Coronial Council of Victoria

Review of Reportable Deaths in Victoria

Final report

April 2020

Coronial Council of Victoria

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The Hon Jill Hennessy MP
Attorney-General
121 Exhibition Street
MELBOURNE VIC 3000

Dear Attorney-General

On behalf of the Coronial Council of Victoria (the Council), I am pleased to present to you the final report of the Council's *Review of Reportable Deaths in Victoria* (the review). The report is submitted under section 110 of the *Coroners Act 2008*.

The review was commenced on the Council's own motion by the former Council chair, Dr Katherine McGrath. The review was informed by submissions and targeted consultations with a wide range of stakeholders, including the Coroners Court of Victoria (the Court), the Victorian Institute for Forensic Medicine, healthcare organisations, multicultural groups and other agencies involved in the coronial process.

The recommendations in this report are aimed at ensuring the Court investigates those deaths where there is greatest public benefit. We have also identified areas requiring further analysis and consideration, including the legislative definition of 'reportable death'.

Should you require any further information, please do not hesitate to contact me on 0419 537 931 or the Council Secretariat on (03) 8684 0805 or coronial.council@justice.vic.gov.au.

Yours sincerely

Clare Morton

Chair, Coronial Council of Victoria

Contents

Glossary of terms

BDM	Registry of Births, Deaths and Marriages Victoria
CA&E	Coronial Admissions & Enquiries
CCOPMM	Consultative Council on Obstetric and Paediatric Mortality and Morbidity
CPU	Coroners Prevention Unit
CT scan	Computed tomography (CT) scan
DHHS	Department of Health and Human Services
DJCS	Department of Justice and Community Safety
Family	Unless explicitly stated, the term family(s) is used to mean family members, friends, and those instrumentally and otherwise involved, e.g., carer.
GP	General Practitioner
IFCE	International Framework for Court Excellence
MCCD	Medical Certificate of Cause of Death
NCIS	National Coronial Information System
NSW	New South Wales
QLD	Queensland
SCV	Safer Care Victoria
The Act	*Coroners Act 2008* (Vic)
The Court	Coroners Court of Victoria
VCCAMM	Victorian Consultative Council on Anaesthetic Mortality and Morbidity
VIFM	Victorian Institute of Forensic Medicine
VSCC	Victorian Surgical Consultative Council

Executive summary

The Coronial Council of Victoria (**the Council**) is a statutory body established under the *Coroners Act 2008* (Vic) (**the Act**). Its role is to provide advice and make recommendations to the Attorney-General on issues of importance to Victoria's coronial system.

The Council has commenced an own motion review of reportable deaths in Victoria (**the review**) following recommendations in the *Reporting reportable deaths in hospitals to the coroner* review undertaken by KPMG.[1] The review aims to ensure the Coroners Court (**the Court**) investigates those deaths where there is greatest public benefit, namely deaths where the Court can reduce preventable deaths and promote public health and safety; or it is in the public interest to undertake an independent investigation of the death.

This report presents the findings of the review. It has been approved by the Council, and is being submitted to the Attorney-General for consideration by government.

The types of deaths investigated by coroners are determined by the Act, which specifies those deaths that must be reported to the coroner. However, these are not the only cases where an in-depth review could provide valuable lessons. There is probably something to learn from a coroner's review of every death, but this is not feasible as coronial reviews are expensive, stressful for families and time-consuming.

This report analyses and makes recommendations to improve the systems and processes by which deaths are reported to the coroner and initially responded to by the Court and the Victorian Institute of Forensic Medicine (**VIFM**). It also examines the definition of reportable deaths in the Act, which is a complex issue. The review focused mainly on the role the Court should have in relation to deaths of the elderly, whether from natural causes, or following an accident or injury. The review recommends that further detailed work be undertaken in relation to the definition of reportable death.

[1] KPMG, Coronial Council of Victoria, *Reporting reportable deaths in hospitals to the coroner – Final Report* (2017) <https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2018/09/15/fb5e93735/Reporting_Reportable_Deaths_in_Hospital_to_the_Coroner.PDF>.

The increase in Victoria's population means the number of deaths reported to the coroner is steadily rising, and, along with Victoria's ageing population, the number and percentage of deaths of older people in our community reported to the coroner is increasing also.

Coroners are increasingly investigating deaths of people in a number of aged care settings including residential aged care facilities. The investigation of the deaths of older people needs to involve a careful balance between the rights of families and the needs of the broader community with regard to maximising community health, safety and welfare, and preventing avoidable deaths. There is a challenge in seeking to achieve a balance between maintaining proper oversight of these deaths and avoiding the delay and resource burden associated with reporting a death where no further investigation is ultimately required.

The key questions are:

- Is our system of death investigation good enough for vulnerable people?
- Are events happening that our system of coronial investigation is not sophisticated enough to uncover?
- Is the coronial system detecting and addressing the right issues?

The establishment of the Royal Commission into Aged Care Quality and Safety, as well as decisions by the Court, highlight the importance the community places on ensuring aged care services are of high quality and safe, and that there is independent and systemic scrutiny of those services.

In undertaking the review, the Council sought and received submissions from the Court, VIFM, the Registry of Births, Deaths and Marriages Victoria (**BDM**), mecwacare, Safer Care Victoria (**SCV**), Victoria Police, Australian Centre for Grief and Bereavement, as well as a number of other institutions and individuals. Together, they provided valuable insights and information. The Council also undertook an analysis of available data from the Coroners Prevention Unit (**CPU**), the National Coronial Information System (**NCIS**), VIFM and broader population data. However, the data analysis was limited due to timing and data comparability reasons.

The review identified a number of opportunities in relation to deaths due to natural causes, deaths in older Victorians including deaths associated with a fall, the impact of multiple investigations, legislative review and reform, and reporting of specific types of death.

The Review makes recommendations across the following four themes:

- Building data systems and acquiring evidence-based, epidemiologically informed insights into patterns of death, focusing on those placing Victorians at unacceptable risk;
- Creating an enhanced triage model to support the more efficient handling of natural causes deaths;
- Establishing better communication between the entities investigating the causes of death and the coronial system; and
- Further reviewing the legislative definition of reportable death.

In some areas, further detailed analysis is required to fully design and implement recommended changes, and the Council recommends, subject to resourcing and other feasibility considerations, that this work be undertaken in 2020.

Further consideration of the issues raised in the review should be informed by the outcomes of the Royal Commission into Aged Care Quality and Safety and the Royal Commission into Victoria's Mental Health System (both of which are due to deliver final reports by the end of 2020), and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability (due to run for three years).

Recommendations

Recommendation 1

The Court should create an Aged Persons Death Register on its database to facilitate the identification of deaths where hot-spots, clusters, patterns or trends suggest that further coronial investigation in any given instance or group of instances should be undertaken in line with the coroner's preventable death function. This register should operate in conjunction with the NCIS to allow the Court to be informed of national trends that may have a bearing on coroners' death investigations in Victoria.

Recommendation 2

To protect the Victorian community, and in particular vulnerable older people, a monitoring and surveillance function should be created in the Court in relation to (at first) reported deaths of the elderly. This monitoring function should take into account information held in the NCIS. The purpose is to identify, on the basis of suitably skilled and experienced epidemiological overview, hot-spots, trends and patterns in such deaths, so that coronial investigations are enhanced, efficient and suitably focused.

Recommendation 3

The Department of Justice and Community Safety (**DJCS**) (including Births, Deaths and Marriages (**BDM))** and the Department of Health and Human Services (**DHHS**) should investigate the potential for monitoring and review of deaths in Victoria, both those that are reported and those that are not, to add value to the preventive insights gained from coroners' investigations.

Recommendation 4

A formal role should be established for VIFM whereby VIFM forensic pathologists assess whether deaths are natural cause deaths and, through the daily operations meeting (which includes input from the senior next of kin), discuss with the coroner an appropriate course of action in relation to whether further coronial investigation is required.

This includes in the case of natural cause deaths, where there are no concerns raised by the family or the VIFM pathologist, subject to the coroner's direction, the ability of a VIFM forensic pathologist to sign a medical certificate of cause of death (**MCCD**) or advise the treating medical practitioner or the deceased's regular local doctor to sign the MCCD.

Recommendation 5

The Court should lead the establishment of formal relationships with healthcare networks and medical colleges or associations that enhance the understanding of published guidelines and processes for identifying deaths that need to be reported in hospitals and residential aged care.

Recommendation 6

The Court should continue to liaise with other investigative authorities, official bodies and statutory officers as required under section 7 of the Act to enhance the quality of death investigations, to avoid unnecessary duplication of inquiries and investigations, and to expedite the investigation of deaths and fires.

Recommendation 7

Subsequent work by the Council should analyse the need to amend the Act to include among reportable deaths those occurring in contexts not currently covered by legislation, and there should be a review of potentially unclear terminology in section 4(2) of the Act, such as ‘unexpected’, ‘unnatural’, ‘resulted directly or indirectly from an accident or injury’ and medical procedure-related deaths.

Recommendation 8

The Attorney-General send a copy of this report to the Royal Commission into Aged Care Quality and Safety, the Royal Commission into Victoria’s Mental Health System and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability for their information.

Recommendation 9

The Secretary of DJCS send a copy of this report to the Secretary of DHHS and to the Registrar of BDM for their information.

1 Introduction

1.1 Terms of reference

The Council's review follows the *Reporting reportable deaths in hospitals to the coroner* report by KPMG, which recommended the Council review section 4(2)(a) of the Act in relation to the 'unexpected' category and section 4(2)(b) of the Act in relation to the term 'medical procedures'. This report also recommended the Council undertake, in collaboration with VIFM, the Court and DHHS, a review of coronial investigations into deaths associated with falls in order to assess the benefits that are being achieved, the financial costs and the impacts on families associated with the current approach to reporting such cases.

The review aims to ensure the Court investigates those deaths where there is the greatest public benefit, namely, those deaths where the Court can reduce preventable deaths and promote public health and safety; or it is in the public interest to undertake an independent investigation of the death.

To meet this aim, the scope of the review has been to analyse and make recommendations to improve:

- the systems and processes by which deaths are reported to the coroner and initially responded to by the Court and the VIFM
- the definition of reportable deaths in the Act.

Further details on the scope and approach to the review can be found in Appendix A.

1.2 The role of the Council

The Council is independent of the Victorian Government and the Court. The Council was established under section 109 of the Act to provide advice to the Attorney-General in respect of:

- issues of importance to the coronial system in Victoria
- matters relating to the preventative role played by the Court
- the way in which the coronial system engages with families and respects the cultural diversity of families

- any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

Matters of importance for the coronial system to be considered by Council may include:

- the identification of themes, trends and patterns that are seen to emerge
- legislative issues
- proposed law reform.

The membership of the Council is set out in Appendix B.

1.3 Governance

A Steering Committee provided oversight and guidance for the review. Its membership included:

- Dr Katherine McGrath, Chair of the Council (and Chair of the Steering Committee)
- Ms Maryjane Crabtree, President, Epworth HealthCare
- Ms Maria Dimopoulos, Managing Director, MyriaD Consultants
- Professor Ian Freckelton QC, Barrister
- Ms Ronda Held, Chief Executive Officer, COTA Victoria
- Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University
- Ms Ann Maree Keenan, Deputy Chief Executive Officer, SCV
- Ms Michele Lewis, Chief Executive, mecwacare
- Dr Cameron Loy, Chair, Victoria Board, Royal College of General Practitioners
- Dr Luis Prado, Chief Medical Officer, Epworth Healthcare and General Practitioner
- Mr Nic Thomas, General Counsel, Melbourne Health

- Coroner Iain West, Acting State Coroner
- Professor Noel Woodford, Director VIFM.

1.4 Stakeholder engagement and gathering evidence

The review acknowledges and thanks all those who contributed to this work by sharing their experiences and knowledge either directly or through a written submission. In particular, the Council would like to thank Acting State Coroner West and Acting State Coroner English, coroners, and staff at the Court and VIFM.

The review engaged with a wide range of stakeholders through a range of techniques including a formal submission process, targeted meetings and workshops, and roundtable discussions. A full list can be found in Appendix C.

In addition, the review completed a partial desktop analysis of coronial systems in other jurisdictions, a mapping of pathways within the Victorian coronial system, as well as an analysis of available data. These have contributed to both the identification of challenges as well as the development of recommendations.

2 The coronial system in 2020

2.1 The role of the Court

The Court is an inquisitorial court and the focus of investigations is to determine what happened, rather than to ascribe guilt, attribute blame or apportion liability. Although it has a lengthy history as a component of the Victorian justice system, the Court was formally established as an inquisitorial court by the Act.

The role of the coroner involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and contributing to a reduction in the number of preventable deaths and fires; the promotion of public health and safety; and the administration of justice. In investigating reportable deaths in Victoria, the coroner is assisted by a range of agencies and organisations including Victoria Police and the VIFM.

The purpose of the coronial system is to serve the community. The Court recognises that a death reported to a coroner involves the intervention of the state in a family's life at an intensely private time. The Court is aware its very process can be a source of secondary trauma.

Of the approximately 40,000 deaths in Victoria during the 2018–19 financial year, 6,757 deaths were reported to the Court – with the vast majority of approximately 32,725 deaths not being the subject of report. Approximately 42 per cent of reportable deaths were found to be due to natural causes.[2]

Natural causes deaths are most commonly reported to the coroner when the death is unexpected. Reporting of the death can occur where a doctor is not available to complete a MCCD, where the MCCD cannot be completed because the doctor does not know the cause of death, or where, even though the medical cause of death is known, the death has occurred in the circumstances set out in section 4 of the Act that make the death reportable. There are many examples of natural causes deaths, but recent cases that regularly come before the Court include cardiac deaths related to ischaemic heart disease, strokes, and rarer events including asthma related to thunderstorms and anaphylaxis as a result of bee stings at work.

[2] Coroners Court of Victoria, Annual Report 2018-19

The Court investigates these natural causes deaths to determine whether in fact the death was a result of natural causes, and to determine whether public health and safety or prevention opportunities exist. Once a coroner has completed their investigation, they deliver written findings as to the identity of the deceased and the cause of death. Where it is in the public interest, or an inquest was held, a coroner will also make findings about the circumstances in which the death occurred. A coroner may determine that a death from natural causes does not require further investigation, or they may make findings without holding an inquest. In fulfilling their preventive role, the coroner may or may not make recommendations. In 2016–17, 14 recommendations were made in relation to those natural causes deaths.[3] For the remaining 62 per cent of non-natural causes deaths, 118 recommendations were made specifically to prevent future deaths from similar causes. 154 recommendations were made in Victorian Coronial findings delivered in the financial year 2018-19 with 20 of those recommendations pertaining to deaths from natural causes.[4]

Currently, approximately 2,800 natural deaths are investigated by the Court each year.[5] The vast majority of these deaths do not proceed to an inquest. Instead, following the VIFM providing the Court with a medical death investigation report, short-form statutory findings are made containing the key information required to register the death with BDM.

[3] Coroners Court of Victoria, *Annual Report 2017-2018.*

[4] Coroners Court of Victoria, email 14 April 2020

[5] Coroners Court of Victoria, *Annual Report 2018-2019*.

2.2 Relevant provision of the Act

Section 4 of the Act defines a death of a person as a reportable death if:

(1)(a) the body is in Victoria; or

(b) the death occurred in Victoria; or

(c) the cause of the death occurred in Victoria; or

(d) the person ordinarily resided in Victoria at the time of death.

And the death was a specified death, as follows:

(2)(a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or

(b) a death that occurs:

(i) during a medical procedure; or

(ii) following a medical procedure where the death is or may be causally related to the medical procedure

and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or

(c) the death of a person who immediately before death was a person placed in custody or care; or

(d) the death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 2014*; or

(e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer; or

(f) the death of a person who is subject to a non-custodial supervision order; or

(g) the death of a person whose identity is unknown; or

(h) a death that occurs in Victoria if a notice under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* has not been signed and is not likely to be signed; or

(i) a death that occurs at a place outside Victoria if the cause of death is not certified by a person who, under the law in force in that place, is

authorised to certify that death and the cause of death is not likely to be certified by a person who is authorised to certify in that place; or

(j) a death—

(i) of a prescribed class of person;

(ii) that occurs in prescribed circumstances.

The focus of the analysis that has been commenced by the Council is into the major categories of reportable death, which are deaths that are:

- unexpected
- unnatural
- resulting directly or indirectly from an accident or injury
- related to medical procedures.

Each of these issues has previously been identified as contentious,[6] examples being the difficult distinctions between when a death is natural or unnatural[7] and when it is expected or unexpected.

Deaths that are violent are reportable deaths, and the criminal justice process precedes the coronial investigation. This aspect of the definition of reportable death tends not to be problematic.

As noted above, in August 2017 the Council reviewed the reporting of reportable deaths in hospitals to the coroner. Among other things, it recommended that:

> **One**: In relation to section 4(2)(a) of the Act, the Council should:
>
> - undertake a detailed assessment of potential amendments to the 'unexpected' category, including revision or removal of this term;
> - develop any amendments to the 'unexpected' category with medical professionals; and

[6] See David Ranson, '"How effective? How efficient?" The coroner's role in medical treatment related deaths' (1998) 23(6) *Alternative Law Journal* (1998) 284; Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest* (Oxford University Press, 2006).

[7] See *R v Poplar Coroner; ex part Thomas* [1993] QB 610; *R (Touche) v Inner North London Coroner* [2001] QB 1206.

- undertake a formal review of any legislative amendments to the 'unexpected' category after a defined time period to identify any unintended consequences associated with the change.

Two: The Council should review section 4(2)(b) of the Act in consultation with medical professionals to:

- consider the appropriateness of the term 'medical procedures' in light of the reportable deaths that fall into this category;
- develop potential amendments to the structure of this section to provide greater clarity to doctors; and
- consider amendments to this provision to expressly include deaths that are the result of an omission to provide clinical care.

These issues continue to need to be addressed.

This report advances the process of reviewing the definition of reportable death, focusing on deaths of older people.

2.3 The effects of population growth

The population in Victoria is steadily growing by around 1–2 per cent a year, and it is ageing (over 65s represented around 15 per cent of the population in 2018, but will represent around 19 per cent in 2033).[8] People are living longer, and many of the deaths reported to the coroner are of people over 85 years of age (21 per cent of cases in 2017).[9]

Currently between 15 and 25 deaths are reported to the coroner each day.[10] With the growth in population and the ageing of the population, it is expected that the number of deaths reported to the coroner will increase in line with these trends.

2.4 Finding the right balance

A challenge facing government is how to balance proper oversight over preventable deaths, for example in hospitals and residential and aged care

[8] *Victoria in the Future* data.

[9] Coroners Prevention Unit data (September 2018).

[10] Victorian Institute of Forensic Medicine, *Annual Report 2018-2019*.

facilities, with the need to minimise the intrusion into private family life that occurs as a consequence of the coronial process.

A further consideration is the current remit of the Court. Should the definition of reportable death be extended so that some of the deaths that currently fall outside the definition in section 4 of the Act be captured explicitly? For example, should the definition of reportable death explicitly include a reference to death by omission or negligent care or abuse? Or are those deaths sufficiently covered by the current definition of deaths that are 'unnatural or violent or as a result of accident or injury'?

Further, do we trust the current definition of reportable death to protect the most vulnerable members of our society? Is the current system of reporting deaths being honoured and complied with by hospitals and aged care facilities and bringing these deaths to the attention of the coroner? How should we ensure that all reportable deaths under the current definitions are in fact being reported, and are we confident that the coronial system is detecting and addressing the right issues?

The Court is expert in investigating individual cases or series of cases in great depth, but is reporting individual cases to the Court the best way of monitoring deaths in the most vulnerable? There may be other ways the Court can lead or participate in the process of death review in addition to its current role, for example through its data collection and analysis functions.

Necessarily, coroners' investigative and administrative processes are often marked by delays that cause distress to families and others who can sometimes wait years for more complex matters to be finalised. Coronial expertise and resources should be prioritised for matters where there is a reasonable prospect of findings and recommendations that will expose systemic flaws, and where there is the potential to advance community health and safety.

For older people, natural causes deaths are often attributable to a combination of multiple medical comorbidities. Accurate identification of the cause or causes of death in older people can be problematic, since these individuals often suffer from multiple organ system failures and natural disease processes associated with ageing that can complicate their response to traumatic events, as well as precipitate traumatic incidents such

as falls. The reason these deaths are reported is because the death is directly or indirectly a result of accident or injury and therefore comes within section 4 of the Act.

Where the cause of death in these cases is unknown or uncertain, the coroner seeks advice from a forensic pathologist as to whether a cause of death can be established. In some cases an autopsy is recommended to establish the cause of death.[11] The coroner will make a decision about whether an autopsy is necessary and appropriate. The importance of the coronial process is such that these deaths are examined independently and expeditiously.

In addition, many of these older Victorians are vulnerable and in the care of either residential aged care facilities or hospitals at the time of their death, and so the question of improper care, neglect or abuse may become a relevant consideration. The Royal Commission into Aged Care Quality and Safety has highlighted a number of these issues, which were not necessarily reflected in coronial investigations or that involved issues outside the current scope of the jurisdiction.

Approximately 10 per cent of deaths are late reports to the coroner where the deceased has already been buried or cremated.[12] This means the death has not been reported to the coroner immediately after the death. These are called 'body not in' cases or BNI cases and are referrals or reports from the Registrar of BDM rather than from doctors or police. These deaths can still be investigated by means of a review of medical and other records with consequent independent review of the death certification process and identification of critical care issues. The investigation process depends on the facts and circumstances of each individual case. Approximately 50% of these cases are finally determined, after investigation, to be reportable deaths. More education is required to ensure awareness of the meaning of reportable death in medical and aged care settings.

[11] Over the past 10 years, the percentages of cases being subject to medical investigation by autopsy in Victoria has dropped from around 80 per cent to less than 50 per cent. This has occurred in association with the instigation of preliminary case reviews and case management meetings between coroners, pathologists and nurses from the Coronial Admissions and Enquiries office. In addition, the establishment of postmortem CT scanning and the possible future introduction of postmortem MRI scanning raises the prospect of further reducing the rate of autopsy as a result of the increased diagnostic potential of these imaging techniques.

[12] Professor David Ranson, Deputy Director and Head of Forensic Services, VIFM, 23 February 2020 and CA&E records

Other jurisdictions use a range of new approaches to find the right balance, some of which are outlined in section 6, 'Next steps'. In addition, the Court has undertaken a number of initiatives to streamline processes for death investigation.

2.5 Duplication and effort in responding to multiple investigations

Deaths may be investigated by multiple entities seeking to identify the cause and ways to prevent future deaths. Many of those deaths fall within the definition of a reportable death in section 4 of the Act. A summary diagram in Appendix D shows the coronial process and other institutional investigating bodies. Appendix D also includes further detail on organisations, their role and responsibilities.

An example of deaths being reported to or investigated by multiple entities is deaths due to falls in older people being cared for in residential care facilities. These may be investigated and reported to at least three entities: the coroner, WorkSafe Victoria and the Federal Aged Care Quality and Safety Commission. It is important to note that the Federal Aged Care Quality and Safety Commission is a regulator, whereas the coroner and WorkSafe Victoria investigate the deaths. Inevitably, there will be some overlap between such investigations. However, it is significant that the focus of each is different.

One example of duplication drawn to the Council's attention was concern and confusion around reporting deaths from falls in residential care facilities to WorkSafe Victoria. Although WorkSafe has a legislative remit in this area (under the *Occupational Health and Safety Act* 2004) and has guidelines on what to report, there is confusion about the meaning of terms used. For example, the scene of a death from a fall must be preserved for WorkSafe inspection. This is less than ideal in a residential facility, where other residents need to continue with normal activities. In addition, WorkSafe might not actually end up attending the scene, and residential care operators indicated that they do not get much feedback from WorkSafe in terms of its findings or reports.

This potential duplication of investigation should be followed up with Worksafe Victoria to ascertain the number of cases its investigators attend at aged care providers following a death from a fall.

Section 7 of the Act states the intention of Parliament is that coroners liaise with other investigative authorities, official bodies or statutory officers to avoid the unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths and fires.

The Court is seeking to improve the way in which it liaises with other agencies in Victoria that investigate deaths. While in criminal investigations, the coronial investigation is suspended until the police investigation and criminal process has concluded, in many other cases there may be opportunity to benefit at an earlier stage of an investigation from the work of another agency.

In recognition of this, as of April 2020, the Commission for Children and Young People, the Victorian Audit of Surgical Mortality, the Australian Maritime Safety Authority, the Inspector General for Emergency Management, the Justice Assurance and Review Office, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, the Victorian Perioperative Consultative Council, St Vincent's Hospital, Office of the Chief Psychiatrist and Safer Care Victoria are just some of the agencies that have been invited to seminars at the Court.

The aim of the program is to strengthen the coroner's role, while ensuring the coronial investigation is effectively focused to avoid unnecessary duplication of inquiry and expedite the investigation.

At the conclusion of the seminar series, a paper will be produced to detail the landscape of death investigation in Victoria and alert the coroner to concurrent investigations. This will enable improved triaging of the coronial investigation at an early point and for the coroner to liaise effectively, as appropriate.

Two further issues raised by stakeholders are that the results of many investigations are not automatically sent from the Court to the hospital or residential aged care facility where the death occurred, and there is a lack of understanding of the requirement for individuals and organisations to register

their interest with the Court.[13] This can lead to frustrations and perceptions that there is limited utility, and a duplication of investigative processes, that add significant administrative burden for the facility without providing benefits in terms of outcomes and feedback.

Following acknowledgment in June 2019 that processes can be improved in relation to cases involving fatal injuries occurring as a result of falls, the Court recently introduced a process whereby feedback and the results of coronial investigations are now provided to hospitals and aged care facilities. The triage form has recently been amended to automate the provision of this information, along with information provided to families and other service providers.

Within the health system, there have long been internal processes for investigating serious adverse events and unexpected deaths. The maturity of clinical governance in health systems has recently evolved further with the establishment of central units focused on identifying and preventing such events. SCV also provides support to independent consultative councils, which report to the Minister for Health:

Victoria's consultative councils are ministerial advisory committees that report on highly specialised areas of healthcare in order to reduce mortality and morbidity through education or system improvement or reform. This is achieved through:

- collection, analysis and reporting of data relating to mortality and morbidity cases
- identification of avoidable or contributing factors
- generation of recommendations that inform priority areas for research, quality and safety improvements, and policy developments.

[13] To do this, individuals and organisations must complete forms 31 and 45 and provide them to the Court.

After an amalgamation of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity (**VCCAMM**) and the Victorian Surgical Consultative Council (**VSCC**), the two consultative councils are:

1. Victorian Perioperative Consultative Council (**VPCC**)
2. Consultative Council on Obstetric and Paediatric Mortality and Morbidity (**CCOPMM**).

Among other functions, CCOPMM has examined every Victorian maternal death since 1952, and every Victorian child death under 15 years since 1985 and under 18 years since 2005. It has been successful recently in identifying a cluster of events at a Victorian maternity service, advocating for child safety, and advocating for improved processes for dealing with children in vulnerable communities.

While the activities of these councils overlap to some degree with the function of the coronial system, their activities represent internal, health-based, confidential enquiries that do not usually engage with families and whose detailed individual findings are usually not available to coroners. Coroners occasionally request a summary of the consultative committee investigations, but coroners are limited in their ability to use the results of these investigations because the basis upon which the information has been obtained is unknown.

3 Gathering evidence

The previous section provides context for the evidence gathered as part of the review. This section summarises both stakeholder perspectives and data analysis. Evidence from a range of sources was captured to help identify particular challenges.

3.1 Stakeholder perspectives

Stakeholders were asked to outline any issues or concerns they had in relation to reportable deaths, as defined by the aims and scope of the review. Further details can be found in Appendix C.

3.1.1 Family concerns

The increased anxiety and stress arising from a delay in issuing a death certificate was an issue raised, particularly in certain multicultural communities:

> *People get stuck in their grief due to words 'unascertained' or 'undetermined'. They are trying to make some sense of it and need answers, which is where we step in as bereavement counsellors. We are working a lot longer with people when the result is 'unascertained' after examination/autopsy.*
>
> Consultation with counsellors from the Australian Centre for Grief and Bereavement
>
> *The family reaches out to community leaders, we deal with the Coroners Court and get told that it has been delayed but are given no reasons why. We accept the need for coronial investigation, but with so many delays, it is hard for family to accept. We cannot start mourning; we cannot do anything.*
>
> Multicultural and multifaith roundtable

In addition, families flagged the need to improve their own awareness in relation to coronial processes, such as through the provision of more accessible and digestible information by the Court. Other suggestions included testing coronial processes with various multicultural communities as well as providing cultural awareness training at the Court and VIFM.

The Court and VIFM are working to address these issues. Two examples are the Court's engagement survey of court users and the recently launched web series.

In 2019, the Court engaged Paxton Partners to develop a survey for families and friends who have been involved with the Court. The survey seeks feedback to help understand the experiences of family and friends with the Court and its processes. This information will help the Court to improve existing services and develop new services to meet the needs of future Court users.

The survey is voluntary and asks questions about families' and friends' views and experiences of the services provided by the Court. The survey information is stored in a non-identifiable way and will not be connected with a name or any identifiable details at any stage.

The 'Afterlife' web series[14] launched by the Attorney-General in November 2019 also goes some way to addressing these communication gaps with the general public. However, other tasks, such as implementing an active program to educate the medical and legal professions on the work and role of the Court's jurisdiction, are resource intensive and represent an ongoing challenge.

3.1.2 Definition of reportable deaths in the Act

Clarity of terms

Consistent with previous reviews, concerns were highlighted around the clarity of terms in the Act, predominantly in relation to section 4(2).[15] Terms of concern included 'unexpected', 'unnatural', 'resulted indirectly' (from an accident or injury), occurs during or 'following' a 'medical procedure', 'registered medical practitioner' etc.

[14] Victorian Institute for Forensic Medicine, *Afterlife* (2019) <https://www.vifm.org/media-and-events/vifm-web-series/>.

[15] KPMG, Coronial Council of Victoria, *Reporting reportable deaths in hospitals to the coroner – Final Report* (2017) <https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2018/09/15/fb5e93735/Reporting_Reportable_Deaths_in_Hospital_to_the_Coroner.PDF>.

The uncertainty around these terms was said to contribute to medical practitioners' lack of understanding of their reporting obligations. For example, in 2018, approximately 400 deaths were reported to the coroner by BDM where the cause of death stated on the MCCD would appear to indicate that the death should have been reported to the coroner. Of these, 155 were either not a reportable death or were a reportable death, but were a natural cause death with no further investigation completed. Traumatic causes of death in the elderly represented the majority of these referrals.

However, other stakeholders highlighted that terms such as 'unexpected' are warranted as they 'encapsulate the unknown', and in a medical environment, there are 'grey' areas that are less than straightforward in terms of categorisation and how they should be handled/reported by clinicians.

Misconceptions among clinicians

Misconceptions among those reporting deaths were highlighted. These misconceptions, which impact upon reporting practices, included:

- coroners only investigating 'suspicious' deaths
- the time limits for reporting, i.e. all deaths that occur within 24 hours of hospital admission
- reports of death always leading to an autopsy
- reports always leading to an inquest.

Falls-related trauma deaths

There were contrasting views among stakeholders about whether there is a public health benefit associated with reporting all deaths in older people from trauma sustained as a result of a fall. This is a complex area. The most common potentially fatal injuries associated with falls in older people are fractures of the neck of the femur, subdural haematomas and rib fractures. The linkage between these forms of trauma and a subsequent death is not always clear cut. Indeed, in a setting of active medical management or supportive therapy, death may occur several weeks after the fall in a person with multiple potentially fatal natural disease comorbidities, which makes final determination of the cause of death problematic.

This issue overlaps with the confusion about the definition of 'unexpected' in the Act. The first issue is 'unexpected by whom': unexpected by the deceased person, unexpected by their family members, unexpected by those caring for them, or unexpected by their treating medical practitioner? The next questions are: unexpected within what timeframe and at what stage in a clinical course?[16]

Some stakeholders were of the view that it is disrespectful to consider deaths in older people from falls as not 'unexpected', and that it is important that these deaths are not excluded from the jurisdiction of the Court.

While it is certainly difficult to prevent all injuries associated with a fall in this population, there may well be falls-prevention or injury-reduction possibilities that could be explored by coroners and health services alike. Issues such as staffing ratios, national standards regarding staffing levels and skills mix, minimum qualifications of personal care attendants including minimum first aid qualifications, design of aged care facilities, availability of disability aids and the development of clear policies addressing issues of dignity of risk are matters that coroners actively contribute to as part of these death investigations.

Stakeholders noted that:

- falls are a common final event in frail older people
- people value mobility and independence, and it is questionable whether falls can be prevented completely without restricting the movements of many frail older people
- referrals to the coroner can:

[16] A very common scenario is where a frail older person with chronic obstructive pulmonary disease, dementia, ischaemic heart disease with cardiac failure and poor mobility slips and falls in a nursing home and breaks the neck of their right femur. They are admitted to hospital the next day and undergo surgical treatment to manage the fracture. Over the next few days, their dementia and injury mean they are difficult to mobilise and as a consequence of this and their chronic obstructive pulmonary disease, they develop a chest infection. They are treated with antibiotics with some initial improvement but one week later they suffer a myocardial infarction with deterioration of their respiratory status and increasing cardiac failure such that they die 10 days after their heart attack. At what point has their death become expected and by whom? Can it be said that their death is directly or indirectly the result of the trauma or the medical procedure? (If so the death **is** reportable to the coroner.) Or has their pre-existing natural disease overtaken the trauma as the true cause of their death? (If so, their death is **not** reportable to the coroner.)

- increase anxiety and distress for families, as they can delay a funeral and raise concerns about possible negligence or mistreatment
- be stressful and time-consuming for doctors.

Notably, the Court has recently modified procedures when investigating deaths following a fractured neck of femur in older people, significantly reducing the need for all such individuals to be transported to the mortuary for medical examination. This process involves people who die in hospital from complications of a fractured neck of femur sustained in a fall. In such cases, the individual remains at the hospital and their medical records are assessed by a pathologist at VIFM. The pathologist advises the coroner as to the medical cause of death and any factors relating to the medical treatment or circumstances of the death that may require further investigation. Families are always consulted to ascertain if there are any concerns regarding the death. Certain vulnerable older people, such as people without a senior next of kin, are not part of this project. If the coroner forms the view that the investigation undertaken in this manner meets the needs of the jurisdiction, there is no further requirement for the deceased to be transported to the mortuary.

While this approach can streamline the approach to medico-legal death investigation so as to better allocate resources to deaths requiring complex investigatory frameworks, with the growth in population and increasing pressure on, for example, residential aged care, the need for an oversight process for deaths in this area is important.

An illustrative coronial decision

In August 2019, Coroner Jamieson handed down a coronial decision that illustrates the potential for the jurisdiction to make an important contribution to protection of vulnerable older people living in care.[17] The deceased man was a 63-year-old resident of an aged care facility in suburban Melbourne. He died after falling head-first from his wheelchair into the bottom drawer of his bedside drawers, a position in which he remained entrapped until found

[17] Coroners Court of Victoria, *Inquest findings in to the death of John Frederick Reimers* (23 August 2019) <https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=reimers>.

by Ambulance Victoria paramedics who discovered him pulseless and not breathing.

Coroner Jamieson found there was a failure by the facility to ensure that the nurse with responsibility for the deceased man had the necessary induction, support and competencies to manage the critical incident that she faced on the relevant day effectively. She also found that the facility's adherence to minimum staff with a minimum combination of qualifications contributed to a number of the shortcomings in the management of the deceased man, including the absence of essential competencies. She concluded that there was clear and cogent evidence that his death was preventable: 'He was not removed promptly from his perilous position in the bottom drawer of his bedside set of drawers by those responsible for his care and there was a delay in the dispatchment and arrival of paramedics.'

She made a series of recommendations, including that:

- the facility provide appropriate nursing support to its residents by ensuring that a Registered Nurse is always located on site or, at a minimum, reasonably proximate to the facility
- the facility provide appropriate nursing support to its residents by ensuring that all staff are effectively trained, as well as providing periodic updates of training in escalation procedures, including but not necessarily limited to when and how to contact the registered nurse for support
- the Australian Minister for Health coordinate with health regulators, health providers and health professional bodies to develop national standards describing the skills mix and staffing levels required to manage the needs of aged care facility residents to prevent adverse outcomes
- the Commonwealth and State Government Health Departments legislate minimum ratios of nursing staff to patients/residents of aged care facilities
- the Commonwealth and State Governments create a legislative mandate requiring personal care assistants to hold a Certificate III in Community and Aged Care and a Senior First Aid/CPR Certificate as

a minimum qualification before they can secure employment in the aged care sector.

The death was a reportable death by reason of having occurred due to an accident and being unexpected, but the role of the coroner extended to making a series of recommendations directed toward reducing the potential for comparable avoidable deaths in such facilities to occur in the future.

Undertaking surgical procedures in frail older people

In relation to natural cause deaths, the concept of ‘heroic surgery’ and of causation was raised. The example given was where a person undergoes major surgery and the risks of death are increased due their age and frailty, but the person and their family consent to the surgery (for example, where there is a 70 per cent chance of survival). The patient may then die during a correctly performed surgical procedure. In this context, the question becomes whether they have died naturally from the disease or from the procedure? Differing medical and legal opinions on whether this should be reportable may both be valid, but a report to the coroner may be interpreted by the family that an avoidable error must have occurred during the surgery. This can lead to significant distress for the family or, following investigation, provide reassurance to the family that the medical management was reasonable and appropriate. Much depends on the communication with the family that takes place by staff from the hospital, the VIFM Coroners Admissions and Enquiry Office (**CA&E**), the Court Registry and the VIFM Pathology Family Liaison Nursing service.

Expanding the definition of reportable deaths

In-care deaths

There is potential to expand the definition of reportable death to other vulnerable groups and therefore potentially reduce preventable deaths. This is a complex area and clearly has resource implications. Future work in this area will be informed by the findings of the Royal Commission into Aged Care Quality and Safety, the Royal Commission into Victoria's Mental Health System and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability.

Although this area was out of scope, the Coroners Working Group requested the review consider a submission in relation to deaths that occur in care situations not currently requiring reports by the Act; namely, Victorians who, immediately before death, were in the care of an institution that was not directly managed by a government service. In particular, this included ensuring deaths in the following circumstances become reportable:

- deaths of Victorians who are under compulsory treatment orders and / or under the use of restraints;
- deaths of Victorians within aged care mental health services, community residential mental health services, National Disability Insurance Scheme (**NDIS**) funded services, and specialist disability accommodation providers;
- deaths of Victorians who are voluntary mental health inpatients; and
- deaths of people newly arrived in detention centres.

The Court also supported the extension of mandatory reporting requirements to encapsulate a broader definition of in-care deaths and vulnerability. This would include a person who is 'dependent on others – the State, the Commonwealth or other entities – to provide care and/or assistance with their daily living activities'.[18] The Council also received submissions on this matter from the Disability Services Commissioner, the Mental Health Complaints Commissioner and the Office of the Public Advocate.

[18] Submission from the Coroners Court Review Working Group 'In-care deaths' (March 2019).

Other deaths

Various suggestions were made to amend the Act to ensure other deaths became reportable. These included:

- neonatal baby deaths, although there were contrasting views on this issue;
- all deaths from hospital infections being reportable; and
- deaths from omissions of care being reportable.

A specific request was made for deaths relating to palliative sedation not to become reportable to the coroner, as this might make doctors more fearful of treating symptoms sufficiently and result in patient harm.

While investigating deaths in this group might have important public health and safety benefits, what is less clear is the impact such an expansion of reportable deaths would have on the workload of forensic medical services, the Court, and Victoria Police. In addition, expanding the range of reportable death would have major implications for community and professional education so as to communicate the new criteria effectively to those responsible for reporting deaths to the coroner.

3.1.3 Systems and processes by which deaths are reported to the coroner

Gaining advice on reportable deaths

Stakeholders raised the need for access to advice on whether a death was reportable.

CA&E in VIFM initiated a new inquiries process approximately 12 months ago whereby medical practitioners are able to telephone experienced practitioners at CA&E for immediate advice on whether a death is reportable. Where the case is borderline, CA&E will take a notification, create a case number and seek input from a coroner. A decision will then be made on whether the death is reportable and the medical practitioner and family will be notified accordingly. CA&E report the process is working well, but that they are continuing to look at ways to fine tune their processes. CA&E further report that they receive at least 250 calls a month seeking advice regarding reportability of deaths.

Handling natural cause deaths

Natural causes death are not within the definition of reportable death in most cases. However, they are captured by the definition of reportable death if they are unexpected. Further, they become reportable if a doctor will not sign a MCCD.

A suggestion was made for the introduction of a system that would enable certain natural cause deaths to be processed quickly through an initial intake process. An option for achieving this would be by granting pathologists the power to sign MCCDs for natural cause deaths. It has been estimated by the VIFM that such a process would greatly reduce the workload on the coroner and the Court Registry.[19] It is possible that between 1,500 and 2,000 deaths could be managed through this process and would result in a MCCD being available in a similar timeframe to that of a death that had not been reported to the coroner.

Alternatively, the Court identified a new process for potentially quickly closing off natural cause deaths that do not need investigation. This included recent amendments to the Act with the commencement of section 16(1A) of the Act on 29 March 2019. This provides that, where a death is reported to the coroner only because a MCCD has not been, and will not be, signed, the coroner may determine that the death is not reportable. In these cases, the medical aspects of the death will be investigated by VIFM, which will provide the coroner with a medical cause of death so that the Principal Registrar of the Court can provide the particulars to the Registrar of BDM, who will then be able to register the death and provide the family with a death certificate.

A subcommittee of the Coroners and Pathologists Working Group is currently working on identifying the types of deaths and processes that might apply. It will also be important to review the effectiveness of section 16(1A) to determine the impact it is having on court processes.

[19] The preliminary examination process (including postmortem CT scanning) provides the forensic pathologist with far more information about a death than would be available to the treating medical practitioner in the community. This information would be discussed with the coroner to ensure that only suitable natural deaths would be managed by this process. This process whereby the forensic pathologist completes the MCCD in natural deaths would not involve a significant increase or decrease in the VIFM forensic pathology workload.

Getting and improving feedback

The need to improve feedback to those Court users involved in a reportable death was highlighted. For example, in residential aged care, although interested parties receive feedback if they register to do so, coronial investigations are often perceived to be of limited benefit to residential aged care providers. Some people associated with aged care residential facilities suggested that few recommendations are currently made by the coroner in relation to residential aged care, and that more should be. These stakeholders were keen to see coronial recommendations positively influence the broader healthcare sector, and see recommendations actively implemented to reduce preventable deaths.

As discussed above, the Court has recently introduced improvements to the process of providing information and findings to hospitals and residential aged care providers. However, the Court expressed the view that coroners are keen to better understand what is currently being missed, where the gaps are, and how processes can be improved to identify red flag areas.

Coroners have made recommendations following investigations in the following areas: infectious disease outbreaks, resident-to-resident aggression, residents' wellbeing during extreme heat events, management following a fall, as well as falls, medication and dementia management.

The use of data and information across the system

Consistent with previous reviews,[20] medical professional stakeholders raised the challenges they face in relation to accessing data and information from the Court. These include:

- the Court and VIFM case management systems use multiple data capture points (some of them manual in nature);
- current IT and data systems are designed and developed for managing 'cases' and not with system monitoring in mind, for example the Court and VIFM have two separate case management systems, but these are not linked to active trend or cluster monitoring systems;

[20] KPMG, Coronial Council of Victoria, *Reporting reportable deaths in hospitals to the coroner – Final Report* (2017) <https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2018/09/15/fb5e93735/Reporting_Reportable_Deaths_in_Hospital_to_the_Coroner.PDF>.

- limited data capture or central record of family interactions with the Court or in terms of 'client' needs, such as surveys. This is highlighted as 'one of the important aspects of the quality approach and the search for excellence' in the International Framework for Court Excellence (**IFCE**);
- data are acquired and stored in various locations, some of which involve non-digital storage systems that are hard to interrogate;
- limited governance across datasets (standards, coding and classifications changes, data quality checks etc);
- limited use of data in linkage, reporting and analysis (particularly on a regular basis or as part of normal case progression);
- limited access to data analysis, epidemiological investigations and the appropriate research skills and capabilities; and
- less than leading practice attitudes towards the application of data and information, such as the need for evidence-based decision making and transparency (balanced with privacy requirements) and defensiveness around research, access to reports and 'big data' analysis.

To be clear, this was mainly in relation to the use of data to support how the system operates, is monitored and improved, and not, for example, how data is used to support specific work in individual organisations.

3.2 Data analysis

To complement stakeholder perspectives, the review undertook an analysis of the available data. It has accessed CPU, NCIS, VIFM and broader population data from *Victoria in the Future 2016*. It has applied basic analysis techniques with some comparators across Australian jurisdictions. However, it is important to note that mainly for timing and recorded classification reasons, there are differences between the exact numbers in each dataset.

There many reasons and rationales for the results. The aim was to provide indications for areas to explore further. Limitations in data access and quality have hindered more detailed analysis. As a result, data analysis was triangulated with stakeholders and through other sources of information.

Deaths and reportable deaths

ABS data show the total number of deaths in Victoria was 39,416 in 2016. and 38,231 in 2018. While generally the number of deaths has risen steadily over the years, broadly in line with population growth, 2018 saw a slight decrease in the number of deaths in Victoria.

Figure 1: Rate of reported deaths per 100,000 population (NCIS data)

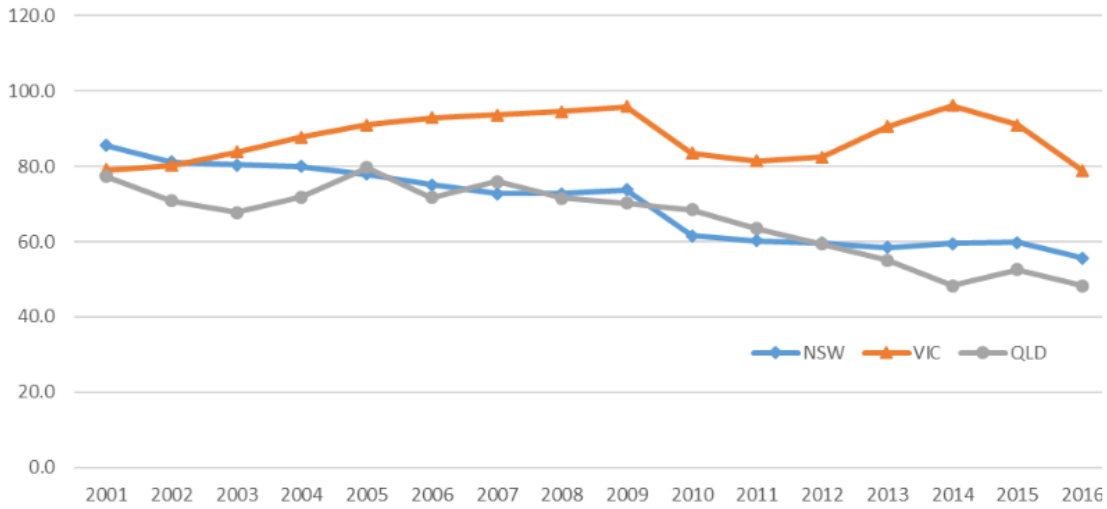
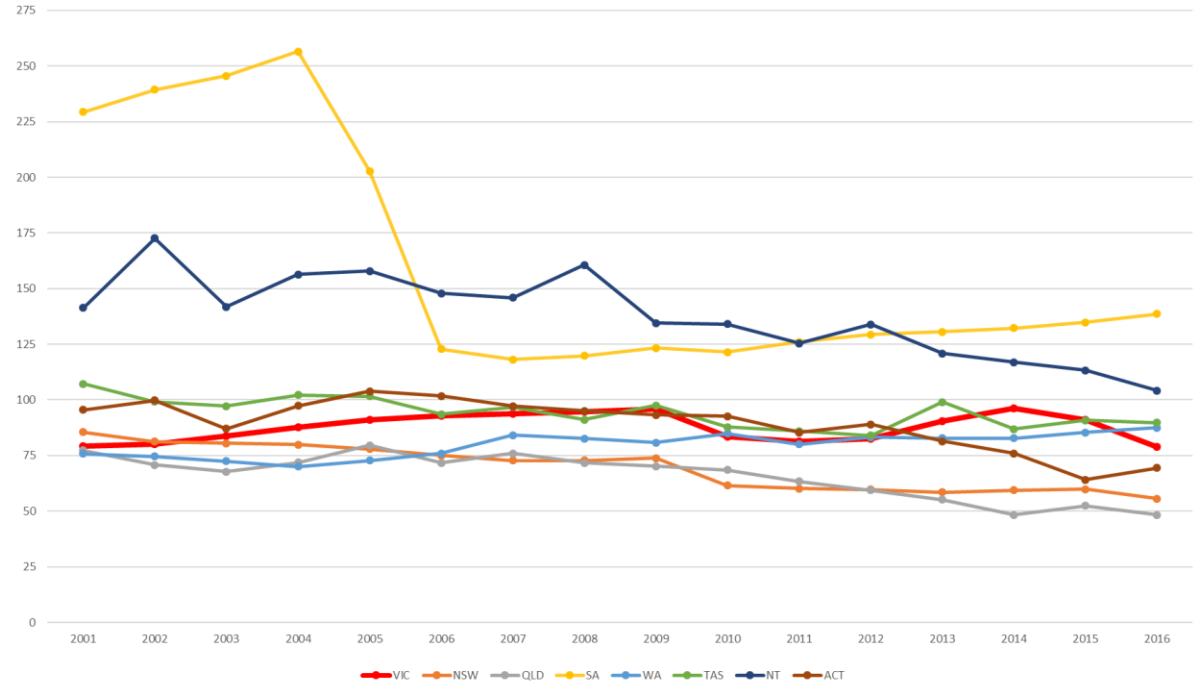


Figure 2: Number of reported deaths to a coroner in Australia (2001–2016) per 100,000 population – NCIS data

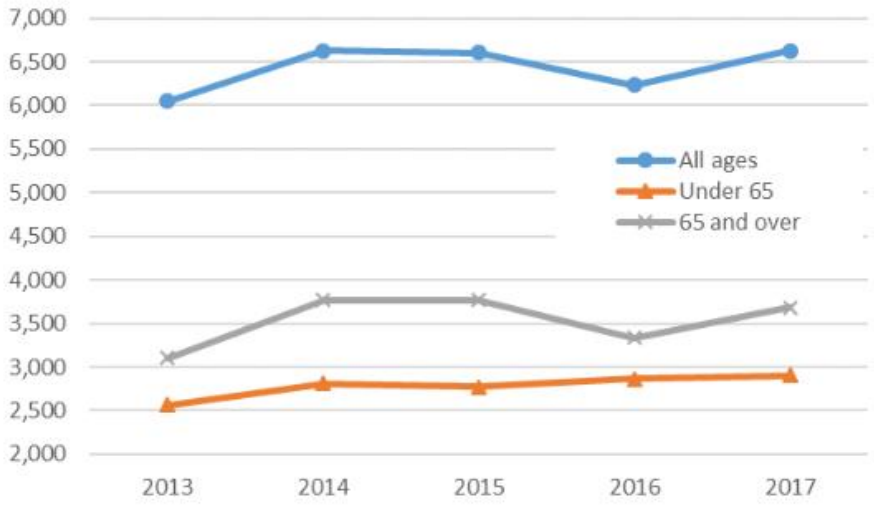


The rate of reportable deaths in Victoria has declined between 2014-2016 but of note is the rate in Victoria when compared with New South Wales and Queensland. Although the rate in Victoria is less than in South Australia, the Northern Territory, Western Australia and Tasmania (all of which have similar provisions to the Victorian model), Victoria is noticeably higher than the other larger jurisdictions. Partly, this relates to diverse statutory requirements in relation to the reporting of death across jurisdictions, including different definitions of reportability.

The current data capture systems and processes do not easily allow for analysis as to why deaths were reported, and therefore why there are changes in rates.

CPU data show the number of reported deaths over the past five years, with a drop in reportable deaths of 6 per cent between 2015 and 2016, and then an increase of the same size (6 per cent) between 2016 and 2017. In 2017, the Court was handling approximately 600 (10 per cent) more cases than in 2013. In 2018, the number of reportable deaths was 6,562 – a reduction of 1 per cent on the previous year.

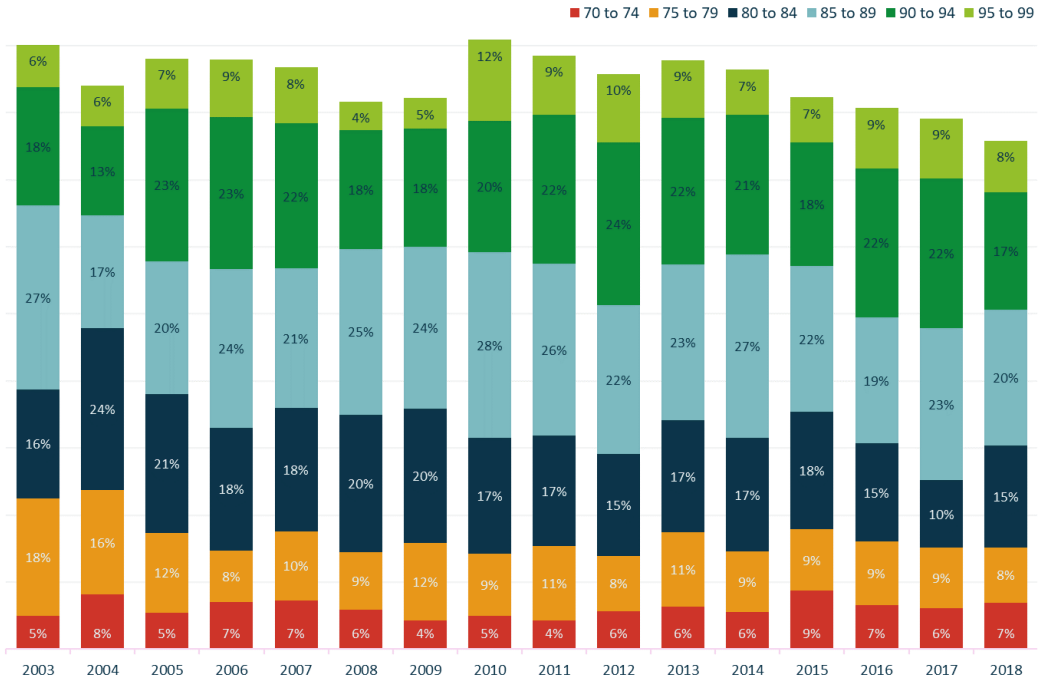
Figure 3: CPU data – deaths/cases reported to the Court



A focus on age cohorts shows a mix of results, but death rates are noticeably higher than population growth rates for specific older cohorts. For example, there was a 20 per cent growth in cases reported in the 65–69 cohort between 2016 and 2017.

In 2017, 79 per cent of cases were related to the 70 and over cohort, and 54 per cent related to the over-85 cohort.

Figure 4: Highest six age groups (by percentage of total) of reported deaths in Victoria (2003–2018) – CSA data graphs



In 2018, approximately 400 potentially reportable deaths were received from BDM and initially accepted by the coroner for investigation. Of these, 155 were either found on investigation not to be a reportable death or were a reportable death, but were natural causes deaths with no further investigation completed.

3.2.1 Population growth

Overall, the population in Victoria is forecast for steady growth of an average of 1–2 per cent annually to 2033 with an increase in the number and proportion of people over 85 years of age as people live longer.

Life expectancy in Victoria is rising very steadily for both females and males. For females, this has increased by one year in the 10 years through to 2016 and 1.9 years for males.[21]

[21] ABS (Australian Bureau of Statistics), *Australian historical population statistics* (2014).

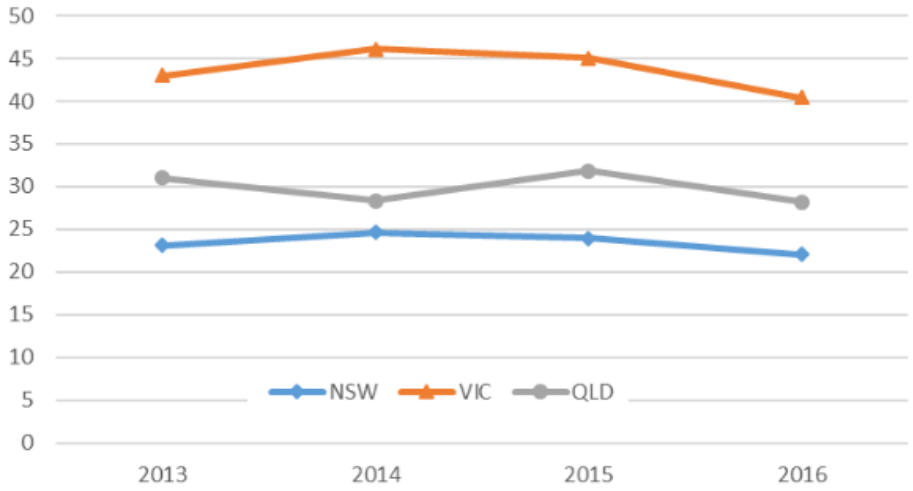
3.2.2 Case types

Of the approximately 6,642 deaths reported to the coroner in Victoria in the financial year 2016–17,[22] approximately 38 per cent were found to be due to natural causes and 62 per cent due to external causes (with fewer than 200 of 'other' case types).[23] Both natural cause and external cause deaths are in line with overall growth in deaths reported to a coroner.

The annual frequency of natural cause deaths reported in Victoria has been decreasing over the past five years. However, and as expected, a significant proportion are related to the older cohorts (52 per cent related to over 70s).

Deaths due to external causes are noticeably higher in Victoria when compared with New South Wales (51 per cent of all deaths reported, versus 40 per cent in New South Wales). In terms of rates, Victoria shows a higher rate of both external and natural cause deaths. However, this needs to be understood in the context of different definitions of reportable death in New South Wales and Victoria, meaning that inferences from the contrasting figures cannot readily be drawn.

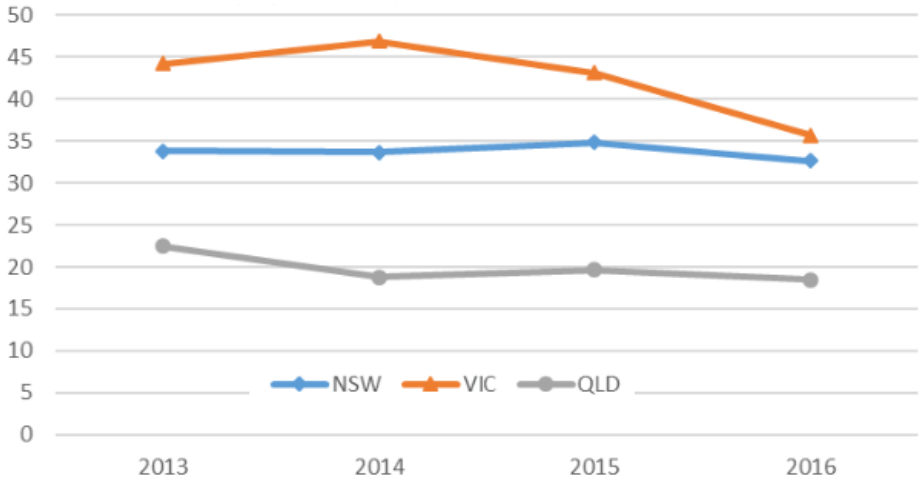
Figure 5: Death due to external cause(s) – rates per 100,000 population (ABS and NCIS data)



[22] Coroners Court of Victoria, *Annual Report 2017-2018*.

[23] Deaths due to natural causes are deaths that were not due to external causes such as accidents, injury and poisoning, or due to ill-defined causes.

Figure 6: Death due to natural cause(s) – rates per 100,000 population (ABS and NCIS data)



Again, data limitations have affected the review's ability to understand the reasons for changes in rates.

The breakdown of external cause deaths highlights falls-related deaths as a noticeable contributor in Victoria.

Figure 7: Death due to external cause(s) – Victoria 2016

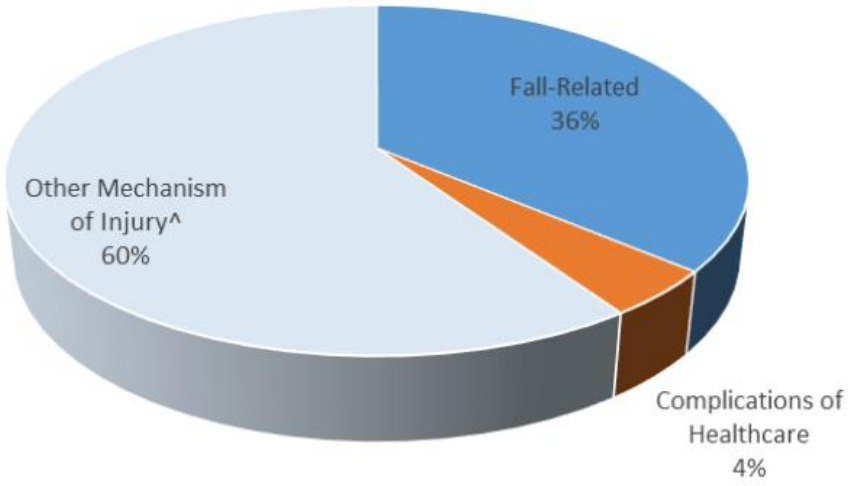
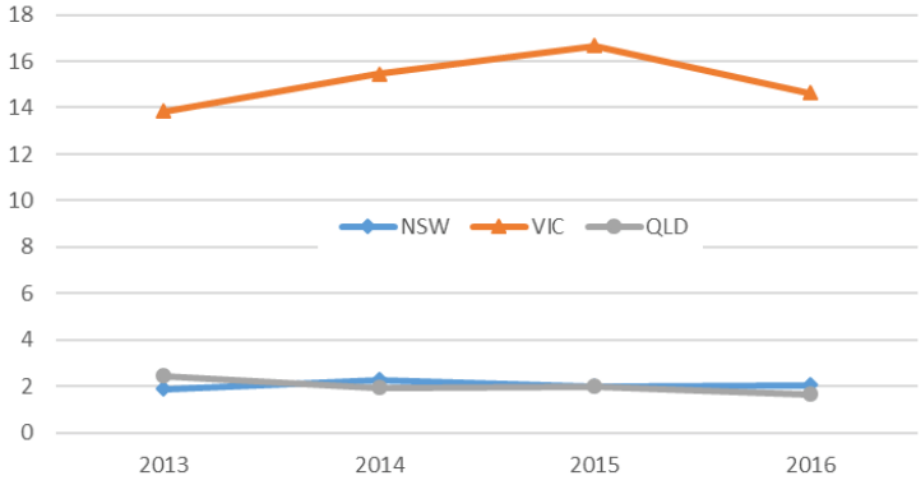


Figure 8: Death due to external causes and falls related – rates per 100,000 population (ABS and NCIS data)



In Victoria, 36 per cent of all external cause deaths are falls-related, compared with between 6 per cent and 9 per cent in both New South Wales and Queensland. Again, these differences need to be understood in the context of different definitions in the Victorian, New South Wales and Queensland legislation. External cause deaths, and in particular external cause deaths that are falls-related, are much more frequently reported to the coroner in Victoria (around 14 per 100,000 population in 2016) than in either New South Wales or Queensland (both around 2 per 100,000 population). The results for New South Wales in this area may well be influenced by legislative changes to handling deaths in older people. In terms of an age breakdown of these falls-related deaths in Victoria, as expected, a significant number (75 per cent) are in the over-80 age cohort.

3.2.3 Outcomes

Outcome measures in relation to deaths that are reported include investigations, inquiries and findings with and without recommendations, recommendations, comments and inquests. There are currently limited outcome measures in terms of the impact of recommendations on prevention and public safety as well as the experience of the process by family members and others affected by deaths, although entities are required to respond to recommendations within three months.

In terms of the natural cause deaths, CPU data show a significant numerical result in the coroner determining the death was a reportable death, but with no requirement for an investigation (an ‘S17, F3’). This is between 1,500 and 2,200 cases each year and more than 12,000 cases during the past six years. Each investigation of a natural causes death is tailored to the circumstances and dealt with as expeditiously as possible.

NCIS data identify that in 2016 for natural cause deaths in Victoria:

- four inquests were held, with no recommendations made as a result;
- an inquest was not held for the remaining 2,225 cases, and of these cases, six led to recommendations being made; and
- 2,219 cases resulted in no recommendations being made.

Recommendations, such as those in the Reimers case, are only one outcome measure for the coronial system, and so this analysis is not a clear determination of whether these cases fall within the definition of reportable. It is also important to consider other outcome measures, such as family experience and delay. Outcomes can also include comments made by the coroner, which might include acknowledgments if restorative and preventive measures have been implemented as a result of the death.

Sometimes the investigation itself will lead to concessions and improvements by the aged care facility or hospital, and therefore a recommendation is not required. Cases of this kind, which result in substantial systems reform, are not currently captured in the Court’s outcome measures.

4 Identifying opportunities

As highlighted in the previous sections, a number of challenges and opportunities have been identified. The following have been considered in further detail:

No.	Opportunity	Covering
1	Natural cause deaths	Whether these can be better identified and processed faster, thus avoiding the need for unnecessary administrative burden in appropriate cases, while ensuring that natural cause deaths that require further coronial investigation receive it. To be considered in the context of understanding the impact of section 16(1A) of the Act.
2	Deaths in older Victorians	Finding the right balance in this increasingly significant cohort in terms of how those cases needing coronial investigation are best identified, and those that do not are processed appropriately and sensitively.
3	The impact of multiple investigations	The potential overlap between multiple investigating agencies as well as the duplication of effort for providers in responding to multiple investigations.
4	Provisions in the Act causing confusion	Provisions that cause confusion or lead to reporting of deaths that do not benefit from a coronial investigation, including: a. the definition of ‘unexpected’ and ‘indirectly resulting from accident or injury’ b. the extension of the definition of ‘medical practitioner’ and ‘medical procedure’ to ‘health practitioner’ and ‘health procedure’ respectively.
5	Reporting of specific types of death	a. Deaths that are reportable, and potentially should not be, including: • where the cause can be identified, but the person’s doctor is not available to sign the death certificate

		• in frail, older people associated with a fall • from ‘heroic’ surgery, where risks are clear and have been consented to • some palliative care deaths. b. Deaths not being reported that should be, including where they are currently not covered by the legislation: • due to omissions of care • still-births • from hospital-acquired infections • In-care deaths from institutions that were not operated by the government, e.g. disability services, mental health services, aged care services.

Further detail on these specific opportunities is included in the following pages.

4.1 Unexpected deaths due to natural causes

As the data analysis has shown, approximately 40 per cent of cases reported to the coroner are finalised as natural cause deaths.[24] This equates to over 2,000 per year in Victoria and is clearly a significant proportion of the coroners' caseload.

These cases are not reported as natural causes deaths but only subsequently confirmed as natural causes deaths following examination at an early stage. These deaths are reported because they are either unexpected or a doctor will not sign a death certificate.

Typically, a forensic pathologist within the VIFM will undertake a medical death investigation comprising a physical examination of the body, a postmortem CT scan and a review of any documentation, including hospital or general practitioner medical records and police documents regarding the circumstances of the death. In addition, toxicology analysis may be performed. As a result of this process, the forensic pathologist prepares a preliminary examination report for the coroner and a case management meeting is held where the coroner determines what the nature of the ongoing investigation will be, including whether an autopsy is necessary. In determining whether an autopsy is necessary the coroner will also consider the wishes of the next of kin. Following a direction from the coroner for an inspection and report, or an autopsy, a pathologist provides a medical examiner's report (**MER**). Where there is a direction for an autopsy, MERs generally take between 12 and 16 weeks, but they can take up to 20 weeks for the death of a child. Where there is no autopsy, the MER can usually be provided in a few days, although this may take a few weeks if toxicology analysis is required to exclude the involvement of drugs or poisons in the death.

These deaths involve a transfer of the body of the deceased person to the coroner's mortuary. This usually results in a 24–48 hour period before release of the body to the family for planning a funeral.

Any delay has the potential to cause significant anxiety, and this is exacerbated for a family if there is speculation about the cause of death such as suspicious circumstances or failure in care. This can disrupt the grieving

[24] Coroners Court of Victoria, *Annual Report 2018-2019.*

process significantly. In many of these cases, the reasons for the uncertainty about the cause of death and the lack of an MCCD can be for a range of reasons, including that:

- the person's own doctor is not available to sign a MCCD;
- the person had multiple comorbidities and the treating doctors were not sure of the final cause;
- the death has followed an injury or accident, which includes falls in older people. Some may be due to neglect or abuse but most are not;
- the death may follow surgery in hospital and in an older, frail person where the increased risk of death has been discussed with the family, but referral to the coroner is required due to the fact that the death followed and was related to a medical procedure and the death was not reasonably expected; and
- the cause of death is not obvious until a computed tomography (**CT**) scan and/or an external examination of the body is completed and a review of the medical records relating to the medical status of the deceased and any treatment they have received is undertaken.

The important balance that needs to be achieved in this context is to ensure resources are deployed appropriately, such that the return on investigations is reasonable. If a significant number of these deaths could be handled differently without diminishing the return to the community (in investigating deaths, reducing preventable deaths and promoting public health and safety), the benefits would include:

- for families, it could help to reduce the stress and uncertainty about the death of a loved one at the moment when the grieving process is at its most acute;
- for the Court and the VIFM, it would reduce administration tasks and help to focus coronial resources on the more complex cases, leading to faster case completion rates;
- for staff of hospitals and residential aged care facilities, it would reduce staff time in paperwork and anxiety about the outcome;

- for Victoria Police, it would reduce unnecessary paperwork and administration; and
- for the taxpayer, it would significantly reduce the costs of transporting bodies from the place of death and would free up resources to be spent in other areas.

4.2 Deaths in older Victorians

It is important for individuals and their families to have a death and grieving process that is as peaceful and free from added stress as possible. This must be balanced with the need to maintain a rigorous coronial system.

As the data show, deaths in older Victorians are more frequently reported to the coroner in Victoria than in either New South Wales or Queensland. This includes deaths from natural causes and deaths from external causes due to the frequency of falls in older people and their contribution to the death. External cause deaths, and in particular external cause deaths that are falls-related are seven times more frequently reported to the coroner in Victoria than in either New South Wales or Queensland. This is due to different definitions of reportability in respective legislation and also the fact that New South Wales has an age reporting limit of 72 years such that a medical practitioner may give a certificate as to the cause of death and not need to report the death to the coroner if the person was **72 years** of age or older and they died after sustaining an accidental injury that was attributable to the deceased's age and was not caused by the act or omission of another person; and no relative of the deceased objects to the certificate being issued.[25]

The demographic data for Victoria clearly show that the growth in the number of people in the older age groups, for example over 65 and especially over 85, is growing well ahead of total population growth. Depending on how the notion of ‘expectability’ of death is construed, death is expected in these populations at a much higher rate than the younger groups and death from natural causes is much more common in this group.

However, it is also true that older people can suffer death due to neglect, abuse or inappropriate traumatic intervention, and these causes need to be

.

identified and prevented. This issue has been highlighted by the interim report of the Royal Commission into Aged Care Quality and Safety, *Neglect*,[26] and is exemplified by the Reimers decision by Coroner Jamieson. It overlaps with the apparent confusion about the definition of 'unexpected' in the Act.

Deaths in older people are often associated with increasing frailty and multiple medical comorbidities. Evidence shows that older people often require multiple admissions to hospital in the last 12 months of their life. However, the final episode is often during a hospital admission, such as for heart failure. They are not necessarily expected to die on a particular day, but they are expected to die within weeks or months. Is such a death unexpected? Many experienced doctors or the person's own GP would sign a death certificate, as they view the death as due to natural causes and expected on the basis of the background medical history. However, for junior doctors and doctors who do not know the person or their medical history, these deaths are often seen as reportable on the basis of not having been expected by them at that time. This issue could be addressed to some extent through the education of doctors on the definition of reportability and what unexpected means.

There is no simple way to differentiate prospectively between those deaths that require investigation and those that do not. However, the terms employed within section 4 in respect of 'reportable death' are an attempt in this regard. The question is whether they are adequate, and if not, how they can be improved.

The process of determining the medical cause of death in any reported death is undertaken by the forensic pathologists at VIFM. Their functions, including their power to receive a body and conduct preliminary medical investigations, arise through the Court's investigative power in respect of reportable deaths. The VIFM pathologists can determine the cause of death from medical notes, post-mortem CT scans, overnight toxicology analysis, physical examination of the body and, where authorised, a formal autopsy.

[26] Commonwealth, Royal Commission into Aged Care Quality and Safety, *Interim Report: Neglect* (2019) vol 1 <https://agedcare.royalcommission.gov.au/publications/Documents/interim-report/interim-report-volume-1.pdf>.

Once death from natural causes has been identified, under current processes, the case proceeds to the coroner to be processed as a death by natural causes. The coroner needs to await the medical examiner's report and then prepares a Form 3 based on the 'natural causes' advice. Often this is straightforward but occasionally there are situations where a coronial focus upon the broader circumstances surrounding the death rather than on the medical cause of death is appropriate.

In jurisdictions outside Victoria, there are processes in place that either divert out of the coronial system or streamline through the system deaths that are most likely due to natural causes and there is no reason to suspect inappropriate care. In New South Wales, for instance, section 38(2) of the *Coroners Act 2009* (NSW) permits a medical practitioner to give a certificate as to cause of death:

> 'if the medical practitioner is of the opinion that the person –
>
> (a) was aged 72 years old or older, and
>
> (b) died in circumstances other than in any of the circumstances referred to in paragraphs (b)–(f) of the definition of 'reportable death' in section 6 (1) or in section 23 or 24 (1), and
>
> (c) died after sustaining an injury from an accident, being an accident that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by any other person.'

In Queensland, the process of intake by the coronial registrar and deputy registrar means that the registrars take responsibility for allowing completion of a death certificate by a local doctor and avoids the need for a coronial process (see description in Appendix F). The efficacy of these two approaches is reflected to some extent in the much lower rates of reporting of deaths of older people to the coroner in these two jurisdictions.

The Council does not support emulating either of these options for a number of reasons. First, it is important that doctors not be placed in a position where, for sinister or self-protective reasons, they are enabled to refrain from reporting deaths that ought to be brought to the attention of the coroner. Second, no mechanism should inhibit the capacity of coroners to investigate

deaths that may have occurred in circumstances of neglect or abuse. Third, imposing a yardstick that incorporates an arbitrary age criterion risks being unwarrantedly discriminatory against persons of that age or older. In addition, while there will be an evaluation of the Queensland second registrar trial at both six months and twelve months from the trial commencement date in September 2019, there has not yet been a rigorous evaluation of whether either of the initiatives has achieved the objectives without allowing deaths which should be investigated to escape investigation.

This set of considerations has persuaded the Council that Victoria should not emulate the objective of either the New South Wales or Queensland initiatives.

There is another important initiative in this area. Between December 2017 and August 2018, the VIFM and the Court undertook a trial of cases in Victoria whereby persons whose death was associated with a fall causing femoral fracture were assessed on medical records supplied by the hospital, and the trauma-based cause of death was ascertained and recorded. This study has been extended to include pelvic fractures, which can also occur via a similar mechanism. Further details are included in Appendix E. This trial was very successful and delivered benefits in terms of:

- positive feedback from families, hospitals and funeral directors;
- the non-admission of a body into the mortuary saving time as well as storage space;
- reduced costs of transporting the body to the VIFM mortuary; and
- the medical investigation report for the coroner finalised by the pathologist within 24 hours, allowing quicker finalisation of these cases.

In October 2018, the Court and the VIFM agreed that the new femoral fracture procedure should become standard practice, and that it should be extended to deaths in older people due to complications following a fractured pelvis.

4.3 Deaths associated with a fall in older Victorians

In Victoria, a significant proportion of external cause deaths are falls-related trauma, and these tend to occur in older people. The proportion of deaths resulting from falls reported to the coroner is higher in Victoria than in any other jurisdiction. However, this needs to be read in light of comments made in the preceding data section of this report.

Figure 9: Percentage of all reported deaths to a coroner in Australia (2016) that are fall-related – CSA data

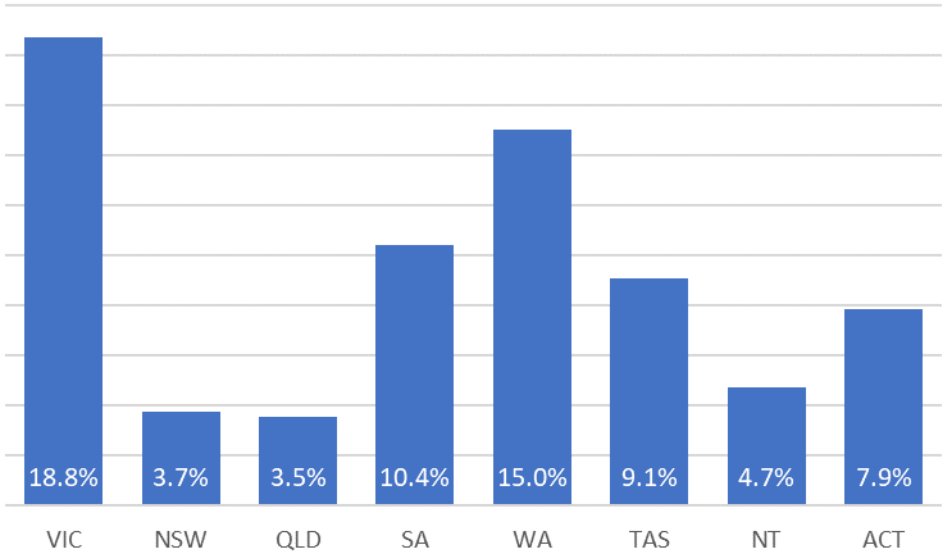
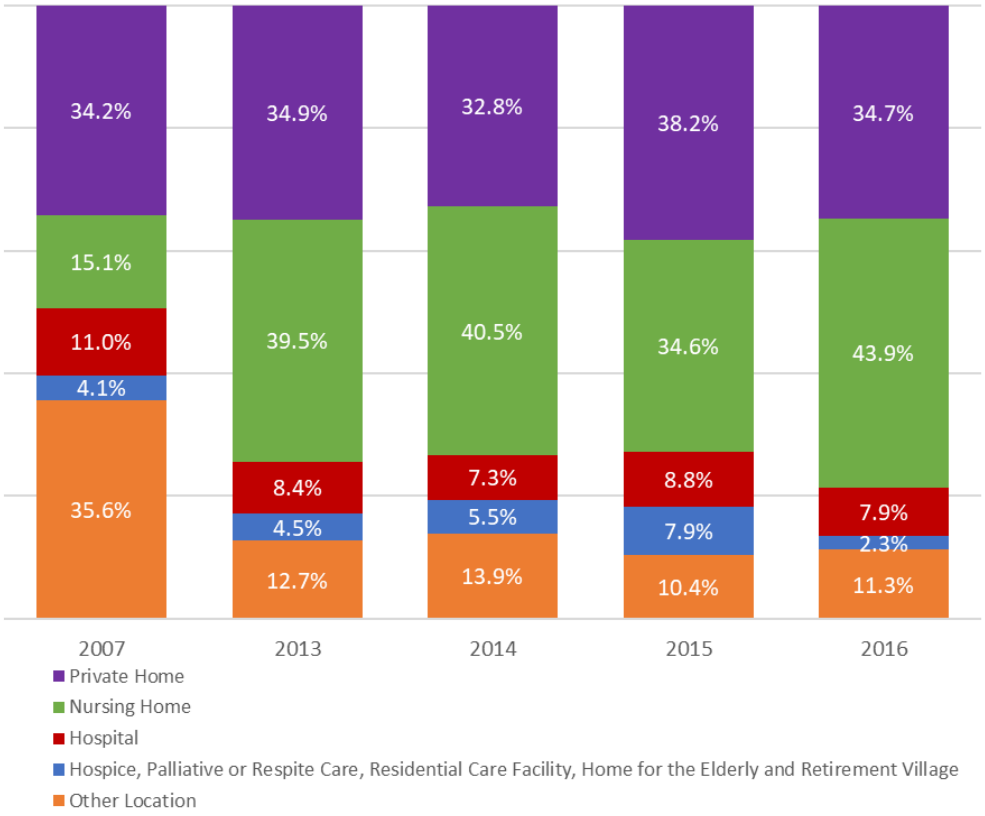


Figure 10: Number of fall-related reported deaths to a coroner in Victoria (2007, 2013–2016) by location of fall – CSA data



The issue of falls, especially in older people, is complex. As people get older, they become frailer and often have impaired mental functioning. Older people, however, still value their independence and the right to take risks. In particular, many want the right to choose whether they can move independently despite their frailty, or to use walking frames and other support mechanisms for mobility.

A fall without significant trauma that is followed some time later by death from natural causes related to underlying medical conditions is not reportable to a coroner, even if it involved circumstances that included a departure from appropriate safe care. However, it is recognised that a fall with or without significant trauma in an older, frail person is quite often the catalyst for their death, although the direct or indirect linkage in non-trauma cases can be hard to demonstrate. Falls may also be evidence of a failure of safety and a sign of poor care.

It is therefore critical to identify situations where care of older, frail people, as in the Reimers case, is substandard and needs to be improved. This issue has the potential to increase as the demand for aged care services grows. The increased pressure on these services has the foreseeable potential to lead to reductions in the quality of care.

A constructive approach may be in part epidemiological – that is, identifying institutions or locations where deaths in older people are occurring at a higher rate than would be expected if care was of a satisfactory standard. A comprehensive system that monitors reported deaths would allow the identification of institutions or geographic locations where higher than expected rates of mortality are occurring. This would then permit more targeted investigations and recommendations for actions by the appropriate authorities. Such a system would potentially be more effective in identifying poorly performing care institutions and address the issues raised by the Coroners Working Party. The Coroners Prevention Unit, subject to resourcing limitations, has the ability to do this in relation to reportable deaths.

4.4 Changing the process of coronial investigations in hospital deaths and the need for police attendance

The previous sections have outlined the breadth of the coronial system, number of investigating agencies and potential for duplication and overlaps.

4.4.1 Use of police resources in reporting

Since 2016–17, a Form 83 project has been conducted by Victoria Police and the Alfred Hospital and St Vincent's Hospital. The project enabled the initial reporting of a hospital death to police by CA&E via phone or email. The initiative resulted in significant benefit to Victoria Police in relation to time efficiency and reduction of impact on resources, as police are no longer required to attend at those hospitals to retrieve information relating to the death. This also benefits hospital staff and grieving families, as the presence of police immediately following a death in hospital can cause additional anxiety for families.

The project covers deaths in hospitals, **excluding** suspicious deaths. It involves CA&E taking the initial report of the death from the hospital. In the case of the Alfred Hospital, CA&E contacts Southbank Police Station, and

for St Vincent's Hospital CA&E contacts Fitzroy Police Station. CA&E sends the medical deposition from the hospital to the police station, and that is used by the police member to draft a Form 83 and to contact family members. The Form 83 is then sent back to CA&E.

The potential for the project to be expanded is being explored.

4.5 The case for monitoring of all deaths in Victoria

This is a broader issue than the remit of the current review.

As outlined previously, approximately 35,000 deaths are not reported to the coroner, but are processed by BDM.[27] Of these, approximately 400 potentially reportable deaths were referred to the coroner from BDM in 2018. This leaves approximately 34,500 deaths per year that are not necessarily being monitored.

The capacity of the current system to rely on the investigation of individual cases to identify potential clusters of similar deaths is limited. Groups of deaths with similar features can easily be missed, as occurred in the Harold Shipman murders in the United Kingdom and the Niels Hoegel murders in Germany. This principle also applies to identification of facilities such as hospitals, nursing homes, disability services, etc. where deaths are occurring as a result of substandard care.

The identification of potential clusters of similar deaths or hot spots in this group of non-reported deaths will usually occur over a period of time, often months or years. Data monitoring systems could be developed that flag where further statistical anomalies occur, and where further investigation is necessary. Without a body to examine such issues, evidence may need to be gathered from a thorough examination of individual clinical records, which is resource intensive. There are different models for how this could be performed, but collaboration between DJCS (including BDM), DHHS (Consultative Councils, including SCV), the Court, VIFM and possibly other departments is clearly required.

With advances in data (capture, management and linkage) reporting and analytics, there is now the potential to monitor all deaths in Victoria more efficiently and effectively, and to highlight clusters, hot spots and other trends

[27] NCIS data.

that may warrant coronial or other investigations. SCV and CCOPMM are useful examples in this regard with their focus on still-births, infant child and maternal deaths as well as deaths from hospital infections (sentinel events).

A more systematic approach to monitoring and surveillance is warranted. Improvements here, alongside the better coordination of an appropriate response, will help to:

1. Ensure vulnerable Victorians are afforded effective oversight and their care better scrutinised, for example for older Victorians or for those in care within disability services, mental health services or palliative care;
2. Identify where care in particular institutions, in particular locations or delivered by particular practitioners is potentially substandard, for example due to omission of care, abuse or neglect;
3. Understand whether other specific types of deaths should become reportable;
4. Reduce the confusion that continues to exist in relation to the obligation to report certain categories of deaths; and
5. Assess whether the extension of the definition of ‘medical practitioner’ and ‘medical procedure’ to ‘health practitioner’ and ‘health procedure’ respectively is warranted.

5 Recommendations

For the opportunities outlined in the previous section, further analysis has been completed and recommendations made across four themes.

The review has completed its approach within the level of resources provided and to a level of detail which has enabled these recommendations to be made. This has included access to expertise across the system and an understanding of the diverse range of views. In specific areas, further analysis is required to fully design and implement the recommended changes.

An overview of each theme is as follows:

1. **Building data systems and acquiring evidence-based, epidemiologically informed insights into patterns of death, focusing on those placing Victorians at unacceptable risk.** This involves suitably qualified professionals regularly reviewing death data to identify patterns and trends so as to isolate areas of concern and of vulnerability for Victorians, which are deserving of in-depth coronial investigation.
2. **Creating an enhanced triage model to support the more efficient handling of natural cause deaths**, which improves the speed and quality of triage of reportable (including potentially reportable) deaths, through collaborative work between VIFM and the Court. This would ensure that coroners carry less of an administrative burden and have more capacity to focus on the more complex cases and would facilitate faster completion rates. Critically, it would continue to ensure that those cases that warrant fuller coronial investigation receive it. This should be undertaken following a review of the impact of section 16(1A) of the Act.
3. **Establishing better communication between the entities investigating the cause of death and coronial systems**, and building better capability, better interactions and understanding across the system. It would help ensure the quality of reporting is improved at its source.
4. **Further reviewing the legislative definition of 'reportable death'** to establish whether it is continuing to meet contemporary needs in respect of the reporting of deaths that require coronial oversight.

Each theme contains one or more recommendations. In developing these, the Review has sought to:

- apply a family and community-centred focus, and a trauma-informed approach to delivery of services, which is fundamental to contemporary public sector systems, the Council and the Court;
- build on a restorative justice approach;
- ensure the important role of the Court is not diminished, with the intention to allow its expertise and resources to be deployed principally for cases in which the coronial processes are most likely to yield constructive outcomes; and
- strike the balance between the need for coronial processes with the need to minimise unnecessary burden, anxiety and stress on families.

An overview of each theme and subsequent recommendations now follows. Collectively these address the opportunities outlined in the previous section.

5.1 Building data systems and acquiring evidence-based epidemiologically informed insights into patterns of death, focusing on those placing Victorians at unacceptable risk

There is an opportunity for better systemic analysis of data within the Court and across data systems held by entities with responsibilities in the coronial investigation area.

The aim is to ensure that (initially) reported deaths of older people in Victoria are better monitored in order to identify locations and associations where death rates are higher than expected; to enable comprehensive investigations where they are required; and to instigate investigations into causes of death where issues of concern have been identified. This system would complement the current coronial process and provide reassurance that preventable deaths are not being missed when the current system does not sufficiently allow for their identification. It would also enable coronial investigative resources to be focused according to epidemiologically informed insights.

A monitoring and surveillance function would:

1. Screen deaths of older people reported to the coroner to identify higher than expected death rates in particular geographic, or institutional locations and associations with particular healthcare practitioners.
2. Allow analysis of this data to monitor and identify clusters and trends that need to be addressed. The ability for analysis and 'hot-spotting' of deaths and potentially reportable deaths would improve the monitoring of a larger proportion of deaths and therefore increase the level of appropriate reporting to the Court and ensure a focus on the right cases.
3. Generate alerts and identify locations where excessive numbers of deaths are occurring, for example, due to omission of care, abuse or neglect in care settings such as in residential aged care, hospitals, disability care and mental health care. This could also extend to other in-care and community settings.
4. Protect vulnerable Victorians and identify communities at increased risk of death.
5. Provide epidemiological capability to the system.
6. Support a means for monitoring system efficiency and efficacy and allow consumer feedback, including from family members.

The United Kingdom has piloted a similar concept (solely within hospitals at this stage) through its Imperial College National Mortality Surveillance System.[28] The system generates monthly mortality alerts for the Care Quality Commission, the national regulator, which then investigates in conjunction with hospitals as required.

Such a function is proposed to review all 'reported deaths' of the elderly, namely those deaths that are reportable and are reported. Fundamental to the efficacy of such a function would be expert epidemiological input.

It should be supported by the creation of an Aged Persons Death Register within the Court's database, which would facilitate capture of data for further analysis and the commencement of identification of hot-spots. While the

[28] Elizabeth Cecil et al., 'National hospital mortality surveillance system, a descriptive analysis' (2008) 27 *BMJ Quality & Safety* 974.

Court already has similar models of registers, as a first step, the Court should undertake an analysis of the resources required.

However, this proposal does not extend to the overwhelming majority of deaths, which are not reportable. For pragmatic reasons, we have proposed as an interim measure that the monitoring and surveillance function commence with reported deaths of older people. If it proves worthwhile, it would be valuable to explore means of extending the function to all Victorian deaths, namely reported and non-reported deaths, including (but not limited to) deaths of older people and deaths of others. We acknowledge this would have significant resourcing implications, however, so would need to be justified on a cost-benefit basis, after a rigorous evaluation of the efficacy of the function proposed above in relation to reported deaths of older people.

There is the potential to draw upon existing resources to develop the proposed new function, which would focus initially on identification of deaths among older people that require further coronial investigation. The next phase of investigation of such deaths (that is, after hot-spots, trends and patterns identify matters requiring further investigation) would involve review of clinical records to ascertain whether deaths among older people were genuinely unexpected. This means being contrary to clinical anticipation, having regard to the individual's state of health and also the expected incidence of like deaths in the location. It would also take into account matters such as the profile of the treating clinical practitioners. It would require cooperation between entities able to provide oversight and analysis of the data, with the results being reported to SCV if appropriate.

This recommendation seeks to leverage advances in technology, data management and analytics. It should be established with incorporation of advice from the Victorian Centre of Data Insights, whose role is to transform 'the way Victorian Government uses data to deliver better policies and services for the benefit of all Victorians'.[29]

The proposed function is not intended to compete with other databases/datasets, but to build upon and provide an extra aspect to what already exists. It is intended to integrate with other datasets as appropriate

[29] Victorian Centre for Data Insights <https://www.vic.gov.au/victorian-centre-data-insights>.

for a more holistic and more focused view of the system based on interagency collaboration.

5.1.1 Delivering a new set of services

This new function should:

- provide services to key stakeholders, which will include the ongoing monitoring of the system (including identifying trends and hot-spots in deaths), performance reporting (including periodic public reporting where required), outcome measurement (including family surveys and consumer feedback), analysis, research and evaluation, and data release;
- contain data management, data governance, reporting, analysis, research and epidemiology facilities; and
- work collaboratively with other organisations, integrating as many relevant datasets as possible to enhance the application of data to further improve the operation of the coronial system.

A key deliverable should be the enhanced monitoring and analysis of deaths in older people (in the context of other recommendations in this report), as well as deaths in government and non-government (but government-funded) care facilities. This would strengthen the monitoring of residential aged care facilities, hospitals and other caring services, and identify those with a higher than expected mortality for further investigation. A critical component will be the ability to connect with organisations that can apply findings and improvements back into the system.

In addition, it is proposed that the Court create an Aged Persons Death Register on its database to facilitate the identification of deaths where hot-spots, patterns or trends suggest that further coronial investigation in any given instance or group of instances should be undertaken. Such a proposal would emulate other registers already created on the coronial database, is likely to be implemented comparatively readily, and should provide significant investigative benefits.

Recommendation 1

The Court should create an Aged Persons Death Register on its database to facilitate the identification of deaths where hot-spots, clusters, patterns or trends suggest that further coronial investigation in any given instance or group of instances should be undertaken in line with the coroner's preventable death function. This register should operate in conjunction with the NCIS to allow the Court to be informed of national trends that may have a bearing on coroners' death investigations in Victoria.

Recommendation 2

To protect the Victorian community, and in particular vulnerable older people, a monitoring and surveillance function should be created in the Court in relation to (at first) reported deaths of the elderly. This monitoring function should take into account information held in the NCIS. The purpose is to identify, on the basis of suitably skilled and experienced epidemiological overview, hot-spots, trends and patterns in such deaths, so that coronial investigations are enhanced, efficient and suitably focused.

Recommendation 3

DJCS (including BDM) and DHHS should investigate the potential for monitoring and review of deaths in Victoria, both those that are reported and those that are not, to add value to the preventative insights gained from coroners' investigations.

5.2 Establishing an enhanced triage model to support the more efficient handling of natural cause deaths

This recommendation aims to improve the speed and quality of the triage of reportable (including potentially reportable) deaths, through collaborative working between the VIFM and the Court. The intention is to ensure that coroners have fewer administrative burdens and greater capacity to focus on

the more complex cases and faster completion rates thereby safeguarding vulnerable Victorians.

To be clear, some natural cause deaths do require a full coronial investigation, and the intention is not to hinder this. However, if a significant number of these deaths could be appropriately handled without having to be the subject of extensive investigation by coroners, it would have major benefits for families, the Court, VIFM, Victoria Police, staff of hospitals and residential aged care facilities and the taxpayer.

Maintaining the engagement of coroners in the triage process for managing these deaths provides important safeguards for the wider community. However, where a natural cause of death can be ascertained as a result of pathological investigations not amounting to an autopsy, such as where postmortem CT scans are undertaken, allowing forensic pathologists with coronial oversight to provide a medical certificate of cause of death could significantly reduce the work of the Court. Any such changes will not hinder the ability for a family member (or carer) to trigger an investigation at any stage based on concerns, and their ability to use coronial processes to gain assurances that similar actions will not happen again in the future must remain. This includes their understanding of the mechanisms and processes to enable this to happen.

5.2.1 Models to tackling similar challenges

Two models have been reviewed that aim to achieve the same outcome. Both models require further careful examination to determine applicability, utility and an assessment of how the models are currently working, given the United Kingdom model in particular has been in operation for a relatively short period of time.

The first model is from Queensland, and it places capability and delegated authority in a coronial registrar and deputy registrar to process a similar cohort of cases. The second is from the United Kingdom, and it builds capability through medical examiners, initially located within hospitals.

Queensland Judicial Registrar and intake process

Since 1 January 2017, the Queensland coronial registrars role changed to managing the triage process for deaths reported directly by clinicians

via the Form 1A process namely health care-related deaths, mechanical fall related deaths and natural causes deaths in care; apparent natural causes deaths where there is no MCCD; telephone inquiries from clinicians about whether a death is reportable and deaths reported by funeral directors. In Queensland, healthcare-related deaths are almost always reported by medical practitioners (rather than police) using a 'Form 1A – Medical practitioner report of death to a coroner'. A Form 1A is used where:

- the practitioner seeks advice from the coroner about whether a death is/is not reportable, or
- the death is reportable and the practitioner seeks the coroner's authority to issue an MCCD because the cause of death is known and no autopsy or investigation appears necessary.

The coronial registrars conduct the triage process for these deaths, and between 2012-13 and 2016-17 finalised 33% of the 25,280 deaths reported across the state. In relation to healthcare-related deaths, the coronial registrars have been delegated authority to advise and conduct the triage process, which is outlined in Appendix F. This ensures these cases are appropriately considered, but avoids the need for a coroner to investigate the death.

Medical Examiner model (UK)

The United Kingdom has long had concerns about the efficacy of its death certification process. The Shipman Inquiry further put these concerns into focus. It concluded that 'the current system of death certification was confusing and provided inadequate safeguards, particularly against the possibility that (as in Shipman's case) the doctor completing the MCCD was himself responsible for the patient's death.'[30]

Following other inquiries into both Mid Staffordshire and Morecambe Bay, the United Kingdom has concluded that weaknesses in the system can be mitigated or eliminated by the introduction of medical examiners (**MEs**).

[30] *Introduction of medical examiners and death certification reform in England: impact assessment* (June 2018).

From April 2019 the United Kingdom's new medical examiner led system began to be rolled out and will:

- ensure all deaths will be subject to either a ME's scrutiny or a coroner's investigation;[31]
- be a non-statutory system;
- be initially introduced within hospitals, with a view to extending this into primary and community care in the future;
- see part-time MEs employed by a hospital, but with external reporting lines to 'ensure there is the appropriate level of separation required for the roles to remain impartial and objective';[32]
- see MEs scrutinise all deaths within the hospital, assisted by a medical examiner officer (**MEO**); and
- establish a national medical examiner to oversee all MEs and MEOs and provide strategic and overarching guidance and direction.

5.2.2 Options for change

The Council does not support adoption of the Queensland model for the reasons discussed above. However, the existing preliminary examination process and case management meeting could be expanded so that VIFM adopts the triage role for potential natural cause deaths and can complete and sign-off a MCCD with the oversight of the duty coroner, and where no relative of the deceased objects to the certificate being issued. A similar concept was proposed previously in Victoria, as part of the 2006 Law Reform Committee review into the effectiveness of the *Coroners Act 1985* (Vic).[33]

There are also existing examples of where the Court and the VIFM have trialled new approaches to subsets of this group, such as for femoral

[31] BMA, *Implementation of the medical examiner system* (2019) <https://www.bma.org.uk/advice/employment/ethics/implementation-of-the-medical-examiner-system>.

[32] BMA, *Implementation of the medical examiner system* (2019) <https://www.bma.org.uk/advice/employment/ethics/implementation-of-the-medical-examiner-system>.

[33] Law Reform Committee, Parliament of Victoria, *Coroners Act 1985 – Final report* (2006).

fractures (see Appendix E), and where these new approaches have achieved benefits (albeit on a smaller scale) and without diminishing the role of the Court. A potential course of action is to build on the successful femoral fractures project with a view to extending it to other like deaths in frail adults. The CA&E function is another good example of this collaborative working between the Court and VIFM.

A model similar to the one outlined above, would benefit from legislative amendments necessary to support the transparent and efficient operation of this process. Such amendments could include:

- an amendment to section 37 of the *Births, Deaths and Marriages Registration Act 1996* (Vic) (**BDM Act**) to allow a forensic pathologist at the VIFM to issue a MCCD in circumstances where the doctor is able to form an opinion as to the probable cause of death; and
- a corresponding amendment to regulation 8 of the *Births, Deaths and Marriages Registration Regulations 2008* (**BDMR Regulations**) to refer to 'probable cause of death' rather than cause of death' in the prescribed particulars for MCCDs.

Further areas of legislative analysis would need to include:

- the clear delegation of powers to VIFM forensic pathologists to sign-off MCCDs;
- the regulations required to support the required documentation and processes in relation to:
    - identifying 'uncertain' or potential natural cause cases for the VIFM to receive and process,
    - confirming coroners are content for the MCCD to be signed off in specific cases;
- the ability to re-open cases if issues and concerns are identified or raised after the case has been closed; and
- the impact of the commencement of section 16(1A) of the Act on 29 March 2019 after sufficient time has passed to enable evaluation of whether the legislative amendment is achieving its objectives and accordingly whether this proposal is necessary.

Recommendation 4

A formal role should be established for VIFM whereby VIFM forensic pathologists assess whether deaths are natural cause deaths and, through the daily operations meeting (which includes input from the senior next of kin), discuss with the coroner an appropriate course of action in relation to whether further coronial investigation is required.

This includes in the case of natural cause deaths, where there are no concerns raised by the family or the VIFM pathologist, subject to the coroner's direction, the ability of a VIFM forensic pathologist to sign a MCCD or advise the treating medical practitioner or the deceased's regular local doctor to sign the MCCD.

5.3 Establishing better communication between the entities investigating the cause of deaths and the coronial system

This recommendation aims to establish and strengthen formal relationships and networks between the Court, entities whose responsibilities overlap with the function of the coronial system and clinicians. The aim is to strengthen capability (in the context of scarce resources), understanding, information sharing and guidance between the coronial system and the health and regulatory system.

As part of establishing formal relationships and gaining a better understanding of the role and responsibilities of the multiple entities investigating the cause of deaths and methods for prevention of future deaths, it is recommended that the Court continue with its work to liaise actively with other investigative authorities, official bodies and statutory officers as required under section 7 of the Act to avoid unnecessary duplication of inquiries and investigations and to expedite the investigation of deaths and fires.

It is intended that the establishment of networks will also improve the understanding by medical personnel of the coronial system and reportable death requirements and generally allow for the better sharing of information and guidance.

This work should be:

- led by the Court;
- build on the good work currently under way by, for example, the coroner's information sessions;
- facilitate the improvement and distribution of Court communications and guidelines, including the development of protocols in specific areas such as intensive care units;
- improve cultural awareness and understanding in relation to deaths; and
- ensure coronial findings are sent to the facilities where the death occurred on every occasion to ensure appropriate lessons are learned.

Recommendation 5

The Court should lead the establishment of formal relationships with healthcare networks and medical colleges or associations that enhance the understanding of published guidelines and processes for identifying deaths that need to be reported in hospitals and residential aged care facilities.

Recommendation 6

The Court should continue to liaise with other investigative authorities, official bodies and statutory officers as required under section 7 of the Act to enhance the quality of death investigations, to avoid unnecessary duplication of inquiries and investigations, and to expedite the investigation of deaths and fires.

5.4 Further reviewing the legislative definition of reportable death

This report has focused on one aspect of reportability in respect of deaths of the elderly. The review found that this is an area of significant complexity. However, there is a lack of clarity around a number of other aspects of the definition of reportability in section 4 of the Act. This is particularly so in relation to the distinction between 'natural' and 'unnatural' deaths, the

meaning of ‘unexpected’ within the Act, and when a death is to be regarded as having ‘resulted, directly or indirectly, from an accident or injury’. The intention of the Council is to address each of these issues, including whether the terminology concerning the reportability of deaths associated with medical procedures is satisfactory, in a subsequent report. This will be done by reference to the approaches adopted interstate and internationally, with a view to identifying whether the current definition of ‘reportable death’ is achieving the objective of ensuring that deaths that need assessment by the coronial system are being reported to coroners, whether the terminology is sufficiently understood by those with a responsibility for making reports about death, and whether deaths that need not be the subject of coronial investigation are being reported to coroners.

This work will take place during 2020 and is not dependent on the findings of the three Royal Commissions because the issues are dependent on the formulation of suitable and sufficient thresholds to reportability of deaths to the coroner.

Recommendation 7

Subsequent work by the Council should analyse the need to amend the Act to include among reportable deaths those occurring in contexts not currently covered by legislation, and there should be a review of potentially unclear terminology in section 4(2) of the Act, such as ‘unexpected’, ‘unnatural’, ‘resulted directly or indirectly from an accident or injury’ and medical procedure-related deaths.

Given the establishment of the Royal Commission into Aged Care Quality and Safety and their remit, it is recommended that the Attorney-General consider sending a copy of this report to the Royal Commission.

Recommendation 8

The Attorney-General send a copy of this report to the Royal Commission into Aged Care Quality and Safety, the Royal Commission into Victoria’s Mental Health System and the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with a Disability for their information.

Recommendation 9

The Secretary of the DJCS send a copy of this report to the Secretary of DHHS and to the Registrar of BDM for their information.

6 Next steps

As outlined in the previous section, the review has completed its approach within the level of resources provided and to a certain level of detail, which has enabled the high-level recommendations to be advanced. This has included access to expertise across the Victorian system and an understanding of the diverse range of views. In specific areas, further analysis is required to design and implement the recommended changes and, for certain recommendations, detailed design work will require further stakeholder consultation to be undertaken, together with additional analysis of interstate and international developments in death investigation.

It is appropriate for the Council to undertake further work to reflect further on changes that might be made to the definition of 'reportable death' in Victoria and to explore the viability of specific options for achieving such prioritisation of the allocation of resources and efficiencies within the coronial system. The pre-eminent role of the Court as the body responsible for investigating reportable death is acknowledged and respected.

It has become apparent that there is a risk that important issues of risk for people, in particular older people, but not only this group, may not be being identified adequately because of the absence of an epidemiological form of oversight. The view of the Council is that further steps should be taken to determine how such an additional investigative component can be integrated into Victoria's death review system. To this end, further discussions need to take place with relevant stakeholders, including the Court and VIFM, factoring into account identifiable cost ramifications of any such initiative.

The view of the Council is that the issues traversed in this report have highlighted a problematic burden upon coronial and VIFM resources to investigate all reportable deaths, in particular those that arise from certain categories of death that are prevalent among frail older people. This burden will become more pressing with the ageing of the population. At present, only a very small percentage of such categories of death are the subject of extensive coronial investigation, but numerically their incidence is substantial and they form a high proportion of coronial investigations. Deaths of older people are rarely the subject of open inquest, and even more rarely generate recommendations relating to public health and safety or the administration

of justice under section 72 of the Act, although, as noted previously, inquests and recommendations are not the only way of assessing the impact and value of a coronial investigation. However, the Royal Commission into Aged Care Quality and Safety has highlighted the potential for deaths of older people, including those from falls, to be attributable to neglect, cruelty and lack of care.

The decision in relation to the conduct of coronial investigations into such matters should remain that of coroners, but the development of administrative mechanisms, including those informed by epidemiological analysis and oversight of deaths, has the potential to direct resources more constructively and efficiently. Such an enhancement has the potential to alleviate distress and trauma for family members and others affected by deaths.

7 Appendices

7.1 Appendix A: Project details

The aim of the review has been to help ensure the Court investigates those deaths where there is the greatest public benefit, namely, those deaths where the Court can reduce preventable deaths and promote public health and safety; or it is in the public interest to undertake an independent investigation of the death.

To meet this aim, the scope of the Review has been to analyse and make any recommendations to improve:

1. the systems and processes by which deaths are reported to the coroner and initially responded to by the Court and VIFM; and
2. the definition of reportable deaths in the Act.

Specific areas that have been out of scope for this review have been:

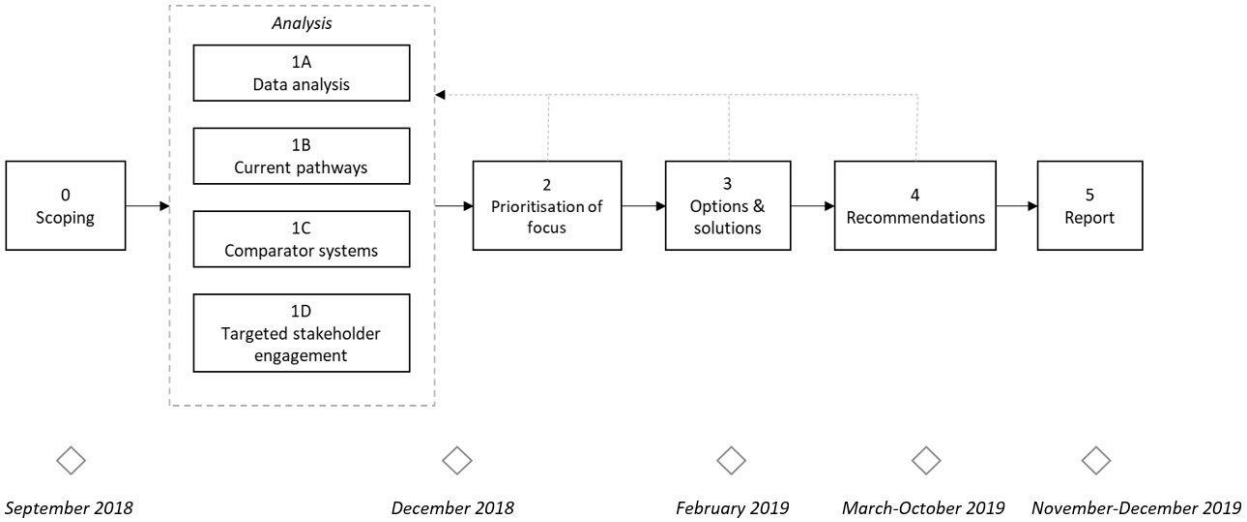
- ‘reviewable’ deaths (as defined in the Act);
- specific classes of reportable deaths including deaths in custody etc. (sections 4(2)(c) to (f) of the Act); and
- voluntary assisted deaths, as defined in the *Voluntary Assisted Dying Act 2017*.

It has not been in the scope of this review to provide guidance, plans or costs for the implementation of any recommendations made.

7.1.1 Approach

Commencing in September 2018, the review has adopted the following approach.

Figure 11: The review's approach



The review has progressed through this approach in terms of gathering evidence (formal stakeholder submissions, stakeholder meetings, analysis of available data, and desktop analysis of approaches in other jurisdictions) and analysing that evidence to agree areas to focus further on.

Within each of its meetings, the Steering Committee has:

October 2018	Agreed the terms of reference for the project. Discussed an overview of CPU data. Reviewed a legislative comparison from other jurisdictions. Provided perspectives on issues and challenges in the context of the project terms of reference. Agreed a separate piece of work, to be completed by the Court on 'in-care' deaths, which are not strictly within scope for this project.
December 2018	Discussed the femoral fracture pilot within VIFM. Reviewed the long list of issues and challenges identified from various evidence sources. Reviewed a system overview and 'pathways' mapping for deaths in Victoria.

	Confirmed a prioritised list of areas to focus further on.
February 2019	Discussed a summary of specific stakeholder consultations including the multi-cultural and multi-faith roundtable and the Australian Centre for Grief and Bereavement. Reviewed a specific stakeholder submission from Victoria Police. Reviewed a data discussion document with data sourced from CPU, VIFM, NCIS and Population data and a particular focus on deaths in older people and falls (identified as a priority area of focus). Discussed a stakeholder consultation with VIFM on an extension to the femoral fracture pilot.
March 2019	Reviewed an interim discussion and agreed areas of focus of focus (prioritisation). Reviewed a submission from the Coroners Court Review Working Group related to In-care deaths. Reviewed data analysis provided by DJCS in relation to the Review.
May 2019	Reviewed a draft report for submission to the Council.

On 30 June 2019, the term of office of the Chair, Dr Katherine McGrath, expired. Associate Professor Robert Roseby was appointed interim Chair from 1 July 2019 to 19 August 2019. On 20 August 2019 Clare Morton was appointed as the new Chair of the Council. From August to December 2019, the draft report was re-drafted to take into account feedback from Council members. The final report was presented to the Council meeting on 9 December 2019.

7.1.2 Project management

Overall project management was the responsibility of Project Lead, Paul Dolan. Mr Dolan prepared a first draft of the report with input from the former chair, Dr Katherine McGrath.

DJCS funded the review and provided the following secretariat functions:

- assistance with project planning, progress reporting, stakeholder communications and consultations;
- supporting the steering committee’s functions;
- sourcing raw data;
- conducting background research as instructed by chair and Project Lead;
- engaging Project Lead.

7.2 Appendix B: Council members

- Dr Katherine McGrath, Council Chair until 30 June 2019, Associate Professor Robert Roseby was appointed interim Chair from 1 July 2019 to 19 August 2019 and Ms Clare Morton was appointed Chair from 20 August 2019
- A/State Coroner Iain West until February 2019, A/State Coroner Caitlin English until 2 December 2019 and thereafter State Coroner John Cain
- Deputy Commissioner Wendy Steendam, Victoria Police
- Professor Noel Woodford, Director, VIFM
- Ms Maryjane Crabtree, President, Epworth HealthCare.
- Ms Maria Dimopoulos, Managing Director, MyriaD Consultants
- Professor Ian Freckelton QC, Barrister.
- Christopher Hall, CEO, Australian Centre for Grief and Bereavement
- Michele Lewis, CEO, mecwacare
- Adjunct Clinical Associate Professor Robert Roseby, Monash Children's Hospital

7.3 Appendix C: Stakeholder engagement

The review has engaged a wide range of stakeholders either through targeted consultations or a formal submission process (request for and receipt of views and perspectives in relation to the aims of the review).

7.3.1 Targeted consultations

In the early stages of the review, meetings with the following stakeholders were held:

1. the Court – coroners, CPU, medical team and legal team
2. VIFM, including the Coronial Admissions and Enquiries department
3. BDM
4. mecwacare
5. SCV
6. Victoria Police
7. Australian Centre for Grief and Bereavement
8. a small number of multicultural and multifaith groups
9. the Queensland judicial registrar.

7.3.2 Formal submissions

A formal request for feedback in relation to the aims of the review was issued and submissions were received from the following organisations:

Australian Nursing and Midwifery Federation Victorian Branch
Douttagalla
Estia Health
Disability Services Commissioner
Mental Health Complaints Commissioner
Victorian Multicultural Commission
Office of the Public advocate
Victoria Police
Mercy Health
Pallative Care Victoria

7.4 Appendix D: System context – organisations, their roles and responsibilities

This following information provides additional context to the material in the main report.

'*The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purpose of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice.*

This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations.'[34]

7.4.1 Legislative history

There was no obligation to report deaths to the coroner under the *Coroners Act 1958* (Vic). The concept of reportable deaths was introduced by the *Coroners Act 1985* (Vic), for the purpose of assisting in the 'detection of dangers to health and secret homicides.'[35]

Under the 1985 Act, a doctor present at or after the death of a person had an obligation to report the death if:

- the death was a reportable death, as defined by section 3; or
- the doctor did not view the body; or
- the doctor was unable to determine the cause of death; or
- no doctor attended the person within 14 days before the death, and the doctor present was unable to determine the cause of death from the deceased's immediate medical history.[36]

A 'reportable death' under section 3 of the 1985 Act included:

- unexpected, unnatural or violent deaths;

[34] *Coroners Act 2008* (Vic) (preamble).

[35] Explanatory Memorandum, Coroners Bill 1985 (Vic) 1.

[36] *Coroners Act 1985* (Vic) s 13(3).

- deaths that resulted, directly or indirectly, from an accident or injury;
- deaths that occurred during an anaesthetic, or as a result of an anaesthetic and not due to natural causes;
- deaths where the person's identity was unknown;
- certain deaths where the cause of death was not certified;
- deaths that occurred in prescribed circumstances; and
- deaths of persons held 'in care' immediately before the death. Where a person was held 'in care' immediately before their death, the person under whose care the deceased was held must report the death.[37]

The 2008 Act established the Court,[38] and introduced amendments to the definition of 'reportable death.' One of the main changes to the definition was the removal of the anaesthetic-related death provisions.[39] The Act introduced a broader medical procedure-related deaths provision.[40]

Reporting obligations have remained largely the same under the Act, except that those responsible for reporting can report deaths either to a coroner or to VIFM.[41]

7.4.2 The Court

The Court was established under the Act as a specialist inquisitorial court that independently investigates certain types of deaths and fires, seeks to reduce preventable deaths and fires, and promotes public health and safety and the administration of justice.[42] The Court replaced the former State Coroner's Office.

The Court is headed by the State Coroner. In recognition of the importance of the role, the Act requires the State Coroner to be a judge of the County Court of Victoria.[43] The Deputy State Coroner must be a magistrate, and acts

[37] *Coroners Act 1985* (Vic) s 13(5). 'In care' was defined in s 3.

[38] *Coroners Act 2008* (Vic) s 89(1).

[39] *Coroners Act 1985* (Vic) ss 3(1)(f), (g).

[40] *Coroners Act 1985* (Vic) s 4(2)(b).

[41] *Coroners Act 2008* (Vic) ss 10-12.

[42] *Coroners Act 2008* (Vic) (Preamble, ss 1 and 89(1)); Coroners Court of Victoria, *Annual report 2017–18,* 12.

[43] *Coroners Act 2008* (Vic) s 91(2).

as the State Coroner when required.[44] In addition to the State Coroner and Deputy State Coroner, there are currently nine coroners on the Court, who must be magistrates or experienced Australian lawyers.[45] All coroners are appointed to the position by the Governor in Council, on the recommendation of the Attorney-General.

Coroners are supported by coronial services delivered by a number of organisations, VIFM and the Police Coronial Support Unit.

Certain decisions of the Court may be appealed to the Supreme Court of Victoria. The findings of a coroner after an investigation or an inquest may be appealed to the Supreme Court by a person with a sufficient interest.[46] Certain other decisions may also be appealed, including a decision that a death is not a reportable death;[47] a direction that an autopsy or exhumation be performed;[48] a decision not to hold an inquest;[49] and a decision not to re-open an investigation.[50]

7.4.3 Reportable deaths

Reportable deaths are deaths that must be reported to the Court and investigated by a coroner. They are defined by section 4 of the Act. These deaths are considered to warrant the independent and public oversight of the Court:

The boundaries of the coroner's jurisdiction are defined by public interest, which ensures that coroners are able to investigate only those deaths which require independent and public oversight. It also recognises that coronial investigations represent state intervention into a private experience of families and should be limited to appropriate cases.[51]

[44] *Coroners Act 2008* (Vic) s 92.

[45] *Coroners Act 2008* (Vic) ss 93, 94.

[46] *Coroners Act 2008* (Vic) s 83.

[47] *Coroners Act 2008* (Vic) s 78.

[48] *Coroners Act 2008* (Vic) ss 79, 81.

[49] *Coroners Act 2008* (Vic) s 82.

[50] *Coroners Act 2008* (Vic) ss 79, 84.

[51] Victoria, *Parliamentary Debates,* Legislative Assembly, 9 October 2008, 4035 (Rob Hulls, Attorney-General).

Coroners investigate reportable deaths for the purpose of determining how and why the deaths occurred, in order to help prevent similar deaths in the future.[52] The Second Reading Speech to the Act notes that:

Our coronial system must take a broad public health approach to investigation to clarify on the public record the causes and circumstances of death, to provide public hearings into those matters where it is appropriate, and to draw lessons from deaths so as to minimise the risks of recurrence, where possible, in the future.[53]

For a death to be reportable in Victoria, it must have a connection to Victoria. This will be satisfied if the body is in Victoria, the death occurred in Victoria, the cause of death occurred in Victoria, or the person ordinarily resided in Victoria at the time he or she died.[54]

Provided that the death has the necessary connection to Victoria, it must fall within one of the following classes (set out in section 4 of the Act) to be reportable:

- unexpected, unnatural or violent deaths;
- deaths that resulted, directly or indirectly, from an accident or injury;
- deaths that occurred during a medical procedure, or after a medical procedure (but still causally related to the medical procedure), where a doctor would not have reasonably expected the death immediately before the procedure was undertaken;
- deaths of persons placed in 'custody or care' immediately before the death;[55]
- deaths of persons who were patients under the *Mental Health Act 2014* (Vic) immediately before the death;
- deaths of persons under the control, care or custody of the Secretary to the Department of Justice or a police officer;

[52] Coroners Court of Victoria, *The Coroners Process: Information for Family and Friends* (October 2017).

[53] Victoria, *Parliamentary Debates,* Legislative Assembly, 9 October 2008, 4034 (Rob Hulls, Attorney-General

[54] *Coroners Act 2008* (Vic) s 4(1).

[55] Persons' placed in custody or care is defined in s 3.

- deaths of persons subject to a non-custodial supervision order;
- deaths where the person's identity is unknown;
- deaths where a MCCD is not signed or likely to be signed;
- deaths that occur outside Victoria where a MCCD is not signed or likely to be signed by a person authorised to do so; and
- deaths of a prescribed class of person that occurs in prescribed circumstances.[56]

Section 4 of the Act:

(1) In this Act, a death of a person is a reportable death if—
  (a) the body is in Victoria; or
  (b) the death occurred in Victoria; or
  (c) the cause of the death occurred in Victoria; or
  (d) the person ordinarily resided in Victoria at the time of death—
  and the death was a death specified in subsection (2).

(2) For the purposes of subsection (1), the deaths are—
  (a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
  (b) a death that occurs—
    (i) during a medical procedure; or
    (ii) following a medical procedure where the death is or may be causally related to the medical procedure—
    and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or
  (c) the death of a person who immediately before death was a person placed in custody or care; or
  (d) the death of a person who immediately before death was a patient within the meaning of the *Mental Health Act 2014*; or

[56] *Coroners Act 2008* (Vic) s 4(2).

(e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a police officer; or

(f) the death of a person who is subject to a non-custodial supervision order under section 26 or 38ZH of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*; or

(g) the death of a person whose identity is unknown; or

(h) a death that occurs in Victoria if a notice under section 37(1) of the *Births, Deaths and Marriages Registration Act 1996* has not been signed and is not likely to be signed; or

(i) a death that occurs at a place outside Victoria if the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death and the cause of death is not likely to be certified by a person who is authorised to certify in that place; or

(j) a death—[57]

(i) of a prescribed class of person;

(ii) that occurs in prescribed circumstances.

7.4.4 Reviewable deaths

A reviewable death is a death of a child who is the second or subsequent child of its parents to have died, provided that one of the specified nexus requirements to Victoria is satisfied.[58] The death will **not** be a reviewable death if:

- the death occurs in hospital; and
- the child was born at the hospital and had always been an in-patient of a hospital; and
- the death is not a reportable death.[59]

[57] There have been no regulations made for the purposes of section 4(2)(j) of the Act.

[58] *Coroners Act 2008* (Vic) s 5(1).

[59] *Coroners Act 2008* (Vic) s 5(2).

The purpose of the reviewable death provision in the Act 'is to ensure that children at risk of death or injury caused by a parent can be identified and protected and that families receive appropriate medical and social support.'[60]

A registered medical practitioner who is present at or after a reviewable death is under an obligation to report it to the State Coroner or VIFM 'without delay'.[61]

7.4.5 What happens after a death is reported?

The Court investigates all deaths reported to it that fall within the definition of 'reportable death'. The general process for its investigation is as follows:

- CA&E at VIFM receives the report of a death and coordinates the initial phase of the coroner's investigation. This includes admitting the deceased person into the care of the Court, contacting the deceased's family, and requesting medical information to assist with the preliminary examination of the deceased.
- For the purpose of gathering information, the coroner may attend the scene of death if 'safe and appropriate to do so'. Victoria Police will also gather information for an initial report to the coroner. A forensic pathologist from VIFM will examine the deceased and provide a Medical Examination Report to the coroner.
- Based on the information and evidence gathered, the coroner will either decide that the reported death requires further investigation or conclude that the death was due to natural causes and end the investigation at this point.
- As part of any investigation, the coroner may:
    - obtain information and documents from various people and organisations;
    - request expert reports and opinions;
    - determine if an inquest is required;
    - request Victoria Police to compile a coronial brief; and

[60] Victoria, *Parliamentary Debates,* Legislative Assembly, 10 September 2008, 4036 (Rob Hulls, Attorney-General).

[61] *Coroners Act 2008* (Vic) s 13(1).

- conduct research and consider potential recommendations.

- The coroner makes a finding or findings after every investigation, sometimes coupled with recommendations as to how deaths in similar circumstances might be prevented. Findings may be made following an inquest (a public hearing into a death held in a courtroom), or may be made by a coroner 'in chambers' without an inquest. The vast majority of matters do not proceed to an inquest. In 2017–18, 99.2 per cent of findings were made 'in chambers'.[62] A coroner will usually only decide to hold an inquest if the circumstances surrounding the death are unclear, or if there are broader issues of public health and safety that need to be examined. In some circumstances, it is mandatory to hold an inquest.[63]

Depending on the complexity of the case, and the type of investigation that is undertaken, it can take many months, or in some cases over a year, for an investigation to conclude.

7.4.6 VIFM

VIFM was established in 1985 to provide forensic pathology and scientific services to the Court and the Victorian justice system.[64] Among other functions, VIFM supports the Court by:

- receiving notifications of reportable deaths for referral to the Court;
- taking deceased persons into the care of the Court and managing the mortuary;
- undertaking medical examinations, autopsies and toxicology scans as directed by a coroner to identify the person who died and their medical cause of death; and
- providing expert reports on the cause of death for the investigating coroner.[65]

[62] Coroner's Court of Victoria, *Annual report 2017–18*, p 19.

[63] Subject to certain exceptions, an inquest is mandatory where the coroner suspects a death was the result of homicide; where the deceased was a person placed in custody or care immediately before death; where the identity of the deceased is unknown; or where a death occurred in prescribed circumstances: *Coroners Act 2008* (Vic) s 52(2).

[64] By the enactment of Part 9 of the *Coroners Act 1985* (Vic).

[65] *Victorian Institute of Forensic Medicine Act 1958* (Vic) s 66(1).

To streamline coronial investigations, VIFM and the Court are co-located at the State Coronial Services Centre at Southbank, Melbourne.

CA&E at VIFM receives all reports of deaths, and inquiries about whether a death is reportable. While the majority of telephone inquiries come from medical practitioners, police officers, funeral directors, family members, and the DHHS, any other person seeking to report a death also make inquiries. If a person is uncertain as to whether a death must be reported, a clinical nurse from CA&E will provide advice on whether it is likely to be a reportable death. When a medical practitioner has called about a potentially reportable death, CA&E asks them to complete a medical deposition.

If a death is reportable, CA&E will generate a case number and arrange for the transfer of the deceased person's body to the VIFM mortuary. There are circumstances where the body is not required to be transported. Firstly, where the death has been referred to the Court by the BDM, which is discussed further below, the body cannot come in. Secondly, a body does not have to be transported to the VIFM mortuary where the death meets the requirements of the Fractured Neck of Femur program (see later in these appendices).

Once a body is transported to VIFM, CA&E contact the deceased person's family to seek their views on autopsy and gather information about the deceased, and request documentation from medical practitioners and Victoria Police to assist with the forensic pathologist's preliminary examination of the body.

Preliminary examination of the body generally involves a whole body CT scan, toxicology analysis and external physical examination of the body, the results of which are provided in a medical examiner report to the coroner. A meeting is then held between the VIFM pathologist and coroner to determine whether the death should be investigated further. If the coroner decides that the death is not a reportable death, the investigation must be discontinued, and a written notice of the coroner's decision is provided to the person who reported the death.[66] In cases where the coroner believes that additional investigation is not necessary and the cause of death is known, a request to

[66] *Coroners Act 2008* (Vic) s 16.

complete an MCCD will be made to the medical practitioner who attended or treated the deceased immediately prior to the death.

Where the coroner decides that further investigation is needed, the pathologist will recommend what type of forensic investigation should be conducted. The least invasive procedure is an external examination of the body. Alternatively, a partial or full autopsy can be performed. After a discussion with the pathologist, a coroner will make a direction about whether an autopsy should be performed. The senior next of kin is then notified and has 48 hours to ask the coroner to reconsider the direction. The coroner will then consider this request and give the senior next of kin written notice of their decision about whether an autopsy is necessary, thereby enabling an appeal to be taken to the Supreme Court, if the next of kin so wishes.

The VIFM forensic pathologist will provide a case opinion to the coroner as to the cause of death and will follow up with clinicians to obtain further medical information about the deceased if required. The forensic death report is provided to the coroner, to aid their investigation. CPU supports the coronial investigation, providing research and data in response to questions from the coroner. When the investigation is concluded, the coroner will make findings, which may include recommendations. BDM is notified and will issue an MCCD for the death.

7.4.7 The role of Victoria Police

Victoria Police attend the scene of a reportable death for the purposes of compiling an initial report for the coroner.[67] If the death proceeds to coronial investigation, the Police Coronial Support Unit (PCSU) within Victoria Police may be required to support the investigation. The Coroner's Investigator, who is a member of Victoria Police, compiles the coronial brief of evidence. If a matter proceeds to inquest, PCSU might prepare the inquest brief, or it can be prepared by Coroners Court solicitors or briefed out. The coronial brief of evidence includes reports, statements and information about the

[67] Note the project discussed on Page 32, 4.4.1. Where the death occurs in the Alfred Hospital or St Vincent's Hospital and the death is not suspicious, the police do not have to physically attend.

death. PSCU can also support other police officers in their investigation of matters on behalf of the coroner.[68]

7.4.8 The role of BDM

A doctor who is responsible for a person's medical care immediately before death, or who examines the body of the deceased person after death, must provide an MCCD within 48 hours of the death to BDM – unless the death is a reportable or reviewable death.[69]

Section 37 of the BDM Act

Notification of deaths by doctors

(1) A doctor who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, must, within 48 hours after the death, notify the Registrar of the death and of the cause of the death in a form and manner approved by the Registrar and specifying any prescribed particulars.

Penalty: 12 penalty units.

(2) When a notice is given under subsection (1), the doctor must also give a notice in the form and manner approved by the Registrar and specifying any prescribed particulars that the death has occurred to the funeral director or other person who will be arranging for the disposal of the human remains.

Penalty: 12 penalty units.

(3) However, a doctor is not required to give a notice under subsection (1) or (2) if another doctor has given the required notices.

(4) A doctor must not give a notice under subsection (1) or (2) if a coroner or police officer is required to be notified of the death under the *Coroners Act 2008*.

Penalty: 12 penalty units.

[68] Coroners Court of Victoria, *The Court* (13 December 2018) <https://www.coronerscourt.vic.gov.au/about-us/our-people/court>.

[69] *Births, Deaths and Marriages Registration Act 1996* (Vic) s 37; Neate et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 402.

Two medically trained BDM staff examine all MCCDs provided to BDM, in order to identify deaths that have not been reported to the coroner when they should have been, and to ensure that causes of death are accurately described.[70] If they believe that a death should have been reported, the BDM officer will refer it to the Court for investigation.[71]

BDM referral of potential reportable deaths began on an informal basis in the late 1990s. The process was formalised in 2003 and now involves the use of key words to trigger a closer look at a case, such as 'fracture', 'fall', 'injury' or 'overdose'.

A 2013 study on BDM referrals by Neate et al. found that out of the 656 deaths referred by BDM to the Court between 1 July 2010 and 30 July 2011, 320 external cause deaths (48.8 per cent) were found to be reportable deaths after investigation.[72] External cause deaths cover 'any death that resulted directly or indirectly from environmental events or circumstances that caused injury, poisoning or other adverse events.'[73] During consultation with BDM in October 2018, BDM staff similarly estimated that approximately half of BDM referred cases are determined to be reportable deaths.[74]

The Neate study found that of the deaths referred by BDM, 80 per cent were people aged 80 years and over. In relation to this finding, the KPMG Report on *Reporting reportable deaths in hospitals to the coroner* noted its consultations confirmed that doctors find it 'challenging to apply the reporting guidelines to elderly patients, particularly those with complex comorbidities'.[75]

The two medical officers currently involved in the MCCD review process are a former nurse/midwife and an overseas-trained doctor who has not

[70] SandraNeate et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 402.

[71] Stephen Cordner, 'Doctors, death certificates and reporting to the coroner – room for improvement' (2013) 199(6) *Medical Journal of Australia* 379, 379.

[72] Neate et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 403.

[73] Neate et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 403, citing the World Health Organisation classification.

[74] Meeting with BDM (30 October 2018).

[75] KPMG, Coronial Council of Victoria, *Reporting reportable deaths in hospitals to the coroner – Final Report* (2017) 14<https://www.justice.vic.gov.au/sites/default/files/embridge_cache/emshare/original/public/2018/09/15/fb5e93735/Reporting_Reportable_Deaths_in_Hospital_to_the_Coroner.PDF>; Neate et al., 'Non-reporting of reportable deaths to the coroner: when in doubt, report' (2013) 199(6) *Medical Journal of Australia* 402, 403.

completed conversion studies.[76] BDM staff noted that while the current BDM oversight role was created following a spike in deaths in a particular residential aged care facility in 2003, current data practices do not allow BDM to identify possible trends or patterns.[77] BDM has recently introduced Registry Information Online (RIO), a new business system that codes all causes of death. It is not yet clear whether RIO will enhance BDM's ability to identify patterns.

7.4.9 Guidance from the Court for BDM

In August 2015, the Court provided BDM with a four-page guidance document.[78] These guidelines are still followed by BDM and have resulted in a decrease in the number of referrals made to the Court. According to data from the CPU, in 2015, BDM referred 683 deaths. In 2016, following implementation of the Court's guidelines, the number of referrals had dropped to 212, followed by 278 referrals in 2017 and 389 in 2018.

The *Guidelines for BDM* provides a number of general principles to assist BDM in identifying which deaths are reportable, including examples of deaths that are generally reportable and those that are generally not reportable.[79]

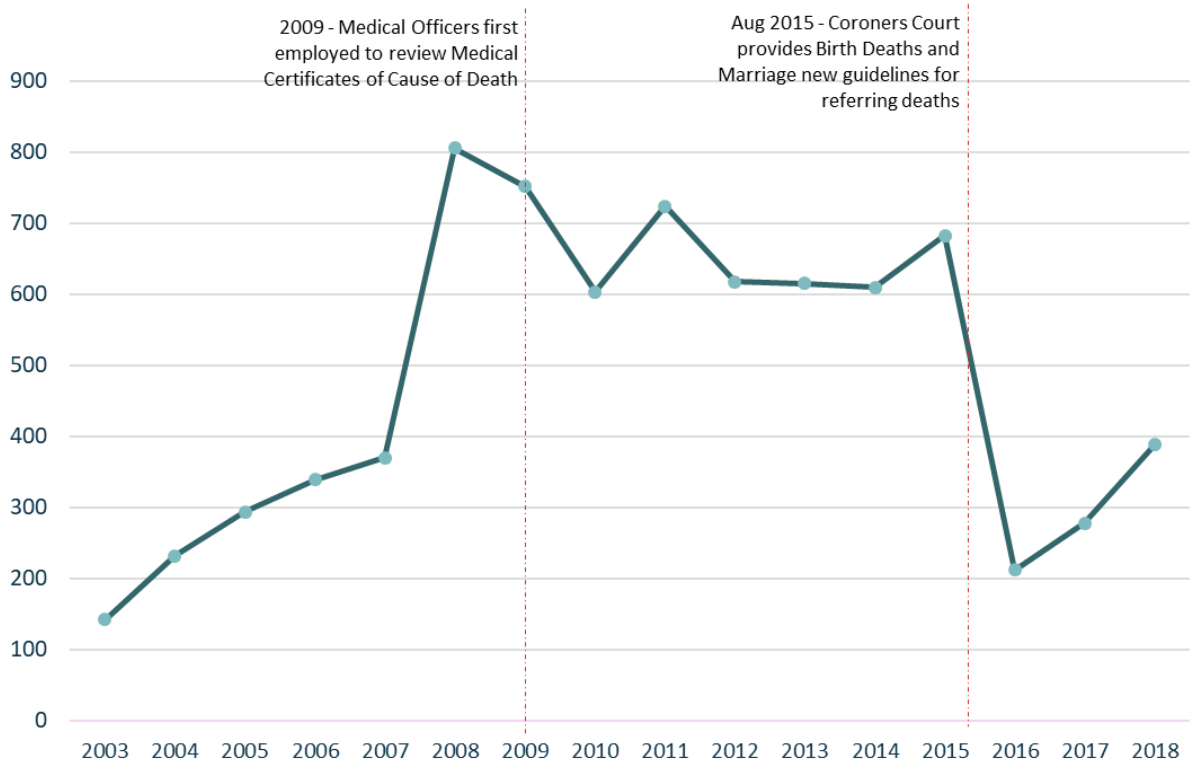
[76] Meeting with BDM (30 October 2018).

[77] Meeting with BDM (30 October 2018).

[78] Guidelines for the Registry of Births Deaths and Marriages for referring death certificates to the Coroner's Court of Victoria.

[79] Guidelines for the Registry of Births Deaths and Marriages for referring death certificates to the Coroner's Court of Victoria.

Figure 12: Annual frequency of BDM-reported deaths by deceased age group, 2003–2018



Source: CPU data – number of BDM reported deaths in Victoria (2003–2018)

7.4.10 Broader Court guidance materials

The Court website was redesigned in late 2018 to improve its accessibility. The home page directs the visitor to the following key information:

- what happens in the first 48 hours after a death is reported to the coroner
- information for families
- information for medical practitioners.

There is a four-page *Information for health practitioners* brochure available on the Court website, which offers some guidance on questions such as 'What is a reportable death?' and 'When does a medical procedure-related death become reportable?'[80] However, the document does not clarify other

[80] Coroners Court of Victoria, Information for Health Professionals (July 2013) <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/info_health_pros%2B4pp%2Ba4%2B2013%2Blr.pdf>.

areas of potential confusion, such as the meaning (in section 4 of the Act) of 'unexpected' or 'indirectly'.

7.4.11 Guidance for medical practitioners

Medical Practitioners Online (MPO) is an online system in which doctors can complete MCCDs. Around 80 per cent of MCCDs submitted to BDM are submitted online. MPO provides (limited) guidance on completing MCCDs by including information on what is a reportable death and providing some examples of reportable deaths.[81]

The Court also holds information sessions at VIFM that are specifically designed for health professionals. These sessions are intended to improve understanding of the coronial process and reporting obligations under the Act, and explore topics such as reporting a death to the coroner, the VIFM forensic pathology investigation, the health and medical investigation process, and inquests.

7.4.12 The role of WorkSafe in investigating workplace deaths

This following information is taken from the WorkSafe website.[82]

The main purpose of WorkSafe's involvement after a workplace incident (including a fatality) is to establish whether or not there was a breach of the Occupational Health and Safety Act 2004 *(OHS Act) and/or other Victorian OHS laws.*

Following a reported incident, WorkSafe's Enforcement Group investigates the circumstances of work-related deaths or serious injuries. A WorkSafe investigator carries out an investigation at the site of a workplace incident. The investigator may interview people, such as witnesses, other employees and the employer to help establish facts about the incident. Occasionally, family members may be asked to make a statement to help in the investigation process. Industry experts may be consulted and the investigator may collect evidence about the incident. Sometimes employment, training and medical records are also required.

[81] Meeting with BDM (30 October 2018).

[82] WorkSafe Victoria <https://prod.wsvdigital.com.au/sites/default/files/2018-06/ISBN-WorkSafe-investigations-2017-05.pdf>.

A WorkSafe investigation is complex and can take many months or longer to complete. WorkSafe Details about evidence collected in an investigation must be kept confidential because disclosure of even a part of the evidence collected may jeopardise the entire investigation.

Once the investigation is complete, it is sent to the WorkSafe legal team for legal review. The purpose of this legal review is to decide whether there is enough evidence to bring a prosecution, or whether other enforcement action (such as a formal caution) is appropriate.

Figure 13: System flowchart

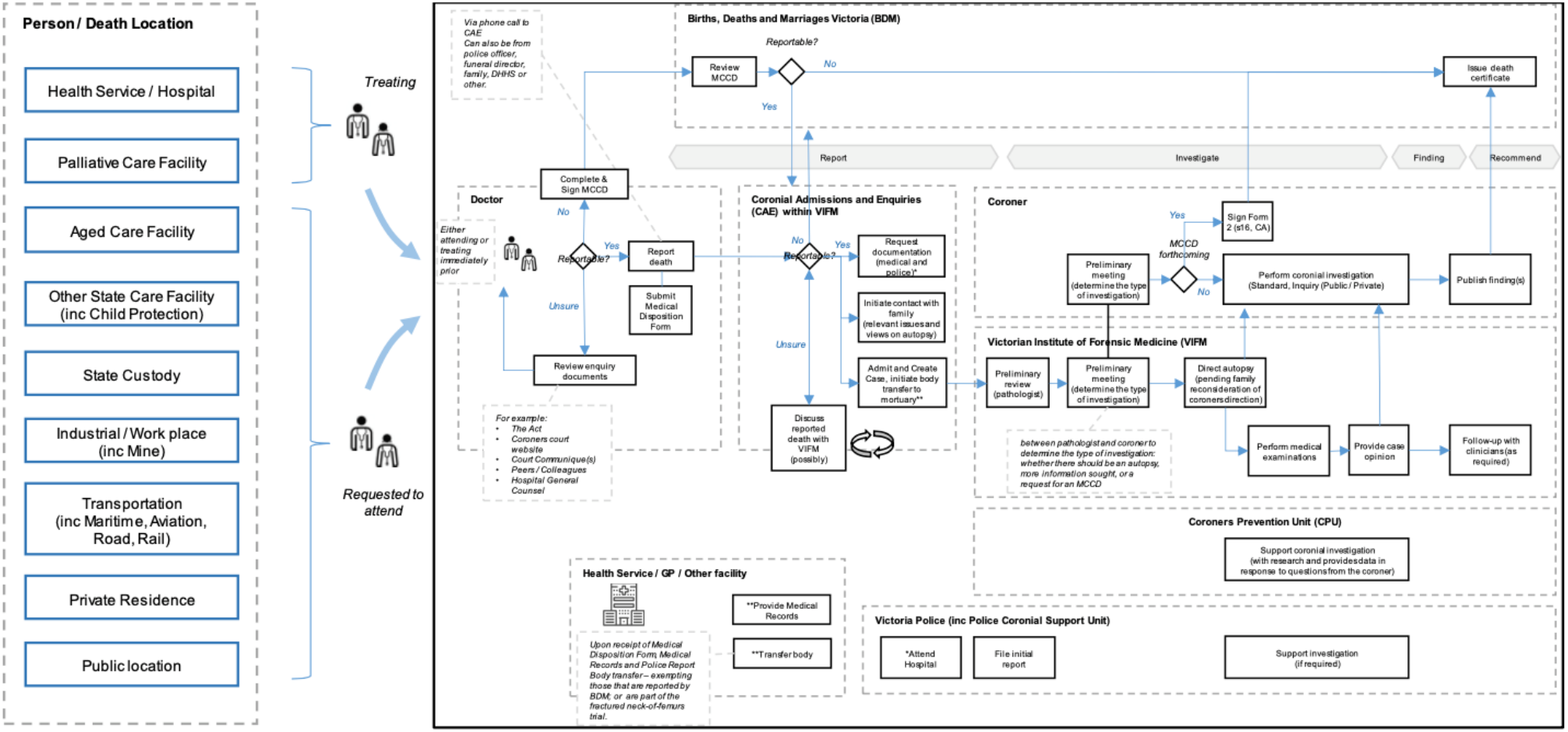
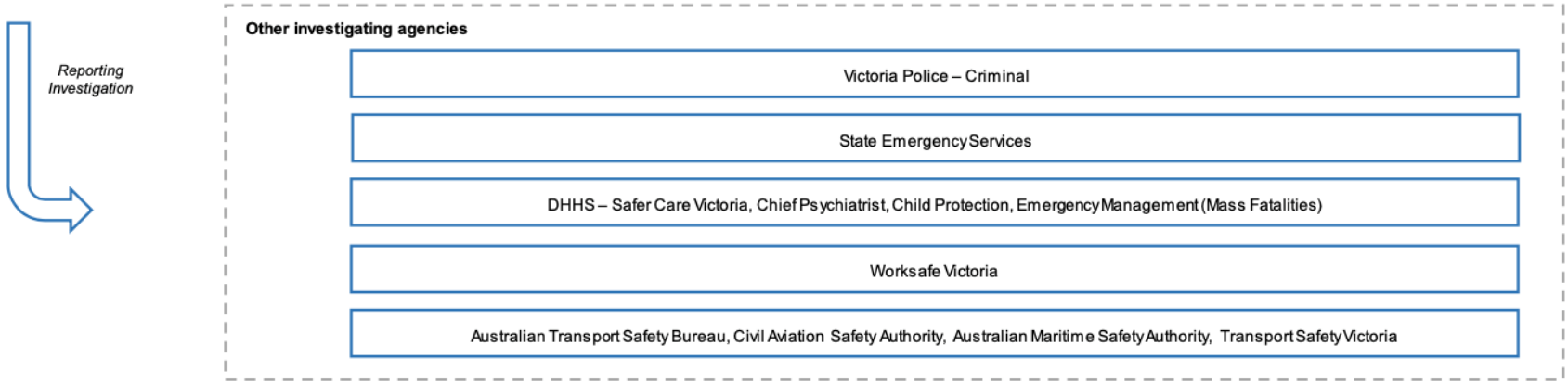


Figure 13: System flowchart (continued)



7.5 Appendix E: VIFM femoral fracture trial

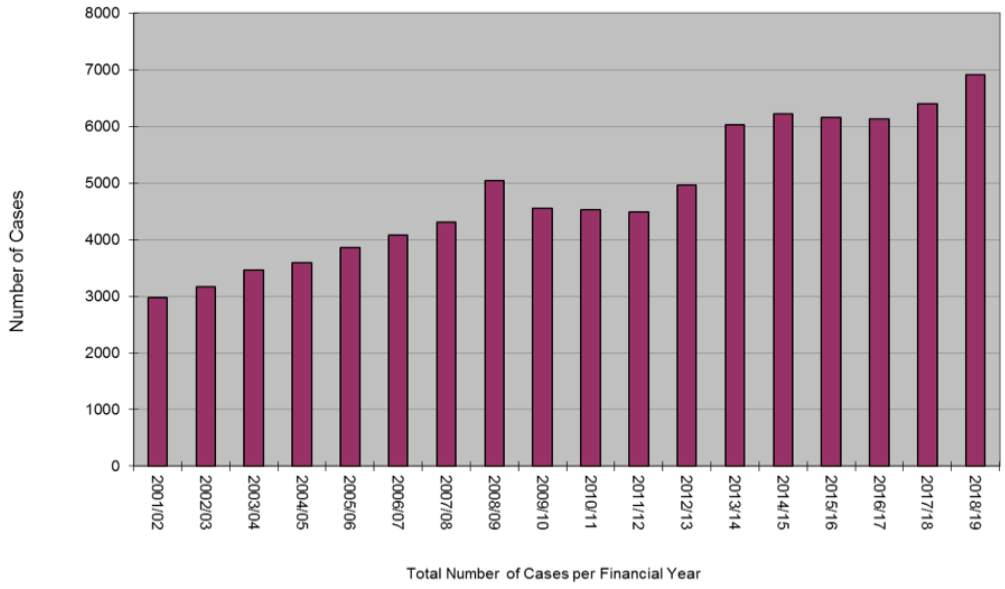
The following paper was prepared by VIFM and presented at the December 2018 Steering Committee meeting to provide an overview of the femoral fracture pilot.

7.5.1 Introduction and driver

Between 2011–12 and 2017–18, the number of new death investigations increased from 4,484 to 6,405 (43 per cent) and the number of admissions of deceased persons increased from 3799 to 5974 (57 per cent).

An increase in the general population and an ageing population indicates this upward trend will continue. This increase coupled with budget constraints and limited resources means we must work smarter and investigate deaths that most warrant coronial attention.

Figure 14: VIFM medico-legal investigations by year – total numbers of deceased admitted to VIFM



7.5.2 Age-related femoral fractures

The Court-VIFM Steering Committee created a Court-VIFM working group to find ways to investigate deaths reported to the coroner more efficiently. This is of benefit to the VIFM, the Court, and families.

We consulted with our forensic pathology staff who suggested that we focus on deaths due to complications following a fractured femur. These

deaths generally concern older Victorians who fall and fracture their femur and die following complications such as pneumonia.

Families are often surprised and distressed to learn that these are coronial cases and the body must be transferred to the VIFM mortuary for examination

Forensic pathologists have reported that the physical examination of the body rarely adds any value to the case – the cause of death could be established from a review of the medical notes.

7.5.3 Femoral fracture cases

Anecdotally, we understood that on average one or two femoral fracture cases were admitted to our mortuary every day. It is difficult to extract accurate data from our case work system, particularly as there is not a consistent description of age-related fracture deaths. However, from an examination of our case data we estimated that deaths related to a fractured neck of femur could account for up to 10 per cent of annual death investigations.

The CA&E also tracked the deaths over a couple of months in 2016 and documented an average of 2.4 cases per day.

7.5.4 The legal framework

Femoral fracture deaths are treated as reportable deaths under section 4(2)(a) of the Act:

4(2)(a) A death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury

Section 15 of the Act provides that the coroner must investigate the death if it appears to be a reportable death. There is no explicit requirement for the investigation to include an examination of the body. A review of the medical records and/or medical deposition can constitute a ‘medical examination’. Section 22 of the Act provides that if the death is being investigated by a coroner, the body is under the control of the coroner until the coroner releases the body under section 47 of the Act.

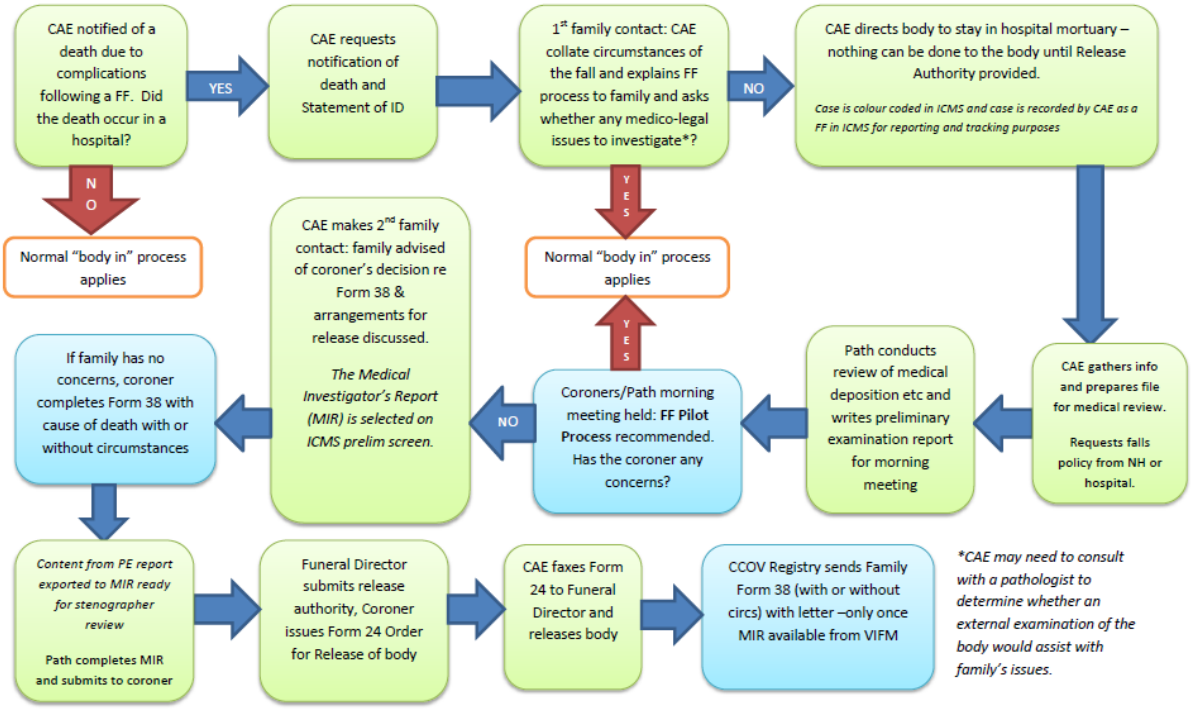
Legal advice confirmed that control may be exercised over the body without physically taking possession of it.

It was agreed that the proposed femoral fracture pilot was likely to promote the objectives of the Act:

- to expedite the investigation of deaths (section 7(b))
- to reduce the time it takes to conduct the coronial investigation as far as possible in the circumstances, thus minimising the distress of family, friends and others affected by the death (section 8(b))
- enhance the efficiency of the coronial system (section 9).

7.5.5 Proposed process

Figure 15: Proposed process



In terms of safeguards, it was decided that the proposed process would only apply to cases where the death occurred in a hospital setting, so that a medical deposition by the treating doctor can be reviewed by the forensic pathologist.

Treating doctors and families are asked by the CA&E whether they have any concerns about the death or the treatment of the deceased person

If doctors or families have concerns of neglect or abuse, the pathologist is consulted and the issue is discussed in the morning meeting with the coroner. The coroner can direct that the body is admitted to the mortuary for examination.

The online Funeral Directors' Portal allows funeral directors to check when the body is released by the coroner and access the necessary paperwork to collect the body from the hospital mortuary.

7.5.6 Consultation process

The Court-VIFM Working Group convened a Coroners Pathologists Workshop. This was the first time all pathologists and coroners met to discuss a policy issue and proposed process change.

The proposed femoral fracture case process was presented and endorsed.

The Court wrote to hospitals and funeral directors to advise them that we would be introducing this process as a six-month pilot, commencing in December 2017.

These parties were generally supportive, acknowledging the great benefit to families who are eager to arrange funerals without the delays created by a coronial investigation.

7.5.7 Outcome of the pilot

Key stakeholder feedback included (names can be provided):

'Let me immediately say that I support this initiative as I think formal post mortem on many of our aged patients, who died subsequent to a fractured neck of femur, is a waste of a scarce resource. I say this because our ageing population has seen a significant increase in the incidents of fractured neck of femur. Falls which result in these fractures are often an early predictor of the end-of-life frailty. As such, I would think that the majority of post mortems in this situation are entirely unnecessary and are likely to cause distress to grieving relatives. However I do support that these incidents are discussed with the coroner prior to a decision being made.' Major Health Service.

'… to facilitate a quick burial once a person has died will not only meet the religious requirement but also ease the unwanted stress on the deceased's family.' Religious organisation

'… I have read the proposed changes as outlined and would fully agree with the change. It would made the process easier and quicker and provide less stress for the relatives of those involved. In most cases we are encouraged to obtain burial arrangements as soon as possible.' Funeral home

In terms of data:

Femoral Fracture Pilot – Overview from Dec 2017 to August 2018	
Total number of reported cases	3976
Total number of Femoral Fracture cases	238 (6% of total reportable cases)
FF cases that met pilot criteria	151 (63% of all FF cases)
FF cases that did not meet pilot criteria (body transferred to VIFM)	87 (37% of all FF cases)
FF cases that met the pilot criteria, but the body was brought to the VIFM due to concerns held by family or medical practitioner	4
Number of regional cases	48 (32% of FF pilot cases)

Agreed benefits of the pilot included the following:

- The feedback from families, hospitals and funeral directors has been positive. The CA&E reports that families are relieved to be told that the body does not have to be admitted to the mortuary – and it should be noted that a third of cases are from regional areas.
- Non-admission of a body into the mortuary saves time in the admission and preliminary processes as well as storage space.
- The Court saves on the cost of transporting the body to the VIFM mortuary for these cases.
- The medical investigation report for the coroner is populated automatically and, in most cases, finalised by the pathologist within 24 hours, allowing quicker finalisation of these cases.

In October the Court-VIFM Steering Committee agreed that the new femoral fracture procedures should become business as usual. It also agreed that (subject to the resolution of any concerns raised) the procedures should be extended to the following cases:

- Deaths in older people due to complications following a pelvic fracture.
- Deaths in private hospitals that have no mortuary facilities.

- Deaths that occur in residential aged-care facilities which are co-located with a hospital, where a medical deposition is completed.

7.6 Appendix F: Queensland triage processes

The cases covered by triage processes in Queensland are:

1. Deaths reported directly by clinicians via the Form 1A process, namely health care related deaths, mechanical fall related deaths and natural cause deaths in care;
2. Apparent natural cause deaths where there is no MCCD;
3. Phone enquiries from clinicians about whether a death is reportable; and
4. Deaths reported by funeral directors.

The Brisbane-based judicial registrars (referred to in Queensland as the 'coronial registrar' and 'deputy registrar') are responsible for these deaths state-wide.

7.6.1 The coronial registrars

When the coronial registrar role was established in 2012 (as part of a pilot project), the registrar was empowered by delegation under the *Coroners Act 2003* (Qld) to:

- investigate apparent natural cause deaths reported to the police;
- authorise the issue of MCCDs for certain reportable deaths; and
- determine whether a death referred to the coroner was reportable.[83]

In practice, this involved directing the investigation of apparent natural cause deaths, reviewing deaths reported directly by medical practitioners or funeral directors, and providing telephone advice to clinicians about whether or not a death is reportable.[84]

The coronial registrar role was formalised in July 2013.[85] Between 2012-13 and 2016-17, the registrar finalised 55 percent (8,269) of the 15,105 deaths reported to the State Coroner's Office, which represented 33 per

[83] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018),14.

[84] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018) 14.

[85] Queensland Audit Office, *Delivering Coronial Services – Report 6: 2018-19* (2018) 27.

cent of the 25,280 deaths reported across the state. This meant that the coroners did not need to investigate a third of the deaths reported during this period.

From 1 January 2017, the registrar's role changed to managing the triage process for healthcare related deaths only - telephone inquiries during business hours, and deaths reported directly by medical practitioners (using a Form 1A) and funeral directors. This change in role was prompted by an expansion of the registrar's reporting catchment area, which had led to an unsustainable workload for a single registrar.

From 1 January 2017, the triage management of apparent natural cause deaths reverted to being dealt with by coroners. As noted in the Coroners Court of Queensland Annual Report 2016-17, the reallocation of the apparent natural cause death triaging and investigations to coroners increased their caseloads, affecting their ability to progress more complex investigations and inquests.[86]

However, in response to recommendations made by the Queensland Audit Office's performance review of coronial services, the Queensland Government allocated temporary additional resources to the coronial system to triage apparent natural causes deaths in the community more effectively where there is no MCCD.

This included additional resources for Queensland Health and Queensland Police to enhance efforts to obtain MCCD for deaths initially reported to police before the death is formally reported to the Coroners Court (known as 'pre-registration triage') and an additional coronial registrar to triage the deaths reported because the pre-registration triage process did not achieve a MCCD. The second registrar trial commenced in September 2019 and will be evaluated at both six and twelve months.

Initial trial data show that the two coronial registrars managed 65.03% (1,177) of the total number of deaths reported to the court (1,810) over the period September – December 2019.

7.6.2 Healthcare related deaths – Form 1A Process

The coronial registrars receive and reviews deaths reported directly by a medical practitioner via Form 1A. The Form 1A process is used when:

[86] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018) 20.

- a doctor seeks advice about whether a death is reportable; and
- a doctor seeks authority to issue an MCCD for a reportable death because the cause of death is known and no coronial investigation appears necessary.

Form 1A is used to report potential healthcare related deaths, mechanical fall related deaths and apparent natural cause deaths in care. The registrars will consider the initial death report and may seek clinical advice from forensic medicine officers to determine what level of investigation is required. The process involves collating and reviewing all relevant medical records and, if required, liaising with family members with the assistance of coronial counsellors. In many of these cases, the registrars will authorise the issue of an MCCD, thereby diverting the death out of the coronial system.

In most cases, the registrar can complete a Form 1A investigation within 24–48 hours of the death being reported and without the deceased's body having to be transported. During 2016-17, the Form 1A process diverted all but 54 such deaths reported to the registrar from full coronial investigation.

In some cases, a funeral director may notify the coroner of a deceased person in their care whose death they believe is reportable. Deaths reported directly by funeral directors are managed by the coronial registrars using the above process. In 2016–17, 34 deaths were reported by funeral directors.

7.6.3 Apparent natural cause deaths triage process

This triage process either diverts out of the coronial system or streamlines through the system, apparent natural cause deaths that have been reported because an MCCD was not issued.

Diversion from coronial system via the issuing of an MCCD

During 2016–17, police reported 1500 apparent natural cause deaths in Queensland, representing 46 per cent of the total number of deaths reported to the coroner by the police. Police reported these deaths on the basis that an MCCD had not been issued and was not likely to be issued.[87]

Generally, in these cases, the body will be transported to the mortuary although the State Coroner's guidelines allow for the death to be

[87] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018), 15.

transported to the family's funeral director if police consider that a MCCD is likely to be issued[88].

From September 2019, the coronial system triages these deaths using a two-phase approach that engages forensic pathologists, coronial nurses and forensic physicians. The involvement of coronial nurses provides an opportunity for family members to raise new issues and information, which might prompt coronial registrars to investigate the matter further.

During the pre-registration phase, police are supported by forensic physicians to identify deaths reported to them for which a MCCD can be issued before the death is formally reported to the Coroners Court. This may involve liaison with treating practitioners, with the forensic physicians also having the capacity to issue a MCCD if they consider they have sufficient information to form a determination about the probable cause of death.

Where the pre-registration phase does not result in a MCCD being issued, police report the death to the coronial registrar who then works with forensic pathologists and coronial nurses to identify whether a MCCD can be issued.

The role of coronial nurses in collating medical history information and speaking with treating doctors contributes significantly to achieving the issuing of MCCDs.[89]

In 2016–17, this triage process diverted 34 per cent (514) of the total apparent natural cause deaths from the coronial system via the issue by a doctor of an MCCD.[90]

Streamlined death investigations for cases where no MCCD can be issued

There are cases where the preliminary investigation will not gather enough information to support the issue of an MCCD or where it is clear from the outset that an autopsy is necessary to establish a cause of death. In 2016–17, the coronial registrar developed and implemented a streamlined approach for coroners to use in the management of apparent natural cause death investigations.[91]

[88] Telephone discussion with Queensland coronial registrar (14 March 2019).

[89] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018) 16.

[90] Queensland Courts, *Coroners Court of Queensland Annual Report 2016–17* (2018) 15.

[91] Queensland Courts, *Coroners Court of Queensland Annual report 2016–17* (2018) 16.

For the majority of apparent natural cause deaths, the cause of death is the only issue warranting coronial involvement.[92] Once the cause of death is established by autopsy or otherwise and a Form 30 has been issued certifying the pathologist's opinion that the death is due to a natural cause, the matter is ready for coronial findings. In such cases, the coroner may issue non-narrative findings in the approved form.

The guidelines for use of non-narrative findings require the coroner to be satisfied that but for the fact that an MCCD was not issued, the death would otherwise not be reportable. The guidelines provide examples of when narrative findings would be more appropriate, such as sudden unexpected child deaths or where the circumstances of the death need to be explained more fully.[93]

Similarly to Victoria, it can take months to complete an autopsy report.[94]

Amendments are currently before the Queensland Parliament to provide discretion to finalise the coronial investigation of a natural causes death without formal findings where the cause of death has been determined.[95]

[92] Queensland Courts, *Coroners Court of Queensland Annual report 2016–17* (2018) 16.

[93] Queensland Courts, *Coroners Court of Queensland Annual report 2016–17* (2018) 17.

[94] Telephone discussion with Queensland coronial registrar (14 March 2019).

[95] Justice and Other Legislation Amendment Bill 2019 https://www.parliament.qld.gov.au/work-of-assembly/bills-and-legislation/Bills-before-the-House