Chapter 8 – Coronial Matters

8.1 Introduction

This chapter deals with the requirements of first response officers and/or investigating officers as provided by s. 7: 'Duty to report deaths' of the *Coroners Act*, which imposes a duty on police to whom a 'reportable death' is reported or who becomes aware of a death that appears to be a reportable death, to report the death to a coroner in writing.

The *Coroners Act* does not limit or otherwise affect the functions or powers of police to investigate a death under another Act or to do something other than an investigation under the *Coroners Act*.

Section 11: 'Deaths to be investigated' of the *Coroners Act* outlines the type of deaths that may be investigated under this Act and the type of coroner who conducts the investigations. The duty of a police officer to help a coroner is stated in s. 794: 'Helping coroner investigate a death' of the PPRA.

Chapter 2: 'Investigative process' of this Manual outlines processes applicable to a wide variety of policing functions, those processes are applicable when responding to incidents of deaths. Officers should be aware that in accordance with the provisions of s. 2.4.1: 'First response procedures at an incident scene' of this Manual, when attending the scene of a death, the first response officer assumes control of the scene until control is relinquished. After the incident has been evaluated, the first response officer may become the investigating officer.

8.2 References to legislation

Frequent reference to legislation is made which impacts on the contents of this chapter. This chapter should be read in conjunction with those statutes, which can be accessed from the legislation page on the Service Intranet.

8.3 Definitions

See SMD.

8.4 Death investigations

8.4.1 Responsibility for investigating and reporting on deaths

Officers are to assist coroners in the performance of a function, or exercise of a power, under the *Coroners Act* and are to comply with every reasonable and lawful request, or direction of a coroner.

Part 2: 'Reporting deaths' of the *Coroners Act* outlines the duty to report deaths and defines the terms 'reportable death', 'death in care', 'death in custody', and 'health care related death'.

Officers are to become conversant with Chapter 19, Part 5: 'Powers for assisting coroners' of the PPRA which provides additional powers when investigating deaths.

Where a reportable death occurs and a doctor issues a Form 1A: 'Medical practitioner report of a death to a coroner', the reporting police officer should not submit a QP 0528: 'Supplementary Form 1'.

Responsibility for investigating and reporting deaths that come within the ambit of Part 3 of the *Coroners Act* rests with the following officers:

(i) in the case of suspicious deaths of adults, the officer assigned to take charge of the investigation;

(ii) in the case of a child reportable death, an officer of at least the rank of detective sergeant or where a detective sergeant is not available, a senior or experienced officer with sufficient criminal investigation experience to carry out investigations (see s. 8.5.8: 'Deaths of children' of this Manual);

(iii) in the case of a child reportable death occurring as a result of a fatal traffic crash, a qualified forensic crash unit trained officer in consultation with a detective sergeant or a senior or experienced officer with sufficient criminal investigation experience to carry out investigations;

(iv) where an adult person's death is found or suspected to be a 'death in care', the matter is to be investigated by a senior or experienced officer with sufficient criminal investigation experience to carry out investigations (see s. 8.5.16: 'Deaths in care' of this Manual);

(v) where the death of a person occurs while that person is in custody, see s. 8.5.19: 'Deaths in custody' of this Manual;

(vi) where a person's death occurs while in police custody in the course of or as a result of police operations or otherwise in the company of police, the death is to be investigated in accordance with ss. 1.16: 'Fatalities or serious injuries resulting from incidents involving members (police related incidents)' and 16.23: 'Deaths in police custody' of this Manual;

(vii) in the case of deaths en route to or in a hospital, an officer stationed in the division in which the incident leading to the death occurred;

(viii) where the deceased was the subject of a search and rescue operation, the investigation should be conducted by a suitably experienced officer who was not involved in the search and rescue operation. If necessary, where the investigating officer is not qualified SARO or FSC, advice should be sought from a suitably qualified SARO or FSC not involved in the search and rescue operation;

(ix) where a person is missing in circumstances that it is reasonably suspected the missing person may be deceased, the officer responsible for the investigation (see s. 8.5.24: 'Missing person reasonably suspected of being deceased' of this chapter); and

(x) in other instances, the first response officer.

Where an officer is completing a coronial report where:

(i) any internal review was conducted in relation to the adequacy of the investigations into a death (including isolated aspects of an investigation such as, an overview of a missing person search by the SAR State Coordinator), they are to ensure a copy of the findings of any such review is provided to the coroner as a matter of course and without delay; and

(ii) additional information or statements are required from persons residing in another division, the investigating officer is to assign a task via QPRIME to the relevant division's OIC, who is responsible for arranging the collection of the information or the taking of statements when requested by the investigating officer.

Where a death relates to a public health service, it should be noted that s. 142: 'Confidential information must not be disclosed by designated persons' of the *Hospital and Health Boards Act* (HHBA) does not apply to the giving of information to a person who requires the information to perform a function under the *Coroners Act* (see s. 157: 'Disclosure to person performing function under Coroners Act 2003' of the HHBA). In circumstances where a public health service does not cooperate or refuses to hand over records or information relevant to the investigation of a reportable death, officers are to advise the OIC, Coronial Support Unit, Forensic Services Group who will refer the matter to the State Coroner.

Coronial investigations

Where a coronial investigation is or is likely to be subject to a coronial inquest, the Coronial Support Unit are to consult with the relevant RCC who is to assign a commissioned officer in their region to overview all submissions to the coroner to ensure the overall adequacy and professionalism of the investigation.

First Nations

In the initial stages of the investigation into deaths of First Nations people, where practical, officers are to consult with one or more of the following:

(i) the First Nations Division;

(ii) a PLO (First Nations); or

(iii) First Nations elder (in the local community),

to understand the cultural sensitivities and funeral protocols when liaising with the family of the deceased.

Cultural considerations

There may be specific religious beliefs, customs, practices and protocols regarding death which the family wish to be respected in the passing of the deceased.

Officers completing a Form 1: 'Police Report of Death to a Coroner' (available in QPRIME) are to consult with the deceased's family to include information about the deceased's ethnicity, faith and autopsy preference and include this on the form. This provides the coroner sufficient information for the coronial investigation.

Officers should interact with the deceased's family members as per the Australian and New Zealand Policing Advisory Agency Religious and Spiritual Diversity Guide for Operational Police (Guide).

Family liaison officers should be appointed in major investigations as the primary point of contact for the family to address their questions and concerns while safeguarding the appointed Investigators from unnecessary vicarious trauma.

ORDER

Police liaison officers (PLO) are not to be used as family liaison officers under any circumstances to minimise their exposure to psychosocial hazards. The role and function of a PLO (see s. 1.4.10 'Role and function of police liaison officers' of this Manual) can provide cultural advice and awareness to members.

8.4.2 First response actions (deaths)

Refer to s. 2.8.2: 'Search (places)' of this Manual and 'First Aid and Infection Control' and 'Police and blood-borne viruses booklet' within the Health, Safety and Wellbeing Division webpage of the Service Intranet for advice with respect to safe procedures for handling and searching bodies.

The first response actions required at the scene of a death will vary from case to case. Priority should always be given to the prevention of further loss of life. Officers are to take any action necessary to ensure that in the circumstances no further danger to life exists.

ORDER

On arrival at the scene of a death, the first response officer is to:

(i) be satisfied that the deceased has in fact died. Where even the slightest doubt exists, medical assistance is to be sought immediately;

(ii) take all action necessary to secure the scene in terms of first response procedures contained in Chapter 2: 'Investigative process' of this Manual; and

(iii) if the body is in view of the public, attempt to cover it in some way if this is possible, without interfering with crime scene integrity.

Officers are to treat all deaths as major investigations until such time as inquiries indicate strongly that no suspicious circumstances exist surrounding the death. Officers may then treat the matter as a routine investigation (see Chapter 2: 'Investigative Process' of this Manual).

In cases of child deaths (see s. 8.5.8: 'Deaths of children' of this chapter) the OIC of the local CPIU or in the instance where no local CPIU is available, CIB, is to be consulted prior to treating any such death as a routine investigation.

Where the death of a person occurs whilst that person is in custody, officers are to comply with the provisions of s. 8.5.19: 'Deaths in custody' of this chapter.

For homicides resulting from acts of domestic and family violence, refer to s. 8.5.23: 'Domestic and family violence related deaths' of this chapter. For homicides generally, refer to ss. 2.6.2: 'Homicide' and 2.7.6: 'Homicide Group' of this Manual.

Where an adult person's death is a 'death in care' as defined by s. 9: 'Death in care defined' of the *Coroners Act*, officers are to comply with s. 8.5.16: 'Deaths in care' of this chapter.

Where the deceased is a foreign national, officers should refer to the 'Detention or death of a foreign national in Australia' webpage, published on the Department of Foreign Affairs and Trade website for specific notification requirements.

Where the deceased is located with the assistance of a volunteer or volunteer organisation, officers should refer to s. 17.5.3: 'Search and rescue operation' of this manual.

Apparent natural cause deaths

At times officers may be required to attend deaths which appear to be from natural causes, with investigations indicating that there are no suspicious circumstances and the family having no concerns about the nature of the death.

Many of these deaths can be finalised by seeking a cause of death certificate from the local or treating doctor, eliminating the need to report the death to the coroner.

Where an apparent natural cause death is reported to the police, the officer is not required to complete a Form 1: 'Police Report of Death to a Coroner' until satisfied a cause of death certificate will not be issued within two business days (see s. 7: 'Duty to report deaths' of the *Coroners Act*).

An apparent natural cause death should only be reported to the coroner if:

(i) the identity of the deceased is unknown; and/or

(ii) the known medical history would not indicate a likelihood that a cause of death certificate should be issued.

Where it is reasonably believed that a cause of death certificate will be issued within two business days, involvement of the Service for these types of deaths is limited to:

(i) obtaining scene photographs of the deceased, and any medications/scripts located at the scene (ensuring that medication labels and number of tablets located are clearly photographed to assist with follow up inquiries with the issuing doctor and/or pharmacy);

(ii) providing reasonable assistance to the next of kin;

(iii) notifying the family they can make arrangements for a funeral director to collect the deceased;

(iv) recording the sudden death – natural causes occurrence in QPRIME; and

(v) ensuring the cause of death certificate is scanned into, and the issuing doctor is linked into, the occurrence.

Officers are not to call the government undertaker to transport the body of the deceased unless exceptional circumstances exist, such as no suitable family member at scene (a suitable family member must be an adult within the definition of the *Acts Interpretation Act*).

There is also no requirement for officers to remain at the scene where:

(i) a cause of death certificate has or is likely to be issued;

(ii) the family of the deceased have been notified; and

(iii) the family are able to make the necessary arrangements for a funeral director to collect the deceased.

Cause of death certificate

Where a person's death is from 'apparent natural causes', officers are to make inquiries including:

(i) establishing the medical history of the deceased, any recent contact with a doctor, and the identity of the doctor; and

(ii) if QAS are in attendance, whether they have attempted to obtain a cause of death certificate; and

(iii) where a treating doctor is identified, contact the doctor and determine their preparedness to issue a cause of death certificate.

The results of these preliminary inquiries should be recorded in the homicide/sudden death report section of QPRIME under 'sudden death – natural causes' occurrence. This should include any reasons provided as to why a cause of death certificate has not been obtained.

If no prior contact has been made with a doctor to obtain a cause of death certificate officers should attempt to contact the treating doctor while at the scene if that is during normal business hours.

When contacting a doctor, officers should advise them that the death is not suspicious and inquiries indicate they are the treating doctor for the deceased. Officers should provide all relevant information about the circumstances of the death to assist the doctor in diagnosing a probable cause of death. Officers should explain that an on-call forensic physician is available to assist the doctor if required.

Officers are not to contact a GP outside of normal business hours. In circumstances where a known medical history has been established, yet it is unclear whether a cause of death certificate is likely, officers may contact the on-call forensic physician after hours to seek advice.

While a Form 1 will not be required to be completed for the majority of these cases, sufficient details to complete a Form 1 should be obtained whilst at the scene, in the event that a cause of death certificate is not issued within two business days. Officers are to ensure that autopsy concerns have been canvassed with the family and recorded on the homicide/sudden death report narrative, to prevent any delays should a certificate not be obtained within two business days.

While a Form 1 may not be required, a 'sudden death – natural causes' occurrence should be created for every apparent natural cause death police attend. Every such occurrence must include a homicide/sudden death report.

The Coroners Court of Queensland has prepared a fact sheet, titled 'Issuing cause of death certificates for apparent natural causes deaths' to assist doctors when considering whether to issue a cause of death certificate. The fact sheet is available on the Queensland Courts 'Publications' website. Whenever practicable, officers should provide a copy of the fact sheet to the doctor to assist them in their decision with regard to the issuing of a cause of death certificate.

The Coroner may accept a cause of death certificate issued outside Queensland, providing the medical practitioner issuing the certificate:

(i) has treated the deceased for a length of time;

(ii) is willing to issue such certificate; and

(iii) there are no suspicious circumstances.

A cause of death certificate will not be issued if the death appears to the doctor to be a reportable death unless a coroner advises otherwise or authorises the issue of a certificate (see s. 12: 'Not investigating or stopping investigation of particular deaths' of the *Coroners Act*).

Where such a certificate is forthcoming, it is not necessary to report to the Coroner on the matter, and involvement of the Service is limited to:

(i) providing reasonable assistance to the next of kin;

(ii) recording the sudden death occurrence in QPRIME; and

(iii) ensuring the cause of death certificate is scanned and the issuing doctor is linked into the relevant occurrence.

Officers are to ensure that the certificate is completed by the doctor within two working days (see s. 94(4): 'Cause of death certificate' of the *Births, Deaths and Marriages Registration Act*.

Where a cause of death certificate is forthcoming, the family of the deceased have been notified and are able to make arrangements for a funeral director to collect the deceased, officers are not to call the government contracted undertaker to transport the body of the deceased.

Where available, a QP 0416: 'Coronial Investigations and the Police Response' should be supplied to the family and friends of deceased persons.

8.4.3 Responsibilities of investigating officers

Where initial inquiries indicate a death is one that falls within the ambit of Part 3: 'Coroner's investigation, including by inquest, of deaths' of the *Coroners Act*, the Service is obliged to investigate and report on the cause of the death. In all cases specific tasks and reports must be completed.

In the case of any death which falls within the circumstances outlined in Part 3 of the *Coroners Act*, the investigating officer is responsible for:

(i) arranging for the delivery of the body to the mortuary and completing all mortuary procedures;

(ii) maintaining continuity of identification;

(iii) taking all action necessary to positively identify the deceased;

(iv) advising relatives;

(v) recording the Sudden Death Occurrence in QPRIME;

(vi) completing a Form 1: 'Police Report of a Death to a Coroner' (in QPRIME);

(vii) assigning a task to their supervisor to have the Form 1 checked;

(viii) creating a QPRIME workflow notification to the Coronial Support Unit (CSU), Coroners Court of Queensland [3213]:

(ix) completing, where applicable, a QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' (in QPRIME), which provides additional information to a coroner or State Coroner and if appropriate the relevant pathologist (this should also be forwarded whenever any proceeding is commenced in relation to a reportable death);

(x) assigning a task to their supervisor to have the QP 0528 checked;

(xi) creating a workflow notification for the QP 0528 in QPRIME to the CSU, Coroners Court of Queensland [3213];

(xii) attending and witnessing the autopsy, where applicable, or arranging for the attendance of another officer according to local arrangements;

(xiii) finalising inquiries and submitting all reports necessary to finalise the matter to the coroner as soon as possible;

(xiv) in cases involving the death of foreign nationals, inform the appropriate consular officer or other national representative of the death and other relevant details;

(xv) in cases involving the death of a child, a copy of a 'Child Death Information Request Search' form (available on the CSU webpage on the Service Intranet), is to be distributed as in paragraph (viii) above; and

(xvi) making inquiries in the vicinity of the scene to determine if there are any visual recordings or images of the deceased from security or surveillance cameras. In such cases officers should also consider s. 2.8: 'Entry, search and seizure' and Chapter 4: 'Property' of this Manual.

The CSU, Coroners Court of Queensland are responsible for providing the:

(i) Form 1 to the relevant local coroner. The relevant coroner's clerk will:

(a) arrange an order for autopsy and provide a copy of the Form 1 to the Government pathologist who is to perform the autopsy; and

(b) in cases of a suspicious death, ensure a copy of the Form 1 is delivered to the location where specimens are forwarded for further examination (see s. 8.4.10: 'Attending the autopsy' of this section);

(ii) QP 0528 to the relevant coroner.

ORDER

In cases involving overseas and/or interstate witnesses, investigating officers are to:

(i) interview and obtain statements from witnesses prior to their departure from the jurisdiction of the relevant coroner; and

(ii) inform the relevant coroner as soon as practicable of the likely departure of any overseas or interstate witnesses to consider an early inquest opening to obtain the witnesses evidence prior to departure from the jurisdiction of that coroner.

Where additional or relevant information that may assist in determining a cause of death prior to an autopsy being conducted becomes available, investigating officers should contact the pathologist urgently and provide that information. A QP 0528 should also be completed and submitted. A copy of the QP 0528 should also be forwarded to the relevant pathologist.

Procedures for an inquest

Where an inquest is to be held, the following forms must be completed with all available information (ensure copies are available for submission to the coroner in compliance with s. 8.4.15: 'Forms' of this chapter):

(i) Form 1 and, where applicable, a QP 0528;

(ii) QP 0001: 'Life Extinct Form';

(iii) QPB 32A: 'Field Property Receipt' for property located on or in the possession of the deceased; and

(iv) police copy of the Autopsy Certificate.

The completion of the Form 1 will generally suffice as the report to coroner, however a coroner may order an inquest. Where a coroner orders an inquest officers are to complete the statutory forms listed above and submit the file to their respective OIC.

8.4.4 Pre-mortuary procedures and removal of bodies from scene

It is the responsibility of the investigating officer to:

(i) arrange removal of the body;

(ii) ensure the removal is not prolonged unnecessarily; and

(iii) conduct a final search of the scene to ensure no human remains are left at the scene (this final search may be delayed in some circumstances e.g. until all the debris from an air crash site has been removed).

Officers should consider the welfare of family members viewing the body and the resulting decay caused by environmental exposure.

When the body is no longer required at the scene, the investigating officer should arrange to have the local contracted government undertaker attend and remove the body to an appropriate mortuary in line with local arrangements (see s. 8.4.22: 'Funeral directors' of this chapter. A person who is involved in transporting the body to a mortuary must comply with any direction by a coroner or police officer (see s. 18: 'Transferring body to mortuary' of the *Coroners Act*).

The contracted government undertaker or in some cases, the forensic officer, will provide the investigating officer with a QP 0070: 'Morgue Tag' and two joined body barcode bracelets with identical barcodes.

Before a body is removed from the scene, the investigating officer should maintain the continuity of identification by:

(i) removing the two bar-coded adhesive labels designated 'morgue tag' from the top body barcode bracelet;

(ii) affixing the labels in the applicable areas on the morgue tag;

(iii) completing the Morgue Tag and:

(a) immediately attaching the top portion of the morgue tag to the left wrist of the deceased; and

(b) retaining the bottom portion of the morgue tag to be lodged later with the completed Form 1: 'Police report of death to a coroner' or as required by local arrangements. This portion is not to be placed with the deceased as it may be contaminated by bodily fluids;

(iv) affixing the bar-coded adhesive label designated 'Police Notebook' from the top body barcode bracelet to the relevant entry in their official police notebook;

(v) separating the two body barcode bracelets and attaching the top body barcode bracelet (from which the adhesive labels designated 'Morgue Tag' and 'Police Notebook' were removed) to the left wrist of the deceased; and

(vi) retaining the second bracelet with the remaining barcode stickers until lodgement of the deceased at the mortuary.

Where the left arm or wrist is missing investigating officers should attach the Morgue Tag and body barcode bracelet to another appendage, or suitable conspicuous place.

Use of sealed body bags

To minimise police time responding to sudden deaths, officers should use sealed body bags to transport deceased persons/human remains to the mortuary.

The contracted government undertaker will provide a security tie. The body is to be placed in the body bag. The zip should be fastened and fixed by placing the body bag security tie through the head/ring of the zip and through the body bag loop at the top of the bag, ensuring that the bag cannot be opened without interfering with the security tie.

If the body bag requires reopening, the security tie should be broken. Contracted government undertakers will assist in breaking the security tie. A new security tie should be used to reseal the body bag. Documentation (Record of breaking of security tie) indicating that the security tie has been broken and by whom is to be completed and placed in the document envelope.

All relevant records and documents are to be placed in the document envelope and sealed. The check sheet on the envelope (QP 0874) is to be completed and signed by the investigating officer.

Where applicable, the document envelope should contain the following documents:

(i) QP 0001: 'Life Extinct Form';

(ii) QP 0872: 'Statement of Formal Identification';

(iii) QP 0450: 'Hospital Identification Statement;

(iv) QPB 32A: 'Field Property Receipt', white copy;

(v) QP 0070: 'Morgue Tag', completed bottom section;

(vi) QP 0873: 'Record of Breaking Security Tie; and

(vii) any other appropriate record e.g. medical/dental records.

Upon completion the document envelope is given to the contracted government undertaker to be conveyed with the body to the mortuary. At no time is the contracted government undertaker to be advised of the contents of the envelope or have access to these records.

Investigating officers are to record the security tie number and the attending undertaker's details in their official police notebook.

There may be some instances where the Sealed Body Bag System is not utilized in accordance with local arrangements.

Officer lodging the body at the morgue

At the mortuary, the officer lodging the body is to:

(i) place the adhesive label designated 'Morgue Register' from the remaining body barcode bracelet into the Morgue Register; and

(ii) attach this body barcode bracelet to the right ankle of the deceased or, if utilising the Sealed Body Bag System to the exterior of the body bag through the security tag or the zipper rings.

Prior to placing a body in a mortuary, the investigating officer should arrange for the completion of a QP 0001. A doctor, registered nurse or paramedic can issue a Life Extinct Form.

Officers may only issue a QP 0001 in cases of 'obvious deaths'.

The definition of 'obvious deaths' is where the state of the body is clearly incompatible with life, such as:

(i) severe incineration has caused charring and blackening of most of the body surface, with exposure of underlying tissues in some areas;

(ii) extensive trauma has caused decapitation, severance of the torso, disruption of vital organ, (e.g. brain), or fragmentation of the body;

(iii) well established decomposition has caused extensive discolouration of the skin, bloating of the body, larval infestation and partial exposure of the bones; or

(iv) advanced decomposition has exposed most of the skeleton.

Where a QP 0001 cannot be obtained at the scene, the form may be obtained from a doctor, registered nurse or paramedic while en route to the mortuary.

There will be instances where other versions of a Life Extinct Form will be used. For example, the QAS will use an 'Electronic ambulance report' form to record the life extinct procedure. In the case of a death occurring in a hospital, doctors may use the 'Hospital discharge' form. In these circumstances, officers should accept these forms in lieu of a QP 0001 and process in the usual manner.

The investigating officer is to retain the QP 0001 and attach it to the Form 1 and scan and import it to the relevant QPRIME Sudden Death Occurrence.

Officers are not to transport bodies in Service vehicles or any other vehicle not specifically designed or used for that purpose unless exceptional circumstances exist.

Officers may transport bodies in Service vehicles in circumstances where instructions have been established for cost sharing arrangements with the registrar of the local coroner's court.

8.4.5 Identification of deceased

Where a death is referred to a Coroner, it is necessary to identify the body to the satisfaction of the Coroner concerned. Generally, visual identification by a relative is a means of identification, however in some cases this will not be practicable. CSU Fact Sheet Number 10: 'Suggested method of identification' outlines methods of identification that have been used to identify bodies.

Where police presence is required at a death scene, the investigating officer should make all inquiries necessary to positively identify the body by a means acceptable to the Coroner. If there is a problem with the identification, the investigating officer is to liaise with the Coroner and ensure the means of identification used is acceptable.

Preferably, the investigating officer should be present with a relative when a body is formally identified. Another officer may be present where the investigating officer is unable to attend.

If a non-suspicious death occurs at a hospital:

(i) and a certificate as to the cause of death is not forthcoming, and;

(ii) the body is identified to hospital staff by a family member or appropriate person who is not present to identify the body to police,

the attending officer should have the relevant staff member at the hospital complete CSU Fact Sheet Number 14: 'Hospital identification statement'.

Where the identification occurs at a later time, officers should refer to CSU Fact Sheet Number 10.

Statements relating to the identification should be submitted with the relevant Form 1: 'Police Report of a Death to a Coroner' or QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' (in QPRIME). These statements should be attached to the relevant QPRIME Occurrence and also submitted with the completed file.

Identification viewing conducted by a government undertaker

A police officer is authorised under s. 18(2)(a) of the *Coroners Act* to direct a government undertaker to prepare a body for identification viewing and perform tasks related to lodging a deceased in a mortuary. In such cases and where appropriate, officers are to ensure compliance with the 'Protocol for preparation of body for an Identification Viewing', (see CSU Fact Sheet Number 11: 'Protocol for preparation for ID viewing').

8.4.6 Continuity of identification

The investigating officer must be able to prove continuity of identification at any time during the investigation.

Prior to removal of a body from the scene, the investigating officer should ensure a Morgue Tag and body barcodes (provided by the attending government undertaker) are attached, see s. 8.4.4: 'Pre-mortuary procedures and removal of bodies from scene' of this chapter.

Where an officer becomes aware a body has been removed from the scene without a Morgue Tag and/or body barcodes being placed on the deceased, that officer should immediately ensure a Morgue Tag and body barcodes are attached in accordance with s. 8.4.4: 'Pre-mortuary procedures and removal of bodies from scene' of this chapter.

Investigating officers are to ensure all body barcode numbers used are recorded in the relevant occurrence within QPRIME.

8.4.7 Advising relatives

Where a death has occurred, regardless of whether it occurs within the circumstances outlined in Part 3: 'Coroner's investigation, including by inquest, of deaths' of the *Coroners Act*, the Service will provide reasonable assistance to advise a deceased's family member of the death. This assistance will extend to, but is not limited to:

(i) advising the nearest family member;

(ii) complying with any reasonable request of the nearest family member to locate and advise other relatives. Where practicable, assistance for this purpose should be offered; and

(iii) assisting officers of the Department of Foreign Affairs and Trade to locate a family member and notify them of the death of Australian citizens overseas.

Officers who advise a relative or friend of a death should provide the person with a copy of the QP 416: 'Coronial Investigations and the Police Response' handout.

Section 19: 'Order for autopsy' of the *Coroners Act* allows a coroner to order a doctor to perform an autopsy. However before ordering an internal examination of the body, the coroner must, whenever practicable, consider the provisions contained in s. 19(4) of the *Coroners Act*. To facilitate the coroner's considerations officers are to inform an appropriate family member an autopsy involving an internal examination is likely to be performed and note any concerns raised on the Form 1. They should also be advised a counsellor may contact them to discuss their concerns.

There is no requirement for permission from family members to conduct such an examination.

In the case of relatives who are interstate, assistance in advising those relatives should be sought from the relevant police agency. In this case, assign a QPRIME task to the duty officer, Police Communications Centre, Brisbane requesting assistance.

In the case of deceased foreign nationals, assistance in notifying relatives overseas should be sought from the consular mission of the deceased's country of citizenship. Where the person is an international homestay school student, see s. 5.12.4: 'International homestay school students' of this Manual.

If the nearest relatives of a deceased Australian national live overseas assistance in advising such relatives should be sought from Interpol. In this case, assign a task via QPRIME to the duty officer, Police Communications Centre, Brisbane requesting assistance.

Where a parent, as the nearest family member of a deceased person, is notified of the death, the notifying member should ascertain the status of the other parent. In cases where the parents are divorced or estranged, officers should ensure, wherever practicable, that the other parent of the deceased is also notified of the death.

Where immediate notification has not occurred, the investigating officer is to advise the relevant coroner directly why this notification has not been made. The officer should consult with the relevant coroner on possible lines of inquiry to complete the notification. The outcome of any additional attempts to deliver the notification to the deceased's family requested by the coroner is to be provided on a QP 0528: 'Supplementary Form 1'.

When the duty officer, Police Communications Centre receives an assigned task, that officer is to ensure a message is directed as requested, if appropriate.

8.4.8 Completion of Form 1

The Form 1: 'Police Report of a Death to a Coroner' is to assist the Coroner in deciding whether to order an autopsy, and to assist the pathologist performing the autopsy to establish the cause of death. Therefore, the investigating officer should complete the relevant parts of the form prior to the end of their shift. In some cases, the form and autopsy procedures may be completed before the deceased is positively identified.

The information contained in the Form 1 also assists in determining the need for an inquest and the extent of examination in an autopsy.

Generally, the autopsy will be carried out on the next working day of the Government Pathologist, Forensic Medical Officer or other medical practitioner, as applicable. The Form 1 should be completed and an order for autopsy obtained before that time.

Where an officer has additional information that could not be included on the Form 1 at the time of submission, the information should be provided on a QP 0528: 'Supplementary Form 1'.

The completed Form 1 is to be checked by a shift supervisor, district duty officer or OIC to ensure accuracy.

When specialist investigative officers attend a reportable death and determine no further involvement from them is necessary, as soon as practicable, they are required to:

(i) complete a QP 0528 summarising the investigation, including witness versions; and

(ii) outline the reasons why specialist investigative involvement is no longer required;

ORDER

Officers are to ensure the full name and date of birth of the deceased is confirmed as being correct before submitting the Form 1.

8.4.9 Placing body in mortuary

ORDER

An officer who places a body in a mortuary is responsible for:

(i) completion of a mortuary register entry. The lodging officer should remove the relevant label from the body barcode attached to the deceased and affix the label in the applicable area on the mortuary register;

(ii) completion of a Form QPB 32A: 'Field Property Receipt' for any property taken from the deceased. See also Chapter 4: 'Property' of this Manual;

(iii) removal of any clothing and property from the body as appropriate;

(iv) placing the body in the body storage area; and

(v) complying with procedures applicable to the relevant mortuary.

An officer who places a body in a mortuary is to take possession of the clothing and any other property on the deceased at the time of death and deal with it pursuant to the provisions of Chapter 4: 'Property' of this Manual (see s. 4.6.9: 'Disposal of deceased person's property').

Officers are not to remove clothing or property from deceased persons where the death is:

(i) a death in custody;

(ii) a death in care or the unexplained death of a child;

(iii) any incident in which the Disaster Victim Identification Squad has been involved;

(iv) a case or suspected case of unlawful killing;

(v) a case where examination of the clothing or the arrangement of the clothing may assist in determining the cause or circumstances of death (e.g. industrial accidents); or

(vi) a case where the severity of decomposition of the body makes it impractical to remove the clothing until the autopsy.

In all these cases, officers are to ensure any clothing or property on the deceased's body remains on the deceased until the Government Pathologist, Government Medical Officer or other doctor, who is to perform the autopsy, has examined the body and approves the removal.

8.4.10 Attending the autopsy

An officer investigating a death is entitled to observe and participate in an autopsy. See s. 21(1): 'Observing an autopsy' of the *Coroners Act*.

ORDER

An officer is to attend and witness every autopsy of a body subject of a police investigation where the death involves suspicious circumstances.

In the Brisbane Metropolitan area, a member of the Coronial Support Unit (CSU) will attend all autopsies. In all other areas, it is the responsibility of the OIC of the region to determine local procedures for the attendance of officers. An officer may be tasked through QPRIME to attend an autopsy. It is desirable that the investigating officer attends the autopsy, or another officer who has knowledge of the investigation.

The officer who attends the autopsy is known as the autopsy officer. The autopsy officer should obtain or arrange to obtain a copy of the Form 29: 'Autopsy Notice' and Form 30: 'Autopsy certificate' from the pathologist whilst attending the autopsy. A copy of these forms should be scanned and attached to the relevant QPRIME Sudden Death Occurrence.

The autopsy officer has responsibility for completing in QPRIME all steps listed in the 'Occurrences: Officer Entered Occurrences: Sudden Death: Manage Sudden Death: Attend and Record Autopsy Results'. This includes updating both the Homicide Sudden Death Report and completing the QP 654: 'Autopsy Results' form with the results from the autopsy (contained on Form 29 and Form 30) and notifying the investigating officer of the results where appropriate.

Non-suspicious deaths

If the death is non-suspicious, officers are not required to take possession of, nor arrange for the transport for, any specimens taken at the time of the autopsy by the Forensic Medical Officer (FMO) or Pathologist. Queensland Health Pathology Scientific Services will arrange for the transportation and delivery of the specimens to Brisbane for further analysis.

Suspicious deaths

If the death is suspicious, the autopsy officer is to collect any specimens retained by the FMO/pathologist and arrange for the transportation and delivery of these specimens for further analysis. The FMO/pathologist will provide appropriate specimen containers for this purpose, generally consisting of tubes/containers, a clip seal plastic bag, a bio bottle or container, a packing box and continuity/security labels.

The provided packaging is designed to comply with relevant legislation for the safe transportation of specimens by road, rail or air.

Packaging of specimens from a suspicious death (autopsy officer)

After the FMO/pathologist has placed the tubes/containers containing the specimens into the appropriate bio bottle/ container and closed and sealed it, the autopsy officer is to:

(i) sign and date two continuity/security labels and ensure the FMO/pathologist also signs same; and

(ii) affix one continuity/security label on the Bio bottle/ container ensuring half is on the lid and the remainder on the bottle/container.

After the FMO/pathologist has placed a copy of the Form 1 and the completed Request for Examination form into the clip seal bag, and placed the bio bottle/ container containing the specimens into the pre-labelled packing box together with the clip seal bag, the autopsy officer is to:

(i) ensure the lid is adequately closed and sealed; and

(ii) affix the second continuity/security label on the packing box ensuring half is on the flap and the remainder on the packing box.

The autopsy officer should not take possession of the specimens until they are packaged and sealed by the FMO/pathologist or mortuary staff.

The autopsy officer has responsibility for delivering or forwarding those specimens with a copy of the Form 1 to the appropriate location for analysis. See subsection 'Lodgement of forensic samples for testing' of s. 2.19.6: 'Forensic Services Group (FSG)' of this Manual and s. 8.4.3: 'Responsibility of investigating officers' of this chapter.

The autopsy officer also has responsibility for maintaining and providing evidence of continuity of possession of those specimens.

Holding of specimen by FMO/pathologists

In some instances, including where an examination of a whole body organ is required, the FMO/pathologist will retain the specimen for a period of time prior to sending to an appropriate location for analysis. In these cases, the autopsy officer should:

(i) request the FMO/pathologist notify the investigating officer when the specimen is ready for collection;

(ii) if the specimen has been placed in a container which has been sealed, sign and date a continuity/security label and ensure that the FMO/pathologist also signs same; and

(iii) affix the continuity/security label on the container ensuring half is on the lid and the remainder on the container.

Packaging of specimens from a suspicious death (collecting officer)

Investigating officers notified that an autopsy specimen is ready for collection are to ensure it is collected and forwarded to the appropriate location for analysis.

The officer collecting the specimen (collecting officer) is to:

(i) if the specimen has been previously placed in a container and sealed by the autopsy officer with a signed continuity/security label:

(a) ensure the container is placed in a packing box together with a clip seal bag containing a copy of the Form 1 and the Request for Examination form;

(b) sign and date a continuity/security label, ensuring the FMO/pathologist also signs same;

(c) ensure the lid is adequately closed and sealed; and

(d) affix the continuity/security label on the packing box ensuring half is on the flap and the remainder on the packing box; or

(ii) if the specimen has not previously been placed in a container and sealed as above:

(a) sign and date two continuity/security labels and ensure the FMO/pathologist also signs same; and

(b) affix one continuity/security label on the container ensuring half is on the lid and the remainder on the container;

After the FMO/pathologist has placed a copy of the Form 1 and the completed Request for Examination form into the clip seal bag, and placed the container containing the specimens into the pre-labelled packing box together with the clip seal bag, the collecting officer is to:

(i) ensure the lid is adequately closed and sealed; and

(ii) affix the second continuity/security label on the packing box ensuring half is on the flap and the remainder on the packing box.

The collecting officer has responsibility for delivering or forwarding those specimens with a copy of the Form 1 to the appropriate location for analysis. See subsection ‘Lodgement of forensic samples for testing’ of s. 2.19.6 of this Manual and s. 8.4.3: ‘Responsibility of investigating officers’ of this chapter.

The collecting officer also has responsibility for maintaining and providing evidence of continuity of possession of those specimens.

8.4.11 Requests for autopsy by relatives or interested party

Where a relative or interested party requests an autopsy to be conducted in situations when:

(i) a cause of death certificate has been issued without an autopsy having been conducted; or

(ii) there is an allegation the person who is to conduct, or help at, an autopsy caused the deceased person’s death (see s. 19(8)(a): ‘Order for autopsy’ of the *Coroners Act*),

the officer receiving the request is to advise the relevant Coroner on behalf of the relative or interested party.

8.4.12 Obtaining autopsy related documents

When compiling a report to a coroner and the investigating officer requires documentation relating to an autopsy (a Form 29 or 30 and statements of continuity of identification) or test results related to an autopsy, those officers should make a request to the Director of the Coroners Court of Queensland via the Coronial Support Unit.

8.4.13 Finalising the investigation

When completing a Form 1: 'Police report of death to a coroner' (in QPRIME), investigating officers are to note in the 'Summary of Incident' section of the form:

(i) if the investigation is finalised; and

(ii) where further investigations are required, the direction of those investigations (i.e. the avenues of investigation and for what purpose).

The submission of a Form 1 for a non-suspicious reportable death should finalise the investigation, except where the coroner orders an inquest or that a death be further investigated. In such circumstances, officers are to compile a report and attach all relevant material. This becomes the file that is forwarded to the coroner for determination.

Where a prosecution is commenced against a person in connection with a reportable death the Coronial Support Unit (CSU) (Coroners Court of Queensland) will provide the presiding Coroner a copy of the Court Brief (QP9). If at the end of the criminal proceedings further information is required, the Coroner may request a copy of the brief of evidence through the CSU, Forensic Services Group.

If requested, the brief of evidence should be accompanied by a general covering report outlining:

(i) the current status of the court proceedings, including forthcoming court dates; and

(ii) any further matters which may not have been reported in the criminal brief but which may be relevant to the Coroner's obligation to make findings (refer to s. 45: 'Coroner's findings' of the *Coroners Act*).

Where officers are advised that a coroner orders an inquest, they will be advised with a Form 17: 'Coroners Notice of Inquest'.

Where a Form 1 has been submitted to a coroner relating to a non-suspicious reportable death, the coroner will advise the investigating officer through the CSU by a 'Coroners direction/request' via a QPRIME tasking, to the OIC of the investigating establishment as to whether:

(i) no further police investigation is required;

(ii) any further statement/information is required;

(iii) a full police investigation is required; or

(iv) any other requests are required.

It is the responsibility of the relevant OIC to ensure the Coroner's direction/request is assigned as a QPRIME task to the relevant investigating officer.

Officers are to comply with any direction given by the coroner.

A coronial file is to consist of the following:

(i) a covering report;

(ii) forms (see s. 8.4.15: 'Forms' of this chapter);

(iii) statement of witnesses;

(iv) in cases of a child, a copy of a 'QPS Child Death Information Request' Form, located on the CSU webpage on the Service Intranet; and

(v) supporting material.

Coronial Support Unit Fact Sheet Number 12: 'Quick guide to handling and reporting on bodies' provides a quick guide to the steps involved in the process of investigating and reporting a death that falls under the jurisdiction of a coroner and is located on the CSU webpage on the Service Intranet.

Section 8.4.20: 'Updating the status of sudden death occurrences in QPRIME' of this chapter provides information on updating the status of the occurrence relating to the stage of the investigation.

8.4.14 Covering report

When submitting a finalised coronial file relating to a death as a result of a coroner's direction requesting a full coronial investigation or a Form 17: 'Coroners Notice of Inquest' from a coroner, the investigating officer should prepare and attach a covering report showing results of inquiries within twenty-eight days to the OIC of the relevant station or establishment.

If a finalised report cannot be furnished within twenty-eight days, the investigating officer is to furnish a QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' (in QPRIME) to that officer's OIC detailing the progress of the investigations, including if any person has been charged with any offence surrounding the death and the result of any court proceedings. The investigating officer is to ensure a further QP 0528 is furnished every twenty-eight days, until the matter is finalised, to the OIC of the relevant station or establishment.

Officers are to ensure a task is assigned to a supervisor to check the QP 0528, prior to workflow notification to the Coronial Support Unit being commenced.

The checking supervisor is to generate a QPRIME workflow to the Coronial Support Unit (CSU) (Coroners Court of Queensland) who will provide the QP 0528 to the relevant local coroner.

Where there are suspicious circumstances, or the finalised coronial file is being submitted by a specialist unit member, the covering report should contain:

(i) an outline of the investigation in chronological order detailing all inquiries made and the results. Where any person has been charged in relation to the death, that person's particulars and details of the charges should be included. All inquiries undertaken should be recorded, including unsuccessful;

(ii) a list of all forms attached to the file;

(iii) a list of all statements attached to the file;

(iv) a precis of the contents of each statement attached to the file; and

(v) a list of all officers involved in the continuity of identification.

Where the following is established at the conclusion of inquiries:

(i) the death is apparently due to natural causes;

(ii) there are no suspicious circumstances; and

(iii) injury is not a contributory cause of death;

the covering report QP 609: 'Sudden Death-No Suspicious Circumstances' should be used.

The report should contain a list of all forms and statements attached to the file.

ORDER

Where an officer wishes to express a personal opinion, as distinct from a fact, on any matter, the officer is to ensure that opinion is clearly identified as an opinion only.

8.4.15 Forms

ORDER

In finalising the coronial report, the investigating officer is to submit:

(i) a copy of the original Form 1: 'Police report of death to a coroner' (available in QPRIME) and a QP 528: 'Supplementary Form 1' if applicable;

(ii) the QP 0001: 'Life Extinct Form' with the original Form 1;

(iii) the copy of the QPB 32A: 'Field Property Receipt' for property located on or in the possession of the deceased;

(iv) the police copy of the Autopsy Certificate (Form 30) and Autopsy Notice (Form 29); and

(v) in cases of a child, a 'QPS Child Death Information Request' form, located on the Coronial Support Unit's webpage on the Service Intranet.

8.4.16 Statements

Statements should be obtained and submitted from all persons who have significant knowledge of the cause or circumstances of the death.

The purpose of supplying statements to a coroner is to provide a complete picture of the events and circumstances surrounding the death. While no specific direction exists as to whom statements should be obtained from, consider:

(i) the person who last saw the deceased alive;

(ii) the person who discovered the body;

(iii) any witnesses to the death;

(iv) any person who may provide information in relation to the scene of the death;

(v) ambulance officers who attended the scene or transported the deceased;

(vi) an expert who may be able to make comment on any particular matter or circumstance which has bearing on the death; and

(vii) any person or member who was involved in the chain of identification.

Statements obtained in respect of a coronial matter may contain hearsay evidence and conversation in the third person. Where possible, conversation should be in first person.

8.4.17 Suicide prevention research and support

Investigating officers are to ensure the suspected suicide section of the Form 1: 'Police report of death to a coroner' (in QPRIME) is completed and the Australian Institute for Suicide Research and Prevention (AISRAP) questions are completed. Investigating officers should seek permission from the next of kin for the Service to forward the family member's details to the AISRAP.

8.4.18 Supporting material

Any other material of investigative value should be scanned and attached to the relevant QPRIME Sudden Death Occurrence. Where appropriate, this will include:

(i) photographs taken of the scene or body;

(ii) certificates of analysis of blood or other body samples;

(iii) sketches or plans of the scene of the death;

(iv) diaries, letters or other personal correspondence, where this provides an insight into the state of mind of the deceased, and is relevant to the investigation;

(v) any medical prescriptions;

(vi) suicide note where applicable; and

(vii) other relevant documentation.

8.4.19 Responsibilities of officers in charge

OICs are to ensure:

(i) the original Form 1: 'Police report of death to a coroner' and any 'Supplementary Form 1 – Police Report of Death to a Coroner' (in QPRIME) is forwarded or caused to be delivered to the local coroner;

(ii) the Sudden Death Workflow notification in relation to the Form 1: and 'Supplementary Form 1 – Police Report of Death to a Coroner' has been sent to the Coronial Support Unit, Coroners Court of Queensland; and

(iii) once in each 24-hour period, the Sudden Death Occurrences for the relevant Division are checked in QPRIME and any appropriate action taken.

8.4.20 Updating the status of sudden death occurrences in QPRIME

The management of coronial investigations within QPRIME is a three-stage process, which is reflected by the status of the occurrence:

(i) 'investigation continuing' when police are actively investigating the death, interviewing witnesses or suspects and compiling the coronial file;

(ii) 'finalised' when all police investigations and coroner's reports have been completed and any relevant charges have been laid. The police investigation into non-suspicious deaths will be finalised prior to the autopsy results being issued by the Coroner.

(iii) 'concluded' – when:

(a) all police investigations have been completed;

(b) a cause of death certificate has been issued by the deceased's treating doctor;

(c) the findings of the coroner have been released;

(d) all criminal proceedings related to the death have been finalised and the appeal period has lapsed; and

(e) all property/exhibits related to the death have been disposed.

The Coronial Support Unit will send a QPRIME task to the OIC of the reporting work unit when the coroner's finding has been released. The task will include advice that all exhibits can be disposed of and the occurrence is to be concluded.

There may be a lengthy period of time between the occurrence being 'finalised' by police and the coroner's findings being released.

ORDER

OICs of divisions are to ensure all deaths occurring within their division are recorded in compliance with the status indicated within this section.

8.4.21 Person of interest check

Officers attending a reported death are to:

(i) conduct a person of interest check, for Queensland and interstate, on the deceased person as soon as practicable after the death by checking QPRIME and the ACC database;

(ii) where the deceased is recorded in QPRIME, ensure a QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' is completed against QPRIME and, where multiple records exist, merge the records (see QPRIME User Guide);

(iii) if the deceased is wanted:

(a) in relation to a matter, forward a task to the Manager, Police Information Centre (PIC), with the deceased's full name, date of birth, date of death, and other relevant information;

(b) on a warrant, cause the warrant to be reassigned through a QPRIME task to PIC with appropriate notations (see 'Incorrect or incomplete details on warrants' of s. 13.18.8: 'Management of warrants' of this Manual); and

(c) interstate, advise the Manager, PIC, who is to ensure that appropriate action is taken, including notifying interstate authorities of the death of a person wanted in that State;

(iv) where:

(a) the deceased's offender history report (Not for production – outstanding charges section) indicates there are unfinalised related court matters related; or

(b) the attending officer is aware that the deceased has been served with a summons or notice to appear, but the death has occurred prior to the court date,

the attending officer is to forward a report to the relevant prosecutor including the Director of Public Prosecutions (State or Commonwealth) if applicable, with the deceased's full name, date of birth, date of death, and other relevant information; and

(v) where the attending officer is aware that a summons exists for service on the deceased, cause a direction to be sought from an officer authorised to withdraw a charge, so that the summons can be withdrawn (see ss. 3.4.4: 'Withdrawal of charges' and 3.5.7: 'Unserved summons' of this Manual).

8.4.22 Funeral directors

Investigating officers are to use the services of the relevant contracted government undertaker. There is no obligation on the family of the deceased person to use the services of this funeral director.

Officers investigating a sudden death are not to:

(i) pass on literature supplied by a funeral director to relatives and friends of the deceased person; or

(ii) supply details of relatives and friends of deceased persons to a funeral director, other than the required details to the relevant government undertaker.

8.4.23 Persons committed for trial or sentence as a result of an inquest

The following policy refers only to coroner's inquest matters for which the *Coroner's Act 1958* still applies. See s. 100: 'When repealed Act still applies' of the *Coroners Act*.

When, as a result of a coroner's inquest, a person is committed to a Superior Court for trial or sentence, in accordance with the *Coroners Act 1958*, and a QPRIME occurrence in respect to the subject matter of the inquest:

(i) was not previously created, the investigating officer responsible for the investigation that resulted in the holding of the inquest, is to ensure a QPRIME occurrence is created; or

(ii) has previously been created (e.g. suspected murder, suspected arson), a QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' (available in QPRIME) should be created by the investigating officer responsible for the investigation that resulted in the holding of the inquest.

At the time a person is committed for trial or sentence in accordance with the *Coroners Act 1958*, as a result of an inquest, the police prosecutor assisting the coroner is to ask the coroner for an order under s. 471: 'Court may order taking of identifying particulars' of the PPRA, for the person's identifying particulars. In cases where a police prosecutor is not assisting the coroner, the investigating officer is to ask the person helping the coroner during that inquest to ask the coroner for such an order.

At the time a person is committed for trial or sentence as a result of an inquest, the police prosecutor assisting the coroner is to ensure particulars of the committal are entered into QPRIME (capture court results) in accordance with s. 3.6.2: 'Responsibilities of police prosecutors' of this Manual. In cases where a police prosecutor is not helping the coroner, the investigating officer is to make the necessary arrangements with the relevant Police Prosecution Corps for the particulars of the committal to be entered into QPRIME.

8.4.24 Coroner's court

Investigating officers are to attend an inquest or pre-inquest conference when required by a coroner. Where the investigating officer is unavailable, an officer with knowledge of the investigation should be nominated to attend.

In cases where a person has been summoned to appear as a witness at a coroner's court where no statement has been previously obtained, the investigating officer is to ensure the statement is obtained wherever possible and added to the relevant QPRIME Sudden Death Occurrence.

Where witnesses will be required to attend an inquest or pre-inquest conference, the investigating officer or delegated officer is to ensure the witness expense claims are completed and submitted (see s. 3.10: 'Witnesses' of this Manual).

Exhibits for a coronial investigation are to be held in compliance with s. 4.6.9: 'Disposal of deceased person's property' of this Manual.

8.4.25 Giving evidence in coronial inquiries

ORDER

Where a member is asked to express a personal opinion, as distinct from a fact on any matter in the course of giving evidence in an inquest, the member is to ensure the opinion is clearly identified as a personal opinion only and not the opinion of the Service.

See 'Public Comment' within 'Standard of Practice' in Professional Conduct of the Human Resources Policies.

8.4.26 Coroner's findings and recommendations

District officers are to ensure any response to a coroner's finding or recommendation is forwarded to the Office of the Deputy Commissioner, Specialist Operations.

8.4.27 Coroner's investigation Coroner's search warrants

Under s. 599: 'Coroner's search warrant' of the PPRA, a coroner may, on his or her own initiative, issue a search warrant for a place if the coroner reasonably suspects that there is evidence at the place that may be relevant to the coroner's investigation.

POLICY

Where a police officer believes that there is evidence that may be pertinent to a coronial investigation, and that a warrant is required to obtain that evidence, that officer should submit a QP 0528: 'Supplementary Form 1 – Police Report of Death to a Coroner' (available in QPRIME) to the relevant occurrence in QPRIME detailing why the evidence is relevant to the coronial investigation and a recommendation for the coroner to issue a Coroner's search warrant.

The powers under a Coroner's search warrant are contained in s. 599(4) of the PPRA.

See also s. 2.8.6: 'Coroner's search warrant' of this Manual.

ORDER

Where an officer executes a Coroner's search warrant that officer is:

(i) to comply with s. 158: 'Copy of search warrant to be given to occupier' of the PPRA (see s. 599(5) of that Act); and

(ii) not to exercise a power under subsection (4)(c) to (f) of s. 599 of the PPRA unless the police officer reasonably suspects that the exercise of the power is necessary for the coroner's investigation.

8.5 Action in special cases

8.5.1 Suicide

An apparent suicide is to be treated as a suspicious death until such time as investigations clearly indicate that the deceased died without the intervention or assistance of another person. This involves complying with the procedures for the investigation of a major incident as outlined in s. 2.4: 'Incident management' of this Manual.

Where the deceased leaves a suicide note or recording, investigating officers are to locate relatives or other witnesses that can identify the deceased's handwriting or voice. Where the handwriting or voice can be identified it is to be included in a statement from the witness and explain how they formed that opinion. Officers may also need to consider the services of handwriting or fingerprint experts in identifying the deceased with a suicide note.

If a suicide note is located, a copy of the note is to be scanned into the relevant QPRIME occurrence.

Officers attending or investigating an apparent suicide are to take possession of anything at the scene which may be relevant to the investigation of the death by a coroner (see s. 597(4): 'Powers for reportable deaths' of the *Police Powers and Responsibilities Act* (PPRA)). For example, in all hangings, officers are to take possession of the relevant rope, ligature or other item used until the coroner determines the cause of death. Where possible the ligature (rope or other

item) should be inserted into the sealed body bag for comparison during autopsy, after being photographed. (see 'Disposal of property seized in connection with a coronial investigation' in s. 4.6.9: 'Disposal of deceased person's property' of this Manual).

ORDER

Where a suicide falls within the definition of a death in custody as outlined in Chapter 16: 'Custody' of this Manual, the provisions of that chapter are to be complied with.

See also s. 8.4.17: 'Suicide prevention research and support' of this chapter.

Investigation of attempted suicides

The Service often receives requests to help with incidents involving persons who have attempted suicide or where there is concern that a person may attempt suicide. A suicide attempt or threatened suicide does not in itself constitute grounds for a belief that the person has a mental illness. It is to be considered in conjunction with any other circumstances or behaviour which would suggest mental illness or an imminent risk that the person would cause significant physical harm to themselves or others.

Reasonable action is to be taken by an officer to ensure the health and safety of the subject person, including where necessary, action under the *Mental Health Act* with sufficient regard to the person's right to privacy and confidentiality. However, the health and safety of the person or any other person is to always be the paramount concern.

Officers attending or investigating an incident which is confirmed to be an attempted suicide or serious suicide threat are to:

(i) take appropriate action under s. 6.6: 'Mentally ill persons' of this Manual where it is suspected the person has a mental illness;

(ii) take possession of:

(a) anything used in the suicide attempt or threat, of such nature and size that it may reasonably be seized (i.e. rope, hose, sleeping pills, weapon, etc.); and

(b) if taking the person to an authorised mental health service, any suicide note or other note written by the person in relation to the suicide attempt or threat;

pursuant to ss. 29(2)(b): 'Searching persons without warrant', 31(5)(b): 'Searching vehicles without warrant' or 609: 'Entry of place to prevent, offence injury or domestic violence' of the PPRA;

(iii) if taken to an authorised mental health service, give any prescription medication or note seized to the staff at the authorised mental health service and obtain a receipt for the items or an acknowledgment of receipt in their official police notebook;

(iv) retain any seized items used or likely to be used in the suicide attempt or threat for a reasonable time to prevent the person from causing harm to themselves, pursuant to s. 691(3): 'Return of relevant things' of the PPRA. In determining a reasonable time to retain an item, officers are to consider, among other things:

(a) the circumstances of the incident;

(b) the apparent mental state of the person; and

(c) the advice of a treating doctor, authorised mental health practitioner or administrator of an authorised mental health service as to whether there is an imminent risk of further suicide attempts by the person;

(v) after a reasonable time has elapsed since seizing the items:

(a) destroy any seized items in accordance with the provisions of the PPRA, namely:

- if the items are of no value, s. 690: 'Forfeiture in particular cases' (see 'Forfeiture of property considered to have no value' in s. 4.6.2: 'Forfeiture of property including orders' of this Manual); or
- if the items have been in possession of the Service for 60 days, s. 718: 'Order for forfeiture of particular relevant things' of the PPRA (see s. 4.9.4: 'Publication of a notice on the QPS website' of this Manual); and
- s. 721: 'Dealing with forfeited things' (see s. 4.6.3: 'Direction for disposal of forfeited property' of this Manual); or

(b) if appropriate, return any seized items to the owner or the person who had lawful possession of the items prior to taking possession of the items, in accordance with s. 691 of the PPRA; and

(vi) disclose appropriate details of the incident including relevant contents of any notes written by the person in relation to the incident, to the person's family, next of kin, or carer where such disclosure may assist in ensuring the health and safety of the person who attempted suicide or threatened suicide or preventing further suicide attempts or threats; and

(vii) if the person is known to be employed in aviation-related safety sensitive activities (e.g. pilots, engineers and maintenance personal, flight attendants and airport ground staff), disclose appropriate details of the incident to the Civil Aviation Safety Authority (see SMCD) where such disclosure is considered necessary to lessen a serious threat to the life, safety or welfare of an individual, or to the public health, safety or welfare.

When completing an 'Emergency Examination Authority' form, officers are to include in the 'Reasons' section:

(i) the time and location of the suicide attempt or threat;

(ii) the means of the suicide attempt or threat;

(iii) any medication prescribed to the person;

(iv) any item, implement, substance or device used in the suicide attempt or threat;

(v) any relevant information supplied by witnesses or next of kin including triggers for suicidal episodes (if known);

(vi) suicide notes;

(vii) any calls for assistance made to police in relation to the person;

(viii) the person's family member, next of kin or carer and their contact details; and

(ix) other relevant information known to police that may assist staff at the authorised mental health service in their examination and treatment of the person including details of any previous attempted suicides.

See also s. 4.3.2: 'Property of deceased/mentally ill persons' of this Manual.

8.5.2 Death of a member of the Service

POLICY

When a member dies, the commissioned officer who had line control of the deceased is to, as soon as possible, personally advise the family member. Where this is impractical, that commissioned officer is to arrange for another commissioned officer to perform this duty.

The commissioned officer who advises the family member should as soon as possible provide or arrange for the provision of all assistance required by the family of the deceased member. The commissioned officer should wherever possible be accompanied by a regional human services officer, police district welfare officer or police chaplain when making initial contact with the family member of the deceased.

As soon as possible after the death, the commissioned officer who advised the family member of the death is to forward by the most expedient means to the Executive Director, Human Resources the following information:

(i) full name, rank, registered number and station of deceased member;

(ii) date of death;

(iii) cause of death;

(iv) time, date and place of funeral, if known;

(v) whether the services of the Police Chaplain, members of the Service (to form a guard of honour), the Police Pipe Band or the Academy colour/lance party are desired by the family member;

(vi) full name and address of the deceased's widow or widower if applicable; and

(vii) the full name and address of the deceased's family member in any other instance.

For further information and procedures relating to Service funeral services and other related matters refer to 'Police service funerals and Administrative Protocol' within Dress and Ceremonial Matters of the Human Resources Policies.

For additional requirements refer to with s. 1.16: 'Fatalities or serious injuries resulting from incidents involving members (Police related incidents)' of this Manual.

Family liaison officer

POLICY

Where an officer dies in the execution of their duty, the Assistant Commissioner of the relevant region where the incident occurred, in consultation with the relevant deputy commissioner, is to appoint one commissioned officer to liaise with the deceased officer's spouse or immediate family members in terms of appraisal of the progress of the investigation into the death until the investigation and any coronial inquest is completed.

Where the death of the officer occurs outside the region where the member is based, consideration should be given to the appointment of a family liaison officer in the region where the deceased officer's spouse or immediate family resides.

The appointed family liaison officer is to notify the deceased member's supervising commissioned officer and officer in charge of their appointment. The family liaison officer is to coordinate their role in with any other support or ongoing liaison role provided to the spouse and family of the deceased officer.

The appointed family liaison officer is to consider the wishes of the spouse and family when performing their role and should comply with any reasonable request for investigation updates or assistance.

Where the death of an officer occurs outside the execution of their duty, consideration of the appointment of a family liaison officer is at the discretion of the relevant assistant commissioner.

The officer in charge or manager of the deceased officer is to ensure that effective provisions are in place to provide the spouse and immediate family members the appropriate level of support and access to relevant information, including the accessing and offering support services (see 'Employee assistance' of the Human Resources Policies).

ORDER

Commissioned officers appointed as family liaison officers are not to be involved in the investigations relating to the death of the officer.

See also s. 1.16: 'Fatalities or serious injuries resulting from incidents involving members (Police related incidents)' of this Manual.

8.5.3 Health care related deaths

POLICY

A 'health care related death' is defined in s. 10AA: 'Health care related death defined' of the *Coroners Act*. Under s. 10AA of the Act, a death is health care related if either:

(i) the health care caused or contributed to the death and immediately before the health care was provided, an independent person would not have expected death to occur; or

(ii) a failure to provide health care caused or contributed to the death and at the time the health care was sought, an independent person would not have expected that there would be a failure to provide health care that could cause or contribute to the death occurring.

A definition of an 'independent person' is provided in s. 10AA(4) of the *Coroners Act*.

In investigating a 'health care related death', the investigating officer should seek statements from all persons:

(i) involved in providing the health care; or

(ii) who failed to provide the health care,

which may have contributed to or caused the death.

The definition of health care under the *Coroners Act* means any health procedure or any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health (see s. 10AA(5) of the Act). The definition of a health procedure under the Act means a dental, medical, surgical or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative or other drug (see Schedule 2: 'Dictionary' of the *Coroners Act*).

Statements obtained from the persons involved in the health care should show the treatment of the deceased preceding morbidity.

Officers who take such statements should, in respect of each statement:

(i) have the witness sign each page of the original statement; and

(ii) have the witness complete:

(a) a declaration under the *Oaths Act* on the final page of the original statement and swear and sign that declaration in the presence of a Justice of the Peace or a Commissioner for Declarations; or on the final page of the original statement and swear and sign that declaration in the presence of a Justice of the Peace or a Commissioner for Declarations; or

(b) an acknowledgement under the *Justices Act* on the final page of the original statement.

Where there is insufficient room on the final page, the declaration or acknowledgement is to be entered on the reverse of the final page. Under no circumstances is the declaration or acknowledgement to be made other than on the last page of the statement.

See also s. 8.4.16: 'Statements' of this chapter.

Investigating officers should note that under s. 19(8): 'Order for autopsy' of the *Coroners Act*, the Coroner must not allow a person to conduct or help at an autopsy if the person is accused by someone, on oath, of causing the deceased's death.

In circumstances where a surgeon or doctor who treated, performed a medical procedure or operated on a deceased patient, will also conduct an autopsy on the deceased, officers should consider the provisions of s. 19(8) of the *Coroners Act*.

The Coroner may then consider any necessary action to be taken. This action may include:

(i) hearing on oath and by personal appearance, any accusation from any person; or

(ii) order an independent pathologist to conduct the autopsy.

For the purposes of s. 19(8)(a) of the *Coroners Act* it is not necessary to make any written application or prepare any affidavit.

PROCEDURE

Before proceeding to interview a staff member attached to a metropolitan hospital, officers should seek the advice and assistance of the plain clothes inquiry officer attached to the relevant hospital.

In some instances of deaths in hospitals, the hospital administrator will provide the investigating officer with some or all of the medical file relevant to the deceased. When this is received, the file should accompany the body to the mortuary and remain there for the information of the pathologist. Medical files should not accompany the completed coronial file.

Officers should ensure that this required information is included in the relevant Form 1: 'Police report of death to a coroner' (available in QPRIME).

Where a health care related death occurs in a hospital or medical facility, officers should refer to the State Coroner's Guidelines 'Preserving evidence when a reportable death occurs in a health care setting', The purpose of these guidelines is to provide health care staff and first response officers with assistance in determining the steps needed to preserve evidence without unduly affecting the capacity of the facility to provide treatment to other patients.

See also s. 8.4: 'Death investigations' and s. 8.5.10: 'Deaths occurring as a result of a reportable event' of this chapter.

8.5.4 Diving deaths and incidents

POLICY

For the purpose of this chapter, a diving death is considered to be the death of a person while using underwater breathing apparatus, whether self-contained, surface supplied or snorkelling equipment.

The scene of any such diving fatality, or diving incident where any person is disabled to the extent that as a consequence of that injury that person is subject to a period of admission to hospital as an in-patient, may fulfil the definition of a workplace pursuant to the provisions of s. 8: 'Meaning of workplace' of the *Work Health and Safety Act*.

Matters involving recreational divers and snorkelers at a workplace come under the *Safety in Recreational Water Activities Act*.

ORDER

In addition to complying with all relevant requirements of the provisions of this Manual, an officer who investigates a diving fatality or diving incident is to:

(i) ensure that all diving equipment, including face mask, breathing apparatus, snorkel, fins, weight belt, wet suit, gauges and computers, compressors, umbilicals, harnesses and cameras, is immediately seized. Consideration should be given to seizing relevant equipment from associated divers such as dive buddies or instructors for comparative purposes;

(ii) ensure that where possible equipment seized is not interfered with. However, in the case of breathing gas cylinders, turn off the supply valve, noting the number of turns required to do so;

(iii) contact the Officer in Charge, Police Diving Unit, through the Police Diving Unit's webpage on the Service Intranet, notifying them of the diving fatality or diving incident and seek assistance from that officer where required;

(iv) arrange for the delivery of all equipment seized to the Officer in Charge, Police Diving Unit, ensuring that continuity of evidence is maintained and all property is linked to the relevant Sudden Death Occurrence. Officers should note that scuba diving cylinders containing compressed air cannot be transported by Queensland Government Air (QGAir) or commercial aircraft. The Officer in Charge, Police Diving Unit, is to be advised so that appropriate arrangements can be made for suitable packaging of the equipment and transportation by road;

(v) ensure that the following are included in the final report to the Coroner and scanned and attached to the relevant QPRIME Sudden Death Occurrence:

(a) the diving history of the diver/deceased for the forty-eight hours prior to the incident giving rise to the investigation; and

(b) a copy of the diver's/deceased's log book if available;

(vi) include any report received from the Officer in Charge, Police Diving Unit, in the final report to the coroner and ensure the report is scanned and attached to the relevant QPRIME Sudden Death Occurrence;

(vii) include in the Form 1 and relevant QPRIME occurrence the name of any vessel involved in the incident together with the name and address of both the owner and its master;

(viii) ascertain what experience the diver/deceased had with any equipment used and the activity being undertaken, if possible; and

(ix) bring to the attention of the medical practitioner or pathologist conducting the autopsy examination the necessity to follow the 'Post Mortem Technique In Fatal Diving Accidents' as published by the Royal College of

Pathologists of Australasia. (A copy of which is available from the Officer in Charge, Police Diving Unit or Police Diving Unit webpage on the Service Intranet).

Actions by Officer in Charge, Police Diving Unit

ORDER

The Officer in Charge, Police Diving Unit, on receipt of diving equipment forwarded for the purposes of investigating a death, is to:

(i) liaise with officers of Workplace Health and Safety Queensland, Department of Justice and Attorney General in relation to the testing of seized equipment received;

(ii) make or arrange for a visual examination of the equipment with a view to evaluating the correctness of assembly;

(iii) where, in the opinion of the officer in charge, it is safe to do so, conduct or arrange for the conduct of a practical underwater test of the equipment;

(iv) where the equipment includes a SCUBA cylinder, arrange for an analysis of the contents of the cylinder;

(v) make or arrange for a physical examination, including disassembly, of the equipment to ascertain whether all parts are functioning correctly; and

(vi) compile a comprehensive report containing information as to tests performed on the diving equipment tested and the results of all tests and examinations conducted. Forward the report and all equipment received, together with copies of documentation, to the officer in charge of the investigation and ensure that the report and any other documentation is scanned in and attached to the relevant QPRIME Sudden Death Occurrence.

The Officer in Charge, Police Diving Unit, is to:

(i) maintain a current copy of the 'Post Mortem Technique In Fatal Diving Accident' as published by the Royal College of Pathologists of Australasia or other established guide; and

(ii) provide appropriate assistance and information to investigating officers upon request.

8.5.5 Fatal mining incidents

ORDER

Officers called to investigate a death at a mine, in addition to carrying out their first response duties (see s. 2.4.1: 'First response procedure at an incident scene' of this Manual) are to ensure:

(i) they identify the danger that may be present, e.g. high voltage electricity, chemicals, heat sources etc. It may be necessary to secure the scene and prohibit entry until it has been declared safe by a qualified person;

(ii) the inspector of mines from the Resources Safety and Health Queensland for the district is notified;

(iii) unless permission of the inspector of mines is given to the officer (by telephone or otherwise) or action is necessary to save life, officers are to:

(a) isolate and secure the incident site, including relevant machinery, equipment and materials involved or likely to have been involved, to prevent interference prior to the inspector's arrival; and

(b) prohibit entry to the secured incident scene unless access is:

- required to assist an injured person;
- required to remove a deceased person; or
- essential to make the site safe or to minimise the risk of a further incident (e.g. disconnect electrical supply);

(iv) the Forensic Crash Unit is requested to attend (see s. 5.9: 'Investigation of major incidents by Forensic Crash Unit' of the Traffic Manual); and

(v) an investigation into the fatal incident is commenced.

The inspector of mines is to be notified of the expiry date of any crime scene warrant and any subsequent extensions, prior to the release of a crime scene.

Incident investigation

Whilst the inspector of mines is responsible for investigating mine incidents under the relevant legislation, the Service is responsible for:

(i) investigating and reporting the death to the Coroner (see s. 8.4.3: 'Responsibilities of investigating officers' of this chapter); and

(ii) conducting investigations to determine whether any criminal offences have been committed.

Inspectors of mines are experienced in the operation of mines and safety procedures and systems used in mines. Internal arrangements exist between the Mines Inspectorate and the State Coroner for notification of fatal mining incidents.

The Service, in accordance with the MOU between the Service and DJAG, is the lead agency for all reportable deaths (see s. 8: 'Reportable death defined' of the *Coroners Act*) and will be the lead agency for all other serious mine incidents until the investigating officer determines there are no outstanding issues.

All fatal mine incidents should be investigated by a CIB officer. Investigators are to conduct a thorough investigation into possible criminal offences and, where appropriate, into the cause and circumstances of any death for reporting to the Coroner. The responsibility for finalising the investigation may be reassigned to another officer if a CIB officer has carried out sufficient investigations to determine that no criminal acts have occurred.

Investigating officers are to liaise with the inspector of mines and any other involved government investigators (e.g. Queensland Fire and Emergency Services) during the investigation and prior to submitting their report to the Coroner. While liaison with other agencies is encouraged, investigative responsibilities cannot be abrogated to another agency.

A copy of the inspector of mines' report is to be attached to the Coronial report.

Exhibits

Generally a thing seized by an inspector of mines can only be retained for one year and must be returned to the owner under s. 146: 'Return of seized things' of the *Mining and Quarrying Safety and Health Act* or s. 149: 'Return of seized things' of the *Coal Mining Safety and Health Act*. Officers are to determine the need to seize the thing prior to the end of the relevant period.

Where it is deemed appropriate to seize a thing in relation to a Coronial investigation, a search warrant can be obtained (see s. 8.4.27: 'Coroner's investigation Coroner's search warrants' of this chapter).

Where practicable, officers are to consult with the relevant inspector of mines in relation to the retention of exhibits connected with a person's death.

Alcohol and drug testing

Depending on the circumstances, investigating officers are to consider any existing legislative provisions which permit the taking of specimens of breath, blood, urine or saliva from mine employees involved in the incident for alcohol and/or drug testing purposes (see Chapter 7: 'Drink and Drug Driving' of the TM and ss. 2.23: 'Forensic procedure orders' & 2.24: 'Non-medical examinations' of this Manual).

Investigating officers are to ascertain if the relevant mine undertakes regular drug and alcohol testing of employees. Some mines have internal policies and procedures that require drug and alcohol testing of employees involved in workplace incidents. In such circumstances, investigating officers are to ascertain if the mine has undertaken drug and alcohol testing of relevant employees, advise the relevant Coroner if they have and if necessary, obtain a Coroner's search warrant to obtain the results (see s. 8.4.27 of this Manual).

Workplace incidents resulting in injury or death are to be recorded in QPRIME.

8.5.6 Fatal workplace or electrical incidents

Officers should be aware of the Memorandum of Understanding (MOU) between the Service and Department of Education detailing the responsibilities and procedures of relevant services at a workplace or electrical incident (see s. 2.6.11: 'Workplace and electrical incidents' of this Manual).

Officers whenever practicable, should ensure a fatal workplace or electrical incident scene is secured until a Workplace, Health and Safety Queensland (WHSQ) or Electrical Safety Office (ESO) inspector attends the scene.

It is not necessary for a WHSQ or ESO inspector to view the body of any deceased person at the incident scene. A deceased person may be removed from the incident scene prior to the arrival of the WHSQ or ESO inspector provided:

(i) the deceased person is photographed in situ;

(ii) notations are made including distances from the original location of any deceased person to other items of interest (e.g. items of plant and equipment); and

(iii) copies of the photographs and notations made are provided to the WHSQ or ESO inspector upon request.

Incident investigation

Whilst WHSQ and ESO inspectors and investigators are responsible for the investigation under the relevant legislation, the Service is responsible for:

(i) investigating and reporting the death to the Coroner (see s. 8.4.3: 'Responsibilities of investigating officers' of this chapter); and

(ii) conducting investigations to determine whether any criminal offences have been committed (other than industrial manslaughter (see subsection 'Industrial manslaughter' of this chapter)).

The Service, in accordance with the MOU between the Service and Department of Education is the lead agency for all reportable deaths (see s. 8: 'Reportable deaths' of the *Coroners Act*) and will be the lead agency for all other serious workplace or electrical incidents until the investigating officer determines there is no issue relating to the incident that needs to progress further.

An officer investigating a fatal workplace or electrical incident is to provide regular briefings to the coroner.

All fatal workplace and electrical incidents should be investigated by an officer from the Forensic Crash Unit, Road Policing and Regional Support Command. Investigators are to conduct a thorough investigation into possible criminal offences and, where appropriate, into the cause and circumstances of any death for reporting to the Coroner.

When investigating an electrical incident, inquiries should be aimed at establishing whether the electrical installation or repair which is suspected of causing the injury or death was installed or repaired by an authorised person. This information should be included in the officers covering report.

Investigating officers should liaise with the WHSQ or ESO investigator and any other government investigators (e.g. Queensland Fire and Emergency Services) involved in the incident during the investigation and prior to submitting their report to the Coroner. While liaison with other agencies is encouraged, investigative responsibilities cannot be abrogated to any other agency.

Where practicable the relevant regional forensic services coordinator should be consulted regarding the method of examinations to be performed and possible forensic services required (see s. 2.19.6: 'Forensic Services Group' of this Manual).

ORDER

Workplace incidents resulting in injury or death are to be recorded in QPRIME.

Industrial manslaughter

Prosecutions for industrial manslaughter under Part 2A of the *Work Health and Safety Act*, Part 2B of the Electrical Safety Act and Part 2A of the *Safety in Recreational Water Activities Act*, under these Acts may only be commenced by WHSQ or ESO investigators or the Office of the Director of Public Prosecutions.

ORDER

Whilst there is no legislated authority for police to prosecute industrial manslaughter, officers are to:

(i) conduct investigations to determine whether other criminal offences have been committed; and

(ii) provide appropriate assistance to the WHSQ and ESO inspector investigating the incident.

Disclosure of information

Information relevant to the investigation of fatal workplace or electrical incidents may be released to inspectors and investigators from WHSQ and ESO as they are declared as law enforcement agencies (see s. 5.6.15: 'Requests for information from other law enforcement agencies' of the MSM).

Support services

The Office of Industrial Relations Coronial and Investigation Liaison Unit:

(i) facilitates grief and trauma counselling; and

(ii) hosts the consultative committee for work-related fatalities and serious incidents,

for workers and families of workers who have been injured or killed in workplace and electrical incidents.

Whenever practicable, officers should provide the contact details of the Office of Industrial Relations Coronial and Investigation Liaison Unit (see SMCD) to the next of kin of the deceased person.

8.5.7 Deaths on board vessels

Section 8(2) of the *Coroners Act* provides for the extent of jurisdiction of a coroner for reportable deaths. In brief, a coroner has jurisdiction to inquire into any death where that death occurs in Queensland; or where a death occurs elsewhere, and the body is in Queensland; or the person, at time of death, was on a journey to or from somewhere in Queensland. This is especially important in terms of deaths on board vessels at sea.

When a death occurs as a result of the operation of a vessel in Queensland, the matter may also be required to be investigated as a marine incident.

See also s. 2.5.9: 'Offences committed at sea' and s. 13.8.3: 'Investigation of marine related offences and marine incident' of this Manual.

8.5.8 Deaths of children

First response actions

First response officers attending a scene of any child death are to make inquiries to establish whether the death is a 'death in care' under s. 9: 'Death in care defined' of the *Coroners Act* and whether the child was known to Child Safety Services, Department of Child Safety, Youth and Women (DCSYW).

The Chief Executive, Child Safety Services, DCSYW may give to an officer investigating, or helping a coroner to investigate, the death of a child, information about the matters stated in s. 159P: 'Release of information for reporting or investigating a death under the Coroners Act' of the *Child Protection Act* (CPA).

For this purpose, first response officers are to make all required inquiries. As part of their inquiries, first response officers are to contact Child Safety Services, DCSYW, Child Safety After Hours Service Centre (see SMCD).

ORDER

Officers to whom information is given under s. 159P of the CPA are to comply with s. 159P(3) with respect to the use or disclosure of the information provided.

For the purpose of this section, a 'child' is an individual under 18 years. See s. 8: 'Who is a child' of the CPA.

Therefore, in addition to contacting Child Safety Services, DCSYW, further inquiries may be required in appropriate cases to establish whether the death of the child was a 'death in care' and therefore a reportable death (see s. 8: 'Reportable death defined' of the *Coroners Act*).

Contacting Child Safety After Hours Service Centre

The Child Safety After Hours Service Centre is to be contacted as soon as practicable following arrival at the scene and after obtaining the required particulars. Initially the Child Safety After Hours Service Centre may be contacted by using:

(i) a mobile telephone;

(ii) a land line telephone; or

(iii) if neither a mobile telephone or land line telephone is available, an appropriate police communications centre or police station.

When Child Safety After Hours Service Centre is contacted following the death of a child, the contacting member is to provide Child Safety After Hours Service Centre as soon as practicable with the e-mail address of:

(i) the first response officer; and

(ii) that first response officer's OIC.

Where the Child Safety After Hours Service Centre is to be contacted by a member, the first response officer is to ensure:

(i) the completion of a 'QPS Child Death Information Request' form (located on the Coronial Support Unit's Web Page of the Service Intranet); and

(ii) an email is sent to the Child Safety After Hours Service Centre with the above form attached. Title the subject line being 'QPS Child Death Information Request' (see SMCD).

Additional e-mail addresses may be provided.

See s. 7.3.6: 'Checks of the Integrated Client Management System (ICMS)' of this Manual.

Child Safety After Hours Service Centre

Child Safety After Hours Service Centre has undertaken to:

(i) complete Part 1 of the 'QPS Child Death Information Request' form (located on the Coronial Support Unit's Web Page of the Service Intranet) from the information provided by the first response officer;

(ii) immediately check ICMS to verify whether the deceased child was known to Child Safety Services, DCSYW;

(iii) advise the first response officer the result of the checks and if the child was known to Child Safety Services, DCSYW, how the child was known; and

(iv) make further extensive inquiries, complete Part 2 of the Form, and e-mail the completed Parts 1 and 2 of the form to the email addresses provided by the contacting member.

Child Safety After Hours Service Centre's information

Any verbal information obtained from the Child Safety After Hours Service Centre and the completed 'QPS Child Death Information Request' form (located on the Coronial Support Unit's Web Page on the Service Intranet) is to be provided to the appointed investigating officer. The investigating officer is to attach a copy of the 'QPS Child Death Information Request' form results to the original copy of the Form 1 to be subsequently forwarded to the coroner and ensure the results are scanned in and attached to the relevant QPRIME Sudden Death Occurrence.

Investigations of child reportable deaths

All child reportable deaths are to be investigated by an officer:

(i) of at least the rank of detective sergeant; or

(ii) where a detective sergeant is not available, a senior or experienced officer with sufficient criminal investigation experience to carry out investigations; and

(iii) in the case of a reportable death occurring as a result of a fatal traffic crash, a qualified Forensic Crash Unit officer in consultation with a detective sergeant or a senior or experienced officer with sufficient criminal investigation experience to carry out investigations.

When preliminary inquiries establish that the death is a reportable death, first response officers are to immediately advise their supervisor of the circumstances of the death.

Supervisors advised in accordance with this section are to advise:

(i) the regional crime coordinator immediately upon notification of a child reportable death; and

(ii) the Child Sexual Assault Investigation Unit via a QPRIME notification task as soon as reasonably practicable.

A **regional crime coordinator** advised in accordance with this section is to:

(i) ensure:

(a) an appropriate investigating officer is appointed;

(b) the investigation is conducted in a thorough, professional and consistent manner and in accordance with the relevant procedures outlined in this Manual; and

(c) the required coronial files are completed in accordance with s. 8.4.14: 'Covering report' of this chapter;

(ii) overview the coronial file in accordance with regional arrangements; and

(iii) in cases where suspicious circumstances exist, as soon as practicable notify the:

(a) Detective Inspector, Homicide Group, CIC; and

(b) Detective Inspector, Child Abuse and Sexual Crime Group (CASCG), CIC.

Officers dealing with a child's reportable death are to:

(i) consider any available information known to police, regarding possible contact that the Child Safety Services, DCSYW has had with the child or their family, including parental history, mental health, drug use, domestic violence and assault history;

(ii) explain to parents/caregivers that investigations are conducted in relation to all deaths and that the adopted procedures are used to assist in determining the cause of death; and

(iii) advise the parents/caregivers of the twenty-four hour Child Death Support Hotline, where trained counsellors from SIDS and Kids Queensland Incorporated can provide counselling and follow-up support, see SMCD.

Investigating officers, in addition to the requirements of ss. 1.11.2: 'Recording an offence in QPRIME' of this Manual and 8.4.3: 'Responsibilities of investigating officers' of this chapter, are to:

(i) assess the risk to any children remaining in the care of the deceased child's parents/caregivers in accordance with s. 7.3.4: 'Initial inquiries by officer investigating the report' of this Manual;

(ii) be aware of the possibility that mistreatment of the child may be the cause, or a contributing factor to the cause, of death;

(iii) consult with the local forensic pathologist, pathologist, forensic medical officer with a view to attending the scene or providing relevant advice if deemed necessary. The on-call Forensic Pathologist, John Tonge Centre may be contacted through Brisbane Police Communication Centre; and

(iv) where the autopsy is to be performed at the John Tonge Centre, Brisbane, ensure that the counsellor at that Centre is advised of the incident during office hours by telephone (see SMCD), and after hours via a QPRIME notification task to the Coronial Support Unit.

When investigating a suspicious death of a child, officers are to refer to s. 2.6.2: 'Homicide' of this Manual.

Officers are to ensure that coronial files relating to non-suspicious deaths of children are completed within 28 days.

QPS Child Safety Director

Upon receipt of:

(i) a child death notification, the Child Safety Director is to ensure an officer of at least the rank of detective sergeant is assigned to liaise with the investigating officer; and

(ii) the completed coronial investigation file, the Child Safety Director is to consider the file in terms of training needs, amendments to Service policy/legislation or operational issues that may affect the investigative response to child deaths.

The assigned detective sergeant, CASCG, is to:

(i) contact the investigating officer; and

(ii) if required, provide advice in terms of this policy and assess the level of operational support required in line with CIC engagement procedures (see Chapter 2: 'Investigative process' of this Manual).

Suspected Child Abuse and Neglect (SCAN) Team representative

The local SCAN team representative upon being notified is to:

(i) conduct a search of the local SCAN data system to establish if any information is available on the deceased child, remaining siblings, parents or caregivers; and

(ii) provide all information relevant to the deceased child to the investigating officer promptly.

If the deceased child, remaining siblings or their parents/caregivers may have previously been known to police in another location, the local SCAN Team representative is to cause an email to be sent to other SCAN team representatives so that a search of local SCAN data systems can be conducted. The results of additional SCAN data systems searches are to be forwarded to the investigating officer in a timely manner.

See also ss. 2.7.6: 'Homicide Group' and 2.7.3: 'Child Abuse and Sexual Crime Group' of this Manual.

Criminal investigations – child deaths

By written notice, the Commissioner can request information, including notifier details, from the chief executive, DCSYW when officers are investigating a child death. The Chief Executive, DCSYW must provide information about the child to assist officers in conducting a criminal investigation (see s. 188E: 'Chief executive must give police commissioner information about deceased child' of the CPA).

ORDER

The investigating officer is responsible for identifying whether a request should be made to the chief executive, DCSYW for information relevant to a criminal investigation about a child death. The power to request information under s. 188E of the CPA is delegated to specific officers (see Delegation D 33.7).

The investigating officer must complete the form 'Request for information under s. 188E of the CPA and seek appropriate approval from an officer with the delegated authority. The request form will be forwarded to the Office of the Director-General, DCSYW to action the request. Officers are to ensure any information received under s. 188E of the CPA is maintained securely and not distributed to unauthorised persons.

8.5.9 Sudden unexplained deaths of infants

Sudden unexplained deaths of infants (SUDIs) are those for which no cause of death was obvious when the infant died. SUDIs may be due to injury, congenital birth defects, infection, or metabolic disorders but where an investigation does not confirm a cause of death, the death is referred to as Sudden Infant Death Syndrome (SIDS). SIDS is the most frequently determined cause for SUDIs between one month and one year of age. The pathologist will determine the cause of death based on information taken from the death scene investigation, autopsy, and clinical history.

The first National SIDS Pathology Workshop in Canberra, March 2004 adopted the definition of SIDS as the

'…death of an infant under one year of age, with onset of the lethal episode apparently occurring during sleep, that remains unexplained after a thorough investigation including performance of a complete autopsy, and review of the circumstances of death and the clinical history'.

POLICY

Officers are to be aware that SUDIs are invariably extremely traumatic for the parents and any investigation is to be conducted in a sensitive, tactful and unobtrusive manner.

Where an officer attends a SUDI, attempts are to be made to interview the parents and arrange identification of the infant before the body is removed to the mortuary. Where possible, efforts are to be made to avoid the trauma of having a parent attend at the mortuary to identify the infant. The parents should be reassured that either they or their relatives may arrange with the funeral director to view the body again if they so desire.

Investigations of sudden unexplained deaths of infants

POLICY

Investigating officers are to be mindful of crime scene contamination and management when the identification process of the deceased infant is occurring.

Investigating officers are responsible for advising the parents or caregivers of the existence of the SIDS and Kids Queensland Incorporated (for the 24 Hour Child Death Support Line, see SMCD). This organisation can assist parents or care givers with follow up counselling and support, if required (see also s. 6.3.14: 'Police Referrals' of this Manual).

In addition to the provisions in Chapter 2: 'Investigative process' of this Manual, when investigating a SUDI the investigating officer is to comply with the provisions as outlined in s. 8.5.8: 'Deaths of children' of this chapter;

PROCEDURE

When conducting an investigation in relation to the sudden unexplained death of an infant, the investigating officer should:

(i) note the following while at the scene, where applicable:

(a) the position of the body and its location;

(b) whether there is any froth, foam or foreign matter in the mouth or nose of the deceased;

(c) full description of:

- the cot or bed;
- the mattress and what it is made of;
- the pillow and what it is made of (kapok, down); and
- the bed clothing (material and position);

(d) if any plastic or rubber sheeting was used on the cot or bed;

(e) the position of the cot or bed in relation to any window or door and whether either of these were open or closed;

(f) are there visible marks on the deceased;

(g) has the deceased had any falls or sustained any injury recently;

(h) the dwelling both internally and externally for any signs of forced entry; and

(i) whether the neighbours may have information relating to possible arguments or domestic violence at the home of deceased;

(ii) have the scene of the death photographed, if possible prior to the removal of deceased's body. Where appropriate conduct a video re-enactment of events at the scene;

(iii) obtain the following information from the parent/s or caregiver/s to assist in establishing a cause of death:

(a) action taken to revive the deceased (this information, the position of the body and lividity should be consistent);

(b) when the deceased was last seen by a doctor or member of a health centre;

(c) whether the deceased was on any medication (list the type and dosage, where appropriate);

(d) any illnesses suffered by the deceased since birth;

(e) any feeding difficulties experienced;

(f) the time the deceased was last fed;

(g) the food the deceased was fed (breast or other, include brand and type);

(h) the position of the body in the cot or bed when located by the parent;

(i) the clothing the deceased was wearing and type of material;

(j) colour of the face and hands when the deceased when located by the parent;

(k) any fluid or vomit seen coming from the nose or mouth;

(l) the precise time at which either parent was last satisfied that the deceased was alive and well;

(m) whether any insect repellent or insecticide or room freshener was used, if so, what type and how frequently or recently;

(n) an estimate of room temperature just prior to the discovery of the body;

(o) pay particular attention to where the deceased is routinely placed. It may be relevant to look for impact signs on the cot or other surfaces; and

(p) if a version is given that the deceased suffered a fall from an object take whatever steps necessary to record the relevant height of the said object. This is important in any later bio-mechanical argument as in detailing the height of any supposed trip or fall;

(iv) where suspicious circumstances exist and to assist in determining a cause of death, the following items should be seized by the investigating officer (see s. 597: 'Powers for reportable deaths' of the PPRA):

(a) clothing, including stained clothes that may have been removed from the baby prior to the arrival of the ambulance;

(b) bedding;

(c) medicines or medicine containers the child may have taken or may have been prescribed but not given;

(d) formula and feeding bottles;

(e) discarded nappies; (blood in stools can give an early indication of internal injuries); and

(f) any property considered to be relevant to the investigation;

(v) where property has been seized as part of an investigation, the investigating officer should ensure that such property is treated in accordance with Chapter 4: 'Property' of this Manual and that it is returned as soon as possible. Normally, this will be after an autopsy establishes the cause of death and the coroner has indicated that no inquest will be held; and

(vi) in cases where Infant Abusive Head Trauma is suspected see s. 7.5: 'Infant Abusive Head Trauma' of this Manual.

See also ss. 2.6.2: 'Homicide', 2.7.6: 'Homicide Group' and 2.7.3: 'Child Abuse and Sexual Crime Group' of this Manual.

8.5.10 Deaths occurring as a result of a reportable event

Under the *Hospital and Health Boards Act* (HHBA) a 'commissioning authority' can appoint a team to conduct a Root Cause Analysis (RCA) where a reportable event occurs at a health service facility (see s. 98: 'Appointment of RCA team' of the HHBA). For the definition of a reportable event refer to s. 94: Definitions of div 2' of the HHBA.

In certain circumstances officers may request a copy of a RCA where a death has occurred as a result of a reportable event.

PROCEDURE

Requests to a commissioning authority for a copy of a RCA will be coordinated through the Coronial Support Unit (CSU). Officers who wish to obtain a copy of a RCA should forward a work request task via the relevant QPRIME occurrence to the CSU.

Any contact made with a commissioning authority should be recorded against the relevant QPRIME occurrence.

On receipt of a RCA the CSU should complete a QP 0528: 'Supplementary Form 1: 'Police report of death to a coroner' via QPRIME advising of the existence and location of the RCA and forward a notification task to the requesting officer advising of same.

The CSU is to hold the RCA on file unless a request is received for the RCA to be forwarded to the requesting officer.

On completion of the coronial file the requesting officer should forward any RCA obtained in the course of the investigation to the CSU where the RCA is to be held on file.

Where a commissioning authority advises that a stop notice in relation to the RCA has been issued, the officer receiving such a notice should note this in the relevant QPRIME occurrence, including:

(i) why the RCA team stopped conducting the RCA;

(ii) if the RCA was stopped under s. 103: 'Stopping conduct of RCA of reportable event–commissioning authority' of the HHBA; and

(iii) the reasons for giving the direction.

8.5.11 Drowning

The death of a person whilst using underwater breathing apparatus, whether self-contained, surface supplied or snorkelling equipment is to be investigated in accordance with s. 8.5.4: 'Diving deaths and incidents' of this chapter.

Pool immersion incidents

A pool immersion incident refers to when a child has died or has been deprived of air and their health and wellbeing adversely affected as a result of immersion under water in a swimming pool. The *Building Act* obliges local governments to investigate all reported pool immersion incidents to enforce pool safety standards.

POLICY

Officers responding to a pool immersion incident should notify the relevant local government agency of the incident as soon as practicable.

When a death occurs as a result of drowning in a swimming pool, the investigating officer should ascertain as much of the following information as is possible and include same on the relevant part of the Form 1: 'Police report of death to a coroner':

(i) whether the pool is in ground or above ground;

(ii) whether fencing around the pool, distinct from fencing around the boundary of the property, exists;

(iii) description and condition of existing pool fencing, including height of the fence, construction materials and method of construction;

(iv) the presence or otherwise of pool gates, including detailed description of their operation; and

(v) details as to why the pool fencing did not prevent the drowning.

PROCEDURE

The investigating officer is to inform the local government agency of a pool immersion incident, so that investigations under the *Building Act* can be conducted to: can be conducted to:

(i) identify any breaches of the Act; and

(ii) provide information to the investigating officer of the compliance of the swimming pool for the purposes of informing the Coroner of the grounds surrounding the death.

The investigating officer should provide an officer from the local government agency with:

(i) the name and age of the injured or deceased child;

(ii) details of parents or guardians of the injured or deceased child;

(iii) the address at which the immersion occurred;

(iv) details of the owner/s and occupants of the address at which the immersion occurred;

(v) other relevant details which would assist their investigation

ORDER

Officers are not to supply a Form 1 to a local government officer.

Drowning death at a surf lifesaving event

Matters involving competitors at an official surf lifesaving event are dealt with under the *Safety in Recreational Water Activities Act*.

ORDER

Officers responding to a:

(i) drowning death; or

(ii) missing competitor who is suspected to have drowned,

at an official surf lifesaving event are to notify the Advisory and Assessment Centre, Office of Industrial Relations through the Duty Officer, Police Communications Centre, Brisbane, or local communication centre.

The investigation of a death at an official surf lifesaving event is to be conducted in conjunction with inspectors from Workplace Health and Safety Queensland in accordance with s. 8.5.6: 'Workplace or electrical incidents causing or likely to cause grievous bodily harm or death' of this chapter.

8.5.12 Aircraft incidents resulting in death

The following section deals only with the requirements for reporting on deaths as a result of aircraft incidents. See s. 17.3.3: 'Aircraft incidents' of this Manual for policy and procedures on the investigation of aircraft incidents generally.

POLICY

For the purposes of this section an aircraft incident includes any incident involving a powered aircraft, glider, hang glider, manned balloon or parachute while taking off, landing or in flight and, where the term aircraft is used, it includes any craft using the within mentioned means of flight.

Due to the complex nature of aircraft incidents, an Australian Transport Safety Bureau trained QPS investigator should be requested to attend an aircraft incident involving a fatality. In the event a trained ATSB QPS investigator is unable to attend, the investigating officer is to contact an ATSB trained QPS investigator to obtain advice.

Officers who investigate a fatal aircraft incident, should ascertain and include in the final report to the Coroner as much of the following information as possible. Additionally any of these reports or statements are to be uploaded to the relevant QPRIME Sudden Death Occurrence. The information relevant includes:

(i) a summary of the events leading up to the incident;

(ii) the time of the incident;

(iii) the names of the first police at the scene and the time of their arrival;

(iv) details of any witnesses;

(v) an accurate description of the incident location, including distance from the airport if applicable;

(vi) number of passengers on board the aircraft;

(vii) number of crew on board the aircraft;

(viii) an accurate description, including a scale diagram if available, of the incident site showing the location, extent of wreckage and the location of bodies;

(ix) the details of members who attended the scene, and the roles each of them filled, (e.g. on scene commander, radio operator, investigating officer);

(x) the assistance provided by State Emergency Service personnel, including the number of personnel, person in charge and the duties performed;

(xi) the number of ambulance vehicles and officers that attended and their stations of origin;

(xii) the number of fire service units that attended, their time of arrival and their stations of origin;

(xiii) full details of any Australian Transport Safety Bureau or Workplace Health and Safety investigators;

(xiv) insurance and ownership details of the aircraft;

(xv) full details of the aircraft, including:

(a) aircraft type and serial number;

(b) age of aircraft and date put into service;

(c) dimensions;

(d) number, make and type of engine/s;

(e) fuel capacity and type of fuel used;

(f) amount of fuel on board at time of incident;

(g) minimum take-off and landing speed; and

(h) aircraft call sign;

(xvi) full details of the pilot and co-pilot, including:

(a) name, address and date of birth;

(b) total logged flying hours; and

(c) all pilot's licence endorsements;

(xvii) full details of any crew, including:

(a) name, address and date of birth;

(b) position in crew; and

(c) position on aircraft;

(xviii) full details of all passengers, including name, address, date of birth and position on aircraft;

(xix) weather conditions at the time of the incident, including conditions at various altitudes through which the aircraft passed in flight; and

(xx) ground conditions.

The report should also include a summary of the result of inquiries into the possible cause or causes of the accident.

External organisations assisting with investigations

POLICY

All examinations or testing conducted by external organisations are to be arranged by the Service. When an external organisation such as the Australian Transport Safety Bureau conducts and completes an examination of an aircraft on behalf of the Service, or the aircraft is to be released to another investigating authority, the responsible officer is to contact the Coronial Support Unit regarding the storage of the aircraft until a coronial inquest is held.

A document titled 'Civil and Military Aircraft Accident Procedures for Police Officers and Emergency Services Personnel' can be located on the Australian Transport Safety Bureau's website (www.atsb.gov.au). This document contains useful information for first response officers when attending an aircraft crash site including explanations of potential hazards, the role of the Australian Transport Safety Bureau and the Directorate of Defence Aviation and Air Force Safety and what information those bodies will require from officers.

The Queensland Police Service is the lead agency for all reportable deaths (see s. 8: 'Reportable deaths' of the *Coroners Act*) and will also be the lead agency for all other serious workplace or electrical incidents until the investigating officer determines there is no issue relating to the incident that needs to progress further. Investigating officers are to

request investigations conducted by external organisations on behalf of the Service are finalised within the nominated timeframes to allow the results to be included with the final report to the Coroner.

8.5.13 Military aircraft

POLICY

The procedures relating to the death of persons in military aircraft are the same as for civilian aircraft except in relation to the location of the autopsy. (See also ss. 8.5.1: 'Aircraft incidents resulting in death', 8.5.2: 'Investigation of deaths involving members of the Australian Defence Force' and s. 17.3.3: 'Aircraft incidents' of this Manual).

All military personnel killed in Department of Defence aircraft accidents will be transported to the John Tonge Centre, Brisbane, for an autopsy. The investigating officer, or another officer to whom the body has been identified, should accompany the body to Brisbane. The Commonwealth Department of Defence will provide air transport to Brisbane for the body and the accompanying officer. Return transport is the responsibility of the Service, although the Department of Defence may allow the accompanying officer to return on the same aircraft which carried the body if it is scheduled to return to the same point of origin.

The Queensland Police Service, in accordance with the MOU between the Queensland Police Service and Department of Justice Attorney-General are the lead agency for all reportable deaths (see s. 8: 'Reportable deaths' of the *Coroners Act*) and will also be the lead agency for all other serious workplace or electrical incidents until the investigating officer determines there is no issue relating to the incident that needs to progress further.

8.5.14 Fatal traffic crashes

For the purposes of this section, the officer who is first detailed to attend the incident is the first response officer.

Responsibilities of first response officer

ORDER

The officer first detailed to attend a fatal traffic crash is responsible for:

(i) taking all action required in terms of the Traffic Manual; and

(ii) complying with all provisions of s. 8.4.3: 'Responsibilities of investigating officers' of this chapter, with the exception of paragraph (x).

First response officers, are to ensure they comply with s. 5.6.1: 'Duties of investigating officer to record information' of the Traffic Manual in relation to reporting requirements prior to the completion of the shift during which they are detailed to attend a fatal traffic crash.

Whether a death occurs at the scene of the traffic crash or on the way to hospital, providing the cause of death is as a result of the traffic crash, only one occurrence in QPRIME is to be entered. First response officers are not to create a QPRIME Sudden Death Occurrence in relation to the fatal traffic crash (as well as a Traffic Crash Occurrence), but are to ensure they complete all of the other steps to report a sudden death to the coroner in QPRIME.

When required to complete the relevant Form 1: 'Police report of death to a coroner' (available in QPRIME), first response officers are to include an endorsement showing the name, rank and station of the investigating officer.

On completion of these responsibilities, first response officers are to submit all documentation to their officer in charge. The officer in charge, on being satisfied that the first response officer has fully complied with the provisions of this section, is to assign the occurrence to the investigating officer via QPRIME.

Responsibilities of investigating officer

ORDER

The officer assigned to investigate a fatal traffic crash is responsible for finalising inquiries, completing the Traffic Crash Occurrence in QPRIME and for submitting all reports necessary to finalise the matter. This includes compliance with ss. 8.4.13 to 8.4.17 inclusive of this chapter.

Deaths at hospitals as a result of traffic crashes

POLICY

To ensure that there is a minimum of delay in updating records on the Traffic Crash Occurrence in QPRIME when a victim of a traffic crash dies later in a hospital the responsibility for modifying the record shall rest with the officer reporting on the death. The officer investigating the traffic crash retains responsibility for making all investigations into the cause and circumstances of the death.

ORDER

An officer detailed to attend at a hospital where a person has died where the cause of death is as a result of a traffic crash is to:

(i) comply with s. 8.4.3: 'Responsibilities of investigating officers' of this chapter with the exception of paragraphs (v) and (x);

(ii) prior to terminating duty on the day such death is reported, the following items are also to be recorded in QPRIME in the Traffic Crash Occurrence:

(a) add major occurrence flag to occurrence;

(b) link deceased person (s);

(c) ensure a person Motor Vehicle Crash (MVC) Report for each deceased person has been completed and modify if necessary;

(d) send notification of Fatal Accident message; and

(e) modify occurrence type to 'Traffic Crash – Fatal' if necessary.

(iii) complete all of the steps to report a sudden death to the coroner in QPRIME. Where the death has occurred in hospital of a person where the cause of death is as a result of the traffic crash, only one occurrence is to be entered in QPRIME, (i.e. Traffic Crash Occurrence and not also a Sudden Death Occurrence);

(iv) immediately notify the officer in charge of the station/establishment which reported on the original traffic crash that the death has occurred through the sudden death workflow in QPRIME; and

(v) submit the file completed in compliance with s. 8.4.3: 'Responsibilities of investigating officers' of this chapter excluding paragraphs (v) and (x) for transmission to the officer in charge of the station/establishment which reported on the original traffic crash.

Officers in charge of stations/establishments who receive a file relating to the death of a person at a hospital in their division as a result of a traffic crash are to transmit the file to the officer in charge of the station/establishment which reported on the original traffic crash.

Officers in charge of stations/establishments receiving advice that persons have died as a result of a traffic crash which occurred in their division are to notify the officer investigating the traffic crash.

8.5.15 Location of possible First Nations burial remains

ORDER

Officers are to treat the location of skeletal remains as a crime scene and comply with the relevant provisions of this chapter and Chapter 2: 'Investigative Process' of this Manual. This continues until police and the coroner are satisfied the remains are First Nations burial remains, are historical and not related to a criminal matter.

If a determination is made that the remains could constitute First Nations historical burial remains, investigating officers deal with the site and remains by:

(i) contacting Department of Treaty, Aboriginal and Torres Strait Islander Partnerships, Communities and the Arts (DTATSIPCA) for specialist advice and guidance. (If correspondence is via email officers are to cc First Nations Division);

(ii) ensuring that appropriate consideration is given to involving a Police Liaison Officer, if available, and local Aboriginal and Torres Strait Islander community groups; and

(iii) providing advice on this matter to the First Nations Division by submitting the details through their Sharepoint site.

Section 12(2)(a): 'Not investigating or stopping investigation of particular deaths' of the *Coroners Act* states "*a coroner must stop investigating a death if the Coroner's investigation shows that the body is indigenous burial remains"*.

Where practicable a scientific officer should attend the scene, along with the members of DTATSIPCA, to assist investigating officers in determining the ethnicity and antiquity of the remains.

Officers who are required to investigate the location of skeletal remains, in addition to complying with the relevant provisions of this chapter and Chapter 2 of this Manual, should be mindful of indications that would suggest First Nations historical burial remains.

Factors which may indicate such a site, particularly when associated within the proximity of:

(i) scarred or carved trees;

(ii) stone arrangements; or

(iii) stone artefacts,

include the location of skeletal remains:

(i) in hollowed out logs or trees;

(ii) wrapped in bark cylinders;

(iii) placed in rock shelters or rocky overhangs;

(iv) buried with artefacts; or

(v) sand hills close to a water source.

The remains may also have been cremated.

If properly identified as First Nations historical burial remains, officers of DTATSIPCA will take responsibility for liaison and reburial with the appropriate Aboriginal and Torres Strait community.

At all stages, minimal disturbance to the remains should be a priority, respectfully dealing with the matter in a sensitive and caring manner.

Officers are to record the details of the properly identified location in QPRIME as a First Nations historical burial site. The location can be added in QPRIME as a 'new address', allowing the entry of GPS latitude and longitude details. In remote areas without mobile device connectivity, latitude and longitude can be obtained from a breathalyser device.

Refer to Chapter 13: 'Miscellaneous' of this Manual for duties regarding the *Aboriginal Cultural Heritage Act* and assistance to the Department of Environment, Science and Innovation.

8.5.16 Deaths in care

Section 9 of the *Coroners Act* defines the term 'death in care'. Section 27: 'When an inquest must be held' of the *Coroners Act* provides that the Coroner investigating a death must hold an inquest if the coroner considers the death is a death in care, in circumstances that raise issues about the deceased person's care.

POLICY

Where an adult person's death is found or suspected to be a 'death in care', the matter is to be investigated by a senior or experienced officer with sufficient criminal investigation experience to carry out investigations.

For deaths of children, see s. 8.5.8: 'Deaths of children' of this chapter.

The officer in charge of the station within whose division the person died is to ensure that a suitable officer is assigned to investigate such a death.

District officers are to consider developing station instructions, in consultation with senior management of facilities or services in their area of responsibility, for the purpose of liaison between investigating officers and a nominated representative from those facilities or services where there is a reasonable possibility of a death in care occurring. For example: an authorised mental health service with in-patient facilities or a level 3 accredited residential service providing for people with a disability covered under the *Disability Services Act*.

Any procedures adopted need to take local issues and conditions into account but are to ensure that a representative from the facility or service is nominated to provide:

(i) assistance to investigating officers with any request they may have relevant to the investigation;

(ii) advice to investigating officers on the procedures of the facility or service relevant to the particular case; and

(iii) contact details to the investigating officers for any future liaison in relation to the investigation.

Use QP 607: 'Reportable Death-Death in Care' as the covering report to a coroner.

See also ss. 2.6.2: 'Homicide' and 2.7.6: 'Homicide Group' of this Manual.

8.5.17 Suspected drug overdoses

If during the investigation of an incident it is suspected that a death has occurred from a drug overdose officers are to:

(i) treat the scene as a crime scene and preserve it;

(ii) notify scenes of crime personnel and request their attendance;

(iii) advise CIB personnel;

(iv) search the crime scene and surrounds in consultation with Scenes of Crime personnel with a view to locating possible exhibits, in particular illicit drugs, drug paraphernalia and prescription drugs;

(v) where prescription drugs are found, record:

(a) the details of the prescription label on the packaging including:

- the drugs' name, quantity and dosage;
- who the drugs were prescribed to;
- the prescribing doctor;
- the pharmacy/chemist that provided the drugs;
- the date the drugs where provided;
- instructions on how the drug is to be taken; and

(b) how many tablets/dosages remained;

(vi) ensure that all exhibits are photographed in situ; and

(vii) ensure any illicit drugs seized are analysed and the Regional Crime Coordinator and State Drug Investigation Squad,

Crime and Intelligence Command advised immediately of the results of that analysis.

Investigating officers are to endeavour to obtain the following information regarding the deceased:

(i) names and addresses of family members and close associates;

(ii) telephone numbers known to have been regularly used, including details of ownership of telephones;

(iii) type, usual quantity and frequency of drug(s) used;

(iv) usual method of administration of drugs;

(v) source of drugs;

(vi) in the case of illicit drugs, how the deceased obtained money for the purchase of drugs;

(vii) in the case of illicit drugs, how the deceased was financially supported;

(viii) in the case of illicit drugs, knowledge of how drug deals were arranged;

(ix) in the case of illicit drugs, usual mode of transport to collect drugs;

(x) medical background;

(xi) history of overdoses (reported to police or otherwise);

(xii) results of analysis of any drugs located; and

(xiii) any other relevant information (including depression, attempts at suicide or other forms of self-harm and use of drugs in company with other persons).

Investigating officers are to record this information on the relevant QPRIME Sudden Death Occurrence and assign a task for information to their local intelligence officer. Intelligence officers are to enter this information on the Australian Criminal Intelligence Database (ACID).

In the case of illicit drugs, as part of the investigation, investigating officers should liaise with their local intelligence officer in an effort to locate the source of supply of the drug(s).

The contents of this section are to be read in conjunction with ss. 2.6.6: 'Clandestine illicit drug laboratories' and 2.6.7: 'Illicit drug crops' of this Manual.

8.5.18 Organ and tissue donation

Organ donors (deaths occurring in Intensive Care Unit of a hospital)

Where persons who have expressed their consent for the removal after death of organs and tissues (see ss. 22: 'Authority to remove tissue where body of deceased in a hospital' and 23: 'Authority to remove tissue where body of deceased not in hospital' of the *Transplantation and Anatomy Act*), personnel from DonateLife Queensland, the State Organ and Tissue Donations Service, will coordinate the legal and medical processes including the surgical retrieval for donation.

Consultation must take place between the treating medical officer, the forensic pathologist performing the autopsy and the coroner before any donated organs and/or tissues can be removed from a body after death. A coroner will only consent to the process if the Government Pathologist, Government Medical Officer, or other medical practitioner, as applicable, who will complete the autopsy, is convinced that the police investigation would not be compromised in any way.

Consent for the removal of any organs/tissues is contained in Part 3: 'Donations of tissue after death' of the *Transplantation and Anatomy Act*. No retrieval can occur without the post death consent of the senior available next of kin, the authorisation of a designated officer and the consent of the coroner. Any consultation which may be required to complete this process will also be handled by DonateLife personnel.

DonateLife personnel will liaise with the next of kin of the deceased and complete the necessary forms relating to the proposed organ donation. This will include:

(i) the QP 0450: 'Hospital Identification Statement' where a third party ID will be performed with the DonateLife personnel and the next of kin; and

(ii) DonateLife personnel will use an identification sticker bearing the Hospital UR number which is unique to the deceased person on all relevant documents.

At the end of the retrieval procedure:

DonateLife personnel will place the Hospital Identification Statement in a clear plastic sleeve and insert inside the mortuary body bag of the deceased.

DonateLife personnel will notify police to transport the deceased to the John Tonge Centre (metro Brisbane) or the hospital mortuary (in regional Queensland) in compliance with the provisions of s. 8.4.4: 'Pre-mortuary procedures and removal of bodies from scene' of this chapter.

Tissue Donors (reportable deaths which occur outside of a hospital Intensive Care Unit)

Tissue donors are those individuals whose death did NOT occur within a hospital Intensive Care Unit (organs are not suitable for donation in these circumstances).

Where a police officer is approached by relatives offering tissue donation on behalf of a deceased, the officer should contact the Tissue Banks (see SMCD) and advise them, where possible, of the deceased's:

(i) name;

(ii) age;

(iii) date of birth;

(iv) date, time, current location and circumstances of death;

(v) address; and

(vi) relative's contact details.

8.5.19 Deaths in custody

Death in custody is defined in s. 10: 'Death in custody defined' of the *Coroners Act*.

For the purposes of the *Coroners Act*, the term 'death in custody' is applied to a wide range of custodial situations. The term will include deaths occurring while a person is detained under an arrest, by a court order, under the authority of a Commonwealth Act or under the authority of a Queensland Act other than the *Education (General Provisions) Act* or the *Mental Health Act*. Consequently, a 'death in custody' may occur while a person is in the custody of the Service, another Queensland agency or a Commonwealth agency. In all cases it is the responsibility of the Service to investigate the death and report to the coroner.

Section 11: 'Deaths to be investigated' of the *Coroners Act* provides that a death in custody must be investigated by the State Coroner, Deputy State Coroner or an appointed coroner or local coroner, approved by the Governor in Council to investigate a particular death in custody or any death in custody, on the recommendation of the Chief Magistrate in consultation with the State Coroner.

Where a person's death occurs while in police custody, in the course of or as a result of police operations or otherwise in the company of police, the death is to be investigated in accordance with s. 1.16: 'Fatalities or serious injuries resulting from incidents involving members (police related incidents)' and s. 16.23: 'Deaths in police custody' of this Manual.

If a death in custody occurs in a Queensland Correctional Centre, see s. 13.5.3: 'Corrective Services Investigation Unit to be advised' of this Manual.

If a death in custody occurs in other circumstances (i.e. while the deceased person is in the custody of an agency other than the Service or Queensland Corrective Services), first response officers should treat the matter as a major investigation (see s. 2.4.5: 'Major investigations' of this Manual).

Subject to any direction by the State Coroner, arrangements are to be made to ensure that the death is investigated, and a report prepared for the coroner, by the Homicide Group, Crime and Intelligence Command (CIC). The investigating officer from the Homicide Group, CIC should liaise closely with any investigators appointed by the agency in whose custody the deceased person was held. However, responsibility for the conduct of the investigation and report to the coroner will remain with the investigator from the Homicide Group, CIC.

Officers investigating deaths in custody, which would not be considered as deaths in police custody, should nevertheless conduct such investigations in a manner consistent with the provisions of s. 16.23: 'Deaths in police custody' of this Manual to the extent that it is practicable to do so and making necessary adjustments such as reporting progress to the Assistant Commissioner, CIC rather than the Assistant Commissioner, Ethical Standards Command.

When completing the covering report for a death in custody, investigating officers should refer to Appendix 16.4: 'Suggested format for reports on deaths in custody or in police company' of this Manual.

Depending on the circumstances of the death in custody, other headings in the covering report may be included. To assist an investigating officer in completing a covering report for such a death, examples of completed reports can be obtained from the Coroners Court of Queensland via the Coronial Support Unit.

See s. 8.4.19: 'Responsibilities of officers in charge' of this chapter for action relating to the completed investigation file.

8.5.20 Deaths resulting from fires

POLICY

All fatal fires should be investigated by an officer from the criminal investigation branch. Officers investigating fatal fires are to conduct a thorough investigation into possible criminal offences and, where appropriate, into the cause and circumstances of any death for reporting to the coroner. The responsibility for finalising the investigation may be reassigned to another officer if a criminal investigation branch officer has carried out sufficient investigations to determine that no criminal acts have occurred in the incident.

Investigating officers should liaise with the Queensland Fire and Emergency Service (QFES) fire investigator and any other government investigators (e.g. Workplace Health and Safety investigators) involved in the incident during the investigation and prior to submitting their report to the coroner. While liaison with other agencies is encouraged, investigative responsibilities cannot be abrogated to any other agency.

When investigating a death which occurs as a result of a fire, investigating officers should seek statements from all persons having any significant knowledge concerning the cause or behaviour of the fire including:

(i) the owner of the premises damaged by the fire;

(ii) the person who first raised the alarm;

(iii) the senior QFES officer in attendance;

(iv) the QFES fire investigator; and

(v) any other person who has knowledge bearing on the cause or behaviour of the fire.

Investigation reports should be sought from external investigators for inclusion in the police submission to the Coroner.

Officers attending fires should also comply with the provisions of s. 2.6.1: ‘Fire investigation’ of this Manual.

8.5.21 Unidentified human remains

POLICY

Where any unidentified human remains are located, investigating officers are to ensure that the Missing Persons Unit is advised by assigning a task for information through QPRIME, and ensure the relevant Sudden Death Occurrence made in QPRIME contains the following information:

(i) a description of the human remains;

(ii) when and where the human remains were located; and

(iii) where possible:

(a) how long has the victim been deceased; and

(b) the existence of any personal belongings including clothing.

The officer responsible for the investigation is to ensure that a Form 1 is completed in compliance with the provisions of this chapter.

8.5.22 Fatalities on Queensland Rail, Citytrain network

PROCEDURE

The first response officer attending the scene of a railway incident on the Queensland Rail, Citytrain network, is to advise the relevant Police Communications Centre immediately upon confirming that the incident involves a fatality. The Duty Officer at the advised Police Communications Centre is to ensure that appropriate arrangements are made for the undertaker to attend the scene.

8.5.23 Domestic and family violence related deaths

To assist the coroner in identifying specific domestic and family violence related factors leading up to a death, officers investigating deaths related to incidents of domestic and family violence are to comply with the requirements of this section in addition to ss. 1.11.2: ‘Recording an offence in QPRIME’, 2.6.2: ‘Homicide’ and 8.4.3: ‘Responsibilities of investigating officers’ of this Manual.

Officers investigating a reportable death, are to:

(i) conduct checks of QPRIME to determine if there are any relevant domestic and family violence occurrences;

(ii) investigate the relevant domestic and family violence occurrences leading up to the death;

(iii) obtain statements from all witnesses including police officers. Investigators should consider any available information known to the police, regarding domestic and family violence and assault history, mental health, drug use, adverse firearms history and possible contact had with the Child Safety Services, Department of Child Safety, Youth and Women, if applicable;

(iv) include any interaction the deceased or other involved parties had with support services such as DV Connect for previously reported domestic and family violence incidents. Consider contacting the Police Referral Services Unit regarding any referrals made, see s. 6.3.14: 'Police Referrals' of this Manual;

(v) ensure a notification task is assigned, as soon as practicable, to the relevant district Domestic and Family Violence Coordinator, in QPRIME. The message is to contain:

(a) the name of the victim (if known);

(b) the name of the offender (if known);

(c) the name of the investigating officer and contact telephone number; and

(d) brief particulars of the incident.

(vi) ensure a QP 0528B: 'Supplementary Form 1 Domestic Homicide Audit' is completed in consultation with the relevant district Domestic and Family Violence Coordinator;

(vii) complete an investigation covering report (contact Coronial Support Unit (CSU) for reports on deaths related to domestic violence); and

(viii) forward the covering report together with a copy of the completed file to the CSU, Coroners Court of Queensland through the chain of command. The report should include the results of the police investigation into the cause and circumstances of the death. All documents should be attached to the QPRIME occurrence.

In the case of a child death or involvement of a child in the death of another, refer to s. 8.5.8: 'Deaths of children' of this chapter and Chapter 7: 'Child Harm' of this Manual.

The file and report will be forwarded to the Coroner to provide sufficient evidentiary basis for the coroner to give consideration as to whether an inquest should be convened having regard to the potential for the Coroner to make preventative recommendation.

8.5.24 Missing person reasonably suspected of being deceased

The State Coroner requires notification by report as soon as a missing person is reasonably suspected of being deceased, and that such death was a reportable death pursuant to s. 8: 'Reportable death defined' of the *Coroners Act*.

Examples of circumstances where a missing person may be deceased:

A person falls off a fishing trawler. Despite extensive searches, the person has not been located.

An angler is washed off rocks by strong waves into the ocean. This was observed by several witnesses. Searches fail to locate the person.

A person goes missing in suspicious circumstances, which leads officers to believe that the person is deceased, as opposed to a person going missing by their choice. Further supporting evidence might include the missing person has had no contact with family and close friends, has left a prized motor car and personal belongings behind, and has not accessed bank accounts, Centrelink, Medicare etc. for an extended period of time.

In cases where a person is missing in circumstances that it is reasonably suspected the missing person may be deceased, the investigating officer is to consult with the Missing Persons Unit (MPU), Crime and Intelligence Command (CIC). It is the responsibility of the MPU to provide notification by report to the Coronial Support Unit (CSU), Operations Support Command, as initial advice (see s. 12.4.4: 'Responsibility of an officer detailed to investigate a missing person occurrence' and s. 12.4.6: 'Report to coroner where missing person reasonably suspected of being dead' of this Manual).

Upon completion of the investigation, the investigating officer is to forward the complete file including a completed QP 0608 to the MPU through the chain of command. The report should include the results of the police investigation into the cause and circumstances of the missing person's disappearance. All documents should be attached to the QPRIME missing person occurrence.

Completion of a QP 0608 twelve months after initial notification

At the expiration of twelve months from when a person is reported missing and:

(i) the person is reasonably suspected of being deceased; and

(ii) a QP 0608 has not previously been submitted,

the investigating officer is to complete a QP 0608 and forward to the MPU, who forward it to the CSU as initial advice.

Missing Persons Unit, CIC

The Operations Leader, MPU upon receipt of the report, is to:

(i) review the contents of the QPRIME missing person occurrence;

(ii) where considered necessary, initiate further inquiries;

(iii) where considered appropriate, request the State Coroner to direct a coroner to investigate the suspected death (see s. 11(6): 'Deaths to be investigated' of the *Coroners Act*); and

(iv) forward that report together with recommendations to the State Coroner.

Coroner's determination

Where the coroner determines the missing person is deceased and that suspicious circumstances exist, the CSU is to:

(i) notify the victim's family of the services and financial assistance available to them under the *Victims of Crime Assistance Act* (see ss. 2.12: 'Victims of crime' and 6.3.14: 'Police Referrals' of this Manual); and

(ii) forward the investigation to the Homicide Group, CIC.

Victims Assist Queensland is only able to assist a family if the Coroner determines the death of the missing person is of a suspicious nature.

8.5.25 Investigation of deaths involving members of the Australian Defence Force

For the purpose of this chapter, an Australian Defence Force (ADF) death is the death of a person whilst serving as a member of the ADF. This includes part time reserve members, ADF personnel who normally reside outside Queensland but die in Queensland, and ADF personnel who die whilst undertaking an overseas deployment and their remains are being repatriated to Queensland.

In some instances, an ADF death may also include discharged or retired members where their military service may have contributed to their death; e.g. suicides where Post Traumatic Stress Disorder may be a factor, or where previous injuries may have contributed to the death.

POLICY

The police investigation and completion of the coronial investigation into ADF deaths is to be conducted by the Coronial Support Unit (CSU). In the case of criminal or negligence related deaths, the CSU will provide assistance to regional investigators, including liaison with the Australian Defence Force Investigative Service (ADFIS) on behalf of the Service, e.g. – exhibit management and retention of ADF property.

Investigators attached to ADFIS are experienced in the investigation of incidents linked to military operations, as well as ADF deaths suspected of being suicide. They may be in a better position to investigate the incident than first responding police officers. Accordingly protocols have been developed between the CSU and ADFIS to ensure appropriate information exchange, investigative response and access to sensitive documents/material.

Investigating police upon being notified of an ADF death or when initial inquiries reveal that the deceased is a previous ADF member are to immediately contact the Officer in Charge, CSU. Upon determining that the death is a reportable ADF death, the CSU will conduct the coronial investigation with the assistance of the initial investigating police.

In the case of a reportable ADF death occurring as a result of a fatal vehicle, industrial or aircraft incident, a qualified Forensic Crash Unit trained officer, in consultation with the appointed CSU investigator, is to assist in investigations.

Specific coronial protocols exist for military aircraft crashes, see s. 8.5.13: 'Military aircraft' of this chapter.

ORDER

An officer investigating a death, who determines that the deceased is an ADF member or previous ADF member, is to ensure:

(i) the Officer in Charge, CSU is notified immediately; and

(ii) a Form 1 is completed in accordance with s. 8.4.8: 'Completion of Form 1' of this chapter.

8.5.26 Voluntary assisted dying

The *Voluntary Assisted Dying Act 2021* (the **'VAD Act'**) commenced on 1 January 2023 to establish the legal framework for voluntary assisted dying in Queensland, allowing eligible persons who are suffering and dying to choose the timing and circumstances of their death. Voluntary assisted dying means the administration of a voluntary assisted dying substance and includes steps reasonably related to that administration (see Schedule 1: 'Dictionary' of the VAD Act).

Voluntary assisted dying is not a reportable death pursuant to s. 8: 'Reportable death defined' of the *Coroners Act* and, in accordance with s. 8 of the VAD Act, voluntary assisted dying is not suicide.

Section 10: 'Eligibility' of the VAD Act outlines strict eligibility criteria for accessing voluntary assisted dying. A person must meet all the eligibility criteria to access voluntary assisted dying.

Pursuant to s. 50: 'Administration decision' of the VAD Act the person may, in consultation with and on the advice of the coordinating practitioner for the person:

(i) decide to self-administer a voluntary assisted dying substance (a **'self-administration decision'**); or

(ii) decide that a voluntary assisted dying substance is to be administered to the person by the administering practitioner for the person (a **'practitioner administration decision'**).

Protection from liability and privacy considerations

Part 10: 'Protection from liability' of the VAD Act provides protections for persons assisting access to voluntary assisted dying or who are present when a substance is administered; persons acting under the VAD Act; and health practitioners and ambulance officers, for certain offences under Chapter 28: 'Homicide—suicide—concealment of birth' of the Criminal Code.

The VAD Act also protects the privacy of people accessing voluntary assisted dying. Section 146: 'Personal information not to be recorded or disclosed' of the VAD Act creates an offence for making a record or disclosing personal information in the course of, or because of, the exercise of a function or power under the Act. It does not apply however for a purpose under the Act, with the consent of the person to whom the personal information relates, in compliance with a lawful process, or authorised or required by law.

Voluntary assisted dying information portal and handbook

Queensland Health are the responsible agency in relation to voluntary assisted dying and have developed a dedicated information portal and produced the Queensland Voluntary Assisted Dying Handbook which is available on the Queensland Health website.

The Queensland Voluntary Assisted Dying Support Service (QVAD-Support) provides advice and support about voluntary assisted dying. QVAD-Support is free for all Queenslanders and is run by care coordinators who are medical, nursing and allied healthcare workers.

QVAD-Support can be contacted Monday to Friday, 8.30am-4pm, (excluding public holidays) via Email: QVADSupport@health.qld.gov.au or Phone: 1800 431 371. For urgent QPS inquiries, officers are to contact QVAD-Support via Phone: 1800 431 371 and select the "Urgent Clinical Contact" option. A secondary contact option is available to members and is listed in the SMCD "Queensland Health – Voluntary Assisted Dying Support" and is not to be provided to the general public.

ORDER

Members of the Service are not to provide advice to members of the public in relation to voluntary assisted dying. All inquiries should be directed to QVAD-Support.

Referrals from the Voluntary Assisted Dying Review Board

The VAD Act established the Voluntary Assisted Dying Review Board (VADRB) to provide independent oversight and monitor compliance with the Act. The VADRB is responsible for reviewing completed voluntary assisted dying requests to ensure legal requirements have been met by all those involved.

If required, the VADRB will refer to an entity, including the Commissioner of Police, issues identified by the board in relation to voluntary assisted dying that are relevant to the functions of the entity (see s. 2.3: 'Functions of service' of the PSAA).

Role of Assistant Commissioner, Crime and Intelligence Command

Allegations of indictable offences committed against the VAD Act (and other indictable offences) may be referred to the Commissioner by the VADRB.

Part 9: 'Offences' of the VAD Act creates the following indictable offences:

(i) s. 140: 'Unauthorised administration of voluntary assisted dying substance';

(ii) s. 141: 'Inducing a person to request, or revoke request for, voluntary assisted dying';

(iii) s. 142: 'Inducing self-administration of voluntary assisted dying substance';

(iv) s. 143: 'Giving board false or misleading information';

(v) s. 144: 'Making false or misleading statement'; and

(vi) s. 145: 'Falsifying documents'.

The Assistant Commissioner, Crime and Intelligence Command (CIC) is authorised to receive referrals and to provide information to the VADRB on behalf of the Commissioner (see Delegation D 15.46, D 154.1 and s. 117: 'Functions' and Part 8, Division 5: 'Miscellaneous' of the VAD Act).

Indictable offences

Where a referral is in relation to an indictable offence under the VAD Act, an offence under Chapter 28 Homicide—suicide—concealment of birth of the Criminal Code, or other indictable offences, the Assistant Commissioner CIC is to:

(i) cause the matter to be recorded in QPRIME (see s. 1.11: 'QPRIME occurrences' of this Manual);

(ii) assign the matter to the relevant group within CIC for investigation; or

(iii) refer the matter to an assistant commissioner in charge of a region where the death occurred for investigation by a district CIB.

The regional assistant commissioner is to report the outcome to the Assistant Commissioner CIC at the conclusion of the investigation.

The Assistant Commissioner CIC is to report the outcome of the investigation by CIC or the relevant region to the VADRB to the Director of the Office of the Voluntary Assisted Dying Review Board via email VADReviewBoard@health.qld.gov.au.

ORDER

Where a voluntary assisted dying death, which was not initially a reportable death pursuant to section s. 8: 'Reportable death defined' of the *Coroners Act*, results in the commencement of a criminal proceeding under the VAD Act or the Criminal Code, that death becomes reportable as per s. 8.4: 'Death investigations' of this Manual.

Non-indictable offences

Where a matter referred to the Assistant Commissioner, CIC by the VADRB is not in relation to an indictable offence, the Assistant Commissioner CIC is to action the matter, or refer the matter to the relevant assistant commissioner or executive director for actioning.

The relevant assistant commissioner or executive director is to report the outcome of action taken (if any) in relation to the referral to the Assistant Commissioner CIC.

The Assistant Commissioner CIC is to report the outcome of the referral to the VADRB to the Director of the Office of the Voluntary Assisted Dying Review Board via email VADReviewBoard@health.qld.gov.au.

First response procedures

In either a self-administration or a practitioner administered decision, the place where the voluntary assisted dying substance may be administered includes the following places:

(i) a public or private hospital;

(ii) a hospice;

(iii) a residential aged care facility; or

(iv) their home or a home environment.

In the event police are called to a voluntary assisted dying related matter at any place, officers should:

(i) conduct discreet inquiries with persons present to ascertain the circumstances surrounding the request for police attendance;

(ii) if necessary, contact QVAD-Support for advice in relation to the matter;

(iii) if a voluntary assisted dying substance has been administered and the person is deceased, officers should enquire as to whether a cause of death certificate is or will be issued by the medical practitioner and that the cause of death was the disease, illness or medical condition from which the deceased suffered in accordance with s. 81: 'Cause of death certificate' of the VAD Act;

(iv) Where officers suspect that an indictable offence under the VAD Act, an offence under Chapter 28: 'Homicide—suicide—concealment of birth' of the Criminal Code, or any other indictable offence has been committed, then officers should refer to s. 2.4: 'Incident management' and s. 8.4: 'Death investigations' of this Manual; and

(v) cause the matter to be recorded in QPRIME (see s. 1.11: 'QPRIME occurrences' of this Manual).

8.6 Miscellaneous coronial matters

8.6.1 Exhumation

To enable an autopsy of a body to be conducted, s. 20: 'Exhuming body or recovering cremated remains' of the *Coroners Act* allows the State Coroner to order a body to be exhumed or the cremated remains to be recovered.

POLICY

As the exhumation of a body is an event which has the potential for causing a great deal of trauma for the relatives and friends of the deceased, the Service will not seek the exhumation of a body or recovering of cremated remains except under the most pressing circumstances.

An application for exhuming a body or recovering cremated remains must be based on a thorough investigation of the circumstances and the information obtained must be capable of being presented in a criminal court proceeding or Coroners Court. Mere suspicion may result in the application being rejected.

An officer who is of the opinion that an exhumation order should be sought is to submit a full and detailed report to the officer in charge of the region or command indicating:

(i) full details of the circumstances of the death and the investigations of the death prior to burial, supported by all available relevant documentary evidence such as certificates and statements;

(ii) a detailed location and description of the grave site supported by documents from the undertaker and the local authority controlling the cemetery and the section's records, or if the body was cremated and the cremated remains may be recovered, the location of the cremated remains;

(iii) full and comprehensive details of the suspicion;

(iv) full and comprehensive details of the investigation into the circumstances of the death and suspicions, supported by all relevant documentary evidence such as statements;

(v) why there is the necessity for an exhumation;

(vi) what further achievements in the investigation would occur should the exhumation order be approved, e.g. charging of a defendant with a serious criminal charge and the establishment of the correct cause of death; and

(vii) whether the deceased's next of kin has been consulted and if so, their attitude to the possible exhumation.

As indicated it is necessary to have a full brief of evidence completed to the stage where all that is required is the details of the exhumation and the results of subsequent examinations.

An officer in charge of a region or command who receives a report seeking approval for an exhumation should make a recommendation before forwarding the report through usual channels to the Commissioner.

Where, an order has been issued by the State Coroner, the authorised investigating officer may enter a place stated in the order and stay there for as long as reasonably necessary to exhume the body or recover the cremated remains. This officer must arrange for the body or cremated remains to be taken, in accordance with the directions of the order, to a place stated in the order.

When an order under s. 20 of the *Coroners Act* is issued, the officer in charge of the region or command is to detail a commissioned officer to attend the exhumation. The Coroner may also attend the exhumation.

The commissioned officer who is to attend the exhumation is to ensure that the investigating officer responsible for the exhumation:

(i) consults the undertaker and sexton as to the practical method of performing the exhumation;

(ii) records every stage of the exhumation process, preferably on video, otherwise by means of extensive notes;

(iii) obtains soil samples at regular intervals from the exhumation site;

(iv) obtains the control soil samples from adjacent areas;

(v) arranges for the exhumation site to be closed from the public, with partitions if possible;

(vi) carries out any other duty as requested by the State Coroner; and

(vii) in circumstances where:

(a) no QPRIME entry exists, add the deceased as a Sudden Death Occurrence in QPRIME; or

(b) if a QPRIME entry exists, update the relevant Sudden Death Occurrence.

The commissioned officer attending is to furnish a report to the officer in charge of the region or command for forwarding to the Commissioner outlining details of the exhumation or the recovered cremated remains.

Reburial

ORDER

The investigating officer is to arrange for the body or cremated remains to be taken, in accordance with directions of the order (Form 11: 'Order for return of exhumed body or cremated remains'), to a place stated in the order. The State Coroner must, as soon as reasonably practical, order the body or cremated remains to be returned to the place from where they were taken. The investigating officer is to contact the next of kin, if possible, and advise of any reburial.

8.6.2 Burials Assistance Act 1965

PROCEDURE

Section 3: 'Burial or cremation of the dead' of the *Burials Assistance Act* places an obligation on the Director-General, Department of Justice and Attorney-General, to arrange for the burial or cremation of a deceased person where no other person has made arrangements for the disposal of the body. Police are obliged to assist the Director-General in this function. The powers provided under the *Burials Assistance Act* are normally used to dispose of the bodies of persons of insufficient means.

Responsibilities of investigating officer

ORDER

When an officer investigates the death of a person and it becomes apparent that no suitable arrangements have been, or are being made, to dispose of the body, that officer is to:

(i) make all inquiries necessary to locate any relatives or friends of the deceased and ascertain if any of these persons are prepared to arrange for burial or cremation; and

(ii) where no friend or relative is able or prepared to arrange for burial or cremation of the body, notify the Director-General, Department of Justice and Attorney-General or the Registrar of the local Magistrates Court outside of Brisbane, as appropriate.

PROCEDURE

When officers are required to notify the Director-General, Department of Justice and Attorney-General or, in areas outside Brisbane, the Registrar of the local Magistrates Court that assistance under the *Burials Assistance Act* is required, they are to complete and submit a QP 0934: 'Report to DJAG – Application for Funeral Assistance' through their officer in charge, and upload it to the relevant QPRIME Sudden Death Occurrence.

Where assistance is sought under the *Burials Assistance Act* it is the responsibility of the Department of Justice and Attorney-General to make the arrangements for the burial or cremation.

Where an officer is able to locate a relative or friend who is willing to take responsibility for the deceased's funeral but is unable to meet the cost of such funeral, the officer should advise the relative or friend to contact the Department of Justice and Attorney-General, or Magistrates Courts Office outside of Brisbane, to request assistance under the *Burials Assistance Act*.

Officers should advise any relative or friend who is seeking assistance under the *Burials Assistance Act* that such a burial must be conducted by the contracted government undertaker for the area.

Interim report

ORDER

When officers are making inquiries with a view to arranging the disposal of a body, and the body has been held at a mortuary for more than twenty-one days, they are to submit a report to their officer in charge outlining the inquiries made to that point and the results of those inquiries.

Responsibilities of officers in charge

ORDER

The officer in charge of a station or establishment who receives QP 0934: 'Report to DJAG – Application for Funeral Assistance' requesting assistance to dispose of a body is to forward the original of that form, as a matter of urgency, to the Director-General, Department of Justice and Attorney-General or the Registrar of the local Magistrates Court outside of Brisbane.

8.6.3 Counselling Service at John Tonge Centre

POLICY

A counsellor appointed by Queensland Health is based at the John Tonge Centre, Brisbane.

The counsellor is available during office hours to assist with support for persons attending the John Tonge Centre to identify deceased relatives or other deceased persons. Officers may also consult with the counsellor about the needs of bereaved persons with whom they may have contact.

The counsellor can provide information to bereaved persons regarding autopsy results, the coronial process generally and resources that exist for counselling and assistance in the local community.

PROCEDURE

Officers throughout the State may contact the counsellor at the John Tonge Centre, Brisbane for advice with respect to matters mentioned in the above policy.

Officers who require the assistance of the counsellor may obtain such assistance by contacting the police office or reception at the John Tonge Centre, Brisbane. If the police office is unattended, officers may contact the counsellor through the Duty Officer, Police Communications Centre, Brisbane.

8.6.4 Removal of body parts

POLICY

Impressions of fingers, palms, feet or teeth of deceased persons may be taken for any of the following reasons:

(i) to establish or confirm the identity of the deceased where:

(a) there are no other means of identification available; or

(b) the body is unrecognisable due to decomposition or mutilation;

(ii) to prevent impersonation of the deceased person by another person;

(iii) to attempt to eliminate the possibility of anyone trying to escape from their true identity;

(iv) by order of a Coroner who may not be satisfied with other forms of identification;

(v) to establish the identity of a person whose fingerprints, palm prints, footprints or teeth (teeth marks) have been located at crime scenes; or

(vi) to assist in police investigations.

In some instances, body parts such as the fingers, hands or teeth of a deceased person may need to be removed from the body to obtain fingerprint, palm print and/or tooth impressions. These instances include where:

(i) the body, including the fingers, hands or teeth, have been badly charred by fire;

(ii) the fingers, hands or teeth are affected by emersion in fluid; or

(iii) the fingers, hands or teeth are mummified.

The need to remove body parts from a deceased person for the purpose of obtaining impressions of the fingers, palms, feet and/or teeth should be determined by a fingerprint technician, scientific officer or scenes of crime officer following a request from the officer in charge of the investigation.

The Coroner is to be notified of the need to remove body parts from the body of a deceased person. Before any body parts are removed from the body of a deceased person, the Coroner's authorisation is to be obtained either in a general consent included in the order for the autopsy, or by separate written authority.

The body of a deceased person that has had any body part removed for examination purposes should not be released from the mortuary in which it is lodged, until the examination is complete and the removed body part has been returned to the body.

Where the examination of a body part will cause a significant delay in the release of the deceased from the mortuary, the officer in charge of the investigation should liaise with the deceased's next of kin or representative to advise them of the delay and reason for the delay.

ORDER

The officer in charge of the investigation is to request the services of a fingerprint technician, scientific officer or scenes of crime officer when the need arises to take impressions of fingers, palms, feet or teeth, for any of the reasons mentioned in the above policy.

A fingerprint technician, scientific officer or scenes of crime officer who requires the removal of a body part(s) from the body of a deceased person, for the purpose of identification or obtaining impressions of a finger(s), a palm(s), foot, feet or teeth, is to:

(i) advise the Coroner of the:

(a) details of the deceased;

(b) body part(s) proposed to be removed from the deceased; and

(c) reasons for removal of the body part(s);

(ii) request the Coroner to:

(a) direct a pathologist or other qualified persons to remove the required body part(s); and

(b) delay the authority to release the body of the deceased until such time as the examination of the body part(s) has been completed and the body part(s) has been returned to the body;

(iii) attend at the mortuary where the deceased is located and request the pathologist or other qualified persons to remove the required body part(s) from the deceased as directed by the Coroner;

(iv) take possession of the body part(s);

(v) in cases where fingers are removed, place the fingers in individual, clearly marked containers indicating the designation of the finger contained therein (i.e. right thumb, left index); and

(vi) complete a Morgue Tag (QP 70) and attach it to the body part(s) or the receptacle in which the body part(s) is placed.

A fingerprint technician or scenes of crime officer who takes possession of a body part(s) is to:

(i) commence examination of the body part(s) as soon as practicable ensuring that the body part(s) is retained for the

shortest time possible; and

(ii) advise the investigating officer if the examination of the body part(s) will cause a significant delay in the release of the deceased from the mortuary.

An investigating officer who receives advice from a fingerprint technician, scientific officer or scenes of crime officer that the examination of a body part(s) will cause a significant delay in the release of the deceased from the mortuary, is to advise the deceased's next of kin or representative of the delay and the reason for the delay.

A fingerprint technician, scientific officer or scenes of crime officer who has completed all necessary examinations of a body part(s) is to:

(i) return to the mortuary where the deceased is held and in the presence of a pathologist or other qualified person, place the body part(s) with the deceased;

(ii) advise the Coroner of the return of the body part(s) to the deceased; and

(iii) where the examination of the body part(s) has caused a significant delay in the release of the deceased from the mortuary, advise the investigating officer of the return of the body part(s).

An investigating officer who receives advice from a fingerprint technician or scenes of crime officer that a body part(s) has been returned to the deceased is to, where the next of kin or representative is awaiting the release of the deceased from the mortuary, notify the next of kin or representative of the availability of the body for release from the mortuary.

8.6.5 Interstate coronial inquiries involving victims of crimes

ORDER

In instances when a death occurs in Queensland of a crime victim who became such a victim within the jurisdiction of another State or Territory, the officer investigating the death is to notify the relevant officer in charge of the police attached to the Coroner's office in the State or Territory where the deceased became a victim.

In instances when a death occurs in another State or Territory of a crime victim who became such a victim in Queensland, the officer in charge of the investigation involving the victim, is to supply to the officers attached to the Coroner's office of the other State or Territory relevant particulars surrounding the infliction of injuries upon the victim when requested.

When the police officer in charge of the John Tonge Centre, receives a request from police attached to a Coroner's Office from another State or Territory in relation to the death of a victim of a crime in that State or Territory from injuries sustained in Queensland, the officer in charge of the John Tonge Centre, is to notify the officer in charge of the investigation involving the victim.

The police officer in charge of the John Tonge Centre, Brisbane, is to maintain a current list of contact details for police attached to Coroner's offices in other States and Territories.

PROCEDURE

The investigating officer is to seek the assistance of the police officer in charge of the John Tonge Centre, Brisbane, if required, to facilitate contact being made with relevant police officers attached to Coroner's Offices in other States or Territories.

8.6.6 Costs in obtaining expert medico/legal opinions and reports

POLICY

Investigations of a death may at times require opinions and/or reports to be provided by suitably qualified experts in various sciences (e.g. engineering, pharmacology, etc.). Costs associated with these types of investigations may be met by the Coroners Court of Queensland. However, the approval of the State Coroner is to be obtained prior to engaging any expert.

Officers who identify the need to, or who are directed or requested to, obtain the services of a suitably qualified expert in relation to the investigation of a death, in cases where costs will be incurred, are to furnish a report to their assistant commissioner for referral to the relevant Coroner. Also, upload the report to the relevant QPRIME Sudden Death Occurrence. The report is to identify the particular investigation, the need for the opinion and/or report of the suitably qualified expert, costs expected to be incurred, and a request for approval by the State Coroner of the required expense.