

State Coroner's Guidelines 2013 Outline



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, fetuses 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

- Introduction
- Legislation
- In principle
- In practice

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

Legislation

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)

Co-ordination of Responses to Serious Adverse Health Incidents

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

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)