Australasian Coroner's Society Conference

The role of the Coroner in accordance with the *Coroners Act 1997*

The *Coroners Act 1997* that apply in relation in accordance with the role of the Chief Coroner includes;

Section 7
Which includes the Chief Coroner's powers and functions

(1) The Chief Coroner is responsible for ensuring the orderly and the expeditious discharge of the business of the court.
(2) Subject to this Act, and after such consultation with the coroner of the court as is appropriate and practicable, the Chief coroner shall make such arrangements as to the Coroner who is to constitutive a court inn particular matter of class matters as the Chief Coroner thinks fit.

Jurisdiction of Coroner

Section 12- General power of Coroner preserved
Section 13 Coroners Jurisdiction in relation to deaths

(1) A coroner shall hold an inquest into the manner and cause of a person who –
    (a) Is killed; or
    (b) is found drowned; or
    (c) dies, or is suspect to have died, a sudden death the cause of which is unknown.
    (d) dies under suspicious circumstances; or
    (e) dies during or within 72 hours after or as a result of
        (i) an operation of a medical, surgical, dental or like nature; or
        (ii)an invasive medical diagnostic procedure.

    Other than an operation or procedure that is specified in the regulations to be an operation or procedure to which this paragraph does not apply; or

    (f) dies and a medical; practioner has not given a certificate as to the cause of death; or

    (g) dies not having been attended by a medical practioner at any time within the period commencing 3 months prior to the death; or

    (h) dies after an accident where the cause of death appears to be directly attributable to the incident; or

    (i) dies, or is suspect to have dies in circumstances that in the opinion of the Attorney- General, should be better ascertained; or

(j) dies in custody.

(2). A Coroner has jurisdiction to hold an inquest into the manner and cause of death, outside the Territory, of a person if –

(a) the person was ordinarily resident in the Territory; and
(b) the death occurred in any of the circumstances referred to in subsection (1)

(3)A coroner has jurisdiction to hold an inquest notwithstanding that-

a. the body of the deceased –
i. is not within the Territory; or
(ii) has been destroyed; or
(iii) is in a place which can not be recovered; or
(c) in the case of a suspected death – the body of the deceased can not be found.

Section 14-Decision not to conduct a hearing
Section 15- Control of the body of the deceased
Section 17- Assistance to State and other Territory Coroners

Division 2- Inquires into Bushfires.
Division 3- Inquires into disasters

Part 4- Post Mortem examination and examinations
Part 5- Inquest and Inquires

Section 34- Hearings
Section 35- Time and Place
Section 36- Ajournment
Section 37- Notification
Section 38- Notice relating to conduct of hearing
Section 39- Non-custodial deaths
Section 40- Hearing in public except in certain cases
Section 41- Hearing to be held without jury
Section 42- Representation at hearing

Division 3- Evidence
Section 47- Procedure
Section 48- Evidence

Division 4- Findings and Report
Section 52- Coroners Findings
Section 53- Interim Findings
Section 55-Adverse comment in findings or report

Division 5- Indictable offences

Division 6- General powers of coroner

Part 6- Deaths in custody – additional provisions

The Coronial Process

Under the Coroners Act 1997 the Coroner has the power to investigate deaths that occur within our community, not just those that are in custody but in respect of all deaths within the community. If however a death does occur in a hospital while a person is under a order under the *Mental Health Treatment and Care Act 1994* then this is considered a death in custody. Therefore the Coroner is under an obligation in accordance with section 74 of the Act to make findings in relation to the quality of care, treatment and supervision of the patient.

Some other issues of concern for the Coroner.

Risk of harm to individuals with mental health issues

- standards of safety in service delivery
- follow- up care and support for those who have suffered an acute episode
- Crisis Assessment and Treatment Team
- Inpatient services in Hospital
- The Design limitations of various psychiatric units
- Management of patients
- The role of policy and procedures in relation to the observation of patients who are acutely ill-i.e. ARC levels, patient progress notes and visual observations.
- Time lag between written observations and visual observations
- Risk and premature discharge
- Potential benefit and harm in video monitoring
- Ethical and legal justifications for placing unwilling patients in seclusion
- Process of obtaining treatment orders
- The *Mental Health Act 1994* limits the treatment given to patients on detention orders to the minimum necessary to prevent immediate risk.

Technical issues in relation to the Coroner's Act 1997

- The issue related to when a death is to be reported to the Coroner. Is it when the person is brain dead or when the person has ceased breathing?
- Possible need for specialised coronial investigators

- The role of AFP investigators relating to the issue of statements and witnesses being called

- The role between the AFP and obligation of citizen to provide statement- social stigma attached to the issue of coronial process being about blame