

State Coroner's Guidelines 2013

Chapter 3

Reporting deaths

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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-10⁶ 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 coroners⁸ 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 ailment, 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 not 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 'visitible 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 kyphoscoliosis 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 any 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 stillbirth¹³ 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 stillborn¹⁶.

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/qcgc/documents/g_still5-0.pdf

¹⁸ *Barrett v Coroners Court of South Australia* [2010] SASFC 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.

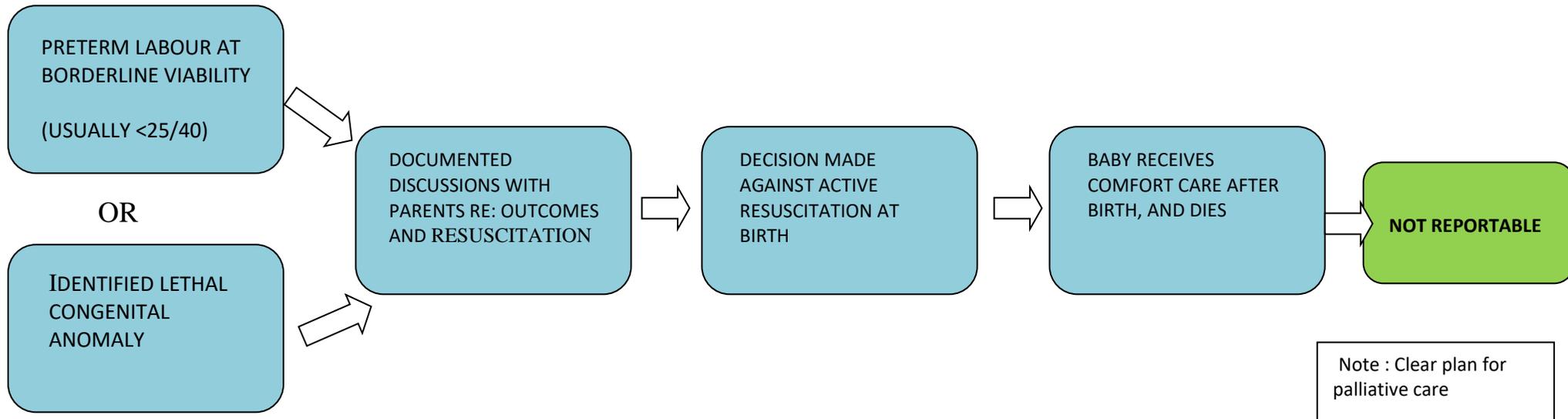
Opportunities for clinical input to the autopsy process

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.

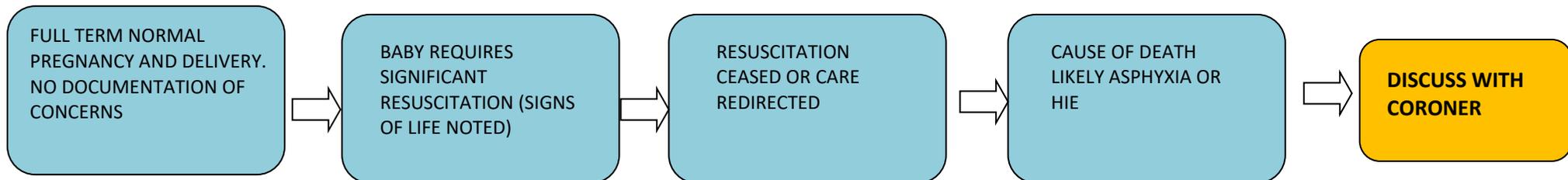
The forensic pathologist may also seek input from independent clinical sources such as an experienced paediatric anatomical pathologist or members of a non-treating hospital's perinatal mortality group.

REPORTING GUIDE FOR NEONATAL DEATHS

SCENARIO 1 – PLANNED NON-INITIATION OF RESUSCITATION

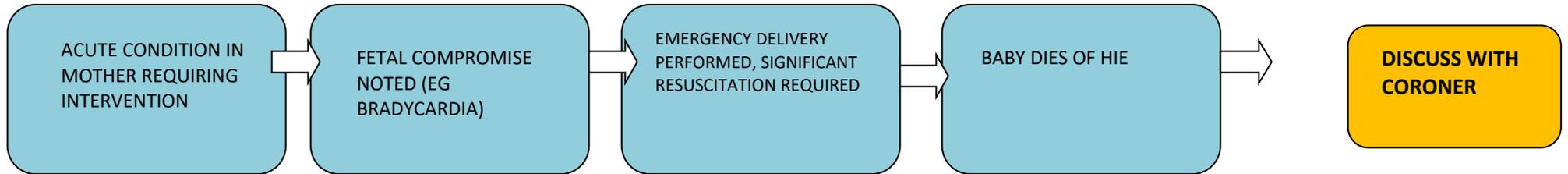


SCENARIO 2 – RESUSCITATED STILLBIRTH AFTER APPARENTLY NORMAL LABOUR



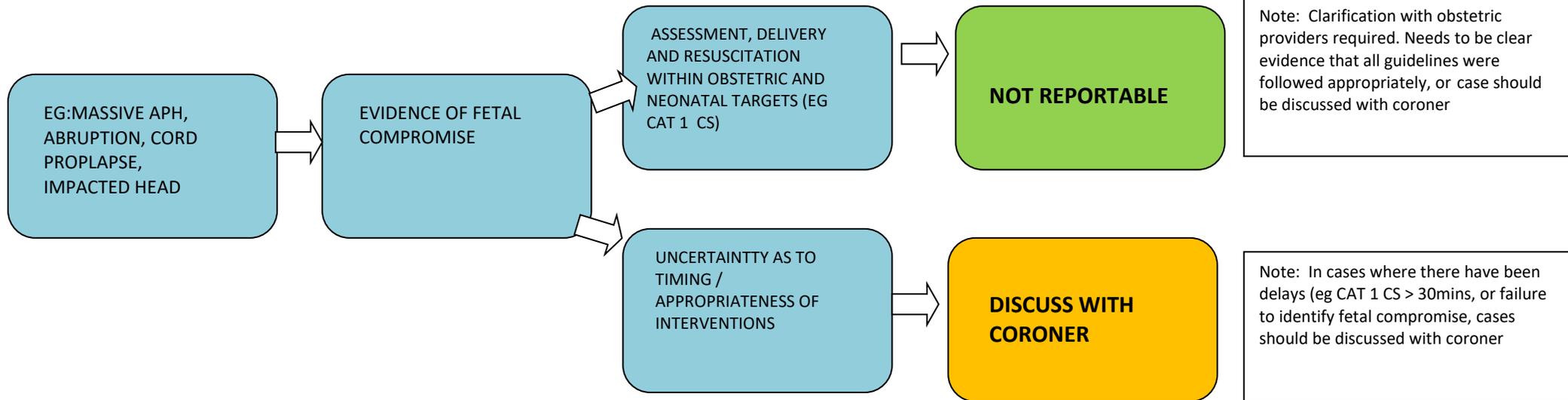
Note: needs to be discussed, neonatal care providers should not be assessing adequacy of antenatal / peripartum management

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

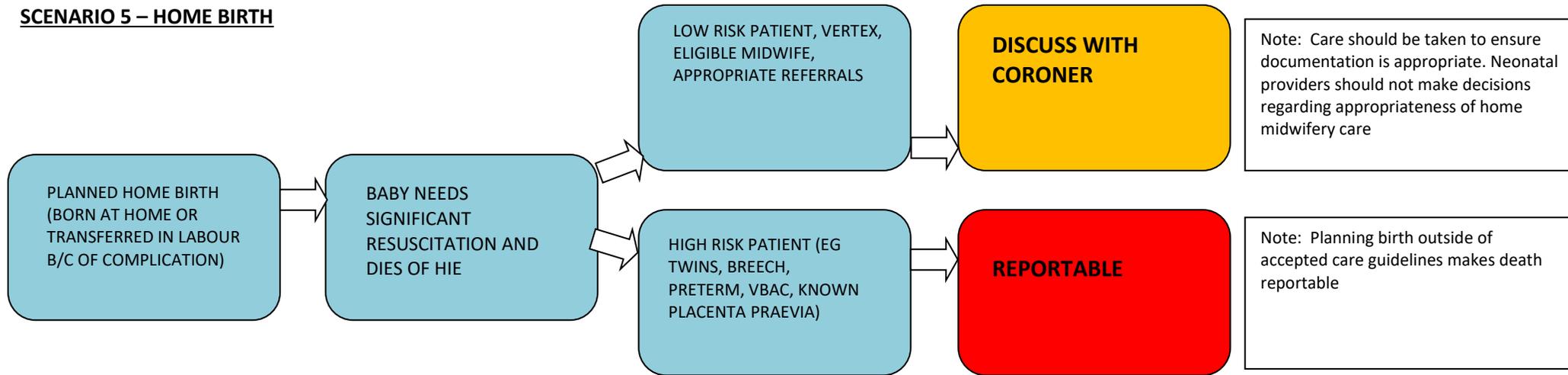
SCENARIO 4 – ACUTE COMPLICATION OF FULL TERM DELIVERY (baby resuscitated but subsequently dies)



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



SCENARIO 6 – COMPLICATION OF ROUTINE NEONATAL TREATMENT



SCENARIO 7 – HIGH RISK NEONATAL TREATMENT



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,

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.