

Information for
Health Professionals

OFFICE OF THE STATE CORONER QUEENSLAND



The coroner's role

The coroner is a magistrate who is responsible for investigating reportable deaths under the *Coroners Act 2003*. When a death is reported, the coroner must investigate to find out:

- the identity of the deceased person
- when and where they died
- how they died
- the medical cause of death.

Reportable deaths – the duty to report

Anyone who becomes aware of a reportable death must report it to a coroner or the police if they do not reasonably believe that this has already occurred. Failure to report is a criminal offence. If you are unsure about whether a death has been reported, contact the Office of the State Coroner or the Patient Safety Centre.

Can a doctor issue a death certificate for a reportable death?

Under section 30 of the *Births, Deaths and Marriages Act 2003*, a doctor must issue a cause of death certificate if they can form an opinion about the probable cause of death. It is not necessary for the doctor to have treated the person as they can consider other information such as the person's medical history.

However, section 26(5) of the Coroners Act states that a doctor must not issue a cause of death certificate in relation to an apparently reportable death unless the coroner authorises it. Penalties apply for a breach of this section.

How are deaths reported to the coroner?

The circumstances of the death will dictate how it is reported to the coroner.

Reporting by police – Form 1

Generally, deaths are reported to the coroner by police using a Form 1. Police will attend the scene and obtain medical records, information and statements about the death from health care staff, family, friends and other witnesses.

The obligation to maintain confidentiality regarding patient information under the *Health Services Act 1991* does not apply to police acting on behalf of the coroner. Police will also arrange for the government contracted funeral director to take the deceased person to a mortuary.

After considering the Form 1 the coroner may order an autopsy and request police to conduct further investigations. These may include taking further statements from health care staff.

Reporting by hospitals/doctors – Form 1A

In some cases, deaths can be reported directly to the coroner by the hospital or doctor who has been treating the deceased person. In these circumstances the hospital or doctor should complete a Form 1A to report the death to the coroner.

A Form 1A can only be used when:

- the doctor seeks advice from the coroner about whether the death is / is not reportable, or
- the death is reportable and the doctor seeks the coroner's authority to issue a death certificate because the cause of death is known and no autopsy or investigation appears necessary.

The Form 1A must be accompanied by the following documents so the coroner can consider whether the death is reportable and whether further investigation is required:

1. a typed discharge summary
2. recent admission notes
3. a draft cause of death certificate.

Consideration must be given to maintaining the placement of medical apparatus such as cannulas, catheters, central lines etc. in case the coroner decides that an autopsy is required (see the scene preservation guidelines).

Police do not need to be called and the body can be released to the family from the hospital mortuary. This can occur only after the hospital has received the cause of death certificate countersigned by the coroner.

Categories of reportable deaths

Reportable deaths are defined in section 8(3) of the Coroners Act as deaths where:

- the identity of the person is unknown
- the death was violent or unnatural
- the death happened in suspicious circumstances
- a cause of death certificate has not been issued and is not likely to be issued
- the death was a health care related death
- the death occurred in care
- the death occurred in custody
- the death occurred as a result of police operations.

The person's identity is unknown

If the identity of the deceased cannot be established, the death must be reported to police even if it is not suspicious. A Form 1A cannot be used.

Violent or unnatural deaths

A death is violent or unnatural if it is caused by an accident, suicide or homicide and is not the result of the natural progression of a disease. Examples include:

- drug, alcohol and poison related deaths
- drownings
- deaths caused by a traumatic event such as a motor vehicle accident or a fall resulting in a fractured neck of femur or subdural haemorrhage.

A death is reportable under this category even if there is a prolonged interval between the incident and death.

In appropriate cases a Form 1A may be used to report a violent or unnatural death directly to the coroner. Deaths caused by suicide or homicide, workplace accidents and motor vehicle accidents must be reported to police because they will require further investigation.

Suspicious deaths

Suspicious deaths must be reported to the police. If police consider there is sufficient evidence to lay charges in connection with the death the coronial investigation will be postponed until those charges are resolved. A Form 1A cannot be used.

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

If the doctor cannot form an opinion about the probable cause of death, the death must be reported to police. The coroner will order an autopsy to determine the cause of death. A Form 1A cannot be used.

Health care related deaths

Health care related deaths are defined in the Coroners Act. Health care means a health procedure or any care, treatment, advice, service or goods provided for the benefit of human health. A health procedure includes any dental, medical, surgical, diagnostic or other health related procedure, including a consultation or giving an anaesthetic or other drug.

A death is reportable under this category if:

1. the health care caused or contributed to the death OR a failure to provide health care caused or contributed to the death

AND

2. death was an unexpected outcome of the health care being provided.

1. Health care causes or contributes to a person's death if the person would not have died at that time if the health care had not been provided. The doctor should ask the following questions to determine whether health care caused or contributed to the death:

- Would the person have died at about the same time without the health care? Yes/No

- Did the death result directly from an underlying disease or injury? Yes/No

- Was the health care carried out with all reasonable care and skill? Yes/No

If no to any of the above – the death is reportable under this category.

If yes to all of the above – the death is not reportable under this category.

A failure to provide health care causes or contributes to a person's death if the person would not have died at that time had health care been provided.

2. Death is an unexpected outcome if, before the health care was provided, a professional peer of the treating doctor would not have expected the person to die. The professional peer should be qualified in the relevant area of health care and be aware of relevant matters including:

- the person's known state of health before the health care was provided, for example, whether they had any underlying disease, condition or injury

- the clinically accepted range of risk associated with the health care.

To determine whether the death was the unexpected outcome of the health care, the doctor should adopt the perspective of a professional peer and ask the following questions.

- Before the health care was provided, was the person's condition such that death was foreseen as more likely than not to occur? Yes/No
- Was the person told that death was foreseen as more likely than not to occur? Yes/No

- Was the decision to provide the health care reasonable given the person's condition including their quality of life if the health care wasn't provided? Yes/No

If no to any of the above - the death is reportable under this category.

If yes to all of the above - the death is not reportable under this category.

In appropriate cases a Form 1A may be used to report health care related deaths directly to the coroner.

Deaths in care

This category applies if the person who died:

- had a disability under the *Disability Services Act 2006* and lived in either a level three accredited residential service (commonly referred to as a hostel) or a government funded or provided residential service
- was subject to involuntary assessment or treatment under the *Mental Health Act 2000* and was being taken to or detained in an authorised mental health service, detained because of a court order or undertaking limited community treatment
- was a child awaiting adoption under the *Adoption of Children Act 1964*
- was a child who lived away from their parents as a result of action by the Department of Child Safety under the *Child Protection Act 1999*.

A death in care is reportable even if the person died in another place, for example, in hospital. In appropriate cases a Form 1A may be used to report deaths in care directly to the coroner.

Deaths in custody or deaths occurring as a result of police operations

A death must be reported to the coroner if the person died while in custody, escaping from custody or trying to avoid being put into custody. Deaths resulting from police operations must also be reported. These deaths must always be reported to police. A Form 1A cannot be used.

Are stillbirths reportable?

Under the Coroners Act coroners cannot investigate the death of a stillborn child. A stillborn child is defined to mean a child who:

- shows no signs of life including breathing or a heartbeat after completely leaving the mother's body
- who is more than 20 weeks gestation or who weighs more than 400 grams.

The coroner may order an autopsy to determine if the child was stillborn but must stop investigating the death once this has been established.

How should the scene be preserved?

The state coroner has developed guidelines to help health care providers and police decide what steps need to be taken to preserve evidence when a death has occurred in a health care setting. Health care providers must balance the following competing priorities:

- the forensic needs of the investigation
- the need for the medical facility to continue to treat other patients
- the family's need to have contact with the deceased.

Greater emphasis should be given to the interests of the investigation if it is likely that a crime has occurred or seriously deficient treatment has contributed to a death. These rare cases can justify treating an operating theatre as a crime scene.

In most cases, priority is given to the hospital's need to have free access to operating theatres and equipment so that patients can continue to be treated. Generally the cause of death and contributing factors can be established from witness statements, photographs of the scene, patient medical records and recorded data from medical equipment. This makes the isolation of the scene unnecessary.

It is preferable to maintain the placement of medical apparatus, such as cannulas, catheters, central lines etc. on the body. This will allow the pathologist to be fully informed if an autopsy is ordered.

However in all cases, the needs of the family should be considered. The desirability of ensuring the viewing is less traumatic should only be overridden if justified by the need to preserve evidence.

The state coroner's guidelines can be accessed at <http://www.courts.qld.gov.au/1710.htm>

Providing information to police or to the coroner

The coroner will require information such as medical records and notes in order to properly investigate the cause and circumstances of the death. The coroner has the power to require statements and other information from health care providers. It is important that this information is provided to the coroner as quickly as possible.

Section 62P of the Health Services Act states that the usual obligation to maintain confidentiality does not apply to someone acting on behalf of the coroner. If health care providers are requested by police to provide information for the purposes of a coronial investigation they must provide it. There are penalties for failing to comply with the coroner's requirements. Under section 16 of the Coroners Act it is an offence to withhold information without a reasonable excuse.

Will there be an inquest?

An inquest is a court hearing conducted by the coroner to gather more information about the cause and circumstances of a death.

Very few coronial investigations proceed to an inquest. An inquest must be held when a death occurs in custody and, in certain circumstances, when there is a death in care. In other cases, the coroner may decide to hold an inquest if it is in the public interest. For example, an inquest may be held if:

- there is significant doubt about the cause and circumstances of death
- holding an inquest may help prevent future deaths or uncover systemic issues which affect public health and safety.

An inquest is not a trial and there is no jury. It is not about deciding whether a person is guilty of a criminal or civil offence. Inquests are less formal than conventional court hearings and coroners can inform themselves in any way they consider appropriate. Although the rules of evidence do not apply the coroner must ensure that the proceedings are conducted fairly.

The coroner's findings

Once the coronial investigation has been completed, the coroner must make written findings about:

- the identity of the deceased
- when, where and how they died
- what caused them to die.

When an inquest is held, the coroner may also make recommendations about matters connected with the death such as public health and safety or the administration of justice. These recommendations are aimed at preventing similar deaths from occurring in the future.

The coroner cannot (under the legislation) make a finding that someone is guilty of a criminal or civil offence. The coroner's findings and recommendations cannot be used as evidence in any other court or tribunal.

However, the coroner can refer a matter to the Director of Public Prosecutions or to a disciplinary body for consideration and possible action.

If the death occurred in a hospital, a copy of the findings is provided to the hospital and to the Patient Safety Centre, Queensland Health. If an inquest is held the findings will be published on the Queensland Courts website at <<http://www.courts.qld.gov.au/1680.htm>>.

Obtaining a copy of the autopsy report

Anyone with a sufficient interest, such as treating doctors and nurses, can request a copy of the autopsy report by writing to the investigating coroner. The report can be released with the coroner's consent. If you have any questions about obtaining copies of these reports or other coronial documents, please contact the Office of the State Coroner.

Where can I get more information?

For information about the coronial system or to obtain contact details for your local coroner contact the Office of the State Coroner at the address below or visit the website at <<http://www.courts.qld.gov.au/129.htm>>.

Office of the State Coroner

GPO Box 1649 BRISBANE QLD 4001
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Outside Brisbane: 1300 304 605
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Patient Safety Centre

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Royal Brisbane and Women's Hospital
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Please note: This publication was produced prior to the current government.