Your Ref:
Our Ref: 20-1085
Enquiries:
Telephone: 7322 3347
Facsimile: 7322 4180

Mr Lee Odenwalder MP
Member of Parliament
2-3, 4 John Rice Avenue
ELIZABETH VALE SA 5112

Email: [redacted]@parliament.sa.gov.au

Dear Mr Odenwalder

Re: Freedom of Information Act application

In reference to your application made pursuant to the Freedom of Information (FOI) Act 1991, access was sought to:

> *"The following documents in full: General Order, Deaths in custody & General Order, offender record management system. Please withdraw any search relating to personal & business affairs."*

Prior to submitting your application, [redacted] spoke with Sergeant Friend via telephone regarding the scope of your request. As a result of that conversation, Sergeant Friend understood the scope would *exclude* personal and business affairs, however your application stated, *"withdraw searches relating to personal and business affairs."* I have processed your application on the premise that you intended for personal and business affairs to be excluded from the scope.

Documents falling within the scope of your request have been numbered and described in the following schedule. The schedule contains details of the determination in compliance with section 23.

SA POLICE - FREEDOM OF INFORMATION UNIT SCHEDULE				
No.	**Document Description**	**Status**	**Act**	**Reason**
1	General Order – Offender Record Management System – date of issue 24 April 2019 and consisting of eleven (11) pages.	Full Release		
2	General Order – Deaths and Deaths in Custody – date of issue 25 October 2017 and consisting of fifty six (56) pages.	Full Release		A portion of text has been redacted and marked ***Out of Scope*** as it relates to business affairs and does not fall within the scope of your request.

In accordance with the requirements of Premier and Cabinet Circular PC045, details of your FOI application, and the documents to which you are given access, will be published on the SAPOL website Disclosure Log. A copy of PC045 can be found at https://www.dpc.sa.gov.au/__data/assets/pdf_file/0019/20818/PC045-Disclosure-Log-Policy.pdf. If you disagree with publication, please advise the undersigned in writing by 10 February 2020.

Yours sincerely,

Senior Sergeant First Class Tracy Gentgall
Office in Charge
Freedom of Information Unit
(Accredited Freedom of Information Officer)

3 January 2020

GENERAL ORDER
OFFENDER RECORD MANAGEMENT SYSTEM

General Order title	**Offender record management system**
Date of issue	24 April 2019
Date of operation	18 April 2019
Review date	April 2022
Review responsibility	Prosecution Services Branch
Replaces	Previous General Order, **Offender record management system**
PCO reference	2007/1673 Addendum B
Gazette reference	SAPG 90/19
Enquiries to	Manager, Prosecution Support Unit Prosecution Services Branch Telephone 732 23978
Corporate Policy Sponsor	Assistant Commissioner Operations Support Service

General Orders provide an employee with instructions to ensure organisational standards are maintained consistent with SAPOL's vision. To this end, General Orders are issued to assist an employee to effectively and efficiently perform their duties. It is important that an employee constantly bears in mind that the extent of their compliance with General Orders may have legal consequences.

Most orders, as is indicated by the form in which they are expressed, are mandatory and must be followed. However, not all situations encountered by an employee can be managed without some form of guidance and so some of these orders are prepared as guidelines, which should be applied using reason. An appendix to a General Order will be regarded as part of the General Order to which it relates. At all times an employee is expected to act ethically and with integrity and to be in a position to explain their actions. Deviation from these orders without justification may attract disciplinary action.

To ensure best practice an employee should be conversant with the contents of General Orders.

The contents of General Orders must not be divulged to any person not officially connected with SAPOL. Requests for General Orders will be managed as follows:

- Civil subpoena and disclosure requests—contact the Information Release Unit.
- Criminal subpoena and disclosure requests—refer to General Order, **Disclosure compliance and subpoena management**.
- Freedom of information requests—contact the Freedom of Information Unit.
- Any other requests (including requests by employees)—refer to instructions provided within General Order, **Corporate policy framework**, **5. GENERAL ORDER REQUESTS/RELEASE**.

CONTENTS

1. GENERAL ORDER STATEMENT

The Offender record management system (ORMS) is an intranet based electronic database for recording information of importance to South Australia Police (SAPOL). Each employee is responsible for ensuring they complete any entries in ORMS as required.

All arrests, reports and first instance warrant applications will be created and managed through Shield including, but not limited to, the Apprehension submission templates, charge discontinuance and prosecution requests for materials (**PD90** requests).

Applications for orders (such as intervention/child protection/paedophile restraint/ firearms forfeiture orders) are to be created in PIMS. Once created in PIMS, the apprehension report relevant to the application for the order must then be uploaded to the relevant Shield occurrence.

Refer to Shield online help for Shield processes.

Any arrest, report or application entered into ORMS prior to the 14 November 2018 will continue to be managed through ORMS and the legacy **PD90** process as contained within this General Order.

Scope

This General Order applies to all SAPOL employees.

2. EXPIATION NOTICES

When a member issues an expiation notice the member must enter the details on ORMS prior to the end of that shift (this is critical to maintain the integrity of the system). Regular audits will be conducted to ensure the date the expiation notice was entered on the database corresponds with the actual expiation notice date.

A supervisor must update ORMS when the expiation notice has been approved and forwarded to the Expiation Notice Branch.

All cancelled notices must be entered and submitted to the relevant supervisor so they can be audited and closed against ORMS. Refer to General Order, **Expiation notices** for procedures relative to submission of expiation notices.

3. PD90

There are four different **PD90s** that can be generated in ORMS. They are:

- **PD90 Disclosure**
- **PD90 Pre-trial conference**
- **PD90 Declarations**
- **PD90 Court attendance notice**.

Prosecutors and Major Indictable Brief Unit (MIBR) members must only generate **PD90s** using ORMS for matters entered prior to 14 November 2018.

All apprehensions from 14 November 2018 are to be managed in Shield. Prosecutors and MIBR members must generate and manage **PD90** tasks in Shield.

Refer to Shield online help and Prosecution Training Unit for Shield processes.

Compliance with PD90 requests

The following applies to compliance with **PD90** requests.

Full completion

When an investigating officer completes a **PD90** the member must:

- update ORMS to reflect completion of the **PD90**
- forward a hardcopy of the **PD90** and requested information to their supervisor.

The supervisor must:

- ensure the investigating officer has signed and supplied the **PD90** hardcopy with the relevant documentation
- examine the **PD90** and ensure the **PD90** has been fully complied with
- update ORMS to reflect completion of the **PD90** and electronically send the **PD90**
- sign and forward the **PD90** hardcopy and requested material to the relevant prosecution unit or MIBR.

Partial completion

In the event the **PD90** is not likely to be completed by the due date the investigating officer must:

- contact the prosecutor or MIBR member initiating the **PD90**; or
- in the prosecutor's or MIBR member's absence, contact the prosecutor's or MIBR member's supervisor.

The prosecutor or MIBR member may:

- grant the investigating officer approval to submit a partially completed **PD90**
- grant the investigating officer an extension of time to submit a fully completed **PD90** and modify the due date on ORMS
- maintain the **PD90** due date.

When a partial submission of a **PD90** is authorised by the prosecutor or MIBR member the investigating officer must:

- update ORMS
- state the 'not supplied reason' prior to forwarding the partially completed **PD90** to the member's supervisor.

A supervisor must:

- ensure the investigating officer has contacted the prosecutor or MIBR member prior to updating ORMS
- ensure the investigating officer has updated ORMS and stated a 'not supplied reason' and expected completion date or alternatively, the investigating officer has been granted an extension of time

- ensure the investigating officer has signed and supplied the **PD90** hardcopy and requested material
- sign and forward the partially completed **PD90** hardcopy and requested material to the relevant prosecution unit or MIBR.

Re-assignment of a PD90

When a supervisor becomes aware a member will not be able to respond to a **PD90** by the due date, the supervisor must:

- delegate completion of the **PD90** (where possible) to another member and update ORMS accordingly
- contact the relevant prosecutor or MIBR member in a timely manner and ensure the prosecution unit is aware of the extenuating circumstances
- update ORMS 'general comments' area outlining why the **PD90** has not been complied with.

Receiving

When receiving a **PD90** a prosecutor or MIBR member must acknowledge receipt of the **PD90** request on ORMS and either:

- accept the **PD90** has been fully complied with and close the record in ORMS
- decline to accept the partially completed **PD90** and electronically return it to the investigating officer (through the member's supervisor)
- accept the partially completed **PD90** and extend the due date on ORMS for the remaining material.

Declaration matters (major indictable)

All **PD90s** calling for declarations will be sent out and centrally managed by MIBR using ORMS for matters entered prior to 14 November 2018.

All matters entered from 14 November 2018 are to be managed through Shield.

Accountability

ORMS reports relating to **PD90s** will be subject to review at the TCG.

There may be instances where **PD90s** are not completed by the due date. When this occurs, TCG delegates will be required to account for overdue **PD90** requests and facilitate the completion of overdue **PD90** requests as a matter of urgency.

4. CORONIAL INVESTIGATIONS

When a member attends a death reportable to the State Coroner, the following procedures apply.

Submission

The following applies to the submission of a reportable death.

Investigating officer

When an investigating officer attends a death that is reportable to the State Coroner they must:

- enter a **PD44 Report of death (PD44)** on ORMS prior to the end of that shift (refer to General Order, **Deaths and deaths in custody**)—statements forming the Coroner's brief (word documents and PDF format of relevant scanned documents) must be attached to the ORMS record during the creation of the **PD44**
- forward the completed **PD44** to their supervisor or duty supervisor.

Supervisors

When an investigating officer submits a **PD44**, the supervisor must:

- vet the **PD44** and attached statements ensuring the **PD44** can read as a standalone document and contains all relevant details
- update ORMS to reflect the **PD44** has been forwarded to the Coronial Investigation Section (CIS)
- forward any original signed statements to the CIS under cover of an ORMS generated **PD63 Coroner's brief cover**.

Coronial Investigation Section

A CIS member must:

- receive on ORMS as soon as practicable to acknowledge receipt of the **PD44**
- vet the **PD44** and attached statements to assess whether the benchmark for quality standards have been met
- close the ORMS record when the **PD44** and attached statements meet the benchmark for quality standards
- when the **PD44** or attached statements do not meet the benchmark for quality standards, the CIS member is to do the following:
  - when the **PD44** is incomplete and does not contain all relevant information and cannot be read as a standalone document, return the **PD44** to the investigating officer through the investigating officer's supervisor for further enquiry and/or correction (this will not alter the investigating officer's responsibilities to submit the completed file prior to the end of their shift)—the **PD44** is to be returned by selecting the 'return PD44 tab' and then selecting from the dropdown box the appropriate category for correction (more than one category can be selected where there are multiple errors/deficiencies)
  - issue a Coronial information request (CIR) where corrections to existing statements are required or additional information is required (refer to processes outlined at **5. CORONIAL INFORMATION REQUEST** further in this General Order).

5. CORONIAL INFORMATION REQUEST

The following applies to CIRs.

Issuing

A CIR must be generated through ORMS.

Full completion

When an investigating officer completes a CIR they must:

- update ORMS to reflect completion of the CIR
- forward a hardcopy of the CIR and requested information to a supervisor.

A supervisor must:

- ensure the investigating officer has signed and supplied the CIR hardcopy with the relevant documentation
- check the CIR request and ensure the CIR has been fully completed
- update ORMS to reflect completion of the CIR and electronically send the CIR
- sign and forward the CIR hardcopy and documentation to the CIS.

Partial completion

In the event the CIR is not likely to be completed by the due date, the investigating officer must contact the CIS by email (SAPOL:Coronial Investigation Section) and advise the status of any outstanding enquiries, the reason why the enquiries have not been completed by the due date and the estimated date of completion.

The CIS may:

- grant the investigating officer approval to submit a partially completed CIR; and/or
- grant the investigating officer an extension of time to submit a fully completed CIR; or
- maintain the required due date.

When partial submission of the CIR is authorised by CIS, the investigating officer must:

- update ORMS
- state the 'not supplied reason' prior to forwarding the partially completed CIR to their supervisor.

A supervisor must:

- ensure the investigating officer has contacted the CIS prior to updating ORMS
- ensure the investigating officer has updated ORMS and stated a 'not supplied reason' and expected completion date or alternatively, that the investigating officer has been granted an extension of time
- ensure the investigating officer has signed and supplied the CIR hardcopy and relevant documentation
- update ORMS and electronically send the CIR

- sign and forward the partially completed CIR hardcopy and documentation to the CIS.

Re-assignment of a coronial information request

When a supervisor becomes aware that a member will not be able to respond to a CIR by the due date the supervisor must:

- delegate completion of the CIR (where possible) to another member and update ORMS accordingly
- contact the CIS in a timely manner and ensure they are aware of the extenuating circumstances
- update the ORMS comments area outlining why the CIR has not been complied with.

Receiving

When receiving CIRs, CIS must acknowledge receipt of the CIR request on ORMS and either:

- accept that the CIR has been fully complied with and close the record in ORMS; or
- decline to accept that the CIR has been complied with and return the CIR to the investigating officer (through the investigating officer's supervisor).

6. SYSTEM INACCESSIBLE

When ORMS is inaccessible, relevant data is to be entered as soon as practicable after ORMS becomes available. A blank **PD44 Report of death** is available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations>. The **PD44** is to be completed and submitted. When the system becomes available the **PD44** is to be uploaded onto ORMS. In order to comply with reporting obligations the hand written **PD44** must be submitted prior to the end of shift if ORMS remains inaccessible.

7. TRANSFER OF INVESTIGATING OFFICER

When an investigating officer transfers from one team to another or to another area of SAPOL, the new supervisor of the transferring member shall forthwith add that member to their new team or area.

A member is not to be removed from teams or areas by using the 'remove team member' function until confirmation has been received that they have been added to their new team or area.

8. REFERENCES

General Order, **Arrest/report procedures and documentation**

General Order, **Brief quality control officer**

General Order, **Committals**

General Order, **Deaths and deaths in custody**

General Order, **Expiation notices**

General Order, **Prosecution**

Prosecution Practice Note 45—*Compliance with offender record management system and use of PD90s* available through the intranet at <police connect home page/ operations support service/prosecution services branch/resources/prosecution practice notes>

Shield online help available through the intranet at <police connect home page/services/information systems and technology service/innovation and solutions branch/program shield>

9. FURTHER ENQUIRIES

District/LSA/branch sub-administrator

Information Systems and Technology Service—Help Desk

10. DOCUMENT HISTORY SINCE 08/05/07

Gazette reference (SAPG)	Date	Action (amendment/deletion/new/review/temporary variation)
133/07	08/05/07	New General Order.
142/12	30/05/12	Review 2011 and 2012.
236/12	19/09/12	Temporary variation of this General Order by the Offence Streaming Model trial (Holden Hill LSA 01/10/12 to 31/03/13).
55/13	06/03/13	Temporary variation of this General Order by the Offence Streaming Model trial (Eastern Adelaide LSA and Sturt LSA 28/03/13 to 31/09/13).
179/13	21/08/13	Review 2013, amendments to processes at **8. CORONIAL INVESTIGATIONS** and **9. CORONIAL INFORMATION REQUEST**, additionally references to General Order, **Deaths** amended to General Order, **Deaths and deaths in custody**.
278/13	25/12/13	Temporary variation of this General Order due to the implementation of the Offence Streaming Model. Reference to State Committal and Disclosure Section amended to State Committal and Disclosure Unit.
122/14	28/05/14	Amendment—inclusion of responsibilities of the BQCO in relation to the Offence streaming model, references to the Criminal Justice Section deleted and replaced with Prosecution Unit, and the temporary variation removed.
129/16	22/06/16	Review 2016—amendments to General Order references. Amendment to reference 'prosecutor' to include SCDU member due to PID changes. Inclusion of instruction on documents to be uploaded on to ORMS for coronial investigations to include scanned PDF relevant documents. Inclusion of advice that a low quality standard **PD44** will result in the issuing of a new CIR. Inclusion of a requirement to provide a hand written **PD44** in the event ORMS is not temporarily out of service.
90/19	24/04/19	Review 2019.

APPROVED BY COMMISSIONER/DEPUTY

.....	.....
Print Full Name	*ID Number*
.....	...../...../.....
Signature	*Date*

Documentation certification and verification

General Order draft—prepared by: Sergeant Michael Tolson, Prosecution Services Branch
General Order—verified by: Superintendent Stuart McLean, Officer in Charge, Prosecution Services Branch

GENERAL ORDER
DEATHS AND DEATHS IN CUSTODY

General Order title	**Deaths and deaths in custody**
Date of issue	25 October 2017
Date of operation	10 October 2017
Review date	September 2020
Review responsibility	Major Crime Investigation Branch
Replaces	Previous General Order, **Deaths and deaths in custody**
PCO reference	13/02450-02
Gazette reference	SAPG 217/17
Enquiries to	Major Crime Investigation Branch Telephone 817 25470
Corporate Policy Sponsor	Assistant Commissioner, Crime Service

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- Criminal subpoena and disclosure requests—contact the State Committal and Disclosure Unit.
- Freedom of information requests—contact the Freedom of Information Unit.
- Any other requests (including requests by employees)—refer to instructions provided within General Order, **Corporate policy framework**, **5. GENERAL ORDER REQUESTS/RELEASE**.

CONTENTS

1. GENERAL ORDER STATEMENT

South Australia Police (SAPOL) is the lead investigator for reportable deaths within the State on behalf of the State Coroner. This General Order outlines the procedures for the investigation of deaths and deaths in custody.

Scope

This General Order applies to all employees.

2. DEFINITIONS

For the purpose of this General Order, the following definitions pursuant to section 3 of the *Coroners Act 2003* apply.

Death in custody means:

the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person—

(a) was being detained in any place within the State under any Act or law, including any Act or law providing for home detention (and, for the purposes of this paragraph, a detainee who is absent from the place of his or her detention but is in the custody of an escort will be regarded as being in detention, but not otherwise); or

(b) was in the process of being apprehended or was being held—

(i) at any place (whether within or outside the State)—by a person authorised to do so under any Act or law of the State; or

(ii) at any place within the State—by a person authorised to do so under the law of any other jurisdiction; or

(c) was evading apprehension by a person referred to in paragraph (b); or

(d) was escaping or attempting to escape from any place or person referred to in paragraph (a) or (b).

Reportable death means:

the State death (other than a State death to which subsection (2) applies) of a person—

(a) by unexpected, unnatural, unusual, violent or unknown cause; or

(b) on an aircraft during a flight, or on a vessel during a voyage; or

(c) in custody; or

(d) that occurs during or as a result, or within 24 hours, of—

(i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure; or

(ii) the administration of an anaesthetic for the purposes of carrying out such a procedure,

not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply;

(e) that occurs at a place other than a hospital but within 24 hours of—

(i) the person having been discharged from a hospital after being an inpatient of the hospital; or

(ii) the person having sought emergency treatment at a hospital; or

(f) where the person was, at the time of death—

(i) a protected person under the *Aged and Infirm Persons' Property Act 1940* or the *Guardianship and Administration Act 1993*; or

(ii) in the custody or under the guardianship of the Minister under the *Children's Protection Act 1993*; or

(iii) a patient in an approved treatment centre under the *Mental Health Act 1993*; or

(iv) a resident of a licensed supported residential facility under the *Supported Residential Facilities Act 1992*; or

(v) accommodated in a hospital or other treatment facility for the purposes of being treated for drug addiction; or

(g) that occurs in the course or as a result, or within 24 hours, of the person receiving medical treatment to which consent has been given under Part 5 of the Guardianship and Administration Act 1993; or

(h) where no certificate as to the cause of death has been given to the Registrar of Births, Deaths and Marriages; or

(i) that occurs in circumstances prescribed by the regulations.

State death means the death of a person—

(a) that occurred in the State; or

(b) where the place of death is unknown but it is reasonably possible that the death occurred in the State; or

(c) where the body of the person is in the State; or

(d) a cause of which occurred, or possibly occurred, in the State; or

(e) where, at the time of death, the person was ordinarily a resident in the State; or

(f) in the case of a death on an aircraft or vessel—where the flight or voyage was to a place of disembarkation in the State.

Interpretation

In order to determine whether or not an incident is a death in custody for the purposes of this General Order, the following factors should be considered.

Attempt deaths in custody/self-harm

For attempts or self-harm incidents in custody where death is not imminent, refer to General Order, **Self-harm in police custody**.

Deaths in police custody

Being held—any person who is under the direct control of a member at the time of their death is considered to be held in police custody.

Custody-related police operation—when a death occurs in the following instances:

- where police have confined (even partially) the person geographically, even though police may not have such close contact with the person as to be able to effectively communicate or significantly influence or control the person's behaviour during the incident (for example a siege situation where the person knows or ought to have known that police are present, or a pursuit where the police have detected an offence and are in pursuit of the person)

- during attempted apprehensions or escape from custody, including high risk driving.

Refer to General Order, **Significant incident investigations and Commissioner's inquiries**.

Death in non-police custody—where a person dies in custody other than police custody, such as Department for Correctional Services custody, custody pursuant to section 32 of the *Guardian and Administration Act 1993* or part 5 of the *Mental Health Act 2009* (Inpatient treatment orders).

Imminent death—any injury or illness, likely to result in death, which is sustained by a person in custody as defined above, should be the subject of an immediate investigation in accordance with this General Order.

In the process of being apprehended—each case must be determined on its own merits; however, a person is deemed to be *in the process of being apprehended* from the time of arrest/apprehension/detention until bailed. This may include a period that comes within the definition of a custody-related police operation.

Prior contact with police—in circumstances where police become aware the deceased had some type of contact with police prior to their death they should seek advice from the on call Internal Investigation Section (IIS) investigator or Officer in Charge (O/C), Investigation Assurance Section (IAS).

3. THE STATE CORONER

The State Coroner is responsible for administering the Coroner's Court and overseeing and coordinating coronial services in the State by inquiring into the cause and circumstances of reportable deaths.

Notification to State Coroner

Statutory requirement

Pursuant to section 28 of the *Coroners Act 2003*, the State Coroner must be notified of all reportable deaths that occur in South Australia or of persons normally resident within the State. The *Coroners Act 2003* requires that a police officer who is notified of a reportable death must immediately notify the State Coroner of the death and of any information that the police officer has, or has been given, in relation to the matter. Notification in these circumstances is facilitated through the submission of a **PD44 Report of death (PD44)** and preliminary coronial file on the Offender record management system (ORMS).

When general duties members have attended a reportable death the investigating officer is responsible for ensuring that a preliminary coronial file is completed and entered onto ORMS prior to the end of the submitting member's shift—refer to **8. COMPILATION OF CORONIAL FILES, Preliminary coronial file** further in this General Order.

General requirement

Notwithstanding notification through ORMS, certain categories of reportable deaths must be communicated to the Communications Centre (ComCen) when all the facts are known by the investigating officer at the scene. Upon receipt of that notification ComCen must advise the State Coroner (through the Coroner's Court manager, who is available on a 24-hour basis) in the following circumstances:

- a death in police custody
- a death during a custody-related police operation
- an un-natural or violent death in a Department for Correctional Services facility
- a death which may raise public concern (for example public transport or plane crash)
- a homicide
- multiple fatality incident (two or more persons).

Where a reportable death is likely to be the subject of media, political or public interest, it is important that the State Coroner is sufficiently conversant with the facts known to SAPOL to enable the State Coroner to properly fulfil the statutory functions of the *Coroners Act 2003*.

In these circumstances the O/C, Major Crime Investigation Branch (MCIB), O/C, Coronial Investigation Section (CIS) and/or O/C, Traffic Support Branch (TSB) will, where practicable, advise the State Coroner of any further details considered appropriate or as requested by the State Coroner. Such advice to the State Coroner should precede any media release by SAPOL. LSA managers must notify the O/C, MCIB, O/C, CIS and/or O/C, TSB (as considered appropriate given the circumstances of the death) prior to any media release.

Where death has not yet occurred but is considered to be imminent and would therefore become a reportable death, the State Coroner is (where practicable) to be apprised. Where the investigation responsibility does not fall to MCIB and/or TSB the relevant manager will seek advice from the O/C, MCIB in respect to the manner and method of apprising the State Coroner.

4. THE CORONIAL INVESTIGATION MODEL

Scope of responsibility

When the deceased is an admitted patient at a hospital, the LSA of which the deceased normally resides is responsible for submitting the coronial file.

All tier 1 coronial files will remain the responsibility of the LSA of where the death has occurred.

In the case of a tier 2, ordinarily the LSA of which the deceased normally resides will be responsible for the submission of the coronial file. It is expected the local general duties and CIB patrols conducts the preliminary investigation and undertake any local enquires prior to transferring conduct of the file to the allocated LSA.

It is accepted that in some circumstances this may not be appropriate. In cases whereby a determination is required the O/C, CIS in consultation with the service co-ordinators will make a determination as to which LSA will have carriage of the investigation taking into consideration the location of the incident, location of where the person normally resides and the capacity of the LSA/branch.

The Coronial investigation model consists of three clear levels of responsibility and accountability (relevant to the police response) to all reportable deaths and the subsequent preliminary investigation, review and submission of coronial file.

Where the tiering classification of any coronial investigation becomes unclear or changes during the course of an investigation the O/C, CIS will determine the tiering level of the investigation. Where there is a dispute, the O/C, MCIB will make the final determination regarding the tiering of any coronial incident.

Full file not required

In a number of deaths, no coronial file is required to be submitted by police, and as a result these deaths may not need to be tiered.

Cause of death provided

Members are encouraged to make contact with the deceased's regular treating medical practitioner. The medical practitioner should be spoken to, to establish the deceased's medical history and provide information to be of assistance to the pathologist.

Where is it known the deceased had a significant medical history, enquiries should be made with the treating medical practitioner as to whether or not the medical practitioner is prepared to issue a Cause of death certificate negating the need for a full coronial file.

By virtue of section 36 of the *Births, Deaths and Marriages Act 1996*, a medical practitioner can issue a certificate if the doctor was *responsible for a person's medical care immediately before death*.

In order to comply with accepted protocols of the Office of Births, Deaths and Marriages in relation to section 36 of the *Births, Deaths and Marriages Act 1996*, members must ensure the medical practitioner has seen/treated the deceased **within the preceding three months**.

Where a medical practitioner is either not prepared to issue, or has not seen the deceased within the preceding three months a preliminary coronial file is required. Members should not pressure a medical practitioner to issue a certificate where the medical practitioner may review and rescind the certificate, resulting in subsequent members preparing a preliminary coronial file. A medical practitioner cannot issue a certificate, and should not be requested to issue, where a deceased is decomposed or identity has not been confirmed or is in question, regardless of medical history.

When a cause of death is provided by a medical practitioner, the member who attended the sudden death and obtained a cause of death from the medical practitioner must email CIS (SAPOL:Coronial Investigation Section) and advise them of the full name of the deceased, date of birth, address, doctor's name and cause given. CIS will provide these details to the State Coroner. No further documentation is required to be submitted, except in exceptional circumstances.

On occasion attending members, their supervisor(s) or the State Coroner may believe that further enquiries are warranted, despite a cause of death being issued. The death may then be tiered as a tier 1 or 2, and the corresponding processes apply. CIS can be contacted for further advice or assistance.

Identification statement request—hospital deaths

Hospitals and nursing homes (other than those that are a licensed supported residential facility under the *Supported Residential Facilities Act 1992*) generally report deaths to the State Coroner by completing a Deposition form (a Coroner's Court document) and faxing it to the Coroner's Court. Nursing homes reporting a death are also able to complete an identification of the deceased when completing their Deposition form.

Hospitals are not able to complete an identification of the deceased. When the State Coroner is notified of a death at a hospital, they request the attendance of a patrol through ComCen to complete a statement of visual identification. An identification proforma is available through ORMS at <pd44/pro-formas/identification of deceased>.

The identification should be completed as a matter of urgency as relatives and/or friends of the deceased are generally present at the hospital when the death is reported, and this will avoid the need to arrange for family/friends to re-attend the hospital. Once the identification is complete, the identification statement should be faxed to CIS who will forward a copy to the State Coroner.

Nursing homes that are a licensed supported residential facility under the *Supported Residential Facilities Act 1992* cannot report any deaths that occur in their facilities. These deaths require the submission of a full coronial file, and will be tiered as appropriate. A list of these facilities is available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations>.

Tier 1

Tier 1 investigations apply to reportable deaths not coming within the criteria of tier 2 or tier 3 and involve investigations into the circumstances of deaths which are not complex and may be attributed to illness, disease or unknown causes. In these matters, all relevant circumstances associated with the death should be obtained and a preliminary coronial file submitted through ORMS by the end of the shift to comply with the statutory obligation to report to the State Coroner.

Tier 2

Tier 2 investigations include the following categories of death (a preliminary coronial file must be submitted through ORMS by the end of the shift to comply with the statutory obligation to report to the State Coroner):

- suicide
- drug overdose
- death of a child who is under 18 years
- suspicious death
- death by fire
- workplace accident fatalities
- aviation
- marine/drowning accidents
- railway fatalities

- significant other reportable death (for example sensitive, government agency involvement or the like, as determined by O/C, CIS)
- death in custody in a non-correctional institution or non-police custody
- death in Department for Correctional Services (DCS) custody (including palliative care prisoners in DCS prison hospitals/facilities)—Police Corrections Section are responsible for the investigation; however, LSA CIB may still be required to attend in the first instance.

Tier 3

Tier 3 investigations include the following categories of death:

- DCS prisoners in palliative care in the community
- coronial investigations allocated by the State Coroner to CIS
- any other coronial incident or investigation as directed by the O/C, MCIB.

Exceptions to the Coronial investigation model

The Coronial investigation model does not apply to deaths in the following circumstances:

- deaths in police custody
- any other significant incident investigation or Commissioner's inquiry
- homicide—refer to the *Major investigation emergency response plan* (refer to **11. REFERENCES** further in this General Order)
- deaths within the ambit of the Major Crash Investigation Section—refer to General Order, **Vehicle collisions**
- at a minimum a **PD44** and identification statement must be submitted and reported to the State Coroner in these categories of deaths before the end of the shift.

Significant incidents

General Order, **Significant incident investigations and Commissioner's inquiries** allocates responsibility and accountability of SAPOL members and managers with respect to the investigation and preparation of reports as follows:

- incident investigation of the cause and/or circumstances surrounding the incident, including compliance with legislative requirements, General Orders and relevant policies, generally culminating in a Coroner's file and/or criminal file
- disciplinary investigation of the actions of the police relative to the incident
- corporate review relative to adequacy and thoroughness of legislation and SAPOL procedures, practices, policy, training, equipment as related to the circumstances of the incident.

Where an investigation within the ambit of General Order, **Significant incident investigations and Commissioner's inquiries** relates to a death, the senior investigator (officer of police) will ensure that SAPOL investigative procedures are followed.

In the case of a death, a full copy of the Coroner's file must be provided to the O/C, Ethical and Professional Standards Branch (E&PSB) for review prior to providing the file to the State Coroner. In the interim the State Coroner will be advised through the normal progress report(s) that the coronial investigation is complete and the file is forthcoming.

The O/C, E&PSB will review the incident investigation report and advise the relevant manager when the original report can be released to the State Coroner. They will also advise the State Coroner of the status of any other relevant investigation.

5. ROLES AND RESPONSIBILITIES—DEATHS

Tier 1

General duties member/patrol

A general duties member/patrol is responsible for:

- initial police response
- crime scene preservation
- the completion of the preliminary coronial file prior to the end of the shift
- submission of the preliminary coronial file onto ORMS prior to the end of the shift
- providing the hard copy of the file to a general duties supervisor for vetting prior to the end of the shift
- ensuring any hard copy documents which cannot be uploaded on ORMS such as a handwritten identification proforma are faxed to CIS prior to the end of the shift.

General duties supervisor

A general duties supervisor is responsible for:

- ensuring the necessary resources are available and coordinated to thoroughly investigate the reportable death
- the collation and vetting of the preliminary coronial file to ensure it complies with format and presentation standards
- electronic transmission of the file to CIS through ORMS by the end of the investigating officer's shift to fulfil SAPOL's reporting obligations to the State Coroner
- providing the hard copy of the file or the ORMS electronic copy to the LSA CIB for review to ensure that all possible lines of enquiry have been identified and sufficiently investigated.

Local Service Area Criminal Investigation Branch

In respect to tier 1 deaths, CIB:

- are not required to attend the scene; however, when CIB do attend the scene they are required to submit a statement for the preliminary coronial file prior to the completion of that member's shift including their opinion of cause of death and sources of any drugs

- must review the preliminary coronial file submitted by the general duties member(s) to ensure that all possible lines of enquiry and other relevant factors have been identified and sufficiently investigated; however, the CIB review of the tier 1 investigation must not impede the uploading of the preliminary coronial file onto ORMS
- reviews of a tier 1 preliminary coronial file shall be in accordance with the criteria in the *CIB Coronial investigations guidelines for review* proforma—available through ORMS at <pd44/pro-formas> (there is no requirement to submit this proforma to CIS for tier 1 reviews)
- where the review identifies additional enquiries the CIB member is to liaise with CIS by email (SAPOL:Coronial Investigation Section) and request that the additional enquiries are tracked on ORMS
- ensure the hard copy of the file is sent to CIS once vetted.

Coronial Investigation Section

Coronial Investigation Section shall:

- receive notification of additional enquiries considered necessary following review by CIB
- apply a quality assurance process to the preliminary coronial file and determine whether any further enquiries are necessary
- liaise with the investigating officer regarding further enquiries necessary and allocate appropriate time frames to undertake the additional enquiries
- coordinate non-visual identification processes when necessary
- issue a Coronial information request (CIR) to provide a tracking and management framework for those enquiries.

Tier 2

General duties member/patrol

A general duties member/patrol is responsible for:

- initial police response
- crime scene preservation
- completion of the preliminary coronial file prior to the end of the shift
- uploading of the preliminary coronial file onto ORMS for vetting prior to the end of the shift
- ensuring the general duties supervisor is made aware of the file for vetting prior to the end of the shift
- ensuring any hard copy documents which cannot be uploaded on ORMS (such as a hand written identification proforma) are faxed to CIS by the completion of the shift.

Where a CIB member does not attend the scene of a tier 2 death the general duties member responsible for the preliminary coronial file must seek advice and guidance in respect to the circumstances of the death and the content of the preliminary coronial file from any of the following:

- an on duty CIB member
- the respective LSA on call officer of police
- the Metropolitan Duty Officer
- the State Shift Manager (SSM).

General duties supervisor

A general duties supervisor is responsible for:

- ensuring the necessary resources are available and coordinated to thoroughly investigate the reportable death
- collating and vetting the preliminary coronial file to ensure it complies with format and presentation standards
- transferring the preliminary coronial file to CIS through ORMS by the end of the investigating officer's shift
- ensuring the hard copy of the file is handed to the investigating officer (may be CIB if applicable) for submission to CIS once the investigation is complete.

Local Service Area Criminal Investigation Branch

An investigator is expected to attend the scene of all tier 2 deaths. Where an LSA CIB member attends the scene of a tier 2 death, they will be responsible for the submission of a statement of their observations/conclusions. This statement need not be submitted with the preliminary coronial file but must be submitted with the *CIB Coronial investigations guidelines for review* proforma, available through ORMS at <pd44*l* pro-formas>.

Where the tier 2 death is to be allocated to a specialist investigation area (such as Police Corrections Section or Major Crash Investigation Section), an LSA investigator will only be required to attend upon request (for example out of business hours).

The attendance of CIB to the scene of a tier 2 death must not excessively delay:

- processing the deceased's crime scene
- transport of the deceased to the mortuary
- the completion of the preliminary coronial file by the end of the shift
- reporting the death to the State Coroner through the uploading of the preliminary file onto ORMS.

Circumstances where CIB may not be able to attend the scene of a tier 2 death include:

- where geographical considerations prohibit their attendance
- when CIB are not on duty
- when CIB are attending to other priority investigations and cannot be released.

Where a CIB member cannot attend the scene of a tier 2 death, the general duties member responsible for the preliminary coronial file must seek advice and guidance in respect to the circumstances of the death and the content of the preliminary coronial file from any of the following:

- an on duty CIB member
- the respective LSA on call officer of police
- the Metropolitan Duty Officer
- the State Shift Manager.

Once the preliminary coronial file has been uploaded to ORMS and the State Coroner's reporting obligations have been fulfilled, a CIB member:

- must review the preliminary coronial file submitted by the general duties member(s) to ensure that all possible lines of enquiry and other relevant factors have been identified and sufficiently investigated
- liaise with CIS by telephone/email (SAPOL:Coronial Investigation Section) regarding additional enquiries and nominating the investigating officer.

The CIB member who is allocated the tier 2 file:

- may allocate enquiries to other members within their LSA, after consultation with their supervisor and the other member's supervisor (for example a general duties member may be requested to obtain a statement from a witness at the scene)
- will remain responsible for ensuring the additional enquiries are completed within the allocated time frame
- will forward the completed coronial file under cover of a *CIB Coronial investigations guidelines for review* proforma (available through ORMS at <pd44/pro-formas>) to CIS by despatch or personal delivery within 6 months (180 days) or earlier as requested by CIS
- must complete and send a progress report to CIS by email (SAPOL:Coronial Investigation Section) at three months (90 days) for deaths in non-police custody, and a six month report if the tier 2 has not been completed within the 6 month time frame, for CIS to conduct a review and or take further action.

Major Crash Investigation Section

The investigation of the following tier 2 deaths will be the responsibility of Major Crash Investigation Section (MCIS):

- persons under the age of 18 who die as a result of a vehicle collision
- suicides involving a vehicle collision.

Railway fatalities

Railway fatalities will be investigated by the respective LSA CIB.

While rail transport movements should not be unduly delayed, scene preservation and management principles must be a priority until appropriate assessment of the circumstances surrounding the death have been established.

Initial response to a railway fatality in metropolitan Adelaide will be provided by LSA general duties members and/or members from Public Transport Safety Branch. A member attending any rail incident should consider the rail corridor (the railway tracks and land nearby) a dangerous environment with hazards including railcars, high voltage overhead electric wiring and rail switch-gear, all capable of causing serious injury or death.

Safety of police and others is the paramount consideration when attending any railway incident. With this in mind, the first members in attendance should position themselves a safe distance from railway tracks and immediately confirm with SAPOL ComCen that rail authorities have suspended any further rail traffic along that section of track.

Initial responding members can then safely manage the scene, where practical limiting entry of persons and vehicles into the rail corridor until the arrival of a rail safety officer, who will direct access and movement of persons or vehicles within the rail corridor.

The rail safety officer will also direct safe evacuation of railcar passengers when required. Initial police response should include preliminary investigation, such as obtaining names and contact details of witnesses and where practical signed notebook statements, and noting observations of the scene in sufficient detail to compile a statement if required.

LSA general duties members and/or members from Public Transport Safety Branch will prepare and submit a preliminary coronial file. Refer to **8. COMPILATION OF CORONIAL FILES, Preliminary coronial file** further in this General Order.

In addition to the information required in a preliminary coronial file, initial investigations should include:

- an opinion as to whether the death was an accident, suicide or of a suspicious nature
- the name of the accredited railway owner/operator responsible for the train—available through the O/C, Public Transport Safety Branch when unknown/ unavailable at the time.

Coronial Investigation Section

A detective sergeant from CIS shall:

- determine whether any further enquiries are necessary
- notify the relevant CIB that the death is classified as a tier 2 death and allocate the file to the nominated CIB member for investigation
- identify additional enquiries required to report the facts surrounding the death to the State Coroner and determine whether a face-to-face meeting is required with the investigating officer
- issue a Coronial information request on ORMS to provide a tracking and management framework for those enquiries
- assess the three-monthly progress report for deaths in non-police custody submitted by the investigating officer to assist CIB in meeting time frames
- assess the six monthly report for tier 2 Coroner's files
- review the completed file to ensure all relevant facts surrounding the death are reported and forwarded to the State Coroner.

In regards to a tier 2 coronial investigation, CIS will further be responsible for:

- coordinating follow-up enquiries relative to all suicides and deaths in custody in respect to:
  - the deceased's interaction with institutions
  - their release and management conditions
  - interaction with specialist medical providers
  - psychological factors
  - any other complex issues considered relevant to the circumstances of death
- providing a consultancy role and assistance to LSAs in the investigation of a tier 2 coronial matter that may include:
  - early intervention through strategy meetings to determine the most appropriate investigation lines of enquiry
  - completing and managing all Adelaide central business district based enquiries on behalf of the regional LSA CIB investigation—this will be at the discretion and direction of the O/C, CIS
  - reviewing progress reports (three months) submitted by the CIB member to identify issues relative to the investigation, with a view to assist the CIB member to meet time frames
  - reviewing the final report—which must be vetted by the submitting member's supervisor prior to submission
  - responding to follow-up enquiries from the State Coroner where practicable
  - where practicable and essential, attending a regional LSA to assist with a coronial investigation, at the discretion and direction of the O/C, CIS.

Toxicology and/or post mortem reports are often not finalised in time for inclusion in the a final tier 2 file. When members have finalised their file and do not have the toxicology report/post mortem report they are required to liaise with CIS and as part of the CIS assessment, a decision will made as to whether the tier 2 file will be forwarded to CIS without these toxicology and/or post mortem reports.

The tier 2 files will be maintained within the CIS office and on receipt of the toxicology and/or post mortem reports, CIS will re-assess as to whether further enquiries are warranted for follow-up by the CIB member. A CIR will then be issued for additional enquiries.

Tier 3

Tier 3 investigations are managed and investigated by CIS at the direction of the State Coroner.

6. ROLES AND RESPONSIBILITIES—DEATHS IN POLICE CUSTODY

A death in police custody may be classified as either a significant incident investigation or a Commissioner's inquiry and must be conducted in accordance with General Order, **Significant incident investigations and Commissioner's inquiries**.

Members involved in a death in police custody

A member responsible for the care and custody of a prisoner must immediately report any death in police custody to the State Shift Manager through their supervisor/manager. Notification must include but not be limited to:

- the circumstances leading up to the incident
- the details of the deceased
- circumstances surrounding the apprehension and death
- the welfare of members involved in the incident.

A member who has been directly involved with the incident must:

- take all steps to preserve life and render assistance to any person(s)
- where practicable, ensure a member not involved in the actual incident takes control of the incident as the forward commander at the earliest opportunity (in remote regional areas the member involved must assume this role until resources are provided)
- ensure the scene is secured and preserved in accordance with crime scene investigations procedures
- liaise with the most senior member not involved in the incident and ensure that all relevant and accurate information and advice is provided to them to ensure that the notification process is conducted in a timely and efficient manner
- prepare independent notes/statements whilst the facts are still fresh in the member's memory and prior to completion of the shift in which the incident occurred without collaborating with other members involved—the notes or statement will be handed to the appointed senior investigator (officer of police) or a person acting on their behalf
- a member may further be requested by an appointed senior investigator (officer of police) to assist with the inquiry by answering certain questions or providing a statement.

A member who is present but is not directly involved in the incident must:

- declare their role in the incident and provide any necessary assistance in the early resolution of the incident/investigation at the direction of the senior police officer acting as the forward commander
- independently complete their statement/notes prior to the completion of the shift during which the incident occurred—the statement/notes will be handed/faxed to the appointed senior investigator (officer of police) or a person acting on their behalf.
- remain on duty until allowed to complete duty by their supervisor/manager.

Forward commander at the scene

To ensure the integrity and thoroughness of the investigation is maintained the forward commander, who must be a member not involved in the care or custody of the deceased, will:

- take control of the incident

- establish a crime scene and protect the crime scene from unnecessary or unauthorised disturbance/entry
- ensure the incident scene is safe and the safety of other persons who may be in the vicinity is considered
- secure any articles/material or other evidence used to cause death or injury
- ensure the integrity of the incident and any subsequent investigation by segregating the member(s) involved to avoid any suggestion of collusion
- ensure all members involved commence to independently prepare notes of the incident whilst the facts are still fresh in their memory
- identify any potential witnesses to allow for the taking of statements
- identify and take steps to secure any other evidence, such as patrol logs, running sheets, and custody management system documentation
- ensure the welfare needs of the member(s) involved are attended to
- appoint an independent person to assist/comfort the member(s) involved during the post incident process
- ensure the submission of the **PD148 Record of death or self-harm in custody** and **PD44** through ORMS.

State Shift Manager

Where the death occurs in police custody the SSM must:

- notify the O/C, LSA (or the nominated on call LSA officer of police)
- within the metropolitan area, notify the Metropolitan Duty Officer (officer of police)
- notify the O/C, Major Crime Investigation Branch
- notify the O/C, Traffic Support Branch (when relevant)
- notify the duty Assistant Commissioner
- notify IIS (when after-hours, notify the nominated on call officer)
- ensure the State Coroner is advised
- ensure prompt notification to the next of kin
- when the person is Aboriginal, notify Aboriginal Legal Rights Movement (ALRM)—when after-hours attempts to contact ALRM are unsuccessful follow-up must occur during business hours to ensure the notification is completed in a timely manner.

Major Crime Investigation Branch

Major Crime Investigation Branch is responsible for the investigation of all deaths in police custody, with the exception of deaths resulting from of a police pursuit.

Major Crash Investigation Section

Major Crash Investigation Section is responsible for the investigation of deaths in police custody as a result of a police pursuit.

Internal Investigation Section

Members from IIS will generally attend the scene and ensure the integrity of the scene, proper collection of evidence and the independence of the investigation.

7. ROLES AND RESPONSIBILITIES—DEATHS IN NON-POLICE CUSTODY

Deaths in non-police custody include:

- deaths in a DCS facility
- deaths which occur whilst on home detention—sentenced prisoner
- deaths which occur whilst on home detention—bail
- death of a *sentenced* prisoner in a health care facility
- deaths whilst under an order granted under section 32(1)(b) of the *Guardianship and Administration Act 1993*
- deaths whilst under an order granted under part 5 of the *Mental Health Act 2009*.

As per section 21 of the *Coroners Act 2003*, a mandatory inquest is held for all deaths in custody by the State Coroner, with the exception of the following circumstances:

- when the deceased was on home detention at the time of death and the deceased was not present at the place in which they are to reside according to their conditions, for example out on leave without an escort or cutting off their home detention bracelet; or
- the deceased was a parolee on strict reporting conditions or electronically monitored.

In these circumstances, the death is not a death in custody as per the *Coroner Act 2003*; however, the direction from the State Coroner is that the death is to be investigated as a death in custody until the State Coroner, in consultation with CIS, deems otherwise. An email is to be sent to the O/C, CIS (SAPOL:Coronial Investigation Section), advising of the death and seeking classification from the State Coroner.

Where the death may be the result of a criminal offence, MCIB must be advised.

A preliminary coronial file is not required to be submitted for any deaths in custody (police or non-police). A **PD44** and identification statement are the only documents required to be submitted through ORMS prior to the end of shift for these matters. Refer to **8. COMPILATION OF CORONIAL FILES, Coronial file—other circumstances** further in this General Order.

Coronial Investigation Section

Coronial Investigation Section will:

- Notify the State Coroner of all deaths in custody (police and non-police)—where there is some doubt as to whether or not a death falls within the definition of a death in custody, the State Coroner, in consultation with CIS, will make a determination. In this instance the death should be treated and investigated as though it is a death in custody until further notice from CIS.
- Act in a consultancy and oversight role for all deaths in non-police custody.

- Be responsible for investigating any death in non-police custody when a DCS prisoner has been transferred to a health care facility for palliative care, for example long term illness and is not expected to survive.

Police Corrections Section

Police Corrections Section will investigate a death in non-police custody where:

- any sentenced or remanded prisoner dies while in DCS custody—DCS facilities include:
  - Adelaide Remand Centre
  - Adelaide Pre-Release Centre
  - Adelaide Womens Prison
  - Cadell Training Centre
  - Mobilong Prison
  - Mount Gambier Prison
  - Port Augusta Prison
  - Port Lincoln Prison
  - Yatala Labour Prison
  - any premises declared to be a prison pursuant to section 18(1) of the *Correctional Services Act 1982*
- the deceased was a DCS prisoner:
  - on home detention (sentenced), for example when a prisoner had been granted home detention to complete the remainder of their sentence outside of a DCS facility
  - who (sentenced or remanded) had been transferred to a health care facility (such as a hospital) to receive treatment on a non-permanent basis (short term stay)
  - who had been transferred to a DCS health care facility
  - who (sentenced or remanded) had been transferred to a secure mental health care facility such as James Nash House, Glenside or the Margaret Tobin Centre to receive treatment on a permanent or non-permanent basis (does not include persons detained at a secure mental health care facility pursuant to section 269 of the *Criminal Law Consolidation Act 1935*).

Local Service Area Criminal Investigation Branch

LSA CIB are responsible for investigating deaths in non-police custody when:

- The deceased was on home detention, but not yet sentenced, for example was on bail/remand awaiting sentence.
- The deceased had been sentenced under the *Criminal Law Consolidation Act 1935* to a health care facility (for example a mental health institution such as James Nash House) to complete their sentence having never been admitted into a DCS facility.

- The deceased was *detained* to reside at a particular place through the issue of an order granted under section 32(1)(b) of the *Guardianship and Administration Act 1993*.
- The deceased was *detained* to reside at a particular place through the issue of an order granted under part 5 of the *Mental Health Act 2009*. These orders are referred to as a Level 1, 2 or 3 Inpatient treatment order (not to be confused with a Level 1, 2 or 3 Community treatment order).
- The deceased was a parolee who was under strict reporting conditions or electronically monitored.

8. COMPILATION OF CORONIAL FILES

Preliminary coronial file

The following documentation is the minimum required in a preliminary coronial file and provides essential timely information to assist the pathologist conducting the post mortem examination and addressing the critical issues of identification and notifying next of kin:

- **PD63 Coroners brief cover**
- **PD44**
- statement of identification (stand-alone statement required)
- statement of last person to see deceased alive
- statement of person finding deceased
- statement of investigating officer, which will include life extinct details from either:
  - certifying medical practitioner
  - South Australian Ambulance Service (SAAS) patient form which has been endorsed by a SAAS paramedic certifying life extinct—this form is to be submitted with the file where applicable.

When one person can provide a statement for more than one of the criteria of the preliminary coronial file, such as the *last to see* and *first to find*, this can be included in one statement. The exception to this is that a separate statement is always required from the person identifying the deceased. The preliminary coronial file must be completed and submitted to CIS via ORMS by the end of shift. Documents that cannot be uploaded onto ORMS such as hand written identification statements need to be faxed to CIS by the end of shift. Any outstanding enquiries (for example when the *last to see* cannot be identified) need to be highlighted by sending an email to CIS (SAPOL:Coronial Investigation Section) or calling CIS before the end of shift or at the latest, 8.00 am the following morning.

A preliminary coronial file is not required to be submitted for all deaths in custody (police or non-police), homicides and major crash investigations. Refer to **8. COMPILATION OF CORONIAL FILES, Coronial file–other circumstances** further in this General Order.

PD63 Coroners brief cover

The coroner's brief cover is generated through ORMS and must include:

- the deceased's full and correct name
- any names (nicknames) the deceased was commonly known by—this information is provided to the Registrar of Births, Deaths and Marriages and the death is registered in both the correct name and the common name
- full and correct contact details, including telephone numbers, of any witnesses who have supplied statements
- full and correct details of the deceased's regular medical practitioner.

PD44 Report of death

When an investigating officer attends a death that is reportable to the State Coroner they must enter a **PD44** onto ORMS prior to the end of that shift.

The Coronial process user manual contains comprehensive information to assist a member to complete a **PD44** and is available through the intranet at <police connect home page/essentials/orms/help/manuals/option 9>.

A member must ensure that free text fields in the **PD44** contain a succinct but detailed summary of information obtained, including essential information contained in witness statements. The information contained in the **PD44** must be of sufficient relevant detail to assist the pathologist conducting a post-mortem examination to determine a probable cause of death.

In the event that ORMS is temporarily offline and an electronic **PD44** is unable to be completed, a hard copy **PD44**, titled '**Emergency printable PD44**' (PDF) is available on the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations>. This form must be completed by the end of shift and faxed to CIS with all other statements which form part of the preliminary coronial file. The file will still need to be uploaded electronically as soon as possible.

Statements

All statements must be prepared on a **PD114 Affidavit (PD114)** and either signed and witnessed, or endorsed 'signed in notebook'. The statements must be electronically uploaded to ORMS during the creation of the **PD44** prior to the end of the shift and hard copies forwarded to CIS. When these statements cannot be provided prior to the completion of the investigating officer's shift CIS must be immediately advised or where after-hours, before 8.00 am the following morning.

All **PD114s** submitted for *police deaths in custody* and *non-police deaths in custody* must be signed before submission to CIS.

All statements must comply with format and presentation standards. In particular, all statements must have a title introducing the matter in which the statement relates. An example of this is:

> **Relative to the death of (insert full name of deceased), born on the (insert deceased's date of birth), of (insert deceased's address)**
>
> **TYPE OF STATEMENT (Such as FIRST TO FIND)**

Examples of statements are available on the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations/coronial briefs – example statements>.

Statement of identification—visual

A statement from the person identifying the deceased must include:

- details of the person who identified the deceased
- the person's relationship to the deceased
- how long the person knew the deceased
- the last time the person saw the deceased
- time, date, location where the identification is made
- name of the member the identification was made to
- full details of the deceased.

In order for the State Coroner to accept a formal identification, the time, date and name of the member the deceased was identified to must be clearly established.

The proforma identification statement which forms part of the **PD44** available through ORMS should be used and the details entered onto this proforma in handwriting must be legible.

In cases of homicide, where an identification statement is to be submitted on a **PD114**, the information provided in that statement must include the following:

At .....(time)..... am/pm on .....(date)....., I identified the body of .....(full name of deceased), born ....., late of .....(address)....., to .....(name of police officer conducting identification).

Identification statements will not be accepted by the State Coroner unless they are signed and witnessed, or are endorsed 'signed in notebook' (in circumstances when a notebook identification statement is obtained).

A visual identification will not be accepted by the State Coroner when the deceased's face is disfigured or shows signs of decomposition. CIS can provide advice or assistance when required. When a visual identification is conducted and then not accepted by the State Coroner, CIS will advise the investigating officer and issue a CIR via ORMS, requesting a non-visual identification. When the investigating officer is no longer on duty and won't return to duty the following day, CIS will contact the responsible LSA and request a non-visual identification be conducted as a priority. Refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Identification**, *Non-visual identification* further in this General Order.

The submission of the identification statement must be treated as a priority during any investigation into a reportable death.

Statement of last person to see deceased alive

An investigating officer must make enquiries to identify persons who saw the deceased prior to their death. The purpose of the statement is to establish the demeanour, wellbeing and circumstances of the deceased in the time proximate to their death. There may be more than one person who can provide relevant information regarding the circumstances of the deceased person proximate to the time of death. In those cases a statement should be obtained from each person.

The statement should include, but not be limited to:

- time, date, place last seen
- mental and physical health of the deceased at that time
- details of deceased's last meal (where known)
- any pertinent conversation the person had with the deceased
- details of any observations the person made about the deceased's behaviour
- any recent medical treatment or hospitalisation the person may be aware of
- any other relevant information.

Statement of person finding deceased

The purpose of this statement is to provide information about the circumstances and environment in which the deceased was found. The statement also records critical information about witnesses' movements at the scene and any movement of or interference with the deceased or other evidence that might occur as part of resuscitative efforts.

The statement should include, but not be limited to:

- time, date and exact location found
- the position of the deceased when found
- circumstances under which the deceased was found
- environmental factors at the time the deceased was found
- observations of any other factors
- details of any injuries, vomit, urine, faeces, blood stains
- any observations of apparent disturbance that may suggest suspicious circumstances
- whether the deceased has been moved prior to police arrival, and where movement has occurred, how and why
- identification of any object involved in the death or which may have contributed to the death
- details of suicide notes (for example written, visual or audio recording or stored on computer) and when they have been handled, removed or erased prior to police arrival
- details of any recent medical treatmlent or hospitalisation
- details of any action taken by the person finding the deceased

- any other relevant information.

Statement certifying life extinct

A separate statement certifying life extinct is no longer required to be submitted. This information is now to be included as part of the investigating officer's statement and can be satisfied by one of the following:

- a SAAS paramedic certifying life extinct, with a copy of a signed SAAS patient report form which has been endorsed by a SAAS paramedic certifying life extinct and is included in the file
- a medical practitioner certifying life extinct
- two medical practitioners have signed that the patient is brain dead, with the hospital certificate included in the file.

The information contained in any of the above documents must be clearly legible and include:

- sufficient details to identify the deceased
- the time and date of death and the time and date that death was pronounced
- the name and signature of the person certifying death.

Statement of investigating officer

An investigating officer's statement must include all the facts, evidence or information obtained up to the time of submission to provide the State Coroner with a clear appreciation of the cause and circumstances which may have contributed to the death of a person. Hearsay or legally inadmissible matters may be included.

The statement should include, but not be limited to:

- observations of the scene
- observations of the deceased
- examination of the deceased
- identification
- personal and medical history of the deceased
- other information relevant to the matter
- exhibits identified and seized (Police property management system (PPMS) number(s) must be included)
- other property retained for safekeeping
- attendance of other police personnel
- conveyance of the body
- opinion as to the cause of death.

The investigating officer must include in the statement their opinion regarding the manner of death. This opinion should be formed and supported by the evidence and all available information gathered during the investigation.

In the case of protracted or complex investigations the investigating officer's statement may not be completed by the end of the shift. In those cases the investigating officer will submit an interim investigating officer's statement containing sufficient information to provide the State Coroner with a clear indication of the likely cause and known circumstances of the death.

Where a member attends a reportable death and commences an investigation that member is required to submit an investigating officer's statement as to their actions at the scene and any enquiries initiated by them regardless of the matter being subsequently allocated to another investigator.

The investigating officer or attending CIB is responsible for investigating and reporting any recent domestic violence (DV) history (where applicable) through including in their statement whether or not DV played a role in the death and whether the deceased is the victim or perpetrator of DV.

Where a cause of death is given ensure the mandatory email to CIS (SAPOL:Coronial Investigation Section) includes:

- the actual cause of death
- any reference by the doctor issuing the cause that the death is in any way heat related.

Hot weather deaths

Additional information has been requested by the State Coroner regarding deaths when the forecast temperature for the day is 35 degrees celsius or above, and where there is no cause of death given. The following additional information must be covered in the investigating officer's statement, and is available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation unit>:

- name and contact details of the treating general practitioner
- details of next of kin
- opinion as to cause of death
- if the current hot weather conditions have contributed to or have been the cause of the death
- the room temperature or a description of how hot it was in the room (or other area) where the deceased was located
- if there was air conditioning in the house/building, if so what kind of air conditioning and whether it was turned on or off
- conditions of house (closed up, stifling et cetera) and what the occupant may have been doing to keep themselves cool (if anything)
- if there is any evidence of power blackout recently or currently in effect at the time of police attendance
- if the deceased suffered any mobility restrictions
- if the deceased suffered any mental impairment
- if the deceased was under the influence of alcohol or drugs
- if the deceased was engaged in any vigorous outdoor work/activity

- any medications known to be used by the deceased, ensuring they are recorded and photographed
- ensuring photographs are taken of the scene, particularly of the body in situ and a full view of the face.

CIB investigating officer's statement

A CIB member attending a tier 1 or investigating a tier 2 reportable death is required to submit a CIB investigating officer's statement.

In respect to attending a tier 1 reportable death the CIB investigating officer's statement should include, but not be limited to:

- the officer's role and their observations of the scene
- enquiries conducted by them and the results of those enquiries
- opinion as to whether the death is suspicious or not
- whether the CIB member is satisfied that all relevant lines of investigation have been considered with reference to the general duties member's tier 1 investigating officer's statement.

The CIB investigating officer's statement submitted by a CIB member attending a tier 1 reportable death must be uploaded to ORMS prior to the end of that shift.

In respect to a tier 2 reportable death the CIB investigating officer's statement must provide a comprehensive summary of all information collected and further enquiries conducted after the submission of the preliminary coronial file.

Particular attention should be given to DV history (where applicable) when investigating deaths. DV should be covered in the CIB investigating officer's statement, including whether the deceased is the victim or the perpetrator of DV and whether or not DV played a role in the death.

Other statements—treating healthcare professionals

It is the responsibility of the investigating officer to ensure the deceased's treating medical practitioner is contacted regarding their ability to issue a cause of death certificate. A medical practitioner cannot issue a cause of death certificate when the death is a reportable death under the *Coroners Act 2003*.

In the event the medical practitioner is unable to issue a cause of death certificate or the death is a reportable death under the *Coroners Act 2003*, a member may be required to obtain a statement from the medical practitioner covering, but not limited to the following:

- opinion as to the most likely cause of death (where appropriate)
- the deceased's medical/psychiatric history
- medications prescribed and reason why prescribed
- any specialist referrals and reason for such referrals
- any recent hospital admissions and reason for those admissions
- details of any recent consultations.

In the event a medical practitioner statement is required, a CIR will be issued to the investigating officer to obtain it.

In relation to tier 2 deaths, a treating healthcare professional's statement will be required in most circumstances. In this instance, a CIR will be allocated to the CIB investigating officer. It is imperative that efforts be made to obtain statements from treating healthcare professionals at the commencement of the investigation to allow the witness time to seek legal advice (when required) and avoid overdue CIRs.

Statements must be arranged through the treating healthcare professional's respective manager/risk manager (where applicable). Statements must be obtained in person or via the telephone and signed by the treating healthcare professional. For further information, refer to the SA Health *Protocol for police requests for information and witness statements in the public health system in South Australia* (refer to **11. REFERENCES** further in this General Order).

Other statements—mental health

When a tier 2 death has occurred, in particular a suicide, and there is a suggestion the deceased suffered with a mental health condition, statements from the deceased's health care professionals will be required when submitting the completed file to CIS. These statements will inform the State Coroner as to the level of care provided to the individual, and to assess whether or not the mental health system is adequate.

Information gleamed throughout the course of the investigation from relatives and/or friends of the deceased should give some indication on the deceased's mental health status at the time of death. Not all deceased persons with a mental health illness engage with mental health services nor are they diagnosed with a mental health condition. It is important the investigating officer establishes the extent of the deceased's mental health condition, how their condition was being treated, whether or not the deceased engaged with further services and whether the treatment the deceased received was appropriate.

Consideration should be given to obtaining statements from, but not limited to:

- the deceased's last known general practitioner
- the deceased's psychiatrist
- the deceased's psychologist
- any counselling service the deceased engaged in
- any known mental health service the deceased person had engaged in, including Assessment and Crisis Intervention Service (ACIS).

Generally when a CIR is issued to the investigating officer, it will include a request to obtain a statement from the deceased's medical practitioner, paying particular attention to the deceased's mental health. Areas to be covered in a statement from a medical practitioner or mental health service provider might include, but not limited to:

- diagnosis of the deceased's mental health condition
- cause of the mental health condition (where applicable) estimated time the deceased has suffered with the mental health condition(s)
- treatment plan(s)
- referral to a specialist for example psychologist, counsellor, other mental health care provider

- whether or not the deceased engaged in further services
- prescribed medications, dosages, side effects, interaction of prescription drugs with other drugs/alcohol et cetera
- stated intentions to self-harm/suicide
- previous suicide/self-harm attempts
- any admissions or assessments with other health care facilities due to mental health
- support available to the deceased for example supportive family/friends, other services
- prognosis.

The investigating officer will need to assess how many statements are required and from which medical professionals, on a case by case basis. When enquiries are conducted into the deceased's mental health and there doesn't appear to be any relevant history or information regarding the deceased's mental health, this information should be outlined in the CIB investigating officer's statement. All attempts and enquiries made by the investigating officer to ascertain the deceased's mental health history should also be included in the statement. CIS can provide further information when required.

Difficulties with obtaining treating healthcare professional statements

Genuine attempts to obtain treating healthcare professional statements must be undertaken by the investigating officer at the commencement of their investigation. When difficulties arise with contacting and obtaining a statement from the treating healthcare professional, the investigating officer will contact CIS for assistance.

The investigating officer must endeavour to make three concerted documented attempts to obtain this statement, prior to liaising with CIS for assistance. CIS will conduct enquiries and if required will take the statement. This will be at the direction and assessment of the O/C, CIS.

Coronial file—other circumstances

Suspicious deaths

Where a death is not a homicide but is being investigated with a view to determining whether it is suspicious, the preliminary coronial file must be followed by a full coronial investigation file within six months of the reported death unless criminal charges are being considered. When the investigation exceeds six months and charges have not been laid, the investigation must be referred to the O/C, MCIB for recording and monitoring. The State Coroner will be appraised accordingly by the O/C, MCIB.

A **RF2185 Body Release Authorisation (RF2185)** is required from the investigating officer before the deceased's body can be released to the family or funeral home. For further information refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Body release** further in this General Order.

Homicide

A **PD44** and identification statement are the only documents required to be submitted through ORMS for all homicides prior to the end of the shift (consultation must occur with a member of the Major Crime Investigation Section prior to submission).

A full Coroner's file must be submitted by the investigating officer in accordance with MCIB requirements once the investigation is complete either:

- within 28 days of the conclusion of the criminal trial process and appeal period; or
- in unsolved cases—in accordance with any agreement between the State Coroner and the O/C, MCIB.

A CIR will be issued for the Coroner's file once all matters in the criminal jurisdiction have been finalised.

A **RF2185** is required from the investigating officer before the deceased's body can be released to the family or funeral home. For further information refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Body release** further in this General Order.

Homicide victims may require their fingerprints taken before the body is released, this is to be organised through the Fingerprint Bureau.

Long term missing persons

A Coroner's file may be required in respect to a long term missing person; however, this can only be determined on a case by case basis. On occasions the family of a long term missing person may request police for a 'deceased' status and seek an inquest. A member must not pre-empt the holding of an inquest on behalf of the State Coroner. The decision to submit a full Coroner's file will be in accordance with any agreement in place between the State Coroner and the O/C, MCIB.

Coroner's files for such cases will be the responsibility of the LSA member responsible for the investigation, unless the matter has been declared a major crime in which case they will be prepared by MCIB.

O/C CIS will consult and seek approval from the State Coroner before a **PD44** is submitted for missing persons.

Major Crash Investigation Section

A **PD44** and identification statement are the only documents required to be submitted through ORMS for all major crash investigations prior to the end of the shift. A full Coroner's file must be submitted by the senior investigating officer in accordance with Major Crash Investigation Section requirements once the investigation is complete.

Additional documents—death in police custody

A death in police custody requires the submission of a **PD44** and an identification statement prior to the end of shift through ORMS. A **PD148 Record of self-harm or death in police custody** is to be completed for deaths which occur in police custody, and faxed to IIS prior to the end of shift. For further information refer to *Death in custody—investigation guidelines.*

A **RF2185** must be submitted to the Coroner's Office before the deceased's body can be released to the family or funeral home.

The O/C, CIS will arrange to meet with the senior investigating officer and State Coroner's Counsel Assisting at the earliest opportunity to address lines of enquiry.

Final report—death in police custody

The appointed investigating officer must ensure the provision of monthly progress reports to the O/C, IAS by the 25th of each month. The O/C, IAS will report the status of the investigation to the OC, CIS on a regular basis, for the OC, CIS to update the State Coroner's Counsel Assisting.

The final investigating officer's report must be provided to the State Coroner within six months of the death. Prior to providing the report to the State Coroner the investigating officer must ensure that a full copy is provided to the O/C, E&PSB for review. In the interim the State Coroner will be advised through the normal progress report that the investigation is under review by E&PSB.

The O/C, E&PSB will review the death in police custody investigation report and advise the relevant manager/investigating officer when the original report can be released to the State Coroner. The O/C, E&PSB is responsible for apprising the State Coroner of the status of any other relevant investigation (that is, a corporate review or disciplinary investigations).

The IAS is responsible for coordinating the submission of the full investigation report. Full investigation reports must be submitted to the O/C, IAS within three months of the incident unless otherwise arranged.

Additional documents—death in non-police custody

A completed **PD44** and preliminary coronial file must be submitted to CIS before the end of the shift.

Final report—death in non-police custody

The investigating officer will submit three-monthly progress reports (vetted by their manager) to the O/C, CIS who will forward to the State Coroner's Counsel Assisting. The final *Death in non-police custody report* will be submitted through their manager for review and then to the O/C, CIS for final quality control. The O/C, CIS will deliver the final report to the State Coroner's Senior Counsel Assisting. Members should also refer to the *Death in custody—investigation guidelines* (refer to **11. REFERENCES** further in this General Order).

9. CORONIAL INQUESTS

The jurisdiction of the Coroner's Court is to hold inquests in order to ascertain the cause or circumstances of the events prescribed by or pursuant to the *Coroners Act 2003* or any other Act. However, where a person has been charged in criminal proceedings with causing the event that is or is to be the subject of an inquest the inquest cannot commence or proceed until the criminal proceedings are concluded. A member may be required to attend and give evidence at an inquest or to provide material for the purposes of assisting the State Coroner to determine the need for an inquest.

Initial notification

Where a member receives initial notification by email and a PD90 **Court attendance (PD90)** pursuant to section 23 of the *Coroners Act 2003* from CIS to attend a Coroner's inquest they are to comply with the requirement and confirm that their LSA/branch is aware that the request is received.

In circumstances where a member receives a request which has not come from CIS they are to contact CIS and their manager immediately and advise them of the details of the request.

Where a SAPOL employee other than the investigating officer has been requested to produce documents or records, they must advise the investigating officer of the request without delay.

Member receiving subpoena

A member receiving a subpoena to attend a Coroner's inquest or to produce documents must notify the following:

- their LSA/branch manager
- CIS and advise the details and requirements of the subpoena their LSA/branch manager
- O/C, IAS.

Refer to General Order, **Disclosure compliance and subpoena management**.

Officer in Charge, Coronial Investigation Section

O/C, CIS will ensure:

- the LSA/branch manager and the investigating officer who submitted the investigation file are aware of the inquest and request for documents and respond in accordance with this General Order
- that staff at the Coroner's Court are spoken to in order to identify all personnel within SAPOL who have or may receive a subpoena
- that advice is provided to the member and where necessary an induction is provided about Coroner's Court processes.

Officer in Charge, Executive Support Section

The Officer in Charge, Executive Support Section will, in the case of an inquest into a death in custody and where a recommendation has been directed at SAPOL, prepare (pursuant to section 25 of the *Coroners Act 2003*) a draft report for the relevant Minister giving details of any action taken or proposed to be taken in consequence of those recommendations.

10. CORONIAL INVESTIGATION CONSIDERATIONS

Aboriginal ancestral remains

The *Aboriginal Heritage Act 1988* provides for the protection and preservation of Aboriginal heritage of over 7300 sites within South Australia. The *Aboriginal Heritage Act 1988* provides significant penalties including imprisonment in respect to breaches concerning the discovery and handling of Aboriginal sites, objects and remains. Aboriginal ancestral remains may be uncovered due to natural erosion or human activity including mining or development of land. It is important that members ensure that the discovery of an Aboriginal site, object or remains are not removed or unnecessarily interfered with other than in accordance with the *Aboriginal Heritage Act 1988*.

Aboriginal burial site where human remains are present

When a member is tasked to attend or is advised of the existence of a suspected Aboriginal burial site (where human remains are discovered), they are to apply normal SAPOL response, investigation and crime scene preservation procedures until it can be established that the remains are not contemporary human remains and/or associated with a suspected homicide.

The site or remains must not be interfered with and the member should comply with the following instructions:

- advise ComCen of the find (when not already tasked) and the exact location, including map number and grid reference
- ensure a crime scene investigator attends to photograph the scene and liaise with Forensic Response Section (FRS) for further advice
- ensure the FRS member receiving advice of the existence of human remains contacts a forensic anthropologist/pathologist to attend the scene—where it is not practicable for the pathologist to attend the scene, the FRS member will arrange for digital photographs of the site and remains to be relayed to the pathologist
- where it can be established that there are no suspicious circumstances, and the remains are ancient Aboriginal remains ensure that the Aboriginal Heritage Branch, Aboriginal Affairs and Reconciliation Division, Department of the Premier and Cabinet are advised on telephone 08 8226 8900 of the following:
  - the circumstances of the find
  - exact location of the site
  - time and date located
  - contact details of the person/company finding the site.

Where a find is made after-hours, a member is to leave a message on the answering service and follow-up with a confirmation telephone call on the next business day—MCIB can provide advice after-hours. Once it is established that the remains are ancient Aboriginal remains the management of the site becomes the responsibility of the Aboriginal Heritage Branch with the relevant traditional owners, and/or individual or organisation/business who made the discovery.

Aboriginal site where no human remains are present

When a member attends or is advised of the existence of a suspected Aboriginal site (other than where human remains are discovered) they are to immediately advise the person locating the site that it must be left undisturbed and that it is an offence to do otherwise. The member must immediately contact the Aboriginal Heritage Branch as above. The management of the site thereafter transfers to the Aboriginal Heritage Branch for further negotiation with the relevant traditional owners, and/or individual or organisation/business who made the discovery.

Authorities

Section 83C(1) of the *Summary Offences Act 1953* allows a senior police officer to authorise police to enter a premises on the grounds that an occupant of the premises has died and their body is in the premises or that an occupant of the premises is in need of medical attention or other assistance. The senior police officer issuing the authority must complete a **PD336 Authority to enter premises pursuant to section 83C (1) Summary Offences Act 1953** and forward a copy to Business Information Unit. There may be circumstances whereby the application of section 83C(1) of the *Summary Offences Act 1953* is not clear or obvious. A member who is unsure whether or not to utilise this authority, must seek direction from their respective senior police officer.

Section 83C(3) of the *Summary Offences Act 1953* allows the Commissioner of Police or delegate, to authorise police to enter a premise for the purpose of searching the premises in which a person last resided before their death for material that might assist in identifying the deceased or relatives of the deceased, and/or to take property of the deceased into safe custody. The officer of police issuing this authority must complete a **PD337 Authority to enter premises pursuant to section 83C (3) of the Summary Offences Act 1953** and forward a copy to Business Information Unit.

Pursuant to section 74BL of the *Summary Offences Act 1953*, the Commissioner of Police may delegate this power to any police officer holding a rank not lower than that of inspector. This has been determined to be the O/C, Forensic Services Branch, regional LSA O/Cs, a State Shift Manager (of or above the rank of inspector) and a Metropolitan Duty Officer (of or above the rank of inspector).

Section 22 of the *Coroners Act 2003* allows the State Coroner to issue a direction to a member of the police force to assist in obtaining evidence in relation to a coronial investigation—refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Coroner's direction** further in this General Order.

Body release

A **RF2185** is required to be completed as a matter of urgency for all deaths where the death **was or is** being treated as suspicious. The form acts as a checklist whereby each area involved in the investigation must authorise their section has completed enquiries relevant to the deceased's body. Without completing the form, the deceased's body will not be released to family for a funeral service. It is therefore imperative a **RF2185** is completed at the earliest opportunity and faxed to CIS. CIS will forward the form to the State Coroner who will complete an *Authority to destroy human remains* so the body can be released to the funeral director for burial or cremation. The **RF2185** is available on the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations/body release authorisation>.

Children

The death of a child (under 18 years) is classified as a tier 2 investigation. The attending general duties member will request the following to attend:

- CIB
- a crime scene investigator
- investigators attached to the Family Violence Investigation Section who will act in a liaison capacity and provide specialist investigative advice.

In circumstances where the child is aged six years or under **and** the death is sudden and unexplained, the investigating officer must request the attendance of FRS and complete a **PD32 Questionnaire relating to a sudden and unexplained death of an infant or child aged six years and under (PD32)**. The **PD32** forms part of the preliminary coronial file and must be provided to the forensic pathologist prior to the post-mortem.

Immediate crisis intervention counselling and longer term support is available for bereaved parents/families through SIDS and Kids SA for all sudden and unexplained deaths of children aged six years and under. Where a family requests this service, ComCen can initiate contact with SIDS and Kids SA, or direct contact can be made on their Crisis Contact Number 1300 799 656.

The *Interagency protocol for the investigation of unexplained infant and child deaths in South Australia* (refer to **11. REFERENCES** further in this General Order). The document provides a best practice approach pertaining to the operating procedures of key stakeholders, including police. These protocols should be followed to guide investigative, support and notification responses.

When a member attends the death of a child under 18 years they must advise the Department for Child Protection (DCP) of that death via the Child Abuse Report Line on telephone 131 478. Details of the deceased (including name, age, date of birth, address and any other information required to identify the child or the child's family) and the circumstances of the death must be provided to the DCP.

Coroner's direction

Section 22 of the *Coroners Act 2003* allows the State Coroner to issue a direction to a member to assist in obtaining evidence in relation to a coronial investigation.

Coroner's directions are commonly used, but not limited to, obtaining medical records from the deceased's treating medical practitioner or a health care facility.

When accessing medical records at a health care facility (which includes all Government SA Health Services and providers including public hospitals, primary health care and dental services and SAAS) a Coroner's direction is required to make the seizure of the documents. Where there is no Coroner's direction available at time of seizure, the health care facility will still provide the medical records. A Coroner's direction must be supplied to the health care facility within 48 hours of the seizure.

When the public health care facility will not release documents without a Coroner's direction, refer them to the above SA Health protocol. For further assistance or advice, contact CIS to arrange a Coroner's direction, or refer to the SA Health *Protocol for police requests for information and witness statements in the public health system in South Australia* (refer to **11. REFERENCES** further in this General Order).

A Coroner's direction is required when accessing medical notes from a private facility.

A member requiring a Coroner's direction must contact CIS who will arrange for the direction to be issued on the investigator's behalf. An email should be sent to CIS (SAPOL:Coronial Investigation Section) stating:

- the deceased full name, date of birth and address
- the full address of the health care facility or place holding documents/exhibits
- what items are intended to be seized for example medical case notes, x-rays, and any other document
- name, rank and identification number of the member seizing the documents.

It is suggested the investigating/seizing officer contact the risk manager at the health care facility to arrange collection of the notes prior to attending. A reasonable time frame should be allowed for the health care facility to make a copy of the notes before handing the original notes to police.

When it is suspected a criminal offence has been committed and a death results, a general search warrant should be used when seizing exhibits/documents. When it appears the death has not resulted from a criminal offence, a Coroner's direction is to be utilised.

When a Coroner's direction is required after-hours, and as a matter of urgency, a pre-typed Coroner's direction (PDF) is available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations/coroners direction>. These should only be used when there is insufficient time or opportunity to request a Coroner's direction be issued through CIS.

Medical notes should not be booked onto the PPMS. Once the notes are supplied to the State Coroner, they become the property of the State Coroner. The Coroner's Office will ensure the notes are returned to the health care facility once the matter is finalised.

Disclosure

A supervisor/member will seek direction from their LSA/branch CIB manager when a member is unsure whether to release a document or thing because it may:

- not be relevant to the State Coroner's inquest
- be subject to a claim of privilege.

A supervisor will ensure that LSA/branch managers are advised of any request/direction from the State Coroner for disclosure of documents and that the O/C, CIS is notified unless the investigator seeking the material is a member of CIS. Further advice can also be obtained from IAS where necessary.

Public interest immunity (PII) can arise when disclosure of particular documentary material would be against the public interest.

McNicol (1992) states:

> ...to ensure that harm shall not be done to the State or the Public Service by the disclosure of documents or information.
>
> McNicol, S. (1992) The Law Privilege, Law Book Co.

Telephone numbers and home addresses of witnesses, when not relevant to the inquest, are confidential information and will also be identified, recorded and progressed with any PII claim. The State Coroner does not normally take issue with confidentiality claims.

The relevant pages of documents where a PII or confidentiality claim is made will be redacted (masked) by IAS. IAS can be contacted for further information or advice.

Claims of immunity in coronial matters usually relate to police procedures, current investigations or intelligence products. Immunity in significant incident inquiries or Commissioner's inquiries are usually identified by the Inquest Management Team from IAS, who are responsible for coordinating any PII claims for these investigations.

The case of Sands v Channel Seven Adelaide Pty Ltd & Anor contains an excellent analysis of PII and the balancing process:

> 173 A court will not order the production of a document, or require a question to be answered if "it would be injurious to the public interest" to do so, even when the evidence is relevant and otherwise admissible.

A non-redacted and a redacted copy of any documents will be provided to the State Coroner.

Drugs

It is the responsibility of the investigating officer to make a thorough search for illicit drugs and prescription medications when investigating any reportable death, regardless of the suspected cause. The **PD44** (generated through ORMS) includes mandatory fields in respect to investigating the source of drugs that may be present at or linked to a reportable death.

On some occasions the involvement of drugs may not be known until the results of the post-mortem are received. When drugs are located at or linked to a reportable death the investigating officer is to ensure that a rigorous and thorough investigation ensues with a view to establishing the source (that is the prescriber and/or supplier) of the drugs.

Prescribed drugs are to be itemised and booked into exhibit property.

When the source of prescribed drugs is established the investigating officer's statement will include:

- a medical inventory of the drugs/description
- name of prescribing pharmacy
- date dispensed
- name of prescribing doctor(s)
- quantity dispensed and quantity of medication remaining.

Statement(s) shall be obtained from any treating/prescribing doctor(s) and should include specialist referrals, hospital admissions and details of any recent consultations.

When the source of illicit drugs is established the investigating officer's statement will include (where possible):

- the identity of the source
- statement/record of interview of the source

- any criminal charges that have or may arise against any person
- the results of an analysis of the illicit drug(s).

Where the investigation into the source of any illicit drug may become complex or protracted, then the O/C of the relevant CIB should be consulted with a view to allocating that part of the investigation to a CIB investigator. Where the source of the illicit drug(s) is established and investigations are ongoing in relation to the supply/possession of illicit drugs, the investigating officer's statement should not disclose any information that may jeopardise an ongoing investigation.

Members can seek advice from the O/C, MCIB in relation to ensuring that the State Coroner is aware of the circumstances and consideration is given to the making of a claim of public interest immunity in respect to the disclosure of relevant coronial documents until the investigation is completed.

Where the source of the drugs (prescribed or illicit) cannot be established the investigating officer's statement must contain a full drug inventory and outline all the enquiries that were conducted in attempting to establish the source of the drug(s).

The O/C, CIS will monitor and review each such investigation through ORMS.

Exhumations

Officers from South Australia's Department of Health are responsible for attending exhumations/re-interments. However, police will attend when the Department of Health advise that their officers are unable to attend.

When a member attends an exhumation/re-interment, they are to place the name of their LSA, station and the date, on the back of the licence and sign it. A member must remain at the scene until the exhumation/re-interment is complete.

Reporting

When a member attends an exhumation/re-interment they must attach a report to the PCO file including:

- full name and age (at death) of the deceased
- date and place of burial/re-interment, with details which identify the portion of the cemetery where the exhumation/re-interment took place—for example number of grave, number of path and name of road (where there is any)
- date of exhumation—where an exhumation is undertaken
- time of re-interment and the name and address of the person re-interring the remains—where a re-interment is undertaken
- whether the exhumation/re-interment was carried out according to the conditions of the licence
- whether the member signed the licence.

Exhumation for Coroner's inquest

Where a member is present at an exhumation ordered by the State Coroner, the member will accompany the remains to the place ordered by the State Coroner.

When a member attends an exhumation which the Attorney-General has authorised on private application, the member will submit a **PD50 Advice of charges for police services** covering the costs for the member(s) attending and a report to the Commissioner of Police. Refer to General Order, **Rates—service fees**.

Foreign nationals

A number of procedures have been put in place by the Australian Government relating to the death of a foreign national. Where a member becomes aware that a deceased person is a foreign national they shall advise the State Shift Manager who will be responsible for advising the Department of Foreign Affairs and Trade and the person's consulate or embassy as soon as practicable. Additionally, Australian authorities are required to inform Chinese, Vietnamese and Indonesian consular officials of the death of their nationals without delay and provide a copy of the death certificate upon request. Further detail regarding the death of foreign nationals is outlined in *Detention or Death of a Foreign National in Australia* (refer to **11. REFERENCES** further in this General Order).

Human remains

A member may sometimes be required to handle disfigured and/or dismembered bodies or body parts. Whilst it is crucial that evidentiary requirements are met for identification and investigation purposes, when confronted with such incidents, it is imperative that:

- the dignity of the deceased person(s) is maintained
- attempts are made to locate and recover all human remains
- personal work health, safety and welfare issues are identified and addressed.

Major Crash Investigation Section and the Forensic Services Branch can each provide advice on the most appropriate recovery method and collection of human remains.

Identification

Members who attend a reportable death are responsible for obtaining and submitting identification evidence for the consideration of the State Coroner. Proof of identity is to be treated as urgent when visual identification is unreliable or impossible.

Where identification is not completed before the end of the shift, the investigating officer must ensure that another member is delegated this responsibility and the identification process remains a high priority. CIS shall be advised of what arrangements have been made as soon as possible by email (SAPOL:Coronial Investigation Section) or fax.

Visual identification

Formal visual identification of the deceased can occur at the scene where the deceased was located, at a hospital or at the Forensic Science SA (FSSA) mortuary.

When a member is required to undertake an identification at (FSSA) mortuary, prior to attendance at FSSA for identification of a deceased person, a time will have been booked with FSSA pathology staff.

The following applies for the visual identification process:

- The person(s) completing the formal identification of the deceased person will attend FSSA security and will be met by the SAPOL member(s) conducting the identification process.
- The member(s) must remain with the attending person(s) at all times whilst at FSSA.
- The person(s) completing the formal identification of the deceased person will be directed to the southern side of the Forensic Science Centre to await entrance to the viewing area.
- FSSA security will notify a pathology staff member to open the southern viewing room entrance.
- In order to ensure the correct deceased has been made available for identification the pathology staff member will invite the member into the viewing area and discretely hand the member log-in details to confirm the name and date of birth of the deceased to be identified.
- Once the member has confirmed these details are correct other attendees will be permitted to enter the viewing area.
- On completion of the identification the member will place the completion card in the northern door slot to advise FSSA staff that the identification is complete.
- The member can use the phone in the viewing area if they require assistance:
  - FSSA security on OUT OF SCOPE
  - pathology staff on OUT OF SCOPE

The investigating officer must be satisfied that a visual identification is appropriate and reliable. When this type of identification is conducted, a relative or other person well acquainted with the deceased must provide the visual identification.

A statement of identification should be obtained from the person providing the visual identification and be submitted with the preliminary coronial file (refer to **8. COMPILATION OF CORONIAL FILES, Statements**, *Statement of identification—visual* previous in this General Order).

When a visual identification is conducted at a mortuary, the witness statement must not refer to the mortuary identification number. The mortuary identification number should only be included in the body of any corroborating police statement.

Having considered the nature of the relationship described in the statement between the deceased and the identifying person or on advice received from the pathologist as to the physical condition of the deceased, the State Coroner or O/C, CIS may refuse to accept a visual identification.

All necessary enquiries to establish identification of the deceased will be allocated to the relevant LSA CIB in accordance with tier 2 protocols.

Where visual identification of the deceased is not accepted, cannot be achieved or is not appropriate due to decomposition, damage, disfigurement or a multiple fatality incident, a non-visual identification process must be adopted.

Non-visual identification

Non-visual identification may be achieved, in the following order, by:

- fingerprints
- dental charts and x-rays
- circumstantial identification (refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Identification,** *Non-visual identification*, **Circumstantial identification** further in this General Order)
- DNA (for example comparison samples obtained from toothbrushes, hair brushes, family members).

Other items/factors that may assist a non-visual identification are:

- a recent photograph of the deceased for facial comparison
- physical features (for example gender, age, build, tattoos, body piercings, scars)
- medical records (for example x-rays, details of scars, metal pins, prostheses or implants).

CIS is responsible for coordinating the non-visual identification process by the relevant identification specialists. The investigating officer must assist the progress of the identification process until the identification is accepted by the State Coroner.

The Major Crash Investigation Section will manage their own non-visual identification process whilst keeping the O/C, CIS informed.

Fingerprints

Use of fingerprint records to identify the deceased by non-visual means is used in the first instance. Generally, CIS will identify that a visual identification is not suitable or will not be accepted by the State Coroner after viewing the **PD44**. CIS will then coordinate fingerprint identification through the Fingerprint Bureau and notify FSSA and the investigating officer of the pending identification.

When the identification cannot be established through fingerprints, dental identification will be the next form of non-visual identification.

Dental identification

Forensic odontology is the application of dental science to administration of the law and involves recognition, interpretation and reporting of dental evidence. The Forensic Odontology Unit is located at the University of Adelaide. Use of the Forensic Odontology Unit for identification of deceased persons for coronial matters (not criminal matters) is approved by the State Coroner and as such, SAPOL incurs no cost.

Once it is established that fingerprint identification is not possible, CIS will email the investigating officer requesting enquiries be made to determine whether the deceased has any private dental records available. Included in this email will be an *Ante mortem dental data collection* checklist to assist the investigating officer in locating dental records and/or items useful for dental comparison at the deceased's home address. CIS will only conduct enquiries in relation to Government dental records through SA Dental Service, care of Adelaide Dental Hospital.

Any dental records/items obtained do not need to be booked onto PPMS, but rather delivered immediately to FSSA reception during business hours who will contact the Forensic Odontology Unit to facilitate the dental comparison.

During the course of attending the deceased's home address for dental data, CIS will also request that items be seized to facilitate possible DNA comparison in the event that dental and circumstantial identification methods fail. This is to avoid police re-attending the deceased's premises and potentially losing evidence (refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Identification**, *Non-visual identification*, **DNA** further in this General Order). This will only be requested when the deceased does not have DNA uploaded on the DNA database.

When there are insufficient dental records/items to conduct a dental comparison, a circumstantial identification statement is required in the next instance.

Circumstantial identification

Where identification of a deceased person cannot be achieved or is deemed to be unreliable the investigating officer must submit a standalone circumstantial identification statement.

In the course of investigating a reportable death, the investigating officer will form a belief as to the identity of the deceased. In some instances this belief will not be able to be supported by visual or forensic based identification. The statement should contain comprehensive details of individual circumstances that together are sufficiently persuasive to prove on the balance of probability that the deceased is the person the investigating officer believes them to be.

A circumstantial identification statement must contain all the circumstances that support the identification of the deceased person.

The statement may include the following types of information:

- a description of the body, including reference to sex, age, tattoos, scars or other physical features—the statement should clearly confirm that the feature being described is the same or consistent with that of the person believed to be the deceased
- a description of the clothing that can be proved to belong to the deceased
- a description of property found that can be connected to the deceased (for example wallet, credit cards, jewellery, drivers licence, utilities accounts)
- any notes or correspondence left that can be connected to the deceased
- surrounding evidence such as brand of cigarette butts, type of drink containers or other items known to be used by the deceased
- that the deceased has not been seen alive since the apparent time of death
- that the deceased resided in the premises alone or when with others, that the other persons have been accounted for
- where the deceased is found in a motor vehicle that the deceased is the registered owner or where the deceased is not the owner, was known to have been in possession of the vehicle
- any other observations that indicate evidence of identity.

The final paragraph of the circumstantial identification statement should read:

> *Based on the evidence obtained, I have come to the conclusion that the deceased person found at (address) cannot be anyone other than (full name, age, date of birth, occupation, and address).*

The State Coroner will ultimately determine whether the circumstances are sufficient to substantiate identification. Where circumstantial identification is not accepted by the State Coroner, DNA comparison will be the next and final form of non-visual identification.

DNA

DNA comparison will be considered as the last option and only once all other forms of identification have been exhausted.

In the first instance, when the deceased has DNA stored on the DNA database, CIS will liaise with FSSA to arrange a comparison using the DNA database.

When the deceased does not have DNA stored on the DNA database, CIS will identify this at the dental identification stage. CIS will subsequently request the investigating officer to collect items suitable for *indirect* DNA comparison at the time of collecting dental items. Items collected may include toothbrushes, razors and hairbrushes (anything that may yield a good sample of the deceased's DNA). These items should be booked onto PPMS until required for DNA comparison, when they can be transferred to FSSA for analysis, in which instance the investigating officer will be notified by CIS.

The State Coroner directs that an *indirect* DNA comparison will be attempted prior to requesting a *direct* DNA comparison be utilised. *Direct* DNA will be requested through CIS to the investigating officer to collect DNA samples from relatives of the deceased which will be used for comparison.

Multiple fatality incidents—including road collisions

A multiple fatality incident is one that results in the death of two or more people. Visual identifications obtained in multiple fatality incidents must be supported by at least one non-visual identification process for each deceased.

When there are two fatalities in the same vehicle and both deceased are of the same gender and of similar appearance, a visual identification must be supported by at least one non-visual identification process for each deceased.

ComCen is responsible for advising the State Coroner of a multiple fatality incident. When attending a multiple fatality incident a member must advise ComCen of the following:

- probable number of deceased
- condition of deceased (for example burned or fragmented)
- nature of the incident
- nature of the terrain (such as hazards).

This information will be used to determine whether the SAPOL's Disaster victim identification emergency response plan (DVI ERP) will be activated. Where the DVI ERP is activated the incident commander and members at the scene will be advised and directed accordingly. The subsequent identification of all deceased will form part of the disaster victim identification process.

When advised that the scene will not be processed in accordance with the DVI ERP, investigating officer(s) must ensure that each deceased is numbered and the specific location from which they were recovered is recorded (such as rear driver's side seat, front bedroom under window, and so forth). A tag clearly marked with the number allocated to the deceased should be placed on their wrist and the same number should be clearly marked on the body bag used for the deceased. Where possible each deceased should be photographed in situ before being moved. Where appropriate a crime scene investigator should assist with scene recovery.

CIS is to be notified of the incident and will provide assistance, advice and coordinate the non-visual identification process.

During the recovery of human remains from a scene, the investigators and crime scene investigators must ensure:

- each human remain is numbered with a single unique identifier
- the tag is to be placed on the deceased's wrist
- where possible, each human remain should be photographed in situ before being moved
- the specific location of each human remain is recorded (for example rear driver's side seat, front bedroom under window).

Commingled human remains

The following applies for commingled human remains:

- a single unique identifier is to be used for the identification of each human remain
- each human remain is to be identified with the aid of a scene marker and single unique identifier which will then be photographed in situ, ensuring the scene marker and the single unique identifier are both visible
- the location of each human remain is to be documented by way of notes
- human remains of an identifiable nature and located separate from each other (that is not commingled) must be treated as separate remains (that is do NOT commingle) this will mitigate the risk of co-mingling which can delay the identification process
- human remains that are located in a commingled state should be collected in that commingled state and managed as one human remain (that is allocated one single unique identifier and packaged together)
- clearly identify the location and description of all collected human remains on the outer packaging
- a single unique identifier (with corresponding number to the single unique identifier used to identify the human remain in situ), is to be adhered to the outer packaging of each human remain.

Where a multiple fatality incident results in fragmentation of body parts, the deceased must be identified by DNA, dental or fingerprint evidence. Information in relation to the identification of deceased persons or body parts must not be provided to the next of kin until authorised by the O/C, CIS.

Refer also to General Order, **Vehicle collisions**.

Disaster victim identification

A multiple fatality incident requires a more controlled and coordinated approach to the recovery of the deceased (and their property). Such a controlled recovery (of the deceased) is a specialist function and forms the first phase of a disaster response. Non-visual identifications are a standard requirement for disaster victim identification.

Once advised of a multiple fatality incident (that is, two or more deaths) ComCen will notify the State Coroner. ComCen will also notify Forensic Services Branch who will respond in accordance with the State disaster victim identification plan and determine whether the incident is suitable to be processed as a *multiple fatality incident* or whether to activate the DVI ERP. The decision must be conveyed back to the scene and incident commander through ComCen at the earliest opportunity. Refer to General Order, **Vehicle collision** and SAPOL's Disaster victim identification emergency response plan.

Next of kin

The investigating officer is responsible for ensuring the next of kin is advised of the death of a person. Notification to the next of kin must remain a priority and must be completed prior to any consideration given to the publication of the circumstances of the death (such as a road fatality or suspicious death). Where the deceased is an overseas visitor or the relatives of the deceased are living or travelling overseas, the investigating officer in consultation with CIS will contact Interpol through the State Intelligence Branch.

Property

Non-suspicious deaths

In the case of non-suspicious deaths where identification or crime scene/evidentiary requirements are complete, the following instructions apply, regarding personal property:

- conduct a thorough search for personal items and remove and retain any valuable items located on the deceased person at the scene
- where a relative or person authorised to receive personal property is present, prepare a list of the property on a **PD88 Field receipt/Property release (PD88)** and use it as a release receipt—include the signature, address and designation (for example relative, solicitor, trustee) of the person receiving the property
- where no suitable person is present to receive the items, record them on a **PD88**, convey the items to the nearest police station and record them on the PPMS with the status of 'deceased'—include the original **PD88** in the preliminary coronial file

- all clothing must be left on the body—a pathologist will examine the clothing later in the mortuary where it will be removed and retained with the body (in non-suspicious cases the clothing will be returned to the funeral director appointed by the family).

No known next of kin

When a person dies and the investigating officer cannot locate the next of kin, they must take possession of the deceased's property and effects and record them on a **PD88**. The member will sign as the person receiving the property, convey the items to their station and record them on the PPMS with the status of 'deceased'. The original **PD88** is to be included in the preliminary coronial file.

When there is extensive property and the premises can be secured, only the effects which are readily portable and valuable such as jewellery, cash or valuable securities should be removed. Where it is likely that no next of kin will be found, or locating the next of kin is likely to be difficult, the investigating officer must also take possession of documents relating to banking records, solicitors, accountants or other similar documents. Any remaining property is to be secured in the premises. The investigating officer is responsible for advising the Public Trustee as soon as possible and a fax should be sent (to the Public Trustee) marked for the attention of the 'Team Leader, New Business' listing the following:

- name of deceased
- last known residential address
- description of property and where held (copy of PPMS receipt to be attached)
- current location of deceased (for example mortuary, hospital, funeral director).

Exhibits

All other items or documents that are relevant to a coronial investigation will be treated as exhibit property and entered onto the PPMS system. Where an exhibit may be relevant to the cause of death (for example mechanical fault with a motor vehicle/vessel where failure of a component may have contributed) or may be a fact or topic of interest to a Coroner's inquest, the investigating officer must ensure that the exhibit(s) are examined by the relevant expert(s).

All property kept for coronial matters (not including deceased's property kept for safe keeping) must be retained for a minimum period of three months past the issue of a finding by the State Coroner.

In the first week of each month the O/C, CIS will notify investigating officers, LSA property officers and CIB investigation managers by email details of all State Coroner's cases that have been closed (for example a finding has been issued) and associated exhibit property that can be destroyed/released. No release of exhibit property relating to coronial matters can occur until authorisation from the State Coroner through the O/C, CIS is received in writing.

When in doubt as to whether a finding has been issued and/or property can be released, CIS can be contacted.

Recommendations from the Royal Commission into Aboriginal Deaths in Custody

Pursuant to section 21 of the *Coroners Act 2003* an inquest must be held into every death in custody. All members should also be aware of recommendation 35 of the Royal Commission into Aboriginal Deaths in Custody which states:

> As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such direction should require, inter alia, that:
>
> a. Investigation should be approached on the basis that the death may be a homicide. Suicide should never be presumed;
>
> b. All investigations should extend beyond an inquiry into where the death occurred as a result of criminal behaviour and should include inquiry into the lawfulness of the custody and the general care, treatment and supervision of the deceased prior to death;
>
> c. The investigations into deaths in police watch houses should include full inquiry into the circumstances leading to incarceration, including the circumstances of arrest or apprehension and the deceased's activities beforehand;
>
> d. In the course of inquiry into the general care, treatment or supervision of the deceased prior to death particular attention should be given to whether custodial officers observed all relevant policies and instructions relating to the care, treatment and supervision of the deceased; and
>
> e. The scene of death should be subject to a thorough examination including the seizure of exhibits for forensic science examination and the recording of the scene of death by means of high quality colour photography.

Recommendation 36 of the Royal Commission into Aboriginal Deaths in Custody states:

> Investigations into deaths in custody should be structured to provide a thorough evidentiary base for consideration by the Coroner on inquest into the cause and circumstances of the death and the quality of the care, treatment and supervision of the deceased prior to death.

Solicitors

Pursuant to section 34 of the *Coroners Act 2003* a member must not divulge information about a person obtained (whether by the person divulging the information or by some other person) in the course of the administration of the *Coroners Act 2003*, except as specified within the *Coroners Act 2003*. A member should refer any requests for the release of information to O/C, CIS.

Suicide (apparent)

All suicides or suspected suicides are classified as tier 2 investigations. LSA CIB are responsible for investigating apparent suicides. An investigating officer will maintain liaison with CIS who is responsible for coordinating follow-up enquiries on all suicides in respect to the deceased person's:

- interaction with institutions
- their release and management conditions
- interaction with specialist medical providers
- psychological factors

- any other complex issues considered relevant to the circumstances of death.

Suicide notes

All suicide notes, diaries, journals, audio, video or computer recordings and similar items relating to the death or events leading up to the suicide will be treated as exhibit property. It is the investigating officer's responsibility to ensure that the deceased is established as the author of the suicide note. Any other hypotheses as to who else may have produced the suicide note are to be eliminated. This can be achieved through fingerprints, DNA or a handwriting sample. In most circumstances it will be important to communicate the content of the suicide note to the deceased's family. This can be done verbally or through producing a duplicate of the suicide note, or a copy through other means (for example video or digital photograph). Generally, a copy can be provided upon request to an appropriate next of kin, and/or the intended recipient.

Suicide notes (in original form) must be entered onto PPMS—using exhibit category 'EXHI'. The investigating officer's statement will identify the field receipt number, PPMS number, location and manner in which the item(s) were seized and packaged.

Copies of all suicide notes, diaries, journals, audio, video or computer recordings and similar items relating to the death or events leading up to the suicide will accompany the preliminary coronial file and be forwarded to CIS.

At the conclusion of the coronial investigation the property will be returned by the investigating officer to the identified relative(s) or to the estate. These articles are not to be destroyed. The investigating officer must contact CIS prior to releasing any property (refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Property,** *Exhibits* previous in this General Order).

Suicides by dangerous substances

Committing suicide by inhaling or digesting dangerous substance is becoming more frequent and presents a significant hazard for responders. These suicides often occur within a closed environment, for example a motor vehicle, toilet, bathroom or bedroom.

The person may or may not place a sign warning of the hazardous environment. When it is suspected to be a dangerous substance, emergency doors or windows must not be opened even if the person shows signs of life unless the person providing medical assistance is wearing the appropriate personal protective equipment (PPE) and all other persons have been excluded from the hot zone.

A member attending this type of event is to put in place a safety cordon surrounding the incident and request the attendance of the fire service. Refer also to the *Health and safety fact sheet 21—Chemical and detergent suicides* available through the intranet at <police connect home page/services/human resources service/health, safety and welfare branch/whs fact sheet and resources (a-z)>.

Suspected homicide

Where the death is a suspected homicide, the investigating officer must arrange for a member from the Fingerprint Bureau to fingerprint the deceased in consultation with the FRS supervisor either at the post-mortem examination or before the release of the body.

Crime scene preservation

Where a member is of the opinion the circumstances surrounding a death are suspicious, they must immediately initiate crime scene preservation processes and contact the LSA CIB and a crime scene investigator (refer to General Order, **Crime investigations** relative to crime scene investigations).

When the crime requires specialist crime scene investigation via FRS, the crime scene investigator will make the necessary arrangements, or in exceptional circumstances, the first response member can arrange this through ComCen.

It is the responsibility of the LSA CIB investigator to immediately notify MCIB of the suspicious death, and to ensure that the State Coroner (through ComCen) is notified. In the event of a murder or suspicious death the Forensic Services Branch is responsible for the coordination of the crime scene investigation response. A forensic pathologist will only attend the scene of a death after a crime scene investigator has assessed the scene. The crime scene investigator, in consultation with the investigating officer and a FRS supervisor, will be responsible for assessing whether/when it is appropriate to contact a pathologist.

A pathologist attending the scene may provide valuable assistance in determining the nature and cause of a death. When requested, a forensic pathologist may attend scenes of:

- homicides
- sudden deaths of children
- deaths in police custody
- sudden deaths where 'time of death' is an important issue
- any other deaths (suicide or unnatural) where examination of the body in situ will further the investigation.

The State Coroner has indicated a preference for a pathologist to attend all suspicious deaths and deaths in police custody.

A **RF2185** must be completed for all suspicious deaths, including suspicious deaths which after an investigation are deemed non-suspicious (refer to **10. CORONIAL INVESTIGATION CONSIDERATIONS, Body release** previous in this General Order).

Transporting bodies

Management of contaminated deceased persons

Depending on the hazardous substance involved in the dangerous substance emergency, it is likely that the deceased will remain contaminated even after undergoing decontamination efforts. Members dealing with a contaminated body are to wear PPE as recommended by the fire service or specialist agency and must be prior trained in using that PPE.

The deceased is to be placed into a special chemical and gas resistant body bag available from FRS or regional crime scene sections.

Depending upon technical advice the body may need to be placed into a second general use body bag for transport to the mortuary.

The Coroner's Office is to be contacted via Comcen for instructions as to transport and body storage arrangements.

Refer to General Order, **Dangerous substance emergencies** and the Crime scene investigation manual, (refer **11. REFERENCES** further in this General Order).

Metropolitan area

When a deceased person in the metropolitan area is to be transferred to FSSA the investigating officer must notify ComCen who will arrange for a forensic conveyancer to collect the deceased. The conveyancer will only require sufficient details to enable them to submit a conveyancer receipt form to FSSA. The member must upload the **PD44** (after being vetted by their supervisor) onto ORMS prior to the end of their shift in accordance with this General Order.

Accident and emergency centres at hospitals

Where a deceased is taken to a hospital but is not being transferred to FSSA, the **PD44** and preliminary coronial file must be provided to CIS. Where the deceased is not subject to a reportable death notification and a medical practitioner has issued a cause of death certificate, the deceased may only be left at the hospital with the permission of the triage manager. The member shall ensure the hospital mortuary staff have details of the medical practitioner issuing the certificate. When the hospital is unwilling to keep the deceased, the member must notify ComCen which will arrange for the body to be transferred.

Regional area

Removing a deceased from a scene to an appropriate place for safekeeping (with appropriate mortuary facilities) can be authorised by the investigating officer. The body should remain at the place of safekeeping until the State Coroner has directed whether a post-mortem is required. In these circumstances the Coroner's Court will provide instructions for conveying the body.

The funeral director will, upon request for the Coroner's Court, SAPOL or FSSA pick up and convey the deceased person from a location specified by the Coroner's Court, SAPOL or FSSA and where necessary, store the deceased person at secure and appropriate premises in accordance with ensuring the body is preserved and protected until such time as the Coroner's Court, SAPOL, FSSA request the body be delivered to FSSA delivery point.

When the requested funeral director is unable to attend to the task of conveying the body to either the funeral home premises or directly to FSSA then the funeral director must, as soon as possible, inform the Coroner's Court or SAPOL of the unavailability of their service so that another provider of such a conveyance service can be engaged to conduct the transfer.

The funeral director will ensure their employees perform the duties of conveying a coronial body on behalf of the State Coroner in a manner that maintains discretion, confidentiality and respect.

When a funeral director cannot be engaged for conveyance, for example in the far north of the State, or in any area where it is not practicable for a funeral director to collect a deceased, SAPOL may be required to facilitate transport.

In these circumstances a member should not convey a body unless:

- during extreme heat, the police vehicle has a suitable air-conditioned compartment or attachment in which to convey a body

- a funeral director is utilised at the nearest location
- the costs for the conveyance are charged to the Courts Administration Authority
- LSA Administration arranges all costing to be returned to the LSA budget.

The funeral director who is removing a deceased will be provided with a Form 15 Authorisation and claim for removal of body (Form 15) with part A completed by the investigating officer. A funeral director should only collect a body from a public place when ambulance personnel are not available. Where practicable, before instructing a funeral director about where a body has to be taken, decide whether it is to be returned or left at the mortuary for collection for burial. The member may have to consult relatives.

A member shall assist the funeral director in every way practicable, especially when it is necessary to lift a body. All movements of deceased persons must be recorded to ensure the chain of evidence for each deceased is maintained. When a local funeral director cannot assist, use the nearest available funeral director. Costs of conveying a body for the autopsy and return will be met by the Courts Administration Authority on a Form 15; however, subsequent costs are to be met privately.

A member should contact CIS when there are difficulties with transporting a deceased or arranging for a post-mortem examination.

Conveyance from regional area to Forensic Science SA

When a member has to transfer a deceased person from a regional area to FSSA, the Coroner's Court will forward an authority to move the deceased and provide a telephone number for the on call forensic conveyancer. The member shall telephone the forensic conveyancer and advise them of the funeral director's name. The conveyancer will contact the funeral director and arrange to transfer the deceased.

Mortuary procedures

Police stations in the regional area have procedures for admitting bodies to their local mortuary.

Funeral directors

A funeral director who is attending to burial arrangements does not have right of access to a body until the post-mortem examination has been completed and the Authority to dispose of human remains form (Courts Administration Authority form) has been forwarded to them from the Coroner's Court.

Wills

A will should not have anything fastened to it or be defaced. Where there are any marks on or holes in a will provide an affidavit for the Registrar of Probates stating the nature of the damages, and any explanation (where possible) of how the damage occurred.

11. REFERENCES

Aboriginal Heritage Act 1988

Coroners Act 2003

Coronial process user manual available through the intranet at <police connect home page/essentials/orms/help/manuals/option 9>

Crime scene investigation manual available through the intranet at <police connect home page/services/operations support service/forensic services branch/crime scene investigation manual>

Death in custody—investigation guidelines available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/deaths in custody>

Death in non-police custody report available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/deaths in custody>

Detention or Death of a Foreign National in Australia available through the intranet at <police connect home page/services/operational support service/state intelligence branch/request forms – SIB and other agencies/immigration>

Disaster victim identification emergency response plan available through the intranet at <police connect home page/services/security and emergency management service/ emergency and major event section/emergency response plans>

General Order, **Crime Management Unit**

General Order, **Dangerous substance emergencies**

General Order, **Disclosure compliance and subpoena management**

General Order, **Media affairs**

General Order, **Offender record management system**

General Order, **Rates—service fees**

General Order, **Significant incident investigations and Commissioner's inquiries**

General Order, **Vehicle collisions**

Interagency protocol for investigation of sudden unexplained infant and child deaths available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section/coronial investigations/infant and child deaths>

Major investigation emergency response plan available on the intranet at <police connect home page/services/security and emergency management service/emergency and major event section/emergency management/emergency response plans/plans-emergency response (sapol)/_corporate>

Mental Health Act 2009

Road Traffic Act 1961

Sands v Channel Seven Adelaide Pty Ltd & Anor [2010] SASC 202 (1 July 2010) available through the Internet at <http://www.austlii.edu.au>

SAPOL Disclosure Guidelines available through the intranet at <police connect home page/training gateway/resources hub>

SA Health *Protocol for police requests for information and witness statements in the public health system in South Australia* available through the intranet at <police connect home page/services/crime service/major crime investigation branch/coronial investigation section>

Summary Offences Act 1953

12. FURTHER ENQUIRIES

Officer in Charge, Major Crime Investigation Branch

13. DOCUMENT HISTORY SINCE 20/05/09

Gazette reference (SAPG)	Date	Action (amendment/deletion/new/review/temporary variation)
167/09	20/05/09	Review 2009.
156/11	01/06/11	Review 2010.
369/11	28/12/11	Review 2011—amendment at subheading **7. CORONIAL INVESTIGATION CONSIDERATIONS, Children**.
31/12	25/01/12	Amendment—deleted references to General Order 8460, **Serious crime plan** and inserted Major investigation emergency response plan.
176/13	21/08/13	Review 2012 and 2013. General Order, **Deaths/attempt self harm in custody** deleted, General Order, **Deaths** renamed General Order, **Deaths and deaths in custody**. Procedures relating to self-harm incidents in custody have been inserted into in General Order, **Arrest and custody management**.
279/13	25/12/13	Amendment—at **9. CORONIAL INVESTIGATION CONSIDERATIONS, Suicide (apparent)**, Suicide notes to reflect u sing exhibit category 'EXHI'
142/14	25/06/14	Amendment—tier 2 investigations, timeframes regarding the submission of paperwork and requirements of the life extinct statement.
217/17	25/10/17	Review 2017.

APPROVED BY COMMISSIONER/DEPUTY

..... *Print Full Name*

..... *ID Number*

..... *Signature*

10/10/2017 *Date*

Documentation certification and verification

General Order draft—prepared by: Detective Senior Sergeant Trevor Rea, Coronial Investigation Section

General Order—verified by: Detective Superintendent Des Bray, Officer in Charge Major Crime Investigation Branch

Appendix A—Deaths in custody

This flow chart is a quick reference guide that should be read in conjunction with this General Order.