



Coroners Court of Victoria

INFORMATION FOR HEALTH PROFESSIONALS

1. What is the coroner's role?

The coroner is a judicial officer who is responsible for the independent investigation of reportable deaths (and fires), with the objective of reducing the number of preventable deaths (and fires) and promoting public health and safety.

In an investigation into a death, the coroner must find, if possible:

- the identity of the deceased person;
- the cause of death; and
- in certain cases, the circumstances in which the death occurred.

2. What is a reportable death?

Reportable deaths are defined in section 4 of the *Coroners Act 2008* as deaths where:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the cause of the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death.

In addition the death must also be one where:

- the death was unexpected;
- the death was violent or unnatural;
 - For example, homicide; suicide; drug, alcohol and poison related deaths;
- the death resulted, directly or indirectly, from an accident or injury (even if there is a prolonged interval between the incident and death);
 - For example, drownings; deaths caused by a traumatic event such as a motor vehicle accident or a fall resulting in complications such as a fractured neck of femur or subdural haemorrhage
- the death occurs during a medical procedure or following a medical procedure¹ where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death² (Please refer to Question 3 below).
- a Medical Certificate of Cause of Death has not been signed and is not likely to be signed;
 - For example, where an opinion about the probable cause of death cannot be formed
- the identity of the person is unknown;
- the death occurred in custody or care (as defined in the *Coroners Act 2008*);
- the person was a patient within the meaning of the *Mental Health Act 1986*; or

- the death is otherwise specified in section 4 of the *Coroners Act 2008*.

The *Coroners Act 2008* requires the reporting to the coroner of any reportable death.

3. When does a medical procedure related death become reportable?

A death is reportable under this category if it meets the following two criterion:

Criteria One – the death occurs during a medical procedure; or following a medical procedure where the death is or may be causally related to the medical procedure

AND

Criteria Two – a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death

In determining whether the death meets Criteria One, the medical practitioner should consider the following questions:

- Would the person have died at about the same time if the medical procedure was not undertaken?
- Was the medical procedure necessary for the person's recovery, rather than optional or elective?
- Was the medical procedure carried out with all reasonable care and skill?

If 'no' to any of the above (and the death meets criteria two) - the death is reportable.

In determining whether the death meets Criteria Two (above), the medical practitioner should consider the following questions as a reasonable competent health practitioner of that kind would³:

- Before the medical procedure was performed, was the person's condition such that death was foreseen as more likely than not to occur?
- Was the decision to perform the medical procedure reasonable given the person's condition including their quality of life?

If no to any of the above (and the death meets criteria one) - the death is reportable.

Please note: the above information is provided as a suggested guideline only.

¹ The new term 'medical procedure' is defined in the *Coroners Act 2008* as being a procedure performed by, or under the general supervision of, a registered medical practitioner and includes imaging, internal examination and surgical procedures.

² Note: the new definition of a reportable death replaces the former references to 'during' or 'as a result of an anaesthetic' (as contained in the *Coroners Act 1985*).

³ A 'reasonably competent practitioner of that kind' should be an ordinary skilled practitioner exercising and professing to have the capabilities required in the particular field of medical practice under consideration; who hypothetically would possess information about all relevant matters including: the person's known state of health before the medical procedure was performed, the clinically accepted range of risk associated with the medical procedure, etc.

4. Are asbestos-related deaths still reportable?

With the commencement of the new *Coroners Act*, the State Coroner has indicated that the meaning of 'unnatural' in the definition of reportable death, will no longer extend to asbestos-related deaths, and therefore no longer be considered by the Coroners Court to be a reportable death. The death will still be considered reportable if it also appears to have been unexpected; violent; to have resulted directly or indirectly from an accident or injury; etc. as per section 4 of the *Coroners Act* 2008.

5. Was the deceased held in custody or care?

A death must be reported to the coroner if the person who died⁴ was:

- a child taken into safe custody;
- under the control, care, custody (including deemed legal custody) or under the guardianship of the Department of Human Services;
- in the legal custody of the Department of Justice or the Chief Commissioner of Police;
- in the custody of a member of the police force or a protective services officer;
- admitted or committed to an assessment or treatment centre under the *Alcoholics and Drug-dependent Persons Act* 1968;
- a patient in an approved mental health service;
- in the process of being taken into custody by a member of the police force or prison officer;
- a person who was dying from an injury incurred while in the custody of the State (including Commonwealth detention); or
- being detained or was in the process of being taken into custody to be detained in a Commonwealth detention facility.

The person who had care, control or custody of the deceased (i.e. the 'Responsible Person') must report the death to the coroner. *For example, the treating psychiatrist of an involuntary patient who dies 'in care' while undergoing treatment for a mental illness.* Failure to do so may result in a fine of 20 penalty units*.

6. Is a still-birth considered a reportable death?

Under the *Coroners Act* 2008 the coroner cannot investigate still-births⁶. Rather, still-births should be referred to the 'Consultative Council on Obstetric and Paediatric Mortality and Morbidity' (ph: (03) 9096 7022).

7. What is a reviewable death?

Under the *Coroners Act* 2008, the death of a child is a reviewable death if the deceased child is the second or subsequent child of either of the deceased child's parents to have died. Such a death must be reported to the State Coroner by a medical practitioner (who was present at or after the death of the child) or any person who has reasonable grounds to believe that it has not been reported. Failure to do so may result in a fine of 20 penalty units*.

The State Coroner then has discretionary powers in relation to further investigation and/or referral to the Victorian Institute of Forensic Medicine. If deemed appropriate, the Family and Community Support Service of the court will contact the family.

The death of a second or subsequent child of a parent will not be considered a reviewable death if the death occurs in a hospital and the child was born at a hospital and had always been an in-patient of a hospital⁷ (and the death was not also a reportable death)

8. Who must report a reportable or reviewable death?

A medical practitioner has an obligation to notify the coroner of reportable and reviewable deaths.

Moreover, anyone who becomes aware of a reportable or reviewable death must report it to a coroner if they have reasonable grounds to believe that it has not already been reported.

Failure to report is a statutory offence and may incur a fine of 20 penalty units*. If a person is unsure about whether a death has been reported, they should contact the Coroners Court on 1300 309 519 and ask for the Initial Investigations Office (open 24 hours/7 days a week).

9. How are deaths reported to the coroner?

Reportable and reviewable deaths can be reported directly to the Initial Investigations Office of the Coroners Court (Ph 1300 309 519) by the doctor who had been treating the deceased person or who was involved in the management of their care. In some circumstances (for example, where the death occurred in a hospital), the doctor will be required to complete a Medical Deposition form.

10. Why do police attend?

Police will attend a hospital (or a scene of death) on behalf of the coroner to obtain details about the deceased, and gather information about the death from health care staff, family, friends and other witnesses.

11. Do confidentiality laws apply?

The usual obligation to maintain confidentiality regarding patient information under the *Health Records Act* 2001 (Vic) and the *Privacy Act* 1988 (Cth) does not apply to requests for information by someone acting on behalf of the coroner.

Hence, if health care providers are requested by the coroner (or a police member acting on their behalf) to give any information or assistance for the purposes of a coronial investigation they must provide it. There are penalties in the *Coroners Act* 2008 for failing to comply with such a requirement.

4 A death in care is reportable even if the person died in another place, for example, in hospital.

6 A stillborn child is defined in the Births, Deaths & Marriages Registration Act 1996 to mean a child who is at least 20 weeks' gestation or with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth.

7 Even if more than one hospital is involved, as may be the case with inter-hospital transfers.

12. Can medical apparatus be removed from the body of the deceased?

Consideration must be given to maintaining the placement of medical apparatus in situ (for example, cannulae, catheters, central lines, ET and NG tubes), as well as devices attached to these (for example, IV bags, syringes, drain bottles and bags, urine bags). Ideally, the body should also be left as it was at the time of death and not washed, so as to provide the forensic pathologist with all the relevant information for their medical examination.

Exceptions can be made to the general rule if there are special circumstances (e.g. removing a needle so the body can be safely handled) or where the family of the deceased desire the removal of surgical apparatus. Please contact the Initial Investigations Office (open 24 hours/7 days a week) in such cases on 1300 309 519.

13. Who completes the Statement of Identification?

All deaths reported to the coroner require a formal identification to be completed. This can be completed at the hospital or at the scene of the death, if deemed appropriate. Someone who was close to the deceased immediately prior to their death and has known them for a reasonable length of time can complete the formal identification of the deceased person.

The Statement of Identification requires the identifier to fill in the personal details of the deceased person, as well as their own details, including their relationship to the deceased and the length of time they were known to them. The form should then be signed by the identifier and witnessed by an appropriate person, for example, by a doctor, police member, etc.

The Statement of Identification must then be forwarded to the Coroners Court with the deceased or via the attending police member. Please contact the Initial Investigations Office for any further information regarding the Statement of Identification on 1300 309 519.

14. What records are required by the coroner?

Medical Records

The original medical record should be transported to the Coroners Court as soon as possible after the death. While the original medical record is usually transported with the deceased person, it is sometimes acceptable to fax the most recent information and courier the original medical record soon after (upon receiving advice from the Coroners Court). Furthermore, in some instances, the coroner may not require the entire medical record at the time of the death, but will require the most recent volume(s) (again advice should first be sought from the Coroners Court). A photocopy of the medical record can be made and kept at the health service for their future reference.

Discharge Summary

Health Services should also include in the medical record any relevant discharge summaries. These summaries should outline the care and treatment received by the deceased person at the health service.

Death Certificate

If a Medical Certificate of Cause of Death has been previously signed in relation to a reportable or reviewable death, a copy of this certificate should also be forwarded with the above documentation.

15. What happens after the Coroners Court is notified of the death?

Upon notification of a reportable or reviewable death, the Coroners Court will arrange for a contracted funeral director to convey the deceased person to a mortuary.

- If the deceased is in Melbourne, they will usually be transported to the Coroners Court in Southbank.
- If the deceased is in rural or regional Victoria, they may be transported to either a local hospital mortuary or to the Coroners Court in Southbank.

Personal property of the deceased person is not normally transported with the body. Items may be given to a family member at the health service (or scene) or alternatively sent to the local police station for collection.

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

Section 37(4) of the *Births, Deaths and Marriages Registration Act 1996* states that a doctor must not issue a Medical Certificate of Cause of Death in relation to a death if a coroner is required to be notified of the death, where the death is a reportable and/or reviewable death. A fine may also apply for a breach of this section (12 penalty units*).

17. Is there a requirement to provide a requested document or statement?

After considering the information provided in the Medical Deposition form and the police member's report (also known as a VP Form 83), the coroner may request the police member or coroner's registrar to conduct further investigations. As part of such an investigation, a coroner may require that one or more health practitioners provide a document (for example: medical records, notes) and/or prepare a statement addressing matters specified by the coroner. Failure to comply with a coroner's request within the period specified may incur a fine of 20 penalty units*.

18. What other penalties are contained in the Coroners Act 2008?

Apart from the fines previously mentioned, the new *Coroners Act 2008* also contains penalties for:

- (i) a failure to give any information or assistance that the coroner requests for the purpose of the investigation (20 penalty units*);
- (ii) a failure to comply with a direction made by the coroner (or member of the police force) to produce a document, operate equipment and/or access information from the equipment (60 penalty units*); and
- (iii) contempt of court, the penalty for which can include a period of up to 12 months imprisonment or a fine of 120 penalty units* (or a fine of 600 penalty units* in the case of a corporation).

19. Who can obtain information about a case being investigated by the coroner?

Generally, a health practitioner (or their health service) need to be an 'interested party' in an investigation to obtain information about a case. To become an interested party, the health practitioner (or their health service) must write to the court and request to be named as an interested party, detailing their (or their organisation's) interest in the case and what documents are required. The coroner will decide if they (or their health service) can access the document(s) sought.

A coroner can also name another person as an interested party if:

- The coroner is satisfied the person has a sufficient interest
- It is appropriate for the person or organisation to be an interested party.

A coroner may also release a document to⁸:

- i) a party if the coroner is satisfied that the party has a sufficient interest in the document,
- ii) a statutory body to allow the statutory body to exercise a statutory function,
- iii) member of police force for law enforcement purposes ,
- iv) researchers where the research has been approved by an ethics committee, or
- v) any person if the coroner is satisfied that the release is in public interest

20. What happens after the coroner concludes their investigation?

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

- the identity of the deceased,
- what caused them to die, and
- in certain cases, the circumstances in which the death occurred.

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.

While the coroner cannot make a finding that someone is guilty of a criminal or civil offence, the coroner can refer a matter to the Director of Public Prosecutions or to a disciplinary body (for example, the Medical Practitioners Board of Victoria, Nurses Board of Victoria) for consideration and possible action.

As of 1 November 2009, in cases which have gone to inquest, and those where recommendations are made, the coroner's findings will be published on our website, unless otherwise ordered by the Coroner

21. Who can verify deaths?

In addition to registered medical practitioners, the following professionals are now able to verify death: registered nurses (divisions 1 & 3) and paramedics .

The Department of Health, through the Nursing Policy unit, has developed a guidance note for the 'verification of death' in Victoria. For this guidance note and further information, please visit the website: www.health.vic.gov.au/nursing/verification-of-death-by-nurses-and-paramedics.

22. Are there any publications that the Coroners Court produces for families?

With the commencement of the *Coroners Act* 2008, the court has produced new printed materials for bereaved persons affected by a reportable or reviewable death. These include:

1. What do I do now? (brochure)
2. Family and Community Support Service (brochure)
3. Coroners Process (booklet)

Copies of these (and other) publications can be ordered by filling in an order form – available on our website or by contacting the court on 1300 309 519.

23. What support service does the Coroners Court offer families?

The Family and Community Support Service of the court offers free, short-term, personal and confidential support and counselling to relatives and anyone else affected by a death. For more information about the Family and Community Support Service contact the court on 1300 309 519 or visit our website at www.coronerscourt.vic.gov.au

24. Where can I get more information?

For more information about the coronial process contact the Coroners Court on 1300 309 519 or visit the website at www.coronerscourt.vic.gov.au

To report a Reportable or Reviewable death, ring
1300 309 519
and ask for the Initial Investigations Office.

⁸ To apply, an application for Access to Documents Form must be completed. To obtain a copy of the application form please contact the Court on 8688 0700 or download the application form from our website www.coronerscourt.vic.gov.au

* 1 Penalty unit = \$116.82 (as of 1/7/2009)