

Obligations to report a death in care

This fact sheet provides information in relation to the obligation to report a death in care in the context of a client receiving accommodation or respite support (including in and out of home support) delivered by the Department of Communities, Child Safety and Disability Services (the Department), or a non-government service provider funded by the Department (funded service provider).

Obligations under the Coroner's Act

Sections 7 and 9 of the *Coroners Act 2003* impose an obligation on a person to report a death in care.

The term *person* in this context covers both service outlets provided by the Department or funded service providers (relevant service provider).

If a client who has died had a disability (as defined in section 11 of the *Disability Services Act 2006*), their death is considered to be a *death in care* if the client received **accommodation** or **respite support** delivered by the Department or a funded service provider.

The relevant service provider **must always** immediately report a death in care to a police officer or the coroner, even if:

- the client died somewhere other than where they ordinarily lived, or where they received respite support (even if it is in a hospital)
- you think the client died of natural causes.

There is no need to report the death where you have been told that someone else has already reported the death or will report the death.

For example, if a client who lived in residential care or received respite support

dies in a hospital of natural causes, and a nurse said that they will arrange for it to be reported, you do not need to report the client's death.

However, if there are **any doubts** whether someone else has reported or will report the death, as a matter of best practice, please **report the death** to a police officer or the coroner.

To clarify, if the client has received accommodation or respite support from the Department or a funded service provider, the **reporting obligation applies** irrespective of:

- The amount/level of accommodation or respite support the client was receiving at the time of death
- Whether or not the client was receiving accommodation or respite support at the time of death
- Where the client was at the time of death.

A penalty of up to 25 penalty units (\$3,000) may apply for failing to do so.

Forensic disability and mental health clients

The reporting obligation **remains the same** for a death in care of a client who is a forensic disability client under the *Forensic Disability Act 2011*.

This includes if the client is:

- being taken to, or detained in, the forensic disability service as a forensic disability client
- being taken to an authorised mental health service under section 37 or 113(2)(b) or (4) of that Act
- undertaking limited community treatment while accompanied by a practitioner within the meaning of that Act
- absent from the forensic disability service under a temporary absence approval

- while accompanied by a practitioner within the meaning of that Act
- awaiting admission at an authorised mental health service under an order for the client's transfer from the forensic disability service to the authorised mental health service.

- www.justice.qld.gov.au
- Email: state.coroner@justice.qld.gov.au

Other additional obligations to report

Further to the obligation to report under the Coroner's Act as set out above, below are **additional obligations** to report a death in care:

- a. Where disability services are provided by the Department – departmental staff are obliged to follow the Department's Critical Incident Reporting Policy available on the Department's website.
- b. Where disability services are provided by funded service providers – as detailed in your organisation's service agreement with the Department, your organisation must:
 - Notify the Department of any major incident, including death, within one business day of you becoming aware of it (Section 4.4.4 Service Agreement (Part A)-Standard Terms of Funding)
 - Have in place organisational policies consistent with the Department's current Critical Incident Reporting Policy (Section 7(a)(ii) Service Agreement (Part B)-Standard Terms of Funding).

Further information

Department of Communities, Child Safety and Disability Services

- Phone: 13 QGOV (13 74 68)
- www.communities.qld.gov.au/disability
- Email: disability@communities.qld.gov.au

Office of the State Coroner

- Phone: 1300 304 605 or (07) 3239 6193