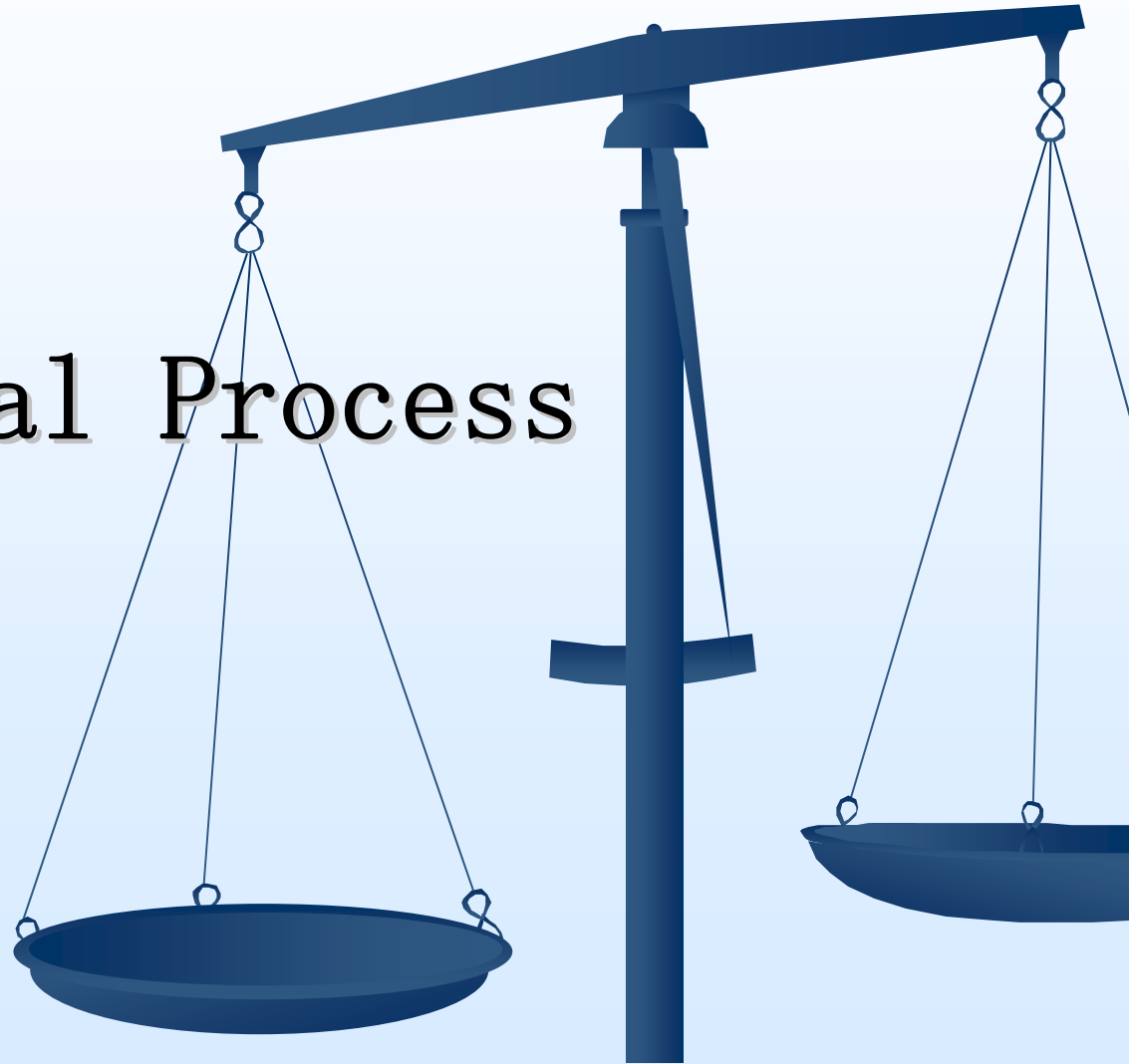




Coroners Court of Victoria

The Coronial Process





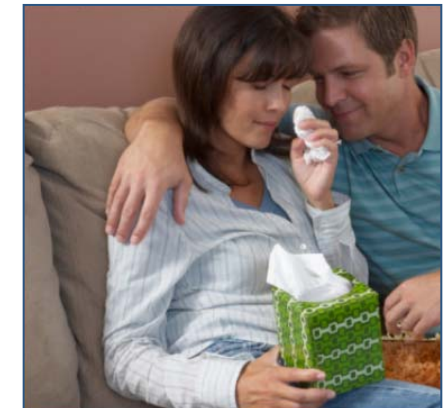
The Role of the Coroner

The coronial system plays an important role in Victorian society. That role involves:

- the independent investigation of deaths and fires for the purpose of finding the causes and to contribute to the reduction of the number of preventable deaths and fires;
- the promotion of public health and safety;

Coroners are not concerned with placing fault on individuals.

Rather a Coroner considers whether there are lessons that may be learned.



The primary focus of the coronial investigation is **not** whether someone should face criminal or civil or disciplinary proceedings but rather, to investigate and analyse the circumstances surrounding the death.

Some Coroners are experienced magistrates.

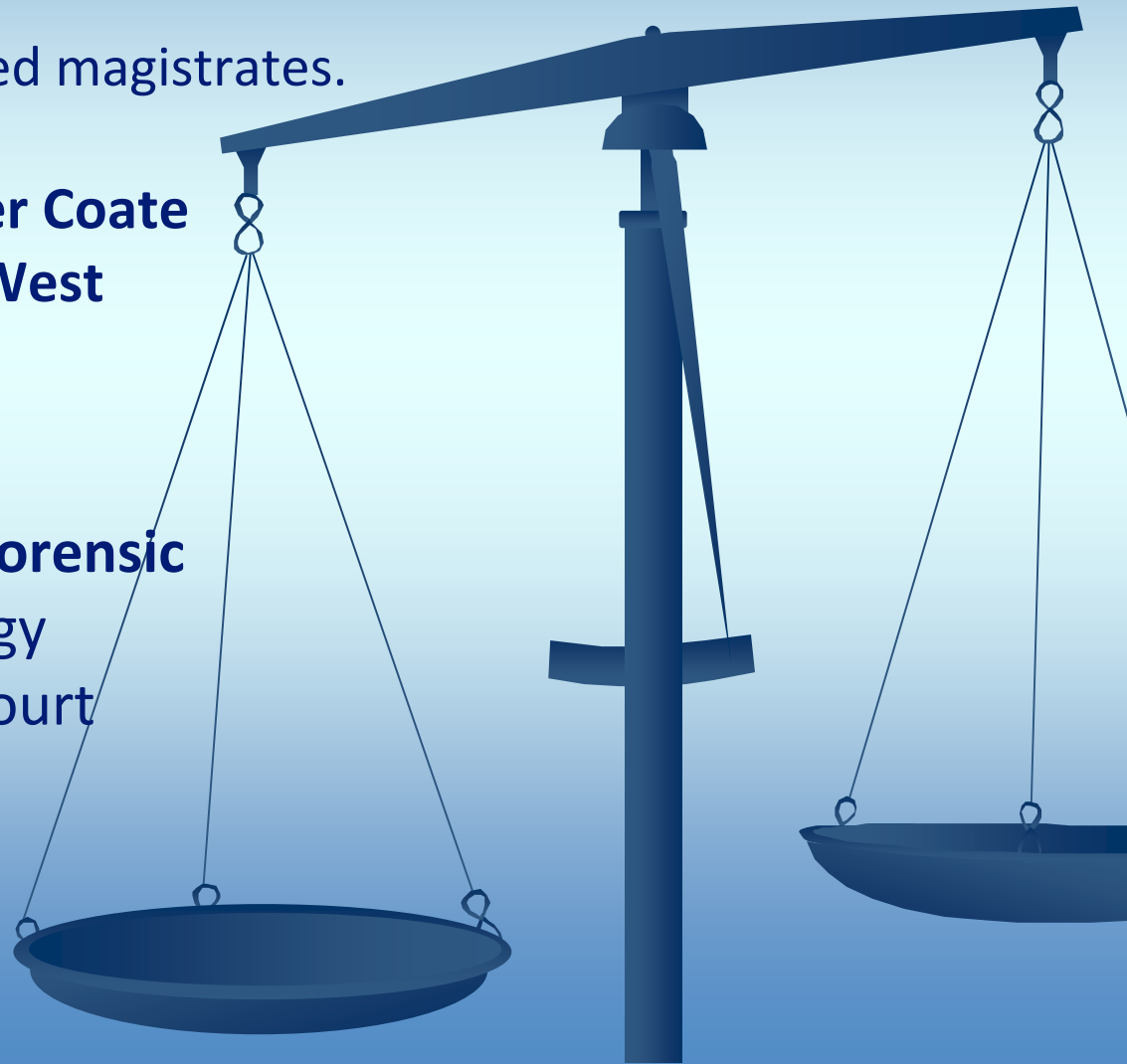
Our current structure is:

State Coroner: Judge Jennifer Coate

Deputy State Coroner: Iain West

Eight full time Coroners

**The Victorian Institute of Forensic
Medicine** provides pathology
services for the Coroners Court
of Victoria.





Reportable deaths

Defined in the 2008 Act - s.4(1). Two requirements:

1. The death must in some way be connected with Victoria
2. The death must meet one of the following criteria:
 - Where the person died unexpectedly & the cause of death is unknown;
 - Where the person died from an accident or injury;
 - Where the person died in a violent or unnatural manner;
 - Where the person was 'held in care' (e.g. by DHS, under the *Mental Health Act*) or in custody immediately before they died;
 - Where a doctor has been unable to sign a death certificate giving the cause of death; or
 - Where the identity of the person who has died is not known.
 - Where the person died during / following a medical procedure (refer next slide)





Reportable deaths

- A death is reportable if the death occurred during or following a medical procedure (where the death is or may be *causally* related to the medical procedure), and where a registered medical practitioner would **not** have reasonably expected the death.
- The term ‘medical procedure’ is defined as being a procedure performed by, or under the general supervision of, a registered medical practitioner and includes imaging, internal examination and surgical procedures.
- *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).*

Application of this section

If the death followed some other kind of health procedure that is not captured by the definition of 'medical procedure', the death would be a reportable death if it came under another category of reportable death.

***For example:** A death following a chiropractic procedure (which was not under the general supervision of a registered medical practitioner) would be a reportable death if the death was considered as being unexpected or resulted directly or indirectly from an accident or injury.*

Reasonably expected death:

***For example:** An 84 year old woman undergoes surgery to correct a life threatening medical condition. It is a high risk operation due to her age and because she has advanced heart disease and is obese. While a general anaesthetic is being administered, she has a cardiac arrest and dies on the operating table. There is no issue that the surgery or the anaesthetic was inappropriate.*

Under the old Act, the death is reportable because it occurred during an anaesthetic. However, under the new Act, the death is **not** a reportable death. As an objective medical practitioner qualified in this medical speciality, aware of this hypothetical woman's medical history immediately before the procedure was undertaken, would have reasonably expected the death.



Reportable deaths

Under The Coroner's Act 2008:

Definition of 'person placed in custody or care'

There is also an expanded definition of a person held in custody or care, which includes:

- deaths involving police or a prison officer attempting to take a person into custody;
- deaths occurring anywhere in Victoria which are caused by injuries incurred while in custody; and
- Commonwealth detention deaths [Regulation 7]

Definition of 'senior next of kin'

In relation to autopsies and exhumations, the definition of 'senior next of kin' has been expanded to include 'a person determined to be the senior next of kin' who the coroner believes had a closeness with the deceased person immediately before his or her death.



Reviewable deaths

- The death of a child (<18 years) is a reviewable death if the deceased child is the second or subsequent child of the deceased child's parent to have died, and the death is in some way be connected with Victoria.
- Note in the new 2008 Act, the definition 'reviewable death' now excludes a neonatal death where the death is not a reportable death and the baby spent his or her whole life in hospital.



DEATHS REPORTED TO A VICTORIAN CORONER IN 2007 (closed on NCIS at December 2009)**

Death due to Natural Cause(s)	Death due to External Cause(s)	Unlikely to be known	Total
2,845	1,447	146	4,438
64.1%	32.6%	3.3%	100.0%

**** Note there are 507 cases reported in 2007 still listed as open on the NCIS. These have not been included in these figures**

EXTERNAL CAUSES REPORTED IN 2007 in VIC (closed cases only)	
Intent on Completion	%
Unintentional	60.4
Intentional Self-Harm	33.2
Undetermined Intent	3.2
Complications of Medical or Surgical Care	1.2
Unlikely To Be Known	1.1
Assault	0.8
Legal Intervention	0
Operations of War, Civil Conflict and Acts of Terrorism	0
Other Specified Intent	0
<i>Total</i>	<i>100</i>

Disclaimer: While best efforts have been taken to collate above information, due to cases still being open or coding errors, information provided should be taken as an indicative measure of deaths reported to Victorian Coroner during 2007, rather than an exact numeric measure)



Practical aspects of Reporting

Leave the deceased person in the same state as at time of death

- Invasive Tubes and access lines must be left in place, permission to remove them must be sought from the Coroners Court of Victoria
- Where possible, leave the scene as found

Immediately report death to Coroners Court of Victoria (24 / 7 access)

- Our office is available for support and advice, and Interpretation of the Act

Where applicable complete ‘Medical practitioners Deposition’ – available on line www.coronerscourt.vic.gov.au

Advice to family and provision of support

- Issue information leaflets (where possible)
- Explain the reasons for the report being lodged with the Coroners Office.
- Explain that it is “normal practice”

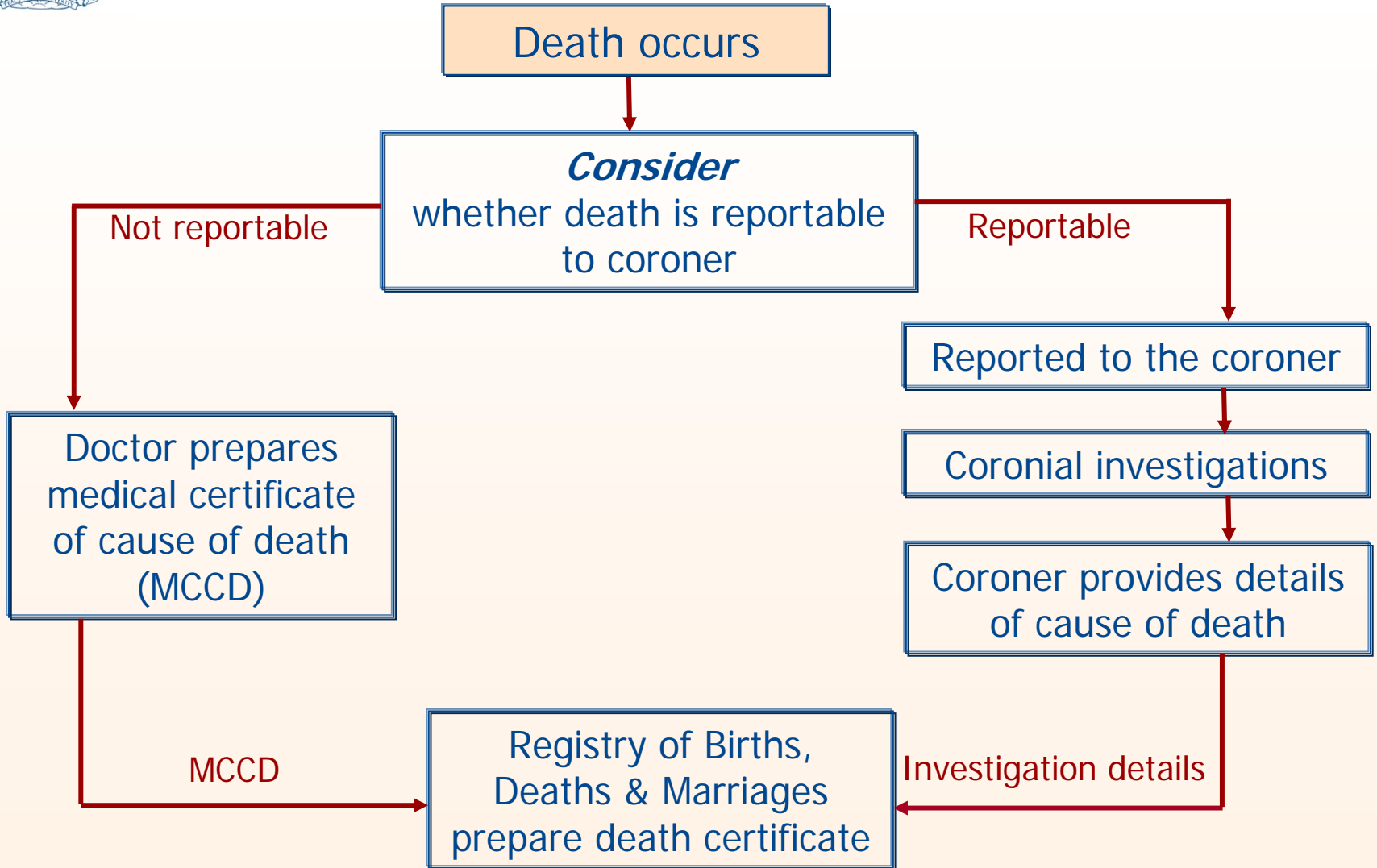
The police will be automatically be contacted by the Coroners office to complete a report on the death (Form 83) and will attend the scene.



Nature of The Coronial Investigation

Autopsies *Under the Coroners Act 2008*

- Coroner has the power to impose conditions on the manner in which an autopsy on a body is to be performed
Example: this could include the number of cavities to be explored or the organs to be removed, and
to direct the medical investigator to perform certain tests on a body or on a tissue or other material removed from the body.
- Senior next of kin can request a ‘reconsideration’ (formerly known as an objection) 48 hours after receiving the notice.
- If after considering a request to reconsider the autopsy direction, the Coroner determines that the autopsy direction is necessary and appropriate, an autopsy may be performed in less than 48 hours if the senior next of kin advises that he or she will not appeal to the Supreme Court against the coroner’s direction.





Nature of The Coronial Investigation

The Coroner can be assisted in their investigation by 3 procedures:

1. Preliminary Examinations
2. Identification Procedures
3. Autopsies

Preliminary Examinations

- Provision of body authorise conduct of preliminary examination.
- Number of non-invasive procedures.

Identification Procedures

- Any procedure including the removal of tissue for the purposes of identifying the deceased person.

Coroners Court of Victoria

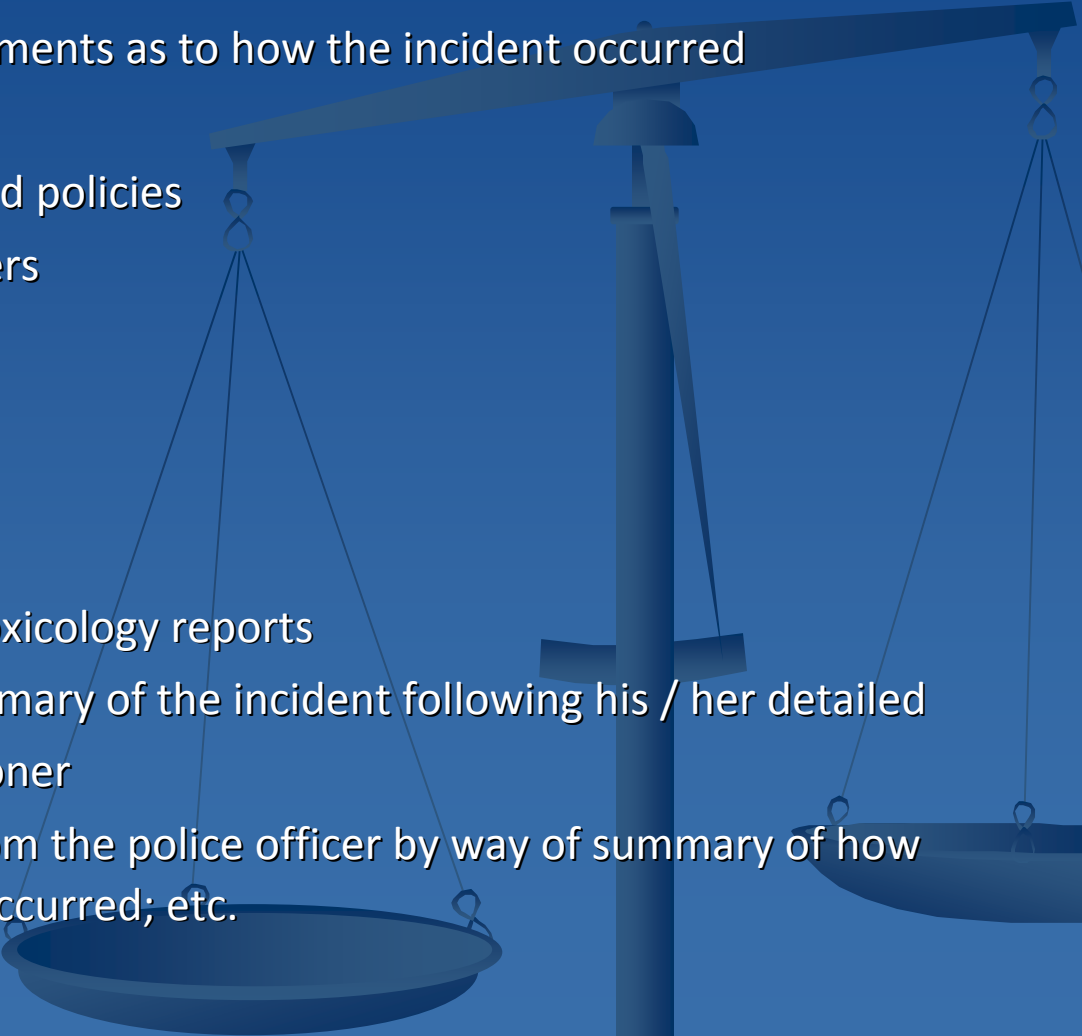
Methods of Identification

- Visual Inspection
- Dental records
- Property / Circumstances
- Medical History
- DNA
- Fingerprints
- Guthrie Card
- ID Protocol for Multiple deaths/events introduced November 2006



Evidence Sources

The *'Brief of Evidence'* may include such items and documents:

- Witness and other statements as to how the incident occurred
 - Medical notes
 - Protocols, procedures and policies
 - Prison files, reports, orders
 - Photographs
 - Maps and drawings
 - Videos
 - Opinions from experts
 - Autopsy, CT Scans and toxicology reports
 - Police investigator's summary of the incident following his / her detailed investigation for the coroner
 - Initial documentation from the police officer by way of summary of how the incident may have occurred; etc.
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Documentation

- Medical deposition form
- Ensure consistent principles of effective clinical documentation
- Document actions
- Document management/treatment outcomes
- Be factual and concise
- Document what happens
- Document discussions
 - ▶ Actions
 - ▶ Family
 - ▶ Police
- Be non-judgemental
- Be objective
- Don't make assumptions





The Coronial Inquest

- An inquest is a court hearing conducted by the Coroner, in which the circumstances surrounding a death are examined.
- Mandatory in certain circumstances.
- Only around 5% of coronial investigations have an inquest.
- Inquests are usually open to the public.

Aims of the inquest:

- The identity of the deceased
- How the death(s) occurred
- The cause of death(s)
- The particulars needed to register the death(s)
- Possibly comment and make recommendations on public health or safety or the administration of justice



Coronial Findings

At the conclusion of an investigation, a Coroner prepares a written finding to establish wherever possible:

- Identity of the deceased
- Cause of death/fire

And in some cases, the:

- Circumstances surrounding a person's death.
- Causal relationship between the circumstances and death.

A finding may also include comments &/or recommendations.



Support

Identification (Initial Investigations Office):

- Assistance with Identifying and/or viewing
- Assist with understanding the potential benefits of viewing
- Counselling service
- Cultural awareness
- Offer of follow up support

Counselling:

- Short-term, office based, outreach capacity limited
 - based on minimum intervention
 - support natural coping skills
 - normalising of grief or trauma reactions
- telephone counselling
- Personal Support/Psychological First Aide for individuals or groups

Referral:

- Linking individuals back into their community for longer term support or support where specific needs have been identified
- Direction of mainstreaming bereavement support via community health



Support

Facilitating access to Coronial evidence or other staff:

- viewing photographs, videos, Coronial files etc.,
- Facilitating the return of suicide notes, and/or copies of reports
- Negotiating and attending meetings with CCOV staff and relevant pathologists

Secondary Consultation:

- Information and liaison with other professionals in their support of bereaved
- Provision of advice and/or information and literature
- Partnerships, networking and working closely with other organisations and stakeholders, eg Department of Human Services, Health Services, Police and Missing Persons

Conclusion

The Coroners Court now has a stronger emphasis on prevention and therapeutic jurisprudence principles.

Information from the Coroner's investigation process is an important resource for preventing health-care related deaths.

It is increasingly important that this process becomes incorporated into:

- Research for better understanding of the nature of adverse events
- Health policy reforms
- Changes to existing practice

