Guidance When the Coroner Calls

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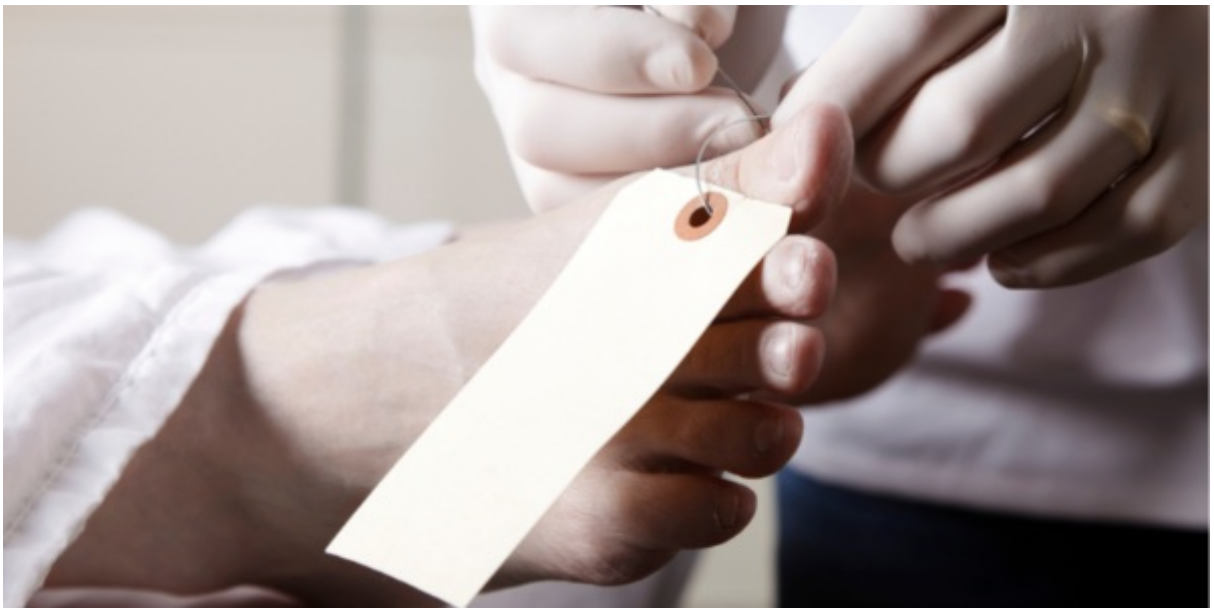

It can be rather unnerving for the uninitiated to receive that call from the Coroner. MIPS often fields enquiries from members who have been contacted by the Coroner's office in relation to an investigation involving the death of a patient.

As each state in Australia has its own Coroner, we have assembled four scenarios that aim to provide some general guidelines on how to navigate through what some people may perceive as a daunting experience. It is very imperative that you check your local jurisdiction for specific local requirements.

Healthcare practitioners, mostly medical can potentially be involved in coroner's court matters. There are typically two reasons for this:

1. The requirement to make a reportable death
2. You have been asked to prepare a statement/report and appear as a witness

Of course, you may have to do both of these things connected with the death of the same patient.

Reportable deaths

The threshold for making a reportable death is very high. Each coroner's court has its own state/territory jurisdiction so what qualifies as a reportable death varies slightly in each state and territory. If you are unsure if a death is reportable, you can contact MIPS for advice.

In general terms, you are obliged to make reports if you are the doctor responsible for a person's medical care immediately before death, or who examines the body of the deceased person after death. You will need to make a report if:

- your patient has suffered a violent, unnatural or unexpected death such as homicide, suicide or death induced by drugs, alcohols or poison – regardless of whether it was deliberate or accidental.
- your patient has died by accident. For example, road or public transport fatalities, accidental falls, workplace deaths, electrocutions, drownings and animal attacks. This even applies where there is a prolonged interval between the accident and death.
- the identity of your patient is not known.
- cause of death of your patient is not known (ie you cannot form an opinion about the probable cause of death and therefore cannot sign a death certificate).
- your patient dies unexpectedly during or after a medical procedure, or other unexpected or accidental deaths in a healthcare

facility.

- a death notice was not signed for your patient and is not likely to be signed.

Preparing statements and appearing as a witness

First and foremost, you should notify MIPS of any involvement and seek our assistance.

MIPS membership includes assistance in preparing appropriate statements and guiding you through the coronial inquest process. This includes advice and representation from expert solicitors and MIPS clinical advisers.

In some cases, a Coronial inquest can impact on the likelihood of a common law action arising from the death. In extreme cases Coroners have referred concerns about a practitioners healthcare to AHPRA for further investigation.

Coroners investigate thousands of deaths each year, however, only a small number (about 5%) proceed to a formal inquest. In other words, findings can be made "on the papers".

If there is an inquest, doctors are sometimes called as either witnesses, for example if you were the treating practitioner who reported the death, or as an expert witnesses to comment on the nature of the death. The following video scenarios illustrate how this would unfold if you were called as a witness.

Scenario 1 - Doctor contacts MIPS after receiving a request from police (3:08)

Each Coroner's Court has good information online about the coronial process and your obligations as a healthcare practitioner. See your local Coroner court website in your jurisdiction for specific local requirements - Coroner's Court of:

NSW | QLD | SA | TAS | VIC | WA

Any queries, contact MIPS