Coronial Matters

CHAPTER CONTENTS

Losing a loved can be an extremely difficult experience, particularly if you are concerned that their death was preventable, or if it is difficult to understand the circumstances surrounding their death. In Queensland, we are fortunate to have a coronial system that has a focus on preventing deaths, and that involves the family of the deceased in a sensitive and compassionate manner (for more information see Queensland, *Parliamentary Debates,* Legislative Assembly, 3 December 2002, 5220 (Rodney Welford, Attorney-General and Minister for Justice)).

The framework for our coronial system is outlined in the *Coroners Act 2003* (Qld) (Coroners Act). This Act sets requirements for when a death must be reported, how the death should be investigated, when a coronial inquest must be held and how an inquest should be conducted. The legislation emphasises the rights of the families of the deceased to be involved in key decisions during coronial investigations, and outlines how you can access information relating to the investigation and obtain a review of the coroner's decision.

To ensure best practice, coroners are bound by the Coroners Act to adhere to the *State Coroner's Guidelines 2013* (version 4, 2019) to the greatest extent possible when investigating a death.

A comprehensive list of legal and social work support services that are available to you during the coronial process are listed under Support Services at the end of this chapter. A full list of community legal centres in Queensland who may also be able to provide support are listed on the Community Legal Centres Queensland website. Caxton Legal Centre and Townsville Community Law have a specialist coronial program for families.

Role of Human Rights

Throughout the coronial process, your rights under the *Human Rights Act 2019* (Qld) (Human Rights Act) must be taken into account. The Human Rights Act provides statutory protection for 23 separate human rights in Queensland. These include rights against discrimination, the right to life, the right to be treated humanely when deprived of liberty, the right to a fair hearing and the right not to be refused emergency medical treatment to name a few (ss 15, 16, 30, 31, 37 Human Rights Act). These rights may be engaged in coronial proceedings where a death involves a public entity and has occurred in care, custody or is otherwise a reportable death (s 30 Coroners Act).

Importantly, coroners are required to act compatibly with the Human Rights Act when exercising their autopsy, investigation and inquest functions, and may, at times, be called upon to interpret the nature and scope of the protected human rights (for more information on the scope of the inquest (see *Kracke v Mental Health Review Board* [2009] VCAT 646). A coroner may also consider whether human rights breaches may have caused or contributed to a person's death

(see Coroners Court of Victoria, *Ruling on Application regarding the Scope of the Inquest into the death of Tanya Louise Day* (2019) 2017/6424).

Coroners and Registrars

The coronial processes in Queensland are facilitated by our State Coroner and Deputy State Coroner, as well as a number of other coroners and coronial registrars. These coroners and registrars work together to ensure that the coronial system runs smoothly, both in and out of court, and appropriately involves the family of the deceased.

There are currently seven full-time coroners located in Brisbane, Cairns, Mackay and Southport. Queensland Courts publishes a list of coroners and coronial registrars in Queensland and their respective geographical areas of responsibility.

In addition, every magistrate in Queensland is also a coroner (a 'local coroner') and acts in that capacity when needed.

Coroners are responsible for:

- investigating reportable deaths to determine the deceased's identity, as well as the circumstances and cause of the death
- presiding over inquests
- making findings and preventative comments to avoid similar deaths in the future.

State Coroner

The State Coroner is a magistrate appointed for an initial term of five years to (ss 70, 71(1) Coroners Act):

- oversee, coordinate and ensure efficient operation of the coronial system
- ensure that reported deaths are investigated to an appropriate extent
- ensure that coronial inquests are held when required
- have responsibility, together with the Deputy State Coroner, for all investigations into deaths in custody and deaths that happened as a result of police operations
- issue directions and guidelines about the investigation of reportable deaths.

Deputy State Coroner

The Deputy State Coroner is a magistrate appointed for an initial term of five years who, in addition to the functions of a magistrate and coroner, also investigates deaths in custody and deaths as a result of police operations. They also act as the State Coroner when required.

The Deputy State Coroner is currently located in Southport and investigates deaths in South East Queensland including the Gold Coast, Beenleigh and Logan.

Coronial registrars and deputy coronial registrars

The coronial registrars are located in Brisbane and are appointed to assist the coroners by:

- investigating deaths reported to police where a cause-of-death certificate has not been issued
- reviewing potentially reportable deaths reported directly by medical practitioners or funeral directors.

Each clerk of the court (other than a police officer) is automatically a deputy registrar, as are other persons specifically appointed to the role (s 85(2) Coroners Act).

The State Coroner, or another coroner with the State Coroner's approval, may delegate some of their powers (e.g. the power to permit cremation or consent to tissue removal) to a registrar or an appropriately qualified deputy registrar (s 86 Coroners Act). The power to conduct an inquest cannot be delegated.

When a Death is Reportable to the Coroner

As part of the coronial system's commitment to learning how similar incidents can be prevented in future, a framework has been created within the Coroners Act for reporting deaths that occur in certain or unusual circumstances. These are known as ‘reportable deaths’.

Types of reportable deaths

A death is a reportable death if (s 8 Coroners Act):

- the person’s identity 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 unlikely to be issued
- the death was related to health care
- the death occurred in care, in custody or as the result of police operations.

Deaths from natural causes, such as a disease or old age, are not reportable to a coroner.

In practice, coroners or coronial registrars are often contacted by medical practitioners or funeral directors to enquire whether a particular death is a reportable death.

Unknown identity

Even if the death has not occurred in suspicious circumstances, if the identity of the deceased is unknown, it must be reported (s 8(3)(a) Coroners Act). Identification of the deceased is important for a number of reasons, including for the family's wellbeing, public health and safety, and where circumstances exist that may be related to a criminal or civil liability for the death.

Violent or otherwise unnatural deaths

A violent or unnatural death is one that occurs because of an accident, suicide or homicide, rather than from natural causes such as a heart attack or an illness. An unnatural death could involve:

- intoxication with chemicals (e.g. alcohol, drugs, poisons)
- deprivation of air, food or water (e.g. asphyxia, drowning, dehydration, starvation)
- physical factors (e.g. injury, trauma, fire, cold, electricity, radiation).

Generally, deaths resulting from lifestyle diseases, such as cirrhosis in alcoholics and industrial deceases such as mesothelioma in asbestos workers, are not considered to be unnatural.

A death is still reportable even if there has been a delay between a death and the incident that caused it. For example, if a person sustains injuries in a motor vehicle accident and dies from those injuries many months later, their death will be reportable to a coroner.

Suspicious death

A death occurs in ‘suspicious circumstances’ if a homicide has occurred or may have occurred. Suspicious deaths will also be reportable as unnatural deaths where it is clear that the death has happened unnaturally, but it is not yet clear whether another person has been involved.

Cause-of-death certificate is unlikely to be issued

If a doctor can determine that a person has died from natural causes, they can issue a cause-of-death certificate. If a doctor cannot (or will not) express an opinion on the probable cause of a person's death, they must report the death to the coroner. This type of reportable death is the most common type of death reported to Queensland coroners.

Health-care-related death

The definition of ‘health care’ is very broad and includes any goods and services that are provided for the benefit of human health such as dental, medical, surgical, diagnostic or other health-related procedures and medication (s 10AA(5) Coroners Act).

A death is a health-care-related death if:

- the health care, or a failure to provide health care (including failure to treat or diagnose, clinical or medication incidents and errors) caused or contributed to the death; and

- before the health care was provided, an independent appropriately qualified clinician would not have reasonably expected the health care to cause or contribute to the death.

Death in care

The Coroners Act recognises the special vulnerabilities of certain groups of people that are cared for by others, by making their deaths reportable to the coroner regardless of what the cause of their death might have been. A death in care will occur if the deceased (s 9 Coroners Act):

- had a disability and was a resident of certain types of supported accommodation or was receiving high-level support under the National Disability Insurance Scheme
- had a cognitive or intellectual disability, and was subject to treatment under the *Forensic Disability Act 2011* (Qld) as the result of a forensic order by the Mental Health Court
- was subject to involuntary mental health assessment or treatment under the *Mental Health Act 2016* (Qld) and was either being taken to, or detained in, an authorised mental health service
- was a child in the care or under the guardianship of the state under the *Child Protection Act 1999* (Qld).

Death in custody

When a person is in custody, there is an inherent power imbalance between that person and the officer detaining them. Due to this, a death in custody is a reportable death, and occurs if a person dies while in custody, trying to escape custody or while trying to avoid being put into custody (s 10 Coroners Act).

A person will be in custody when they are detained by a police officer, corrective services officer, court officer or other law enforcement personnel, or are under arrest or under the authority of a court order or state or Commonwealth legislation.

Death in the course of police operations

Deaths that occur outside of the custody context but involve police operations are also reportable (s 9(3)(h) Coroners Act). For example, if a bystander is killed during a police motor vehicle pursuit, this death would be reportable.

Suspected deaths

Although not specifically included as a category of reportable deaths under the Coroners Act, if there is reason to suspect that a person has died in suspicious or unnatural circumstances, but the body has not yet been found, the state coroner should be notified. In practice, where a person's whereabouts are unknown, the person's relatives or friends usually report the missing person to police, who in turn notify the Missing Persons Unit that commences an investigation.

Reporting a Reportable Death

Any person who becomes aware of a reportable death, and does not reasonably believe that the death has already been reported, must immediately report it to a police officer or coroner (s 7(1), (3) Coroners Act). Failure to report a reportable death is an offence under the Coroners Act and is punishable by 25 penalty units (for the current value of one penalty unit see r 3 *Penalties and Sentences Regulation 2015* (Qld)).

If a death happens in care, the service provider must report the death, even if they believe that someone else has already reported it.

The way in which a reportable death should be reported depends on the category of the reportable death.

Violent or otherwise unnatural deaths

Violent or otherwise unnatural deaths (other than those from mechanical falls) should be reported to police. Police will then submit a Form 1 to the coroner who is in charge of the area where the death occurred. The completed Form 1 will also be sent to the Coroners Court so that the Register of Deaths can be updated. This register contains information about all reported deaths, including the date on which the death was reported and the findings of the investigation (s 92 Coroners Act).

Health-care-related deaths and deaths in care

If the death is a health-care-related death, a death from injuries sustained in a mechanical fall or a death from natural causes in care, medical practitioners should report the death directly to coroner using a Form 1A. The coroner will conduct a preliminary investigation to decide whether the death is a reportable death and if so, whether a cause-of-death certificate should be issued or whether further investigations, such as an autopsy, should be conducted.

Death in custody or in the course of police operations

If the reportable death is a death in custody or occurred in the course of police operations, it must be reported directly to the State Coroner or the Deputy State Coroner (s 7(3) Coroners Act).

Multiple fatalities

In cases where multiple deaths have occurred, such as in car accidents, natural disasters or as a result of terrorism, the initial Police Report of Death to a Coroner (Form 1B Disaster Victim Identification Squad use only) describing preliminary information about the incident must be reported to the coroner. Once all of the victims are identified, a Police Report of Death to a Coroner (Form 1) is completed by police and submitted to the coroner.

After a Death is Reported to the Coroner

The next step after a death is reported to the coroner is working out why the death occurred. That will often involve the use of medical opinion and/or forensic testing.

Preliminary examinations

Once police submit a Form 1 to the Coroners Court, the coroner's investigation begins with a range of preliminary procedures performed by forensic pathologists. The scope of these preliminary examinations will depend on the circumstances of each death, and may include:

- visual examination of the body, including dental examinations
- post-mortem imaging of the body, including CT scans, MRI scans and x-rays
- taking and testing blood, urine, saliva, swabs and other samples
- fingerprinting
- collating information about the deceased's medical history.

The purpose of these preliminary examinations is to help inform the coroner about whether the death is a reportable death, and whether further coronial investigations, such as an autopsy, are required. In 40% of cases where a death is reported because a cause-of-death certificate is not issued, no further coronial investigations are required because a forensic pathologist is able to issue the certificate outlining the cause of death.

In practice, the taking of samples and testing is time critical and needs to occur within 6 to 12 hours of a person's death. In urgent cases, a coroner or coronial registrar may allow a pathologist to carry out preliminary examinations after the death is reported to the coroner in writing (e.g. by email), without the Form 1 being lodged first.

Considerations during preliminary examinations

Any concerns that you have about that the preliminary examinations (e.g. a sampling process being invasive) should be outlined in the Form 1. The examiner must take these concerns into account and must also consider the cultural traditions and spiritual beliefs of the deceased person and their family, when determining the types of samples that should be taken (s 11AA(5) Coroners Act).

Written preliminary report

A written preliminary examination report must be prepared and provided to the coroner as soon as practicable after the preliminary examination is completed (s 11AA(6) Coroners Act). This report is confidential and cannot be given to anyone other than a coroner or the Coroners Court. The report will contain:

- information considered by the examiner including the deceased's medical and circumstantial history
- results of any imaging, sampling, testing and other procedures performed as part of the preliminary examination
- a view about the likely medical cause of the person's death or a recommendation as to the type of autopsy that is likely to establish the cause of death.

In circumstances where there are questions as to whether a cause-of-death certificate can be issued, or what type of autopsy should be ordered, a coroner will consider the preliminary examination report before ordering an autopsy.

If it is clear from the outset that preliminary examinations will not help the coroner in determining whether the death is a reportable death, or the type of autopsy that would identify the cause of death, a preliminary examination report will not be issued. Instead, the results of the preliminary examinations will form a part of the autopsy report.

Finalising a matter following preliminary examinations

If a death has been reported because a cause-of-death certificate had not been issued, and the cause of death can be established from preliminary investigations, a coronial nurse or coronial counsellor will consult the deceased's family about any concerns they may have about the circumstances of the death. If no concerns are raised by the family, the coroner may decide to discontinue the coronial investigation, not order an autopsy and issue a cause-of-death certificate, which will then be placed on the coronial file in the Coroners Court registry.

The decision not to order a coronial autopsy puts an end to the coronial process, and must not be made unless the coroner considers that the death is not a reportable death or that no further coronial investigation is needed. The file will then be closed with a note about the decision made that the death was not reportable. The family will then be informed that they can arrange for release of the body and arrange the funeral.

Ordering a Coronial Autopsy

A coroner may order a doctor to perform a coronial autopsy if it is considered necessary for the investigation or in order to determine whether a baby was stillborn (s 19(2) Coroners Act).

The coroner must order a coronial autopsy where a medical cause of death or the circumstances contributing to the death are not sufficiently clear and raise a reasonable doubt. If a coronial autopsy is required for some other reason, such as resolving public safety concerns, the coroner may order an external examination of the body to continue the coronial process.

Unlike coronial autopsies, clinical autopsies can be performed for medical educational or research purposes, but can only be performed with the deceased's family's consent.

Forms of coronial autopsies

A coronial autopsy may involve (s 19(3) Coroners Act):

- an external examination of the body
- an external and partial internal examination of the body
- an external and full internal examination of the body
- an examination of the cremated remains of the body, if the body has been cremated.

Internal examinations are expensive, invasive and cause alterations to the deceased's body. They also expose the examiner to potential health and safety risks.

It is important that before ordering an internal examination, that the coroner (s 19(5) Coroners Act):

- takes into account any concerns raised by a family member or another person with a sufficient interest in relation to the form of the examination
- considers that the family may be distressed by an internal examination (e.g. because of cultural traditions or spiritual beliefs).

Views of family members

Like in the preliminary investigation stage, the views of the deceased's family members will be considered prior to an autopsy being taken. If a family member is suspected as being responsible for the deceased's death, their views will not be sought.

If, despite the concerns of the deceased's family, the coroner decides that it is necessary to order an internal examination to make findings under s 19(6) of the Coroners Act, the coroner must give a copy of the order for autopsy and written reasons to the concerned family member. The internal autopsy will, in most circumstances, then be postponed for 24 hours to allow that family member to seek judicial review of the coroner's decision.

As it is a requirement for the coroner to consider the views of the family member whenever practicable, if the identity of the deceased person is unknown, the coroner may order an internal autopsy without waiting for the family members to be found to express their views.

Views of people with a sufficient interest

Other people with a sufficient interest should also have their concerns considered by the coroner (s 19(5) Coroners Act). This group includes people who are involved in transporting or examining the deceased's body, as they are likely to be exposed to infectious diseases and other risks.

Which form of autopsy will be ordered?

The coroner must order the least invasive form of autopsy that will resolve all questions about the death, and allow the coroner to make the necessary findings required under s 45(2) of the Coroners Act. When deciding what form of autopsy to order, the coroner must take into account the medical history of the deceased, as well as physical and witness evidence, and may consult pathologists with experience in forensic matters.

Aside from any testing directly ordered by the coroner, the examining pathologist is also permitted to undertake other tests if these tests are consistent with the form of the autopsy ordered by the coroner (s 23(3) Coroners Act). Blood and urine can be collected regardless of the form of autopsy (s 23(5) Coroners Act).

Releasing the Body for Burial or Cremation

The timely release of the deceased's body for burial or cremation is crucial for preventing unnecessary distress to family members. Despite this, the decision to release a body requires balancing of the need to investigate with the family's wishes and the deceased's cultural and religious beliefs.

Requesting a release order

The funeral director who is working with the family must submit a request for a release using Form 14A and a *Cremations Act 2003* (Qld) (Cremations Act) Form 1 if cremation has been chosen.

Releasing the body

Before releasing the body, the coroner will consider whether releasing the body could impact on their ability to make the findings required under s 45(2) of the Coroners Act. During this process, the coroner will consider the matters outlined in sections 8 and 9 of Form 3, including whether:

- any tissue donation is complete
- the examination of the body is complete
- all retained tissue has been returned to the body
- the body has been formally identified.

The coroner may decide that a tissue sample should be retained for investigative purposes but should order the release of a body if the deceased has been identified and retaining the body is not necessary for the investigation.

Generally, following an approval, the deceased's body will be released to the family so that they can organise the funeral. In practice, the funeral director will usually collect the body from the

mortuary and prepare for burial or cremation. Sometimes family members collect and transport the body themselves to reduce conveyance costs—prior to doing this, you should contact coronial counsellors for further guidance (see Support Services at the end of this chapter for the contact details of the counsellors at the Coronial Family Services).

Before releasing the deceased's body, the coroner will complete a Form 14 to indicate any infection risks to those transporting the body. Similarly, the release of a body for cremation will not be ordered if the body poses a cremation risk (e.g. presence of a pacemaker or radioactive implant) or if there are other objections to the cremation (ss 6(7), 8 Cremations Act). If the deceased has left signed instructions that they are to be cremated, this will override any other objections (s 8(1) Cremations Act). The coroner is not required to further investigate objections to a cremation, so it is important to be proactive if you do not want to see your loved one cremated.

Cultural and religious considerations

Coronial counsellors can make the coroner aware of any cultural or religious issues that may impact on the timing of release of the body. For example, in Indigenous, Islamic, Taoist-Buddhist, Jewish and Hmong cultures it is important that a body is buried soon after the death occurs.

Release of Indigenous burial remains

If the deceased's body are Indigenous burial remains, the coroner must stop the investigation and order the release of the body to the minister responsible for the *Aboriginal Cultural Heritage Act 2003* (Qld) and the *Torres Strait Islander Heritage Act 2003* (Qld) as soon as practicable using Form 12 (ss 12(2), 26(2)(a) Coroners Act).

Resolving disputes

Sometimes, there are disputes among family members about whether the deceased should be buried or cremated. These disputes may arise between a subsequent spouse and children from a previous relationship, or between estranged parents of a deceased child. These disputes may result in the coroner receiving more than one request for release and, in that case, the coroner will explore dispute resolution options between the parties and a referral to Coronial Family Services.

If the dispute cannot be resolved, the coroner will consider each person's views before making an administrative decision and giving written reasons regarding the release of the body. As part of this process, the coroner may consider whether:

- there is evidence of a family dispute on the coronial file

- the release request is made by the marital spouse of the deceased, but it is clear from the file there is a de facto spouse
- the release request is made by an estranged de facto spouse
- the release request is made by an adult family member who lives in a different area to the deceased
- the deceased person is Indigenous, and the applicant lives in a different community to them.

Once the coroner decides who to release the body to, it may be necessary for you to urgently seek an order from the Supreme Court that the body be released in accordance with the coroner's administrative decision to ensure that it can be enforced in the face of further disputes.

When to Investigate a Death

Coroners have broad powers to investigate deaths so that they can make findings and comments about the death. Coroners may only investigate reportable deaths (s 11(2) Coroners Act) and are encouraged to proactively manage cases and refer the matter to other relevant agencies where appropriate.

Deaths that must not be investigated

A death must not be investigated, or further investigated, if:

- the cause-of-death certificate has been issued (s 12(2)(b) Coroners Act)
- the death occurred outside of Queensland and the Attorney-General or State Coroner has not provided a direction to investigate (ss 11(4)(b), 12(1) Coroners Act)
- it is established that the remains being investigated are Indigenous burial remains (s 12(2)(a) Coroners Act)
- the investigation is trying to determine how a child came to be stillborn, noting that the coroner can only order an autopsy to determine whether a baby was born alive (s 12(2)(c) Coroners Act)
- the State Coroner has directed a coroner to stop an investigation (e.g. where a death has already been adequately investigated).

Gathering information and referrals

The coroner has the power to direct police or other agencies to make all necessary enquiries when investigating a death. As part of this process, the coroner may obtain:

- investigation reports from certain agencies (e.g. police and other state government departments and agencies that may have information relevant to the death)
- statements from those involved in the events leading up to the death (e.g. treating doctors, correctional centre staff, care workers)
- expert reports from any person that can interpret injuries and inform the investigation (e.g. forensic medicine officers from the Queensland Health Clinical Forensic Medicine Unit and mental health clinicians from the Queensland Health Directorate of Mental Health).

Where appropriate, the coroner may also refer the matter to other investigative agencies. If, for example, the coroner has a reasonable suspicion that a person has committed an offence, the coroner must pass evidence of this suspicion onto an appropriate prosecuting authority. Similarly, the coroner may refer information about official misconduct or police misconduct to the Crime and Corruption Commission (CCC), and information about a person's professional or occupational conduct to a relevant regulatory body such as the Office of the Health Ombudsman (OHO) or the Australian Health Practitioner Regulatory Agency (AHPRA) (s 48 Coroners Act).

The way that the investigations are conducted will depend on the way that the death occurred and the particular facts of the case.

Investigating Deaths in Custody

A death in custody that appears to be a suicide will be subjected to an independent inquiry by the Queensland Police Service (QPS) Corrective Services Investigation Unit to explore whether the death was not self-inflicted or the result of natural causes. It is expected that such investigations will be completed within six months of the death, but sometimes delays are unavoidable.

The Office of the Chief Inspector from Queensland Corrective Services may appoint independent external inspectors to investigate particularly for systemic failures within a correctional centre.

Any deaths occurring during police operations will be investigated by officers from the Ethical Standards Command of the QPS, with that investigation being overseen by the CCC.

Case Study: Mulrunji (Cameron Doomadgee)

On 19 November 2004, within one hour of being picked up by police for public nuisance, Mulrunji died in custody at the Palm Island Police Station. Senior Sergeant Hurley claimed that Mulrunji sustained his injuries by tripping on a step.

On 28 February 2005, a coronial inquest into Mulrunji's death commenced. Within a week, State Coroner Michael Barnes stood down following challenges to his impartiality. Later that year, the inquest recommenced under Deputy State Coroner Christine Clements (*Inquest into the death of Mulrunji* (2006) COR 2857/04(9). The Aboriginal and Torres Strait Islander Legal Service in Townsville played a significant role in the inquest, representing Mulrunji's partner. Ultimately, Coroner Clements found that Hurley fatally assaulted Mulrunji and recommended that criminal charges were laid.

Hurley was subsequently charged with manslaughter and assault, but was acquitted by a jury. Hurley successfully applied to have Coroner Clements' findings overturned. Following a fresh inquest, Deputy Chief Magistrate Brian Hine found Hurley had not intentionally inflicted the fatal injuries (*Inquest into the death of Mulrunji* (2010) COR 2857/04(9)). Despite this outcome, Magistrate Hine recommended that future investigations of deaths in custody involving unnatural causes or police actions should be handled by the Crime and Misconduct Commission, rather than by the QPS in order to mitigate the impacts of impartiality and bias.

Investigating Health-care-related Deaths

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 written summary by the CFMU doctor can help reassure families that concerns have been considered and informed by independent clinical opinion. If the CFMU doctor does not have any concerns with the deceased's health-care management, the coroner should authorise the death certificate and advise that no further investigation is required. If the CFMU doctor has concerns about the treatment, the coroner will not issue the death certificate and will advise the further investigations required. These further investigations may involve obtaining witness statements, medical records, Medicare records, a root cause analysis and hospital policies.

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.

Case Study: Lilli Sweet

On 25 August 2013, Lilli Sweet (6 years old) presented to her GP with vomiting, diarrhoea and a headache. Given Lilli's underlying medical condition, which made her particularly susceptible to infection, her GP referred her onto the Nambour Hospital Emergency Department for blood tests. Despite her symptoms continuing, the blood tests were not taken until that evening. The results indicated that Lilli's white blood count was elevated, suggesting serious sepsis. It was

not until the next morning when Lilli rapidly deteriorated, that intravenous antibiotics were commenced and she was transferred to the Royal Children's Hospital in Brisbane.

The next day, she was declared dead from meningitis. The coroner found that medical staff at the hospital missed opportunities to act earlier and prevent Lilli's death (*Inquest into the death of Lilli Sweet* (2016) 2013/3454).

The coroner also noted that the Sunshine Coast Hospital and Health Service (HHS) and Queensland Health had already implemented a number of recommendations from the root cause analysis into Lilli's death, including establishing clear processes, procedures and systems for tracking diagnostic results to ensure they are received, reviewed and actioned. As a result of the significant changes made by the HHS and Queensland Health, the coroner did not propose any further recommendations, highlighting that HHSs can instigate reform prior to specific recommendations being handed down by the coroner.

Investigating Domestic and Family-violence-related Deaths

In Australia, on average, one woman per week is murdered by her current or former partner as a result of domestic and family violence (DV Connect *Domestic Violence Statistics*). Domestic and family violence is a broad concept and encompasses physically, emotionally, psychologically or economically threatening and abusive behaviours designed to control a family member or intimate partner.

The Domestic and Family Violence Death Review Unit (DFVDRU) is able to provide specialist assistance to coroners during their investigations by:

- asking the QPS Coronial Support Unit to provide preliminary details regarding the death and any history of domestic and family violence between the victim and the perpetrator
- obtaining records from other relevant agencies.

Police may also assist with the investigations by obtaining:

- witness statements
- a history of domestic or family violence (including stalking or obsessive behaviour) involving the victim or the perpetrator
- the status of their relationship at the time of the death
- a history of suicide threats or attempts, or other threats to kill (including against children or other family members)
- a history of drug or alcohol abuse
- any known mental health issues

- details of any factors related to the incident (e.g. separation, new partner, financial problems, custody issues or an upcoming court appearance).

The DFVDRU will provide interim and final reports to the coroner to assist with identification of the key issues, and will inform the coroner's decision as to whether an inquest is necessary to make their findings.

The DFVDRU and the Centre for Domestic and Family Violence Research also play an important role in identifying and monitoring any patterns or trends in relation to domestic and family-violence-related deaths to assist policy responses from the government.

Case Study: Tracy Beale

Late on 20 January 2013, during a fight with her husband about their financial situation, Tracy Beale (45 years old) was put in a chokehold until she became limp. Despite Tracy being unresponsive, her husband did not provide CPR. By the time paramedics arrived, she was declared dead. A police investigation raised questions about whether Tracy's death was caused by the neck compression or the sudden drop in heart rate and blood pressure associated with a sympathetic vasovagal episode.

Given the involvement of domestic violence in Tracy's death, the Women's Legal Service was represented at the inquest. Drawing on Professor Heather Douglas' evidence, the coroner concluded that the offence in s 315A of the *Criminal Code Act 1899* (Qld) relating to choking, suffocation and strangulation in a domestic setting overlooks circumstances where the neck compression actually triggers a reflex cardiac arrest or vasovagal reflex. To further protect women from domestic violence, the coroner adopted Professor Douglas's recommendation that a wider community education program on the dangers of neck compression should be implemented (*Inquest into the death of Tracy Ann Beale* (2018) 2013/246).

Investigating Child Protection Deaths

The coroner may investigate the death of a child where there are concerns about a family's contact with the child protection system, especially if there may have been a missed opportunity for protective intervention. Sadly, child deaths may arise because of domestic and family violence, neglect or self-harm. An inquest can help to further the community's understanding of the risks faced by children in care, including as they relate to health, housing, education, child protection and police, and help to inform broader system-wide improvement.

In any case where a child dies after being involved with a relevant agency (e.g. Department of Children, Youth Justice and Multicultural Affairs, QPS, Education Queensland, Queensland Health), the compulsory child death review process will commence (ch 7A *Child Protection Act 1999* (Qld) (Child Protection Act)). Initially, the chief executive will investigate whether the child was known to the department within 12 months of their death (s 245E Child Protection Act). This

report will be provided to the Child Death Review Board as well as the investigating coroner via the state coroner, and will help narrow the issues requiring investigation (ss 245N(1), 245P Child Protection Act).

If it becomes evident that the department's involvement with the child or their family is outside of the 12-month timeframe, the coroner may seek the approval of the Minister for Children, Youth Justice and Multicultural Affairs to undertake a child-death review (s 245F Child Protection Act).

If the child death review does not address the issues required for the coronial investigation, the coroner may obtain:

- the child's departmental case file
- statements from departmental or third-party service-provider staff (e.g. those who provide support to foster parents) in relation to the management of the child's case
- any relevant departmental policies and procedures
- a statement from a senior departmental officer about the extent to which the child death review recommendations have been addressed or implemented
- an independent expert review of the child's management, with the state coroner's permission.

The Domestic and Family Violence Death Review and Advisory Board is also able to support the coroner in relation to the systemic issues in child protection (ss 91A, 91D Coroners Act).

Case Study: Mason Lee

On 11 June 2016, Mason Lee (22 months old) died of abdominal injuries inflicted by his mother's boyfriend William O'Sullivan. An autopsy showed that Mason had been severely abused by O'Sullivan in the days leading up to his death.

Many agencies appeared at the inquest, including the Department of Child Safety, Youth and Women (now the Department of Children, Youth Justice and Multi-cultural Affairs), Queensland Corrective Services, the Commissioner of Police and the Department of Health. Both O'Sullivan and Mason's mother did not attend at the inquest as they were serving jail time for manslaughter and cruelty.

The inquest found that although the department was aware that Mason was an abuse victim, it did not take sufficient action to protect him. The coroner found that a number of the department's employees failed to carry out their duties (*Inquest into the death of Mason Jet Lee* (2010) COR 2857/04(9)).

Prior to the coroner's findings being handed down, the government enacted significant reforms to child safety. The coroner also made a number of recommendations all of which were adopted by the government.

Investigating Suspected Deaths (Missing Persons)

It can be extremely concerning for families when a loved one has disappeared, but their body has not been or cannot be located. In Queensland, the coroner's ability to investigate missing persons is limited to situations where:

- there is reason to suspect a person is dead, and that the death was reportable as determined by the state coroner
- the Attorney-General has directed that the suspected death be investigated by a coroner.

Generally speaking, missing persons are first reported to the QPS Missing Persons Unit and, if a death is suspected, the state coroner is notified. Before concluding that a person is dead, a coronial investigation may be commenced to explore whether sufficient evidence can be obtained to exclude the possibility that the missing person has assumed another identity. It may be useful to conduct checks with the Australian Taxation Office, Centrelink, Medicare, financial institutions, interstate Registries of Births Deaths and Marriages, Australian or overseas police services and immigration authorities. Family, friends, treating doctors and co-workers may be able to shed light on whether the disappearance was staged.

Case Study: Daniel Morcombe

On 7 December 2003, Daniel Morcombe (13 years old) disappeared while he was waiting alone for a bus in his local area. Following five years of unsuccessful police investigations that had failed to locate his body, Daniel's parents called for a coronial inquest into his disappearance (*Inquest into the disappearance and death of Daniel James Morcombe* (2019) 2009/1210).

As a person of interest, Brett Cowan was called to give evidence at the inquest. Cowan's implausible account caused police to commence an undercover operation. During the operation, Cowan confessed and took undercover police to the place where he had assaulted and killed Daniel.

As a result of the evidence obtained during the operation, on 13 March 2014, Cowan was found guilty of murder, indecent dealing with a child and interference with a corpse, and was sentenced to life imprisonment.

Despite Cowan's imprisonment, Daniel's parents called for the coroner to reopen the inquest, specifically relating to how evidence is examined by police. Daniel's parents highlight how the family members of the deceased can have a significant impact on the conduct and recommendations of an inquest.

The inquest into Daniel's death also shows that a coronial inquest can proceed without any evidence of the deceased's remains. Further, coronial and police investigations can supplement each other and ultimately lead to a conviction and better outcomes for the public in general.

Making findings on the papers

Following any investigation, a coroner may decide it is appropriate to make findings about the death without convening an inquest, otherwise known as ‘findings on the papers’.

The Decision to Hold an Inquest

Once the coroner has completed their enquiries and investigations, they will consider whether to hold an inquest into the death.

When a coroner is satisfied that an inquest should be held, the family and other interested parties will be notified and an online notice will be published on the Courier Mail and Queensland Courts websites (s 32 Coroners Act).

A coroner's decision to hold an inquest including the reasons is to be recorded on a Form 26 and provided to:

- the Office of the State Coroner
- the QPS
- any other agency that has provided reports to the coroner or conducted an investigation into the death to discharge its statutory duty (e.g. WorkSafe Queensland)
- the senior family member
- any other party who has made submissions to the coroner concerning the holding of an inquest.

When a Form 26 is sent to a deceased's family, a letter should also be enclosed that provides reasons for the coroner's decision and highlights that the family members have the right to have the decision reviewed by the State Coroner or the District Court (s 30 Coroners Act).

When an inquest must be held

There are a number of mandatory circumstances where an inquest must be held including (s 27 Coroners Act):

- deaths in custody
- deaths in care, where the circumstances raise questions regarding care received
- deaths in the course of police operations unless the coroner is satisfied the circumstances of the death do not require the holding of an inquest
- if the Attorney-General, State Coroner or District Court directs an inquest to be held.

When an inquest may be held

The coroner may also decide to hold an inquest for a reportable death in the public interest (s 28 Coroners Act). The coroner may consider any one or more of the following as being in the public interest:

- an inquest is likely to help explain the cause of death
- there are unresolved suspicious circumstances
- publicity through inquest may help to prevent future deaths in similar circumstances.

The coroner may decline to hold an inquest if there is a more appropriate way to investigate a death (e.g. the role of a health practitioner in a death may be more suitable for investigation by the Office of the Health Ombudsman) (see *Dupois v State Coroner of Queensland Michael Barnes* [2012] QDC 304).

If there is a suspicion that a death is the result of a crime, but police have not gathered sufficient evidence to charge someone, police may request an inquest so that witness accounts can be tested, and to require witnesses (who have refused to cooperate with police) to give an account. If a witness is compelled to give evidence to a coroner, they can claim the privilege against self-incrimination, which means that their evidence cannot be used in later criminal proceedings. For an example of evidence adduced at a coronial inquest being used in court, see the Daniel Morcombe case study at section 16.36. The evidence may, however, be used against a co-accused witness.

When an inquest must not be held

An inquest must not be held, or must be postponed if already commenced, when someone is charged with a criminal offence in connection with the death (s 29 Coroners Act).

Applying for an Inquest to be Held

A written request can be made by any person for an inquest to be held following a person's death (s 30 Coroners Act). This commonly occurs when family members believe someone is negligent or criminally responsible for a death, but no charges have been laid. The request must detail the public interest grounds for why an inquest should be held and can be completed by filling out a Form 15 (s 30(2) Coroners Act).

The coroner must provide written reasons within six months of receiving an application for holding an inquest, or a longer period if that is required to gather relevant information (ss 30(3), (9) Coroners Act).

If an application is denied by a coroner, a further application can be made to the State Coroner by submitting a Form 16. Within 14 days of receiving the State Coroner's reasons to deny an

inquest, a person can also apply to the District Court for a coronial inquest to be held (ss 30(4)–(8) Coroners Act).

What Happens at an Inquest?

Once a decision has been made to hold an inquest, the coroner will often hold a pre-inquest conference to determine the scope or questions to be resolved in the inquest and to discuss the evidence and witnesses required (s 34 Coroners Act). Counsel Assisting will discuss the issues with unrepresented families before the pre-inquest proceedings to ensure their views are heard and expressed.

It is acknowledged that attending the Coroners Court for an inquest might be the first time that you have attended court, and it can be intimidating and overwhelming. To prepare for the inquest, it is helpful if you understand how the inquest will operate and the types of recommendations that the coroner may give once it concludes.

Role of Counsel Assisting

The role of Counsel Assisting, usually fulfilled through in-house lawyers or external counsel for complex or contentious matters, is to support the coroner at an inquest by impartially and fairly presenting evidence. Counsel Assisting will help to identify issues to be examined, call and examine witnesses, work through possible preventative recommendations and make submissions to the coroner about proposed findings. If required, Counsel Assisting may also prepare draft findings for the coroner by summarising evidence and outlining any relevant law. It is important to note, that while Counsel Assisting provides a key support role, the coroner is responsible for assessing the evidence and making findings.

Rights for family to appear and have legal representation

Any person who has a sufficient interest may appear, examine witnesses and make submissions at a coronial inquest. This may include a family member of the deceased or a representative of a company who is alleged to have an involvement in the death (s 36(1)(c) Coroners Act).

If a family member decides to appear, they have the right to be legally represented in the inquest proceedings (s 36(4) Coroners Act). Having a lawyer may help a grieving family to ensure that witnesses are asked questions about the matters that are of concern to them and to make submissions to the coroner.

If a family member does not have legal representation or prefers to observe and not participate in the proceedings, Counsel Assisting may play an important role. While Counsel Assisting does not represent the family members of the deceased, they can assist in relaying their views at the pre-inquest and inquest proceedings. Some practical examples of this include:

- advising the court of specific issues that the family wishes to be examined
- inviting a family member to give oral evidence at the beginning of the inquest
- providing the family's written submissions to the coroner
- identifying specific questions a family member would like a witness to be asked
- asking for permission from the coroner to examine witnesses on a family member's behalf.

Procedure for inquest

Coronial inquests are ordinarily held in the Magistrate Court nearest to where the death of the person occurred.

A coronial inquest is different to ordinary court proceedings. It is an inquisitorial rather than adversarial process, and it does not seek to answer questions of criminal or civil liability. An inquest is conducted for the purpose of gathering information about the cause and circumstances of a person's death. This enables the coroner to make recommendations regarding the person's death that may assist in preventing similar deaths in the future.

In terms of procedure, a coronial inquest will generally be conducted in the following order:

1. Counsel Assisting and the parties appearing in the inquest will introduce themselves.
2. Witnesses (including experts) will be called to give evidence on oath or affirmation.
3. Counsel Assisting, parties and the coroner will ask questions of witnesses.
4. After hearing witness evidence, evidence will be closed.
5. Parties will make final oral or written submissions to the coroner.
6. The coroner will adjourn proceedings to consider evidence, submissions and findings.
7. The coroner will make and deliver findings (usually adjourned to a later date and the appearing parties will be invited back to hear the findings).
8. Inquest findings will be published on Queensland Courts website.

The length of time between the evidence being heard and findings being delivered will vary depending on the complexity of the case (s 44 Coroners Act). The coroner will, however, advise the nominated next of kin and all interested parties when findings have been made.

Broadening the inquest scope with human rights

The intersection of human rights and the coronial process was discussed in the inquest into the death of Tanya Day in Victoria, which has similar human rights protections (Coroners Court of Victoria, *Ruling on Application Regarding the Scope of the Inquest into the Death of Tanya Louise Day* (2019) 2017/6424; Coroners Court of Victoria, *Inquest into the death of Tanya*

Louise Day (2020) 2017/6424. Ms Day, a Yorta Yorta woman, was arrested for being drunk in a public place (on a train) and taken into police custody. While in custody, Ms Day had a series of falls where she hit her head, causing brain injuries. Although police officers on duty checked on Ms Day throughout her time in custody, medical help was delayed. Despite surgery, Ms Day died from the brain injuries caused by the series of falls in police custody. The coroner determined that human rights issues, including discrimination and systematic racism, could be considered as a part of the inquest into Ms Day's death and ultimately found that Ms Day had been subjected to an unconscious bias on the part of the train conductor in deciding that she should be removed from the train.

Witness evidence

The coroner may order a person to attend a coronial inquest to give evidence as a witness (s 37(4)(a) Coroners Act). While giving evidence, the coroner may order a witness under oath or affirmation to answer a question relevant to the proceedings (s 37(4)(b) Coroners Act). There are significant penalties, including fines and arrest, for failing to comply with an order or attend an inquest without reasonable excuse (ss 37(6)-(7) Coroners Act).

Prior to the inquest being held, the witness will receive a written notice advising the time and date they are required to attend. A person may be entitled to compensation for travel and other related expenses regarding their involvement as a witness. An investigating police officer will usually be able to provide details of the claim process after the witness has provided evidence.

The Coroners Court of Queensland provides a number of practical tips for the role of witnesses at a coronial inquest. If you are called to give evidence as a witness you should:

- bring a copy of the summons and any statement you have prepared
- dress neatly, noting that formal dress is not required
- arrive at least 15 minutes before the time allocated for your evidence—the court location and number will be on your notice
- wait outside the courtroom until you are called—witnesses are not usually allowed in the courtroom before they give evidence. Note that there can be unexpected delays
- you will usually be able to speak to Counsel Assisting before you give evidence
- once you are called, enter the courtroom and bow your head to the coroner as you enter
- you will be directed to the witness box where the coroner will ask if you would prefer to take an oath on the Bible or an affirmation to show your commitment to tell the truth
- Counsel Assisting will ask questions first. If you have provided a statement, you will usually be shown a copy of that statement and you may refer to it while giving evidence

- other parties or their lawyers may ask questions, and sometimes the coroner will also ask questions. Refer to the coroner as 'Your Honour' if you speak to them directly. The length of your evidence will depend on the circumstances
- when all parties have finished asking questions, the coroner will excuse you and you can leave the court or take a seat in the public gallery to observe the rest of the inquest.

Special circumstances for witnesses

There are circumstances where a witness may be excused from giving evidence at an inquest. This was discussed in the inquest into the deaths of Hayden Duncan, Glen Duncan and Reginald Fisher (see *Inquest into the deaths of Hayden Duncan, Glen Duncan and Reginald Fisher* (2009) COR 868-870/06). In this case, the driver of the train involved in the incident that lead to the deaths was excused on the basis of psychiatric evidence. An application was made that asserted that the train driver had suffered depression and post-traumatic stress disorder as a result of the incident, and that there would be a real risk of harm if he was required to give evidence.

The coroner may also direct that a witness is only required to give written rather than oral evidence (s 37(4)(a)(i) Coroners Act). For example, in Christensen v Deputy State Coroner, it was established that while the coroner may order a person to give evidence as a witness, there is no requirement that this must be performed orally rather than in writing (see *Christensen v Deputy State Coroner* [2021] QSC 38). The Supreme Court held that it was within the coroner's power to excuse a witness who was suffering from post-traumatic stress disorder from giving oral evidence to avoid adverse impacts to their mental state.

The inquest into the death of Marcia Anne Kathleen Maynard highlighted the pressures that can be placed on witnesses in coronial investigations (see *Inquest into the death of Marcia Anne Kathleen Maynard* (2020) 2015/3872). Ms Maynard was a registered nurse who provided care to prisoner Garnet Mickelo prior to his death. As this death occurred in custody, an inquest was required to be held. Ms Maynard was required as a witness in the proceedings and expressed to her family, lawyers and colleagues that she was experiencing significant stress in relation to having to present evidence. Before the inquest was held, Ms Maynard committed suicide and a coronial investigation into the circumstances of her death was conducted.

In response to Ms Maynard's death, the coroner made a number of comments and preventative recommendations in relation to witnesses in coronial proceedings under s 46 of the Coroners Act. Having regard to the considerable stress that witnesses experience in the coronial process, the coroner commented on the need to minimise counter-therapeutic consequences. It was recommended that the Queensland Government facilitate and fund a counselling program called Coronial Family Services for families and witnesses involved or impacted by the coronial process.

Expert evidence

The coroner may obtain expert opinion where it is considered necessary for the investigation. Forensic medicine officers and mental health clinicians are often consulted to review investigation material and provide preliminary opinions in relation to the evidence. Depending on the complexity of the case, the coroner may also seek approval from the State Coroner to obtain an independent expert report where specialist clinical or technical expertise is required.

Expert witnesses may also be required where there is doubt or competing opinions in relation to the cause of death. Depending on the circumstances, this may require a forensic or specialist pathologist to conduct an autopsy to resolve the issues in question. However, these procedures are invasive, and these issues can often be resolved locally with external examination by an appropriately qualified practitioner and review of police evidence.

Making submissions

As noted previously, a family member or another person with sufficient interest has a right to appear, examine witnesses and make submissions at an inquest (s 36 Coroners Act). When a person is making submissions, the issues must be limited to those upon which the coroner can comment such as public health or safety, the administration of justice and strategies for preventing future deaths in similar circumstances (s 36(3)(b) Coroners Act).

The discretion of the coroner to restrict submissions was discussed in the case of *Annetts v McCann* (1990) 170 CLR 596. In this case, relating to events in Western Australia, counsel for the deceased's family sought permission to make closing submissions on any aspect of the inquest before the coroner reached a final decision. The coroner refused that request on grounds that, while the family members had sufficient interest, this did not extend to making submissions on any potential finding, including that may be adverse to their own or the deceased's interests. The coroner asserted that they had an unfettered discretion to refuse counsel's closing address. On appeal, the High Court disagreed that the coroner had an unfettered discretion. Rather, the deceased's family members had a common law right to be heard regarding potential adverse findings against themselves or the deceased. The majority of the High Court held that this accorded with the principles of natural justice and that the coroner's legislation had not excluded a right to comment on adverse findings. However, it was established that this right did not extend to the ability to comment on the broader subject matter of the inquest as claimed on behalf of the family.

The extent to which family members are entitled to make submissions to a coroner in Queensland was discussed in the inquest into the death of Hamid Khazaei (see *Inquest into the death of Hamid Khazaei* (2018) 2014/3292, pp. 6-10). It was accepted that the decision in Annetts v McCann did not limit the matters to which family members could make submissions in Queensland. This was on the basis that Queensland's Coroners Act did not restrict or limit

matters on which family members could make submissions. The coroner held that on the basis of legislative history, the reasoning in Annetts v McCann did not apply to an inquest in Queensland. In other words, family members and those with a sufficient interest are entitled to make submissions with respect to findings that the coroner is required to publish and any recommendations that may be made under the Coroners Act (ss 36, 46 Coroners Act).

Statutory Requirements of Coronial Findings

The coroner is required to make findings about whether or not a death has in fact occurred (s 45(1) Coroners Act). When investigating an actual or suspected death, the coroner must report findings on (s 45(2) Coroners Act):

- the identity of the deceased person
- how the person died
- when the person died
- where the person died (Queensland or interstate)
- the cause of death.

However, the scope of a coronial inquest is extensive and does not have to be confined solely to these matters (see *Doomadgee v Clements* [2005] QSC 357, 360; *Queensland Fire & Rescue Authority v Hall* [1988] 2 Qd R 162, 170). *The State Coroner's Guidelines 2013* provide guidance on how the coroner is likely to approach making these findings in practice.

A written copy of the coroner's findings must be given to a family member of the deceased who has indicated acceptance on behalf of the entire family (s 45(4)(a) Coroners Act). If a coronial inquest is held, a copy must also be given to any person with a sufficient interest who attended the inquest (s 45(4)(b) Coroners Act).

Where a death has occurred in care, custody or in relation to police operations, the coroner is required to give a copy of the findings to the Attorney-General, the relevant chief executive and minister (s 47 Coroners Act).

Coronial Recommendations

The coroner is able to comment and make recommendations on anything connected with an inquest that relates to public health or safety, the administration of justice or preventing future deaths in similar circumstances 9s 46(1) Coroners Act). A written copy of these comments must be given to the relevant family member and any person with a sufficient interest who attended the inquest (s 46(2) Coroners Act). The coroner must not include any statements relating to the civil or criminal liability of any person in their findings or comments but may refer matters to another agency for further investigation (s 46(3) Coroners Act).

Recommendations may be specifically directed at agencies in order to prevent deaths from similar circumstances in the future (s 3(d) Coroners Act). Recommendations may have a broad rather than direct connection to the death being investigated (see *Doomadgee v Clements* [2005] QSC 357, 360; *Thales Australia Limited v The Coroners Court & Ors* [2011] VSC 133). However, any recommendation must relate to public health or safety, the administration of justice or death prevention (s 46(1) Coroners Act).

Before making a recommendation, the coroner will usually seek input from affected agencies to ensure that the proposed recommendation can be practically implemented. Where practicable, this will occur prior to the inquest to ensure that the parties have sufficient time to consider the circumstances and make suggestions for the coroner's recommendations.

While the Coroners Act does not mandate a government response to coronial recommendations, there is an administrative arrangement that requires relevant government agencies to publicly report on their response. These responses are published on the Department of Justice and Attorney-General website.

Case Study: Dreamworld

On 25 October 2016, the Thunder River Rapids Ride at Dreamworld malfunctioned, causing two rafts to collide. Although the ride operators and emergency services immediately responded to the incident, the four riders died at the scene (see *Inquest into the deaths of Kate Louise Goodchild, Luke Jonathan Dorsett, Cindy Toni Low and Roozbeh Araghi* (2020) 2016/4486, 2016/4485, 2016/4480, 2016/4482).

The inquest highlighted serious failures to review and update safety procedures at Dreamworld. The coroner also identified a lack of clarity in the standards governing theme park rides, and recommended changes to Queensland's regulatory framework around inspecting and licensing major amusement park rides.

The government responded by introducing comprehensive new safety requirements under the *Work Health and Safety Regulation 2011* (Qld). The government is also considering a Code of Practice for amusement rides in order to update standards.

Publication of Findings

Where a death is investigated through an inquest, the coroner must publish their findings and any comments on the State Coroner's website (s 46A(1) Coroners Act). Where a death investigation does not proceed to inquest, the coroner may publish findings where it is in the public interest to do so and family members of the deceased have been consulted (s 46A(2) Coroners Act).

Non-publication orders

The coroner may make orders prohibiting the publication of information relating to a pre-inquest conference or inquest proceedings. This could include indications that the cause of death may have been a suicide or any information that may incriminate a witness (s 41(1) Coroners Act). There are significant penalties for contravening a non-publication order by the coroner (s 41(2) Coroners Act). The Coroners Act also prohibits the publication of a question disallowed by the Coroners Court during a pre-inquest conference or inquest proceedings and any answer given in response (s 41(3) Coroners Act).

The coroner may also prohibit a person from filming, photographing, sketching or recording anything in or near the location where the inquest or pre-inquest conference is held. This prohibition extends to publication, with significant penalties for contravention where a person does not have a reasonable excuse (s 41(4)-(5) Coroners Act).

The coroner may also make an order prohibiting part or whole of the publication of the record of proceedings under the Coroners Act (s 41(6)).

Next of kin in the coronial process

The next of kin is usually a family member of the person who has died.

A family member includes a spouse, de facto partner, child, parent, grandparent, grandchild or sibling of the person who died. If the person who died was an Aboriginal person or Torres Strait Islander, family members will also include appropriate persons as determined by the tradition or custom of the community they belonged to (sch 2 Coroners Act).

When someone dies unexpectedly, police usually visit the immediate family to inform them about their family member's death. During the visit, police will ask who the family's nominated next of kin is and provide this information to the staff at the Coroners Court of Queensland.

The family's nominated next of kin is the main point of contact between the Coroners Court and the family. A family member who is not the nominated next of kin may also be able to obtain information from the Coroners Court with the permission of the coroner or coronial registrar investigating the death.

If you are a family member and you disagree with who has been nominated as the next of kin or the person who is the nominated next of kin is not sharing information with you, you should contact the staff at the Coroners Court so that your concerns can be raised with the coroner or coronial registrar.

Access to information

Accessing information relating to the coronial process may inform you about the death of a loved one. It is also important that certain organisations have the right to access information so

that they can conduct other investigations or legal, financial or systemic reviews. However, as the information coming to light in a coronial investigation is often confidential, personal or distressing, there are also checks and balances to ensure that information is being released to the right people in the right circumstances.

Types of material that may be accessible

A request for access to coronial documents and investigation documents can be made, including when the coroner is still investigating the death (s 54(4) Coroners Act).

Coronial documents are defined as documents prepared specifically for a coronial investigation or inquest, and include (sch 2 Coroners Act):

- autopsy reports
- toxicology certificates
- a pathologist's preliminary advice to the coroner
- police photographs of the death scene
- police reports to the coroner
- witness statements
- independent reports commissioned by the coroner
- the final report outlining the cause of the death and the coroner's findings.

Investigation documents are documents that were created for a purpose other than the coronial investigation, but were obtained by the coroner to inform their investigation. Examples of investigation documents include suicide notes, texts, emails, telephone recordings, medical records, departmental records and policy documents, CCTV footage and confidential documents obtained by the coroner under other legislation.

Access to information will be declined if it is (s 52 Coroners Act):

- subject to legal professional privilege (e.g. Counsel Assisting's legal advice to the coroner)
- likely to prejudice a fair trial, the investigation of an alleged offence or the maintenance of law enforcement or public security measures
- likely to lead to the identification of a confidential source of information for law enforcement purposes
- likely to endanger a person's life or safety
- likely to facilitate a person's escape from custody
- about a person's personal affairs (e.g. their sexuality or criminal history)

- obtained by the coroner under other legislation (instead you will need to apply for access using the process outlined in that legislation) (s 54(4) Coroners Act).

If a document has been prepared by a government department, you may be able to access the document directly from the department via a 'Right to Information' request.

A transcript of the inquest can be obtained directly from Auscript via their website or phone 1800 287 274.

Access to material for people with a sufficient interest

The coroner involved in the investigation can permit a person to access coronial and investigation documents (s 54(1)-(3) Coroners Act) or a physical exhibit (s 62A Coroners Act) if:

- that person has a sufficient interest in accessing the document
- the access is in the public interest
- the coroner has, to the extent practicable, consulted with and had regard to, the view of the family of the deceased.

In determining whether a person has a sufficient interest, the coroner may consider:

- the applicant's connection with the deceased person
- the nature of the applicant's involvement in the events leading to the death
- why the applicant wants to access the document—mere curiosity, newsworthiness, a trivial interest or a general public interest is not enough.

The following categories of applicant will generally be regarded as having sufficient interest (s 54 Coroners Act):

- the immediate family members of the deceased (s 54(3)(a) Coroners Act)
- any person or entity whose actions may have contributed to the death, particularly when it is possible the coroner may make an adverse finding about that person
- a person who was materially involved in the events leading to the death
- any person given or eligible for leave to appear at an inquest
- the deceased's personal representative
- a person's legal representative in criminal or civil proceedings relating to the death
- an investigative entity whose statutory function enables or requires it to inquire into the death (e.g. WorkSafe Queensland, Australian Transport Safety Bureau, health regulatory authority, Crime and Corruption Commission, and Office of Aged Care and Quality Compliance)

- an insurer, superannuation fund or workers compensation entity considering a claim in respect of the death or the incident in which the death occurred
- a health practitioner or service advising a family member about possible genetic predisposition to the condition that caused the death
- a public official or regulatory entity with public health or safety responsibilities (e.g. the Chief Health Officer, Therapeutic Goods Administration, Australian Health Safety and Quality Commission, Office of Fair Trading, Civil Aviation Safety Authority).

Access to material in the public interest

The coroner can also permit access to material if the coroner considers the access to be in the public interest and, to the extent practicable, has consulted with and had regard to the views of a family member of the deceased person (s 54(3)(b) Coroners Act). Information is generally considered to be in the public interest if it will inform death prevention policy initiatives, raise public awareness, correct public misinformation or inform industry regulators.

The coroner can also refuse access to material in the public interest (s 56 Coroners Act). For example, it may be appropriate to withhold information that could trigger copycat suicidal behaviour.

Applying for access to material

If you meet the criteria of having sufficient interest or you have a public interest, you can apply for access by completing an Application for Access to Coronial Documents.

You will be required to include:

- proof of your identity documents (e.g. full birth certificate, Australian passport (current or expired within the last two years), Australian Citizenship Certificate, international passport (current or expired within the last two years), current photo driver licence, current Department of Veterans Affairs Card, current Centrelink or Social Security Card or 18 plus card)
- proof of relationship documents (if applicable) (e.g. birth certificate with both parents' details or evidence of Child Support payments)
- change of name documents (if the name on your request is different to the name on your identification and proof of relationship documents) (e.g. a marriage certificate issued by a registry or celebrant, Registration of change of name issued by a Births, Deaths and Marriages registry, divorce papers or a deed poll).

You are not required to have any of these documents certified.

If the coronial investigation is still in progress, you will need to send your application to the investigating coroner. You can contact the Coroners Court if you are unsure who the investigating coroner is.

If the coronial investigation has been finalised, you will need to send your application via:

- email to state.coroner@justice.qld.gov.au
- post to Coroners Court of Queensland, GPO Box 1649, Brisbane Qld 4001.

If your matter is current, or less than nine years old, it can take up to five weeks to process your application.

Fees for access to material

When accessing coronial investigation material, you may be required to pay a fee. If you need to pay any fees, the Coroners Court will tell you how much you owe and how to pay (generally by cheque or money order) before releasing the material.

Conditions on access to material

The coroner will usually place conditions on your access to the material. It is common that the coroner will only allow you to use the information for coronial purposes, and will not allow you to disseminate the information for any other purposes. If you breach these conditions, you may be imprisoned for up to two years (s 55(2) Coroners Act).

Decisions Made by a Coroner

The coroner may make a number of decisions after a death has occurred. If you are unhappy with a coroner's decision, you can request an explanation of the decision. The coroner's explanation will show you what information was taken into account by the coroner in making the decision, and help you to identify anything you think the coroner incorrectly decided.

Decisions you may request an explanation for

The coroner is not required to provide an explanation for every decision made (see *Public Service Board (NSW) v Osmond* (1986) 159 CLR 656). However, you will be able to request an explanation for a decision if:

- the decision is an ultimate decision and not just a step along the way in the coroner's reasoning process (ss 8, 21 *Judicial Review Act 1991* (Qld) (Judicial Review Act)) (see *Attorney-General (Cth) v Queensland* (1990) 25 FCR 125, 142; *Australian Broadcasting Tribunal v Bond* (1990) 170 CLR 321, 337). Generally, if the decision is provided for in the Coroners Act and, by itself, affects your legal rights or obligations, it will be reviewable (see *Griffith University v Tang* (2005) 221 CLR 99)

- you have been adversely affected by the decision (s 7 Judicial Review Act) to a greater extent than the general public.

You will also be able to request an explanation for a decision if, in making the decision, the (ss 20, 32(1) Judicial Review Act):

- rules of natural justice were not upheld
- coroner did not follow the required procedures
- Coroners Act or other legislation did not authorise the decision
- decision was an improper exercise of the power conferred by the Coroners Act
- decision involved an error of law
- decision was induced or affected by fraud or was not justified by evidence or was otherwise contrary to law.

Generally, you will be able to request an explanation if the coroner decided:

- that a death is, or is not, a reportable death (s 11A Coroners Court)
- to hold, or not to hold, an inquest (s 28 Coroners Act)
- about your right to appear, examine witnesses and make submissions at an inquest (s 36 Coroners Act)
- about excluding someone from the inquest or the pre-inquest conference (s 43 Coroners Act).

To make the request, you must give written notice to the coroner who made the decision by:

- emailing the state.coroner@justice.qld.gov.au
- sending a letter to the Coroners Court of Queensland, GPO Box 1649, Brisbane Qld 4001.

Coroner's explanation

If your request is approved, the coroner must provide you with a statement containing the reasons for their decision (s 34 Judicial Review Act) including their findings on key factual issues and reference to the evidence on which those findings are based (s 27B *Acts Interpretation Act 1954* (Qld)) (see *Gibson v The Minister for Finance, Natural Resources and the Arts* [2012] QSC 132). This statement must be provided to you, as soon as practicable and within 28 days of receiving the request (s 33(1) Judicial Review Act).

If the coroner's statement does not properly explain their conclusions or lacks detail, the statement may not be compliant (see *Our Town FM Pty Ltd v Australian Broadcasting Tribunal* (1987) 77 ALR 577, 594–596; *Ergon Energy Corporation Ltd v Rice-McDonald* [2010] 1 Qd R

516 [23]; *Salazar-Arbelaez v Minister for Immigration and Ethnic Affairs* (1977) 18 ALR 36) and you can apply to the court for an order to comply (s 38 Judicial Review Act) or an order to provide a further statement (s 40 Judicial Review Act). To do this, you will need to fill out a Form 55. Once you have filled out the form, you will need to go to the registry at a court house to have it signed and sealed by the registrar. Following this, you will need to serve it on the coroner via email or post as outlined above.

Refusal to give an explanation

If the coroner refuses to give reasons, they must, within 28 days of receiving your request:

- advise you why you are not entitled to make the request
- apply to the court for an order declaring that you were not entitled to make the request (s 33(2) Judicial Review Act).

The coroner can also refuse to give reasons if you have not requested the reasons within a reasonable time after the decision was made (s 33(4) Judicial Review Act). In that case, they must give you written notice stating why your request was denied (s 33(5) Judicial Review Act).

Review of Decisions Made by a Coroner

There are a number of decisions that are made throughout the investigation and inquest process. If you are not satisfied with the outcome of a particular decision, then you may be entitled to seek some form of review or reconsideration of the decision.

Compared with other jurisdictions, the coronial jurisdiction is relatively informal. Before pursuing formal review options, you may wish to write to the investigating coroner if you have questions or would like to seek further information at any stage throughout the investigation or inquest process.

Review options available under the Coroners Act

Decisions about whether a death is reportable

If you are not satisfied with a coroner's decision about whether a death is a 'reportable death', then you can seek a review of the decision.

If the decision was made by a coroner other than the State Coroner, then you will need to apply to the State Coroner for a review of the decision.

If the decision was made by the State Coroner, then you will need to apply to the District Court for a review of the decision.

You must make this application within 14 days of receiving the State Coroner's written reasons for the decision.

Setting Aside Coroner's Findings

A coroner will hand down findings at the conclusion of an inquest. If you are not satisfied with a finding the coroner made, you may wish to seek a review (see Review of Decisions Made by a Coroner).

The State Coroner may set aside a finding in two circumstances:

- if new evidence casts doubt on the finding
- if the finding was not recorded correctly (s 50(4) Coroners Act).

If the State Coroner decides to set aside a finding, then they may reopen the inquest to reconsider that finding, hold a new inquest or direct another coroner to take one of these steps (s 50(6) Coroners Act).

If the State Coroner refuses to set aside a finding, then you can apply to the District Court for a review of the finding, even if your application to the District Court is on the same or substantially the same grounds as your previous application to the State Coroner (s 50(2) Coroners Act).

The District Court may set aside a finding in four scenarios:

- new evidence casts doubt on the finding
- the finding was not correctly recorded
- there was no evidence to support the finding
- the finding could not be reasonably supported by the evidence (s 50(5) Coroners Act).

If the District Court decides to set aside a finding, the District Court may order the State Coroner to reopen the inquest to reconsider that finding, hold a new inquest or direct another coroner to take one of these steps (s 50(7) Coroners Act).

Review of comments or recommendations made by the coroner

There is no legal right under the legislation allowing people to seek review of comments or recommendations, as distinct from formal findings, made by a coroner.

Review of District Court Decisions

If you are unhappy with the outcome of a review by the District Court, you can seek leave to apply to the Queensland Court of Appeal for an appeal of the District Court decision (s 118 *District Court of Queensland Act 1967* (Qld) (DCQ Act).

The Court of Appeal may not grant you leave to appeal the District Court decision. In determining whether to grant you a right to appeal, the Court of Appeal may:

- inform itself about the case in any way that it considers appropriate, which includes referring to the appeal record (being the records from the District Court and/or Coroners Court)
- decide the application for leave summarily without hearing any evidence (s 118(4) DCQ Act).

The Court of Appeal may grant you leave to appeal if it considers that there is a reasonably arguable right of appeal (s 118(5) DCQ Act). Generally, an appeal to the Court of Appeal will be held by way of rehearing (r 765 *Uniform Civil Procedure Rules 1999* (Qld) (UCP Rules)). This means that the Court of Appeal will only consider the evidence that was before the District Court, not any new evidence. You must apply for leave to appeal within 28 days of the date the District Court decision was given (r 748 UCP Rules).

Judicial Review

In addition to the review options outlined above, you may also be able to seek judicial review of recommendations or findings made by a coroner.

Judicial review is narrower than other forms of appeal or review. A court undertaking judicial review of a decision will consider the legality of the decision, rather than the merits of the decision. In other words, the issue before the court is whether the decision was made in accordance with the law and procedural requirements, not whether the decision was a good decision.

For more information about judicial review generally, refer to the Queensland Law Handbook chapters on Complaints against Government—Judicial Review and Complaints against Government—Administrative Appeals. In the coronial context, this would mean considering whether the coroner was legally permitted to make the relevant findings or recommendations, not whether the findings or recommendations were justified based on the evidence or circumstances of the case.

Examples of the grounds on which you may seek judicial review of a coronial finding or recommendation include:

- breach of procedural fairness or natural justice
- fraud
- bias
- an error of law on the face of the record
- a jurisdictional error
- unreasonableness (s 21 Judicial Review Act).

You must apply to the Supreme Court for a judicial review within 28 days of the contested decision being made (s 26 Judicial Review Act).

Decisions by coroners that have been the subject of judicial review in Queensland were, for example, a decision:

- to excuse a witness from giving evidence at an inquest (see *Christensen v Deputy State Coroner* [2021] QSC 38)
- to access or admit certain documentary evidence during an inquest (e.g. the complaint history of a police officer) (see *Commissioner of Police v Clements* [2005] QSC 203)
- to call on evidence from a particular witness (see *Doomadgee v Clements* [2005] QSC 357, 360; *Walter Mining Pty Ltd v Coroner Hennessey and Ors* [2009] QSC 102)
- to admit evidence from an expert to assist the coroner with making any recommendations at the conclusion of the inquest (see *Beale v O'Connell* [2017] QSC 127)
- about whether to reopen an inquest (see *Jones v State Coroner* [2019] QSC 175; *Yu v Attorney-General for the State of Queensland* [2010] QSC 195)
- about the cause of a person's death (see *Milu v WJ Smith & Ors* [2003] QSC 430)
- not to refer information obtained during the course of a coronial investigation to the Director of Public Prosecutions (see *Nona and Anor v Barnes* [2012] QSC 35).

Administrative Decisions and Human Rights

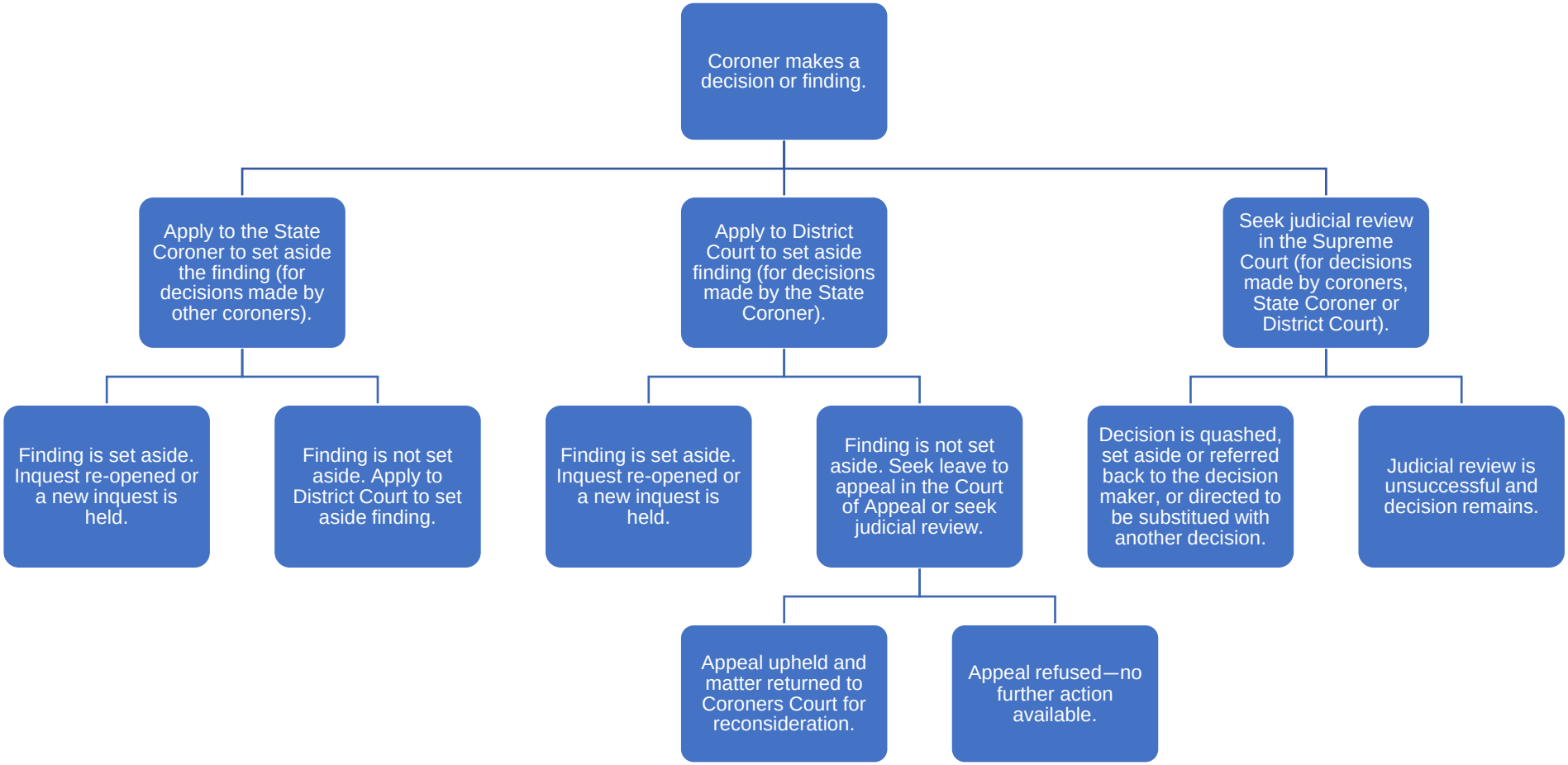
Human rights may also be relevant to the coronial jurisdiction, and failure to act in accordance with human rights could be relevant in a potential appeal or review of a coroner's decision (see also the *Queensland Law Handbook* chapter Human Rights Law in Queensland).

The *Human Rights Act 2019* (Qld) (Human Rights Act) makes it unlawful for public entities to act or make decisions in a way that is not compatible with human rights or to fail to give proper consideration to human rights when making a decision (s 58). Section 9(4)(b) of the Human Rights Act provides that a public entity does not include a court or tribunal, except when acting in an administrative capacity. As such, a coroner acting in an administrative capacity must not act in a way that is incompatible with human rights. Additionally, a coroner acting in a judicial capacity is bound to interpret legislation in a manner that is compatible with human rights (s 48 Human Rights Act).

If you think that a coroner has failed to act in accordance with the Human Rights Act, you can complain directly to the Queensland Human Rights Commission. However, it is important to note that breach of the Human Rights Act is not by itself a ground for appeal or review of a decision. There is no standalone legal remedy for a breach of the Human Rights Act. If you

have another ground on which to bring an action in a court or tribunal, then you can add or 'piggy-back' the human rights complaint onto the other ground (s 59 Human Rights Act).

Formal review options in the coronial jurisdiction



Support Services

Service	Focus and contact details
Legal advice	
Queensland Coronial Legal Service (QCLS) at Caxton Legal Centre or Townsville Community Law	Lawyers at the QCLS can assist by: • providing legal advice about the coronial process and associated issue • providing representation for bereaved family members appearing in particular inquests • connecting families with social workers, counselling and other support services. Book an appointment with: • Caxton Legal Centre (Brisbane) on (07) 3214 6333 or • Townsville Community Law on (07) 4721 5511.
Aboriginal and Torres Strait Islander Legal Service (ATSILS)	ATSILS provides culturally focused legal services for Aboriginal and Torres Strait Islander peoples across Queensland. You can contact ATSILS via: • the toll-free helpline on 1800 012 255 (24 hours, 7 days) • phone on (07) 3025 3888 • email at info@atsils.org.au.
Counselling and support	
Coronial process	
Coronial Family Services (**CFS**)	CFS counsellors, social workers and psychologists can assist by: • supporting the family of a loved one whose death is being investigated • explaining the process when a coroner is investigating a death • providing information about autopsy examinations • providing support for identifications and viewings • providing referrals to support groups and local services • advocating and liaising with other agencies on your behalf. You can contact CFS via: • free call on 1800 449 171 • phone on (07) 3096 2794 • email at fss.counsellors@health.qld.gov.au.
Court Network	The Court Network volunteers provide non-legal support to people accessing the court system, including the matter progress into an inquest. You can contact the Court Network via: • phone on 1800 267 671 • the online form at www.courtnetwork.com.au/contact/?reason=general.

Grief and support	
Lifeline	Trained crisis support workers can provide support to anyone experiencing a personal crisis, contemplating suicide or caring for someone in crisis. You can contact Lifeline via: • phone on 13 11 14 (24 hours, 7 days) • text on 0477 13 11 14 (12 pm to midnight (AEST)) • online chat at www.lifeline.org.au/crisis-chat/ (7 pm to midnight (AEST)).
Beyond Blue	Beyond Blue provides supports and services to people affected by anxiety, depression and suicide. You can contact Beyond Blue via: • phone on 1300 22 4636 (24 hours, 7 days) • online chat at www.online.beyondblue.org.au/WebModules/Chat/InitialInformation.aspx (from 11 am to midnight (AEDST) • completing the email form at www.online.beyondblue.org.au/email/#/send (with a response within 24 hours) • posting in the online peer support forum at https://www.beyondblue.org.au/get-support/online-forums.
Kids Helpline	Kids Helpline is a free and confidential counselling service for young people aged 5 to 25. You can contact Kids Helpline via: • phone on 1800 55 1800 • email at counsellor@kidshelpline.com.au • online chat on www.kidshelpline.com.au/get-help/webchat-counselling.
Salvation Army	The Salvation Army provides services to people experiencing hardship. You can contact the Salvation Army via: • phone on 13 72 58 • the online form at www.salvationarmy.org.au/contact-us/.
Queensland Transcultural Mental Health Centre	The Queensland Transcultural Mental Health Centre provides culturally responsive mental-health care and support to people from culturally and linguistically diverse backgrounds. You can contact Queensland Transcultural Mental Health Centre via: • phone on 3317 1234 • the toll-free phone on 1800 188 189 • the general queries email at QTMHC@health.qld.gov.au.
Relationships Australia (Queensland)	Relationships Australia provides counselling, mediation, education and support services relating to children and family, addiction, trauma issues and diverse groups in the community. You can contact Relationships Australia via: • the client contact centre on 1300 364 277

	• the online form at www.raq.org.au/contact.
Australian Centre for Grief and Bereavement	The Australian Centre for Grief and Bereavement provides a range of grief and bereavement education such as counselling training and grief consulting. You can contact the Australian Centre for Grief and Bereavement via: • phone on (03) 9265 2100 • the national phone on 1800 642 066 • email at info@grief.org.au.
GriefLine Community and Family Services	GriefLine provides 24/7 access to tools, wellbeing practices and coping strategies for people experiencing grief. You can contact GriefLine via: • the Queensland HelpLine on (07) 3062 7327 (7 days, 6 am to midnight) • the national toll-free line on 1300 845 745 (7 days, 6 am to midnight) • the online moderated forum at www.griefline.org.au/forums/ • the enquiry form at www.griefline.org.au/contact-us/.
National Centre for Childhood Grief	The National Centre for Childhood Grief provides: • free and unlimited grief counselling for bereaved children aged 3 to 18 years • grief counselling for recently bereaved adults for a fee • education and training for individuals, schools and other organisations handling the grief of children and young people. You can contact the National Centre for Childhood Grief via: • phone on 1300 654 556 • the general email at info@childhoodgrief.org.au • the bereavement counsellor email at drmckissock@icloud.com.
Death by suicide	
StandBy Support After Suicide	StandBy Support provides support for anyone who has been bereaved or impacted by suicide at any stage in their life, including: • face-to-face and telephone support, accessible 24/7 in your area • expertise, understanding and resources • follow-up contact continuing for up to two years. You can contact StandBy Support via: • phone on 0429 147 491 • email at national@standbysupport.com.au • the online contact form at www.standbysupport.com.au/#Contact.
Survivors of Suicide Bereavement Association	The Survivors of Suicide Bereavement Association provides support for those who have lost loved ones to suicide. They run support groups across Queensland, offer awareness and education and promote prevention.

	You can contact the Survivors of Suicide Bereavement Association via: • phone on 1300 767 022 • the online contact form at www.sosbsa.org.au/contact • email at secretary@sosbsa.org.au.
Death of a child	
Red Nose (formerly SIDS and KIDS Queensland)	Red Nose provides support services for families impacted by the death of a baby or child during pregnancy, birth, infancy and early childhood. You can contact Red Nose via: • phone on 1300 308 307 (24 hours, 7 days) • online live chat at www.rednosegriefandloss.org.au/live-chat (10 am to 3 pm (AEST), Monday, Wednesday and Friday).
Stillbirth and Neonatal Death Support (SANDS)	SANDS provides: • a safe space for bereaved parents to talk with volunteer supporters who have experienced an early pregnancy loss, stillbirth or newborn death • resources on grief and loss for the wider community and advocates. You can contact SANDS via: • the phone support line on 1300 308 307 (24 hours, 7 days) • the online form at www.sands-miscarriagestillbirthnewborndeathsupport.aus.rit.org.uk/forms/contact-us.
Compassionate Friends Queensland	The Compassionate Friends is an international self-help support organisation for parents, siblings and grandparents grieving the loss of a child, offering: • support-group meetings to connect and share with other parents and families who have experienced the loss of a child • informal coffee chats on the first Monday of every month • annual seminars and remembrance services for families to gather and celebrate the life of their child. You can contact Compassionate Friends Queensland via: • the Queensland support line on (07) 3540 9949 • the national helpline on 1300 064 068 • the drop-in services between 9.30 am and 3.30 pm in their Brisbane office; • the support email at admin@tcfqld.org.au • the online form at www.compassionatefriendsqld.org.au/contact-us-online/.
Crime	
Victim Assist Queensland	Victim Assist provides information and advice for victims of crime, including information about support services, victims' rights and financial assistance. You can contact Victim Assist via: • phone on 1300 546 587 (during business hours)

	• email at victimassist@justice.qld.gov.au • the information request form at www.qld.gov.au/law/crime-and-police/victims-and-witnesses-of-crime/request-victim-of-crime-information.
Victims Counselling and Support Services	The Victims Counselling and Support Service is a counselling and support service to Queensland residents who have been personally affected by violent crime. You can contact the Victims Counselling and Support Service via: • phone on 1300 139 703 (24 hours, 7 days) • live chat at www.vcss.org.au/ (9 am to 5 pm, Monday to Saturday).
Queensland Homicide Victims' Support Group	The Homicide Victims' Support Group offers counselling, support and information to families and friends of homicide victims. You can contact the Homicide Victims' Support Group via: • the 24-hour support line on 1800 774 744 • email at admin@qhvsg.org.au • the online form at www.qhvsg.org.au/contact-us/.
Sisters Inside	Sisters Inside advocates for the collective human rights of women and girls in prison. You can contact Sisters Inside via: • the Brisbane free-call phone on 1800 003 242 • the Townsville free-call phone on 1800 290 662 • the online form at www.sistersinside.com.au/contact/.
Other	
Registry of Births, Deaths and Marriages	The Registry website outlines the process for applying for a death certificate. For assistance with the process, you can contact the registry via: • phone on 1300 366 430 • email on bdm-mail@justice.qld.gov.au.
Public Trustee	The Public Trustee website contains information about managing a deceased estate. For assistance with the process, you can contact the Public Trustee via: • phone on 1300 360 044 • the online form at www.pt.qld.gov.au/contact/contact-us/make-contact/.
DonateLife Queensland	DonateLife coordinates all organ and tissue donor activities across the state, and offers care and support to donor families. You can contact DonateLife via: • phone on (07) 3176 2350 • email at donatelife@health.qld.gov.au.
Translating and Interpreting Service (TIS)	TIS is an interpreting service for people who do not speak English, and for agencies and businesses that need to communicate with their non-English speaking clients. You can contact TIS via:

	• the immediate phone interpreting service on 131 450 (24 hours, 7 days) • the pre-booked enquiries email at tis.prebook@homeaffairs.gov.au • the online form at www.tisnational.gov.au/en/Help-using-TIS-National-services/Contact-TIS-National.
National Relay Service	The National Relay Service provides support for phone and video calls for people who are deaf, or find it hard to hear or speak on the phone. You can contact the National Relay Service via: • the voice relay phone number on 1300 555 727 (24 hours a day) • the SMS relay number on 0423 677 767 (24 hours a day) • the Type and Read service on 133 677 (24 hours a day) • the chat call form at www.nrschat.nrscall.gov.au/nrs/internetrelay • the caption relay service at www.nrscaptions.nrscall.gov.au/nrs/captionrelay.

Legal Notices

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