section 26 is amended to allow another coroner release the body in circumstances where the investigating coroner is not available.
Organ and tissue donation

A new s54AA allows the State Coroner to enter into arrangements to give tissue banks prescribed under the Transplantation and Anatomy Act 1979 access to reports under s7(4) (i.e. police reports of deaths to the coroner). A new s18A allows prescribed tissue banks to assess donor suitability by conducting an external examination of the body. This donor screening process cannot occur if the deceased person was known to object to the removal of tissue from their body. The person conducting the examination must comply with the State Coroner’s guidelines and consent must be obtained from the coroner and family before tissue retrieval occurs.

Inquests

Section 28 is amended to provide that a coroner may hold an inquest if satisfied that it is in the public interest for an inquest to be held.

The requirement in s30 for a person to apply ‘in the approved form’ for an inquest to be held has been removed. However, the application must be in writing and must outline why it is in the public interest for an inquest to be held. The 6 month timeframe within which a coroner must decide an application for inquest may be extended if the coroner is waiting for information that is relevant to the decision.

Section 32 now requires the inquest notice to include the issues to be investigated at the inquest and the notice must be published at least 28 days before the inquest (extended from 14 days). Section 32(4) also requires the issues to be investigated and the date, time and place of inquest to be published on the Office of the State Coroner website.

Section 34 gives the Coroners Court discretion to publish notice of a pre-inquest conference and mandates the requirements of the notice if it is published. If notice of the pre-inquest conference is published there is no requirement to publish notice of the inquest. This reflects the current practice.

Section 35 extends the coroner’s power to give directions and make orders for the conduct of an inquest to pre-inquest conferences. The coroner’s powers at inquest to make a non-publication order (under s41) or an exclusion order (under s43) are similarly extended to pre-inquest conferences.

Section 36 is amended to make it clear that standing can be given to public interest intervenors to appear at inquest. However, under s36(3), the standing is limited: the person may not examine witnesses without leave and may only make submissions about matters on which the coroner may comment under s46(1).

Section 88 is amended to provide the same protection for a person assisting the coroner under s36(1)(a) as applies to a lawyer appearing for a party in a Supreme Court hearing.

Findings and comments

The reference in s45(3)(b) to s12(1) is amended to refer to s12(2). The effect of this amendment is that the Act no longer requires coroners to make findings where the coroner decides that an autopsy is not necessary and authorises a death certificate to be issued.
Under s46 if a coroner makes comments about a matter that is dealt with by a government entity, the coroner must provide a copy of the comments to the Attorney-General as well as the Minister administering the entity and the chief executive of the entity.

Section 47 requires copies of findings and comments in relation to deaths resulting from police operations to be provided to the Minister and chief executive administering the Police Powers and Responsibilities Act 2000.

Section 42 of the Births, Deaths and Marriages Registration Act is amended to require the death register to be updated to reflect the coroner’s findings if these are different to the information entered in the register.

Reopening inquests and investigations

A new s50A is inserted to allow the investigating coroner or the State Coroner to reopen an inquest or hold a new inquest on his or her own initiative. The coroner must be satisfied that new evidence casts doubt on a finding or it is in the public interest. The coroner may accept as correct any of the evidence given or findings made at the earlier inquest.

Section 50B provides that the State Coroner may act on his or her own initiative to reopen an investigation or direct the investigating coroner or another coroner to reopen an investigation if the State Coroner considers that:

- the circumstances of death warrant further investigation
- the coroner’s findings could not be reasonably supported by the evidence
- new evidence casts doubt on the findings.

Under s50B the investigating coroner may also reopen an investigation if he or she considers that the circumstances of the death warrant further investigation or new evidence casts doubt on the findings.

Release of information

Section 52 is amended to take into account the new s23A which allows an application to be made for testing for infectious or notifiable conditions. The amendment ensures the applicant can be advised of the test results. The section also makes it clear that access can be given to documents containing personal information if the information is relevant to a matter about which the coroner may make findings under s45(2) whether or not the coroner has actually made the findings.

Section 53 is amended to improve the release of information to researchers. The following changes are made:

- the requirement for the chief executive of the Department of Justice and Attorney-General to determine that a researcher is a ‘genuine researcher’ able to access documents under the Act has been removed
- researchers will be able to access documents before the investigation is finalised if the State Coroner considers it appropriate having regard to the importance of the research and the public interest
- the State Coroner will be able to approve access by a researcher to specified types of documents for a specific period or on an ongoing basis until approval is revoked.
The definition of ‘coronial document’ is amended to remove documents seized by a police officer in connection with the investigation from the definition. A range of minor consequential amendments are made to ss54, 54A and 56.

Return of physical evidence

Section 60 is amended to clarify arrangements for the return of physical evidence. Physical evidence is forfeited to the State in circumstances where the coroner does not order the return of the physical evidence because it’s not lawful for the owner to possess it or because under the State Coroner’s guidelines it is not desirable for it to be returned because of its nature, condition and value.

Coroner’s powers and jurisdiction

Under new s63A a person who ceases to be a coroner (other than because of death or removal from office) may, if they agree, continue to be a coroner for the purposes of making findings in matters that had been under investigation by the coroner and which are identified by the State Coroner in consultation with the Chief Magistrate.

Section 71 which sets out the State Coroner’s functions and powers is amended to recognise the State Coroner’s function to promote public awareness of the coronial system and to give the State Coroner power to enter into arrangements with government entities to facilitate the entity’s relationship with the coronial system. The amendments also clarify that the State Coroner may be appointed as a member of the Child Death Review Committee and may be appointed to another office which is compatible with office of State Coroner.

A new s71A is inserted to allow the State Coroner to exercise his or her powers to assist a coronial investigation in another jurisdiction. The State Coroner may also request assistance from an equivalent office holder in another jurisdiction.

Section 77 now requires the State Coroner’s annual report to be tabled in Parliament and to contain names of persons given access to documents as genuine researchers under s53.

Section 74(6)(b) provides for the Deputy State Coroner to act as the State Coroner. The language used in s74(6)(b) is amended to make it consistent with that used in s74(1)(b).

A new s79A is inserted to provide that the Deputy State Coroner may resign from that office but retain appointment as a magistrate.

Section 86 is amended to confirm that coroners may delegate powers and duties to the registrar or deputy registrar including the power to order the disposal of tissue, the release of a body or the release of investigation documents where the investigation is finalised.

Definitions

‘Family member’ – this definition has been expanded to include a person nominated in writing by the deceased before death.

‘Indigenous burial remains’ – this definition has been amended to update references to legislation.

Please note: This publication was produced prior to the current government.