Chapter 1 - Introduction and the scope of the coroner’s role

1.1 Introduction

1.2 The scope of the coroner’s role
   - In principle
   - In practice
   - Summary

1.3 Further reading

Chapter 2 - The rights and interests of family members

2.1 Introduction

2.2 Deciding who is the family member
   - Legislation
   - In principle
   - In practice

2.3 Family views about autopsy and organ retention
   - Legislation
   - In principle
   - In practice

2.4 Communicating with the family
   - In principle
   - In practice
   - Assistance of coronial counsellors
   - Assistance of Aboriginal and Torres Strait Islander Legal Service
   - Notification of death
   - Cause of death information and autopsy reports
   - Information about the coronial process

2.5 Viewing the body and death scene

2.6 Release orders and family disputes

2.7 Case management and keeping families apprised
   - In principle
   - In practice

2.8 Management of family concerns about the death
   - In principle
   - In practice
2.9 Access to coronial information

Legislation
In principle
In practice

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

Legislation

2.11 Involvement in inquests

Legislation
In principle
In practice
Notification of coroner’s decision to hold inquest
Access to brief of evidence
Standing to appear at inquest
Role of Counsel Assisting when family not separately represented
Opportunity to be heard
Recognition of deceased person in life

2.12 Right to receive findings and comments

Legislation

Chapter 3 - Reporting deaths

3.1 Introduction

3.2 What is a reportable death?

Legislation
In principle
In practice
Apparently reportable deaths
Location of Death
It is not known who the person is
Violent or otherwise unnatural deaths
Infectious disease deaths
Lifestyle and industrial diseases
Suspicious circumstances
Health care related death
Legislation
Did the health care cause or contribute to the death?
Did failure to provide health care cause or contribute to the death?
Was the death not reasonably expected?
Cause of death certificate has not been issued and is not likely to be issued
Death in care
Legislation
Death of a person who had a disability
What is a disability?
Relevant facilities
Death of person who was receiving treatment under the Forensic Disability Act 2011
Death of a person who was subject to involuntary assessment or treatment under the Mental Health Act 2000
Death of a child under the care or guardianship of the Department
Death in custody
Legislation
Death in the course of police operations
Legislation
Suspected deaths
Legislation
In principle
In practice

3.2 How are deaths reported?
Legislation
In principle
In practice
Multiple fatalities – Form 1B and the disaster victim identification process
Form1B
DVI Phases

3.3 Reporting of particular deaths
Stillbirths
Scope of coroner’s jurisdiction
Reportability
Autopsy outcomes
Neonatal deaths - when and how they should be reported
Introduction
Reportability
Deaths not reportable to the coroner
Deaths reportable to the coroner via the police
Deaths reportable directly to the coroner via the Form 1A process
Scene preservation
The coroner’s decision
Opportunities for clinical input to the autopsy process
Reporting Guide for Neonatal Deaths

3.4 Triaging natural causes deaths
Legislation
When are natural causes deaths ‘reportable’?
In principle
In practice
Guidelines for first response officers
If a cause of death certificate does not issue
Guidelines for coroners – advice to treating doctors
Triaging natural causes deaths at the preliminary investigation stage
Chapter 4 - Dealing with bodies

4.1 Introduction

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

Legislation
In principle
In practice
Guideline for first response officers attending an apparent natural causes death in the community
If a cause of death certificate does not issue
Guideline for coroners – arrangements for bodies when impracticable for body to remain at hospital or nursing home pending outcome of coroner’s preliminary investigation

4.3 Dealing with possible indigenous burial remains

Legislation
In principle
In practice

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

In principle
In practice
Preserving the death scene
Preserving medical equipment attached to the body
Preservation of other evidence in a health care setting

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

Legislation
In principle
In practice
Transportation of bodies
Transportation of hospital records with the body

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

In principle
In practice
When is a viewing not appropriate?
When can a viewing be conducted?
Managing family conflict
How should a viewing be conducted?

4.7 When can organ and tissue donation take place?
Legislation
In principle
In practice
Process for obtaining coronial consent for organ & tissue donation
Process for obtaining coronial consent for tissue donation – donor in coronial mortuary
Arrangements for accessing forms 1
State Coroner’s guidelines for external examination of potential tissue donors
Prior to the examination
During the examination
Immediately after the examination
Documentation of organ and tissue retrieval

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

In principle
In practice

Chapter 5 - Preliminary investigations, autopsies and retained tissue

5.1 Introduction

5.2 Preliminary investigations, issue of cause of death certificates
   Legislation
   In principle
   Issue of cause of death certificates for natural causes deaths
   In practice
   Guidelines for forensic pathologists – preliminary investigation
   Guidelines for coroners – preliminary investigation
   Guidelines for coroners – where a doctor issues a cause of death certificate after an autopsy order is made

5.3 When should an autopsy be ordered?
   Legislation
   In principle
   In practice

5.4 What type of autopsy should be ordered?
   Legislation
   In principle
   In practice
   Obtaining extra medical evidence for autopsy
   Autopsy testing - toxicology
   Testing for infectious diseases
   DNA testing for identification purposes
   Genetic testing
5.5 Limiting internal autopsies
In principle
In practice
Guidelines for coroners - autopsy orders
Examples

5.6 Who should be consulted before an internal autopsy is ordered?
Legislation
Family concerns
In principle
In practice
Guidelines for police - obtaining the views of family members
What if family members are in disagreement?
What if the deceased has not been identified?
What if family members are suspects?
Others who may be exposed to risk
In principle
In practice

5.7 Who should conduct an autopsy?
Legislation
In principle
In practice

5.8 Who may be present at an autopsy?
Legislation
In principle
In practice

5.9 Notifying families of autopsy results

5.10 Autopsy notices, autopsy certificates, doctor’s notice to coroner after autopsy and autopsy reports
Autopsy notices and autopsy certificates
Legislation
In principle
In practice
Guidelines for pathologists regarding autopsy certificates
Doctor’s notice to coroner after autopsy – Form 3
Autopsy reports
Legislation
Guidelines to pathologists regarding autopsy reports

5.11 Performing a further autopsy
Legislation
In principle
In practice

5.12 Retention of tissue, whole organs, foetuses and body parts
Legislation
In principle
In practice
Definitional difficulties – what tissue is caught?
What is an organ?
What is a whole organ?
What is an identifiable body part?
What is a foetus?
Informing the coroner
Informing the family member
Disposal of prescribed tissue
Summary
Paternity testing

Attachment 5A
Guidelines for coroners and pathologists: toxicology samples at autopsy

Attachment 5B
Categories of autopsy cases and levels of expertise

Attachment 5C
Specialist pathologists with qualifications & scope of practice

Attachment 5D
Anatomical structures that are prescribed tissue and those that are not

Chapter 6 - Release of bodies for burial or cremation

6.1 Introduction

6.2 Release of bodies for burial or cremation
Legislation
In principle
In practice
Consideration of request for release order
Is the body no longer required for the investigation?

Chapter 7 - Investigations

7.1 Introduction

7.2 How should deaths generally be investigated?
Legislation
In principle
In practice
Which deaths must be investigated?
Which deaths must not be investigated or further investigated?
Deaths outside Queensland
Indigenous burial remains
Authorisation of cause of death certificate where autopsy not necessary
Stillbirths
Direction to stop investigation
Investigation and case management strategies
Initial investigations
Proactive investigation and case management
Investigation reports
Obtaining statements
Obtaining expert reports
Referral to other investigative agencies
Suspected commission of an offence
Official misconduct or police misconduct
Professional or occupational conduct issues
Referral of issues not relevant to coronial investigation
The impact of criminal proceedings

7.3 How should deaths in custody be investigated?

Legislation
In principle
In practice
Correctional Centre Deaths
Natural Causes deaths
Deaths involving police
All deaths in custody

7.4 Deaths in a health care related setting

Legislation
When is a death potentially ‘health care related’?
Provision of health care
Failure to provide health care
How can health care related deaths be reported?
Management of deaths reported via a Form 1A
CFMU review
CFMU review identifies no health care concerns
CFMU review identifies health care concerns
Autopsy decision making
Timely investigation
Deaths involving non-psychiatric treatment issues
Deaths involving paramedic response issues
Deaths involving mental health treatment issues
Independent expert reviews
Informing inquest recommendations
Death review processes in Queensland hospitals
Clinical incident management in QH facilities
Clinical incident management in private health facilities
Referral to another investigative agency
Health Quality and Complaints Commission (HQCC)
Australian Health Practitioner Regulatory Agency
Office of Aged Care Quality & Compliance
Clinical review or health service investigation
Official misconduct investigations
Conclusions

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

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

Chapter 8 - Findings

8.1 Legislation
   In principle
   In practice
8.2 The identity of the deceased
   Visual
   Fingerprints
   Dental identification
   DNA
   Circumstantial identification
8.3 How the person died
8.4 When the person died
8.5 Where the person died
8.6 What caused the person to die
8.7 Confirming draft findings and no inquest decision
8.8 No findings of criminal or civil liability
8.9 Burden and standard of proof
   Presumption against suicide
8.10 The making of comments – preventative recommendations
8.11 Dissemination of findings
8.12 Drafting ‘chamber findings’
   Include all pertinent details
   Complete the picture
   Social circumstances
   Basis of non-visual identification
   Medical or mental health history and treatment
Provide procedural fairness
Find manner of death
Be sensitive to the impact of language

8.13 Balancing confidentiality of child protection information

Chapter 9 - Inquests

9.1 Introduction
9.2 When should an inquest be held?

Legislation
In principle
In practice
Mandatory inquests
Deaths as a result of police operations
Deaths in care
Discretion to hold an inquest

9.3 The right to request an inquest

Legislation
In principle
In practice

9.4 Communicating decisions to hold/not hold an inquest

In principle
In practice

9.5 The role of Counsel Assisting and seeking approval to brief external counsel

In principle
Freckleton and Ranson’s Death Investigation and the Coroner's Inquest contains a useful discussion of the role of counsel assisting
In practice

9.6 Notification of inquests

Legislation
In principle
In practice
Inquest notice
Balancing confidentiality of child protection information
Additional notification

9.7 Preparing for an inquest

9.8 Pre inquest conferences

Legislation
In principle
In practice
Balancing confidentiality of child protection information

9.9 Leave to appear

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

9.11 Power to compel witnesses

Legislation
In principle
In practice

9.12 Inquest findings and comments

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

9.13 Management of s. 48 referrals

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

9.14 Review of inquest findings and reopening inquests

Legislation
In principle
In practice

Chapter 10 - Access to coronial information

10.1 Introduction

Legislation
10.2 Access to investigation documents for other than research purposes

In principle
In practice
What are ‘investigation documents’?
Coronial documents
Investigation documents
Documents that can not be accessed
Coronial consent
Who has sufficient interest in an investigation document?
Journalists and media organisations
Authors, television producers, film makers etc
Proof of applicant’s identity
When can access be given in the public interest?
When should conditions be placed on access?
Redaction and de-identification
When can access be refused or postponed?
Timing of access
Access to sensitive or distressing investigation documents
Suicide notes
Photographs and audio-visual footage

10.3 Application of RTI to coronial information

10.4 Access to non-documentary physical evidence

10.5 Access to inquest exhibits

10.6 Access to records of pre-inquest conferences and inquests

10.7 Responding to subpoenas

10.8 Access for research purposes

In principle
In practice
Who is a genuine researcher?
What is genuine research?
When can investigation documents be released for research purposes?

10.9 Access for tissue banking purposes

10.10 Access by the Children’s Commissioner

Chapter 11 – Memoranda of Understanding

11.1 Introduction

Legislation
In principle
In practice
Protocol between the Australian Defence Force and the Queensland State Coroner concerning the deaths of ADF members
Investigation of death arising from police related incidents (2008)
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)