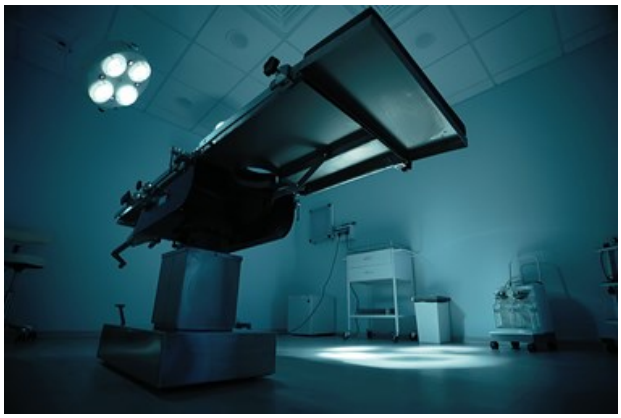
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LEGAL PRACTICE



Coronial inquests in health care related deaths

Author: Claire McGee
Email: cmcgee@gnl.com.au
Phone: 0450 630 612
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In all Australian states and territories, a healthcare professional responsible for a deceased person's medical care immediately before death or who examined the deceased's body must issue a cause of death certificate to the Births, Deaths and Marriages Registry within 48 hours of the death or its discovery. However, a doctor must not issue a certificate if the death falls into a 'reportable' death category under the relevant *Coroners Act 2003.*

In this article, we look at:

- reportable deaths in Queensland;
- the definition of a health care related death;
- health professionals' obligations to report a death;
- health professionals' requirements to provide medical records or a written statement;
- the role of the coroner; and
- what happens at a coronial inquest.

Reportable deaths in Queensland

In Queensland, reportable deaths are defined in section 8(3) of the *Coroners Act 2003* as deaths where:

1. the identity of the person is unknown;

2. the death was violent or unnatural;
3. the death happened in suspicious circumstances;
4. a cause of death certificate has not been issued and is not likely to be issued;
5. **the death was a health care related death**;
6. the death occurred in care;
7. the death occurred in custody;
8. the death occurred as a result of police operations.

What is a health care related death?

In Queensland, health care related deaths are defined in the *Coroners Act 2003*. 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**
1. the death was an unexpected outcome of the health care being provided.

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.

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.

Death is an unexpected outcome if, before the health care was provided, a professional peer of the treating healthcare professional would not have expected the person to die.

Health care professionals' obligations to report a death

Anyone who becomes aware of a reportable death must report it to a coroner or the police if they do not reasonably believe that the death has already been reported. Failure to report is a criminal offence.

If you are being investigated for failure to report a death, you should seek legal advice immediately.

Get legal advice: 07 3361 0222 (available 24/7)

A health care professional can report a death directly to the Coroners Court. In these circumstances, the hospital or health care professional should complete a Form 1A to report the death to the coroner.

What happens after a health care related death is reported

After a death has been reported, an independent forensic medicine doctor from the Queensland Health Clinical Forensic Medicine Unit (CFMU) will undertake an initial investigation by reviewing the deceased's medical records and seeking further information from members of the treating team. The CFMU doctor will then prepare a written summary of their review with their opinion about the deceased's health care management, flagging any concerns they may have.

The outcome of the CFMU review will be provided to the coroner in a formal report, which, at the appropriate time, may be released to the family and the treating practitioners.

Are health professionals required to provide the medical records or a written statement after a health care related death?

It is not uncommon for a health care professional, either in a private or public setting, to be asked to provide a statement, give an interview to police or to provide clinical records in the context of a coronial investigation.

If you receive a request for a statement, interview, or to provide records in a coronial investigation, you should seek legal advice immediately.

Get legal advice: 07 3361 0222 (available 24/7)

Section 157 of the *Hospital and Health Boards Act 2011* 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 2003,* it is also an offence to withhold information without a reasonable excuse.

After reviewing the available evidence, the coroner may decide that a matter needs to progress to a coronial inquest. An inquest is a court hearing conducted by the coroner to gather more information about the cause and circumstances of a death.

What is a coronial inquest?

Coronial inquests in Queensland are public hearings held to examine the cause and circumstances surrounding a death which occurs in unusual or unnatural circumstances. Inquests are conducted by coroners (i.e. magistrates who perform that role), and the proceedings are heard in the Coroners' Court.

There are certain deaths for which a coronial inquest must be held. This includes deaths in custody and deaths in care. For other deaths, whether an inquest is held or not is at the coroner's discretion.

Role of the coroner

The coroner is a magistrate who is responsible for investigating reportable deaths under the *Coroners Act 2003 (Qld)*. 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; and
- the medical cause of death.

What happens at the coronial inquest?

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 other 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.

If necessary, health practitioners may be required to give evidence at a coronial inquest. If this is to occur, you will receive a summons.

Conclusion

While coronial inquests are fairly common, a request from a coroner can still be a source of stress and worry for individual healthcare professionals, particularly if they have little experience with the process. Our office can assist healthcare practitioners through the entire process, from producing a statement to appearing at an inquest.

Contacting Gilshenan &Luton Lawyers

07 3361 0222 (24/7)

gnl@gnl.com.au

This blog is of a general nature and should not be relied upon as legal advice. If you require further information, advice or assistance for your specific circumstances, please contact us.