NSW Coronal Jurisdiction

Coroner’s Act 2009
NSW Hierarchy of Coroners

State Coroner (Lidcombe)

5 Deputy State Coroners (Lidcombe)

2 Deputy State Coroners (Wollongong & Newcastle)

Magistrate Coroners

Coroners

Assistant Coroners
Role of Coroner

A Coroner must establish:

1. **Identity** of the deceased person
2. **Date** of death
3. **Place** of death
4. **Cause** of death
5. **Manner** of death
Examples of Coronial Legal Powers

- Possession of the body (s.56)
- Order post mortem examination (s.89)
- Authorise release of the body of the deceased (s.101)
- Direct police to investigate matters on her/his behalf (s.51)
- Obtain certain documents (s.53)
- Order exhumation of body (s.91)
- Hold or dispense with inquests (s.25)
NSW Coroners investigate approximately 6000 deaths annually
Coronial Process

Death is reported to Coroner
Reviewed by staff in the Coronial Case Management Unit:
Coroner/Pathologist/Police/Family Liaison/Clinical Nurse Consultant

Police Narrative
Death Circumstances
Medical Information
Objection

Full Post Mortem (3 cavity)
Or Limited/Staged PM

External Examination + Toxicology
Review Medical Records (Hospital/GP)

PM required
No PM required

Coroners Certificate
No PM

Opinion as to COD given
Or ‘Unascertained Natural Causes”

No longer a Coronial matter

Doctor’s Cert
No PM
Reportable Deaths 1

In NSW, a death must be reported to the police and subsequently to the Coroner if the person has:

**Section 6**

- Died a **violent or unnatural** death
- Died a **sudden** death, the cause of which is unknown
- Died under **unusual or suspicious** circumstances
- Not been seen by a Doctor within the previous **6 months** or the Doctor **will not certify** cause of death
- The person's death was **not the reasonably expected outcome** of a health related procedure carried out in relation to that person (We will explore this more)
- Died whilst in, or temporarily absent from, a **mental health facility** in which the person was a resident and receiving services
Reportable Deaths

Section 23

- Died in custody or whilst in, or temporarily absent from, a detention or correctional facility
- Died in the course of a police operation

Section 24

- Child in care
- Child about whom a report was made to DOCS within 3 years preceding the child’s death
- Sibling of child (above)
- Child whose death may be due to abuse, neglect or is suspicious
- Person (adult or child) living in or temporarily absent from residential care home/centre
Let’s consider the reportable death where a death was ‘not the reasonable expected outcome of a health related procedure’

- Act does not define “reasonably expected outcome”

- Guidelines to assist the medical practitioner determine whether or not the death should be reported (examples not exhaustive and each case should be judged on its own merits using your professional judgement):

Is the death a REPORTABLE death?

Consider:

a) Did the health related procedure cause the death, and

b) Was the death an unexpected outcome of the procedure?

If the answer to both of these questions is yes, then the death is reportable.
a) Did the health procedure cause the death?
Consider:
- was the health related procedure **necessary** to improve the patient’s medical condition, rather than an elective or optional procedure, and
- was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers to be **competent medical practice**?

If the answer to both of these questions is yes, then **the death may not be reportable.**
b) Was the death an unexpected outcome of the health related procedure?

Consider:

- whether the patient’s condition (factoring in age and co-morbidities) at the time they underwent the health related procedure was such that *death was likely to occur if they did not undergo the procedure*.

- was death recognised as being a significant risk of the procedure given the patient’s medical condition, but the patient, family and/or medical practitioner believed that the *potential benefits of the procedure outweighed the risk*.

- was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers to be *competent medical practice*?
Note: Section 38(2) (Geriatric deaths)

A Medical Practitioner is authorised to give a death certificate concerning a cause of death if:

- The person is aged 72 years or older
- Died after sustaining an injury from an accident which is attributable to age of that person
- Not caused by someone else or by act of omission of another person
- There is no objection by the next of kin to the writing of a death certificate
- Even if the accident or fall occurred within a hospital or nursing home

Note:

A doctor certifying such a cause of death must state on the certificate that it is given in pursuance of this subsection
Medical Clinicians:

- As a general rule – Don’t do anything to the body. Do not remove surgical equipment/apparatus
- Assist families to understand the normality of the process (eg: why the police are involved, why a “crime scene” has been established)
- Explain need to provide a formal identification of the deceased person
- Explain the requirement that the deceased has to be transferred, how and to where
- Re: Post Mortem
Hospital Deaths

- All reported deaths should be on the prescribed forms:
  - **Form A:** Report of Death of a Patient to the Coroner
  - **Form B:** Report of Death Associated with Anaesthesia/Sedation

- Deaths associated with anaesthesia must also be notified to the Special Committee Investigating Deaths under Anaesthesia
Case Example

- 49 y.o woman
- History of sinus infection
- 2 x cardiac arrest post IV meds
- Organs harvested.
- Is the death Reportable?
- Any comments on the form A?
89 y.o male
Emphysema. Medicated.
Pinned on fence post by own utility vehicle.
Extensive injuries
12 May – transferred to Sydney hospital
15 May – chest drain
Deteriorated.
3 June – deceased. Certificate prepared by hospital Dr.
Is the case reportable?
Post Mortem/Autopsy

Hospital (Clinical) Autopsy

Coronial (Forensic/Medico-Legal) Autopsy
Post Mortem/Autopsy – cont...

- Purpose
- Procedure
- Appearance of body after PM
- Release of body time frames
- ?Organ donor
- Objection to PM
- Whole organ retention
Coronial Process – Further Investigations

Statements called for by Coroner
Gathered by Reporting Police
(may take months)

These statements constitute
"Brief of Evidence"

Brief reviewed by Coronal Advocates and Coroner

Matter Dispensed With
i.e. No Inquest

Inquest Held
(May be many months/years after date of death)
Inquests

Purpose:
- Identity, time, place, manner and cause
- Recommendations

Process:
- Inquisitorial
- Based on the coroner’s investigation
- No Juries
- Burden of proof: Balance of probabilities

Procedure:
- Coroner assisted by “Counsel Assisting”
- Formal rules of evidence (as in civil and criminal matters) do not apply
- Procedural fairness does apply
“The coronial investigation into the death of a person is one that, by its very nature, involves much grief and anguish. The emotional toll that such an investigation, and any resulting inquest places on families and friends of a deceased person is enormous. A coronial investigation seeks to identify whether there have been any shortcomings or failures, whether by an individual or organisation, with respect to any matter connected to that person’s death. It seeks to identify them not to assign blame or fault but, rather, so that lessons can be learnt from mistakes and so that hopefully, these mistakes are not repeated in the future. The mere assigning of blame or fault rarely produces a positive outcome and often only serves to add to the anguish that a family member may be experiencing. If families of deceased persons must re-live painful and distressing memories that an inquest brings with it then, where possible, there should be some hope for a positive outcome. The recommendations made by coroners are made with the hope that they will lead to some positive outcome by improving general public health and safety.”

Coroner Derek Lee.

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