Coroners and Other Acts Amendment Bill 2009

Explanatory Notes

Objectives of the Bill

The main objective of the Bill is to amend the *Coroners Act 2003* (the Act) to improve operational efficiency in the coronial regime. The Bill also makes:

- a coronial related amendment to the *Births Deaths and Marriages Registration Act 2003;* and
- consequential amendments to the *Cremations Act 2003*

Reasons for the Bill

When the Act came into force in 2003, it established a new coronial regime focussed on finding the truth of what occurred in order to prevent deaths from similar causes happening in the future. This represented a marked departure from the repealed *Coroners Act 1958* which gave the coronial process an undue focus on criminal liability. The Department of Justice and Attorney-General (DJAG) has conducted an operational review of the Act to identify any necessary amendments to enhance administrative efficiency and to clarify the scope and operation of the Act**.**

Achievement of the Objectives

The proposed amendments are primarily for the purpose of clarification, or procedural or technical in nature, and do not involve a shift in the fundamental policy underpinning the legislation. In particular, the Bill includes amendments to clarify the scope and operation of the categories of reportable deaths, including amendments to address one of the coronial issues raised in the *Report of the Queensland Public Hospitals Commission of Inquiry* (the Davies Report) which was tabled on 30 November 2005. This relates to the operation of the provision requiring the reporting of deaths that are the "*not reasonably expected to be the outcome of a health procedure"*. The Davies Report did not make a recommendation for

amendment of this specific provision but identified ambiguities in its language which could contribute to under-reporting of health care related deaths. The State Coroner has also raised issues regarding the language and interpretation of the provision. The Bill contains amendments to address this by requiring the reporting of "health care related deaths" (replacing the current category of "deaths that were not reasonably expected to be the outcome of a health procedure") and inserting a comprehensive definition of a "health care related death". Other amendments include:

- amendment of the definition of "death in care" in relation to children in care to ensure it applies to all "out of home" placements
- amendment of the "death in custody" definition to cover deaths in detention under all State and Commonwealth legislation (subject to specified exceptions)
- establishment of a new category of reportable death -"*the death happened in the course of, or as a result of, police operations*" which must be reported to the State Coroner or Deputy State Coroner
- implementation of a model "aid to coroner" provision agreed to by the Standing Committee of Attorneys-General to facilitate cross-jurisdictional assistance
- provision for review of decisions as to whether a death is reportable and clarification of the coroner's powers in the preliminary investigation to determine whether a death is a reportable death.
- amendments to clarify and improve investigation and pre-inquest conference processes and to facilitate reopening of investigations and inquests
- amendments to facilitate access to investigation documents by genuine researchers

Estimated Cost for Government Implementation

The implementation of the changes to the coronial regime is not expected to involve additional costs to Government

Consistency with Fundamental Legislative Principles

Coronial investigation – rights to bodies after death and to excised body parts and tissue

Clauses 13, 18, 20, 23 and 26 raise the issue of rights to bodies after death or to the excised body parts and tissue. The Bill does not alter these rights which are established under the existing framework of the Act.

The philosophy underpinning the Act, and coronial legislation in other Australian jurisdictions, is that certain deaths must be reported to, and investigated by, the coroner, and that as part of this process, the coroner must take control of the body.

The Act strikes a careful balance between the public interest in the effective conduct of the coronial investigation and the rights and interests of families.

The Bill does not alter the current balance of rights and interests but simply makes amendments for the purpose of clarification or procedural efficiency consistent with the philosophy underpinning the current regime.

Duty to help investigation

Clause 15 amends section 16 which currently provides that a coroner investigating a death may require a person to give the coroner information that is relevant to the investigation. The amendment ensures that the duty to provide help to the coronial investigation extends to giving a "document or anything else" relevant to the investigation. As with the existing section 16, the exception to the right to silence, and any impact on the right to privacy of personal information, is justified by the public interest in the effective conduct of the coronial investigation. The section is no wider than is necessary in that it provides that a person does not have to give the coroner information, a document or anything else if the person has a reasonable excuse. Under current section 16(6), a reasonable excuse includes that the information would tend to incriminate the person. Accordingly there is an appropriate protection against self-incrimination.

Standing in Inquests

Clause 33 amends section 36 to clarify standing in inquests for public interest interveners who have specialist expertise in matters on which the coroner may make comments under the Act (eg public health or safety). In one sense, the Bill extends the rights of such persons because it is currently unclear whether they qualify for standing under the "sufficient interest" test.

The Act does not define "sufficient interest". However, it is doubtful that public interest interveners would qualify under the traditional approach to standing in coronial inquests. This is illustrated by the comments of Beach

J in *Barci v Heffey* (Unreported Victorian Supreme Court of Victoria 1 February 1995) who stated standing was a question of fact to be determined after a consideration of the circumstances surrounding the death. His Honour identified the following persons as having sufficient interest:

- Persons closely related to the person whose death is being investigated.
- Any person whose actions may have caused or contributed to the death, where there is a reasonable prospect that the coroner may make a finding adverse to the interest of that person

The Bill limits the right of appearance of public interest interveners to making submissions on matters on which the coroner can make comments under section 46(1) and examination of witnesses only with the leave of the coroner. This can be justified on the basis that it is in the public interest that hearings are not unnecessarily protracted and the purpose of granting standing to public interest interveners is appropriately served by the right to make submissions on the areas in which they have special expertise. In the past, there have been cases where some coroners have given a liberal interpretation to the "sufficient interest" test in order to grant standing to persons with specialist knowledge or expertise. Accordingly, there may be persons whom the court has already determined to have standing in a particular matter who have not yet exercised their rights. Transitional provisions ensure that the restriction will not apply to a person whom the court may have already considered has a sufficient interest in a particular inquest but who has not yet exercised the person's right to appear.

Tissue Bank Amendments

Clause 44 makes amendments to enable the State Coroner to enter into arrangements with prescribed tissue banks to access information for donor assessment purposes. This amendment raises an issue of sufficient regard for a person's privacy.

The amendment does not extend the current scope of access to this information but simply allows it to be provided more expeditiously to ensure opportunities for tissue retrieval are not lost through delay. Currently, tissue banks must access this information under the general document access regime which means they must obtain the consent of the investigating coroner on a case by case basis. This can cause unnecessary delay as the timeframe in which to retrieve tissue for transplantation is very short (within 24 hours of death).

The amendments provide appropriate protection for confidentiality. Consistent with current practice, the provision expressly provides that access does not include giving the tissue bank a copy of the document. It is also an offence for a person to directly or indirectly disclose information in a document accessed under section 54AA. The purpose of providing for such an offence is to safeguard the right to privacy. The section provides that a person does not contravene the provision if disclosure is made in the performance of a function under the *Transplantation and Anatomy Act 1979* or is permitted or required under this or another Act. The reversal of the onus of proof in relation to the offence is justified in that a person who discloses the information for these purposes would have peculiar knowledge of these facts and would be best positioned to disprove guilt.

Consultation

The State Coroner and all government departments were consulted.

The Commission for Children, Young People and Child Guardian was consulted on the amendments to the "death in care" definition in relation to children in care.

The Commonwealth Attorney-General was consulted on the definition of "death in custody".

The Queensland Branch of Australian Medical Association; the Private Hospitals Association of Queensland; the Rural Doctors Association of Queensland; Royal Flying Doctor Service (Qld section); the Office of Health Practitioner Registration Boards; the Queensland Nursing Council; the Pharmacy Guild of Queensland; and the Australian College of Midwives (Queensland) have been consulted.

Notes on Provisions

Part 1 Preliminary

Clause 1 sets out the short title of the Act

Clause 2 provides that the Act commences on a date to be fixed by proclamation.

Part 2 Amendment of Coroners Act 2003

Clause 3 provides that this Part amends the *Coroners Act 2003.*

Clause 4 amends section 7 to provide that, in relation to a "death in care" under section 9(1)(a), the service provider at the place where the person ordinarily lived for the purposes of being in care will have an obligation to report the death, even if the death occurred elsewhere, and even if some other person has reported, or may report, the death. This will ensure that such deaths do not go unreported because the service provider of the relevant residential service is under the misapprehension that a hospital has reported, or will report, the death, and vice versa.

In addition, the section is amended to provide that if a death happened in the course of, or as a result of police operations the death must be reported to the State Coroner or the Deputy State Coroner. This relates to the insertion of the new section 8(3)(h) which establishes a new category or reportable death - that is, a death which "*happened in the course of, or as a result of police operations*".

Clause 5 replaces subsection 8(3)(d) which currently requires the reporting of a death which is *"not reasonably expected to be the outcome of a health procedure"* with a new section which requires reporting of a "*health care related death*". "*Health care related death*" is defined in section 10AA.

It also inserts section 8(3)(h) which provides for a new category of reportable death – "*the death happened in the course of, or as a result of police operations"*. A death in this category which would also be a death in custody will continue to be treated as a death in custody for the purposes of the Act. The new category will capture for example, the death of a third party bystander killed in the course of an attempt by police to detain a suspect. These deaths would, in almost all cases, be currently reportable under an existing category of reportable death (for example- violent or otherwise unnatural death). However, the designation as a separate category of death which must be reported to and investigated by the State Coroner or Deputy State Coroner will ensure such deaths are appropriately

subject to this level of scrutiny and assist with identifying any systemic issues relating to deaths in this category.

The section also makes amendments to clarify what is meant by an "unnatural death" for the purposes of s8(3)(b).

Clause 6 amends the definition of "death in care" in section 9.

There are minor amendments to section 9(1)(a) to update terminology relating to residential services.

There are also minor amendments to section 9(1)(b)(that is, the definition of "death in care" in relation to certain persons under the *Mental Health Act 2000)* to address anomalous references.

The amendments to section 9(1)(d) ensure the definition of death in care in relation to children in care captures a range of "out of home" placements that are within the intent of the section but, because of the current linkage of the definition to section 82 of the *Child Protection Act 1999*, would not previously have been caught by this section. The majority of such deaths would currently be reportable under some other category of reportable death. The purpose of the amendment is to ensure these deaths are properly categorized as "deaths in care". The amendments will also clarify that the death of a child in the custody or guardianship of the Chief Executive of the Department of Communities is a "death in care" for the purposes of the Act even if the child has left a placement and self-placed.

Clause 7 extends the definition of "death in custody" in section 10 to capture deaths in custody under all State and Commonwealth legislation (subject to specific exceptions). At present, "death in custody" is defined in terms of detention by a police officer or under the *Corrective Services Act 2006* or *Juvenile Justices Act 1992.*

Clause 8 inserts the new section 10AA which defines a "*health care related death*" referred to in section 8(3)(d). The Davies Report identified specific aspects of the current section 8(3)(d) which make it difficult to apply in practice and which could contribute to the under-reporting of medical deaths. In particular, the Davies Report commented on the difficulty in identifying "whose expectation" is relevant in determining whether a death would be reasonably expected and to what standard the outcome must have been unreasonable.

The new definition provides that a death will be a health care related death if a person dies at any time after receiving health care that either caused or was likely to have caused, or contributed or was likely to have contributed

to the death and immediately before receiving the health care an independent person would not have reasonably expected that the health care would cause or contribute to the person's death. An independent person is an independent person appropriately qualified in the relevant area of health care who has had regard to all relevant matters. These include the deceased person's state of health as it was thought to be when the health care was started or sought and the clinically accepted range of risk associated with the health care. The section also expressly captures not only the provision of health care, but failure to provide health care where the failure either caused or is likely to have caused, or contributed to, or is likely to have contributed to the death. "Health care" is broadly defined to mean "*any health procedure or any care, treatment, advice, service or goods provided for, or purportedly for, the benefit of human health*".

Clause 9 amends section 10A to take account of the changes to section 7 by replacing a reference.

Clause 10 amends section 11 to ensure that deaths which happen in the course of, or as a result of police operations, like deaths in custody, are investigated by the State Coroner or Deputy State Coroner or an appointed coroner or local coroner approved by the Governor in Council to investigate a particular death.

Clause 11 inserts a new section 11A which provides that a person dissatisfied with a coroner's decision about whether a death is a reportable death may apply for an order as to whether it is a reportable death. If the coroner is not the State Coroner the application must be made to the State Coroner. If the coroner is the State Coroner the application must be made to the District Court.

Clause 12 amends section 12 to update references to legislation and streamline the drafting of the section.

Clause 13 amends section 13 to clarify that a coroner investigating a death has the power to authorize a doctor or nurse to take a sample of the deceased person's blood for testing for the purposes of the coronial investigation. An example of where this might occur would be where blood samples may need to be taken urgently to assist in the diagnosis of death from anaphylactic shock.

Clause 14 amends section 14 to broaden the power of the State Coroner to issue guidelines to ensure best practice in the coronial system.

Clause 15 amends section 16 which empowers the coroner to compel the giving of information relevant to the coronial investigation unless a person has a reasonable excuse. The amendment will ensure that the policy intent of the section is fully achieved by ensuring that the requirement to give help to a coronial investigation extends to requiring a person to give the coroner a document or anything else relevant to the investigation – for example, a person may be required to give a statement or produce a document, such as a report. The person must comply with the requirement unless the person has a reasonable excuse. The section preserves the privilege against self incrimination by providing that it is a reasonable excuse for the person to fail to comply with the requirement if complying would tend to incriminate the person.

Clause 16 amends section 17 which provides for disclosure of information to the Coroners Court if the relevant legislation allows for the release of confidential information to a court or a party to a proceeding in a court. The amendments will enable the disclosure of this information to a coroner during the coronial investigation preceding the constitution of the Coroners Court. The same rights and protections apply to the disclosure of the information in this phase of the investigation as apply once the court is constituted – that is, the amendments preserve a right to non-disclosure if the legislation allows a person to refuse or requires consent before information is released. A coroner may also only disclose the information obtained under the section for a purpose connected with the investigation.

Clause 17 inserts a new section 17A to provide protection against civil or criminal liability or under an administrative process for a person providing information, documents or anything else to the coroner under section 16 or confidential information under section 17.

Clause 18 inserts a new section 18A to provide for the arrangements for, and guidelines about, assessing the suitability of a body for the removal of tissue for the *Transplantation and Anatomy Act 1979*. If a prescribed tissue bank is a party to an arrangement under section 54AA to access section 7(4) reports, the tissue bank (or a person acting on its behalf) may conduct an external examination of the body for the purpose of assessing whether the body is suitable for the removal of tissue under the *Transplantation and Anatomy Act 1979*. This "donor screening" process cannot occur if the State Coroner, the coroner investigating the death or a person acting for the tissue bank, is aware that the deceased had objected during his or her lifetime to the removal of tissue from his or her body. The person who conducts the examination must comply with any directions of the coroner

and any guidelines issued by the State Coroner about the conduct of the process. If the examination indicates a suitable donor, the tissue bank must obtain the consent of the coroner and the next of kin before any retrieval of tissue can proceed (as is required under the *Transplantation and Anatomy Act 1979*).

Clause 19 replaces section 21 which sets out the entitlement of certain persons to observe and participate in autopsies. The amendments clarify there are three distinct regimes for attendance. The coroner and investigating police officer may attend as of right. If the coroner considers it appropriate, a person may attend for vocational or clinical education or training. This takes account of the contemporary structure of medical training under which observation at autopsies is no longer a compulsory component. An attending doctor would be an example of a person who may be allowed to attend for clinical education and training purposes. The coroner may also allow a person with sufficient interest to attend.

However, even if a person demonstrates sufficient interest, the coroner has a discretion to permit their attendance at the autopsy. In exercising this discretion, the coroner must take into account whether the person's attendance would compromise the integrity of the investigation and, if practicable, consult with a family member of the deceased and the doctor conducting the autopsy.

Clause 20 makes minor technical amendments to section 22 which provides that a coroner may require specified persons to provide certain medical evidence to the coroner or the doctor who is to conduct the autopsy. The section does not currently take account of the fact that these may be required after the doctor has conducted the autopsy. The purpose of the amendments is to rectify this anomaly.

There are also amendments to section 22(3) to ensure that a person may send a written report or medical records to the doctor by fax or other electronic means unless the notice requires the original copy of the report or records to be given.

Clause 21 amends section 23 which provides for autopsy testing to take account of the new section 23A (ie testing for an infectious or notifiable condition). The amendments enable a coroner to make an order for any of the tests provided for in section 23A on the coroner's own initiative or on an application under section 23A

Clause 22 inserts a new section 23A to enable a person to apply to the coroner for an order that the doctor who has been ordered to conduct an

autopsy also test for an infectious condition or notifiable conditions under the *Public Health Act 2005*. An example of where such an application may be made would be where a police officer or a "good Samaritan" comes in contact with blood at a death scene and is concerned at the implications for their own health. The coroner may grant an application only if the coroner is satisfied the applicant has a sufficient interest in the test results.

Clause 23 amends section 24 which sets up a tissue retention and review regime when tissue is removed for testing. While "tissue" is defined to include part of a body or foetus, the current sections 24(2) and 24(5) use inconsistent terminology and are expressed to apply only to a whole organ or foetus. Hands (for fingerprinting) and jaws (for forensic odontology) are the body parts most commonly removed and the amendments ensure these are covered by the retention and review regime. In addition, section 24(4) currently provides that if the organ or foetus has been removed, the coroner must not order the release of the body unless satisfied that, if practicable, a family member has been informed of the removal, and the retention of the tissue is necessary for the investigation of the death. There is currently no express provision to "close off" this process by providing the pathologist must return the items to the body if the matters under section 24(4)(a) and (b) are not satisfied. There are minor amendments to address this.

There are also minor amendments to section 24(8)(a) which provides for release of tissue to a family member if the coroner has ordered disposal of the tissue. The amendments clarify that the tissue may be released to the family for testing, some other lawful purpose or burial.

Clause 24 makes amendments to section 24A to reflect in the legislation what is currently the common practice, by requiring the doctor who conducts an autopsy to provide both the autopsy notice and autopsy certificate to the coroner who ordered the autopsy. This will apply in addition to the current requirement to provide these to the Registrar-General under the *Births Deaths and Marriages Registration Act 2003*.

Clause 25 amends section 25 to improve autopsy information exchange processes and ensure it is subject to appropriate safeguards. The amendments will ensure that if the chief executive or health chief executive requests a copy of an autopsy or test report, the State Coroner will be able to advise the relevant chief executive in writing that the report is not to be given, and the reasons why.

Clause 26 amends section 26 which provides for when the coroner starts and stops having control of the deceased person's body. The section is currently structured in terms of the investigating coroner having control of the body. On some occasions, the investigating coroner may be absent or otherwise unavailable to order the release of the body for burial when it first becomes practicable to do so and this creates unnecessary delay and distress to the family. The amendments will allow another coroner to order the release of the body in such situations where this is appropriate,

Clause 27 amends section 27 to take account of the establishment of a new category of reportable death in section 8(3)(h), that is, "*the death happened in the course of or as a result of police operations*". The amendments provide that these deaths, other than a death which is also a death in custody (and therefore subject to a mandatory inquest), must have an inquest unless the coroner considers the circumstances do not require it.

All deaths in custody will be subject to the mandatory inquest requirement even if the death is also reportable under another category, unless the death is a death in detention under the *Public Health Act 2005*.

A death in detention under the *Public Health Act (*eg under the public health emergency powers; a controlled notifiable condition order; or a care and treatment order for a child) must be reported to the State Coroner or Deputy State Coroner but an inquest is not mandatory. However, if a death in detention under the *Public Health Act* is also a "death in care", an inquest must be held if the circumstances raise issues about the deceased person's care.

Clause 28 amends section 28 to achieve consistency in the language of sections 28 and 30.

Clause 29 amends section 30 to remove the requirement for a person to apply in an approved form to the coroner to hold an inquest. In addition, the amendments will allow a coroner to defer making a decision about whether an inquest is to be held (i.e. until after the six month time limit has passed) if it is necessary to enable the coroner to obtain relevant information to make the decision.

Clause 30 amends section 32 to provide that the information to be included in the inquest notice must include the issues to be investigated at the inquest. The inquest notice must be published at least 28 days before the inquest. This is consistent with the amendment proposed by the Ombudsman in the *Coronial Recommendations Project Report* which was tabled on 19 December 2006. It also provides that if the Coroners Court has

published a notice about a pre-inquest conference, the requirement to publish an inquest notice does not apply. The Coroners Court will also be required to publish a statement of the issues to be investigated at the inquest and the date, time and place of the inquest on an appropriate website.

Clause 31 amends section 34 to give the Coroners Court a discretion to publish a notice of a pre-inquest conference, and mandate the requirements of such a notice if it is published. As proposed by the Ombudsman in the *Coronial Recommendations Project Report* a pre-inquest conference notice must include a statement of the proposed issues to be investigated at the inquest and be published at least 28 days before the conference is to be held.

Clause 32 amends section 35 to give the Coroners Court the power to give directions and make orders the court considers appropriate for the conduct of pre-inquest conferences.

Clause 33 amends section 36 to ensure that the Coroners Court can grant standing to persons where it is in the public interest and consistent with the purposes of the Act to allow the person to make submissions on matters on which a coroner may comment under section 46(1). This may apply, for example, to specialist advocacy groups or public interest interveners that may have special expertise in the systemic issues relating to the death. The section also provides that if persons are granted standing on this basis the person may make submissions on the matters on which a coroner may comment under section 46(1) but may not examine witnesses except with the leave of the court.

Clause 34 amends section 41 by extending the coroner's power to make a non-publication order to either before, during or immediately after a pre-inquest conference.

Clause 35 amends section 43 to extend the coroner's power to make an exclusion order to a pre-inquest conference.

Clause 36 amends section 45 to remedy an inaccurate cross-reference.

Clause 37 amends section 46 to ensure that if a coroner makes comments which relate to matters dealt with by a government entity, the coroner must provide a copy of the comments to the Attorney-General as well as the Minister administering the entity and the chief executive officer of the entity.

Clause 38 amends section 47 to require the coroner to provide copies of comments and findings in relation to deaths in the course of, or as a result of police operations to the persons specified in the section.

Clause 39 amends the heading to section 50 to take account of the fact that section 50 relates only to the reopening of inquest on application.

Clause 40 inserts new sections 50A and 50B. Section 50A allows the coroner who held an inquest, or the State Coroner, to reopen an inquest, or hold a new inquest, on his or her own initiative. The coroner must be satisfied new evidence casts doubt on the finding or it is otherwise in the public interest. Section 50B allows the State Coroner to act on his or her own initiative to reopen an investigation (other than an inquest) or to direct a coroner who has conducted an investigation or another coroner to reopen an investigation. The State Coroner may take this action if he or she considers that the circumstances of the death warrant further investigation, the coroner's findings could not reasonably be supported by the evidence or new evidence casts doubt on the findings. The coroner who conducted an investigation may also reopen an investigation on his or her own initiative if he or she considers that the circumstances of the death warrant further investigation or new evidence casts doubt on the findings.

Clause 41 amends section 52 to take account of section 23A which allows an application to be made to the coroner for testing of a deceased person for infectious or notifiable conditions. For example, where a police officer, health professional or a "good samaritan" comes into contact with blood at a death scene the person may have concerns at the implications for their own health and may make such an application. It is in the public interest to enable such applications to be made and for the applicants to be informed of the results. The amendment ensures that information about the test results can be provided to the applicant.

It also clarifies an ambiguity in the wording of the current section 52(1)(c) to ensure it achieves the policy intent of the section and is not interpreted to apply only when a coroner has made findings. It ensures that access can be given to investigation documents containing information about a living or dead person's personal affairs if the information is relevant to a matter about which a coroner can make findings, whether or not the coroner has made the findings.

Clause 42 amends section 53 to improve access to investigation documents for research purposes. The amendments will allow access while an investigation is on foot if the State Coroner considers it appropriate having

regard to the importance of the research and the public interest in allowing access before the investigation is finished. This is because the current section 53 can operate against the public interest in certain circumstances – for example, it can mean time lags in the correlation of important statistical data. The amendments also allow the State Coroner to approve access by a genuine researcher to specified types of documents on an ongoing basis, until approval is revoked.

Clause 43 amends section 54 to make consequential amendments to take account of amendments to other provisions. The amendment to section 54(2)(b) takes account of the fact that, under section 86, a coroner may delegate to the registrar the function of consenting to access to documents if an investigation to which the document relates is completed. The removal of the example in section 54(3) takes account of the specific provision for access to information by prescribed tissue banks in section 54AA.

Clause 44 inserts the new section 54AA which allows the State Coroner to enter into arrangements with prescribed tissue banks for access to the reports under new section 7(4) (ie reports of deaths by police to the coroner). The section provides safeguards for privacy by making it an offence for a person to disclose the information other than in performance of a function under the *Transplantation and Anatomy Act 1979* or unless the disclosure is permitted or required by legislation. The amendment also reflects the current practice by providing that access does not include giving the tissue bank a copy of the document.

Clause 45 amends section 54A to take account of the amendments to section 7 by replacing references.

Clause 46 omits the definition of "document" in section 56(5). This definition is unnecessary because it is defined in Schedule 2.

Clause 47 amends section 60 to clarify the linkage between sections 60 and 61 which operate together to provide a regime for dealing with physical evidence. If the coroner does not order the return of the physical evidence because it is not lawful for the owner to posses the evidence or because, under the State Coroner's guidelines, it is not desirable it be returned because of its nature, condition and value, the evidence is forfeited to the State and may be dealt with in accordance with the State Coroner's Guidelines.

Clause 48 replaces the heading to Part 3 Division 6 to take account of the insertion of the new section 63A.

Clause 49 inserts new section 63A to address the situation where a person ceases to be a coroner (other than because of death or removal from office) and the person was conducting an investigation before the person stopped being a coroner. If the person has not made all the findings in that investigation, the person will continue to be a coroner (if the person agrees) for the investigation, so far as it is necessary to make findings for matters the State Coroner, in consultation with the Chief Magistrate, decides are matters for which the coroner should make findings.

Clause 50 amends section 71 which sets out the functions and powers of the State Coroner. The amendments expressly recognise the function of the State Coroner to promote public awareness of the coronial system and give the State Coroner a specific power to enter into arrangements with government entities to facilitate their interface with the coronial process.

Clause 51 inserts a new section 71A to allow the State Coroner to exercise his or her powers to assist a coronial investigation in another jurisdiction.

Clause 52 amends section 74(6)(b) which provides for the Deputy State Coroner to act as the State Coroner. The amendments create consistency between the language of sections 74(1)(b) and 74(6)(b) and ensure that the Deputy State Coroner can act as the State Coroner if the State Coroner is not available to perform the State Coroner's functions because of absence or another reason.

Clause 53 amends section 77 to require the tabling of the State Coroner's Annual Report and to require the inclusion in the report of the names of persons given access to investigation documents as genuine researchers.

Clause 54 inserts a new section 79A to enable the Deputy State Coroner to resign as Deputy State Coroner but retain his or her appointment as a magistrate. This achieves consistency with section 72 which provides that if the State Coroner resigns as State Coroner the State Coroner does not stop being a magistrate.

Clause 55 amends section 86 to provide for the delegation of appropriate duties or powers to the registrar.

Clause 56 amends section 88 to provide the same protection for a person assisting the coroner under section 36(1)(a) as applies to a lawyer appearing for a party in a Supreme Court proceeding.

Clause 57 amends section 96 which sets out which provisions of the Act apply to a still born child. Where an autopsy identifies that the body is that of a still born child, the autopsy is not continued and the possible cause of

death is not pursued. If the death is considered suspicious, police will investigate the death under the Criminal Code. In the few cases where an autopsy enters the coronial system and the autopsy determines it is a stillbirth, the current practice is for an autopsy report to be prepared for the coroner. This is not currently covered by section 96 and these amendments will ensure there is authority to provide these autopsy reports to investigating police.

Clause 58 amends the Part 6 headings.

Clause 59 inserts a new Part 6, Division 4 which provides for transitional arrangements for the Coroners and Other Acts Amendment Act 2008.

Clause 60 amends key words and phrases in Schedule 2 (Dictionary).

The amendments include amendments to the definition of "family member" to ensure that documentary evidence of the deceased person's wishes as to whom should be the "family member" for the purposes of the Act can be taken into account. In addition, the amendments give the coroner the discretion to treat as a "family member", an adult who, immediately before the deceased person's death, had a relationship with the deceased person that the coroner considers is sufficient for being a family member. This would only apply when there is no person in any of the other specified categories available to act as the "family member".

The definition of "investigation" is also amended to make it clear that it includes the preliminary investigation by a coroner to determine whether a death is reportable.

Part 3 Amendment of Births, Deaths and Marriages Registration Act 2003

Clause 61 provides that this part amends the *Births, Deaths and Marriages Registration Act 2003.*

Clause 62 amends section 42 to require the updating of the death register to reflect the coroner's findings if these are different to the information entered in the register.

Part 4 Amendment of Cremations Act 2003

Clause 63 provides that this part amends the *Cremations Act 2003*.

Clause 64 amends section 4 to update references to legislation.