

## Coroners Cases and the Coroners Act 2009

**Summary** To provide medical practitioners, health care workers and managers in the public health system with specific information about the Coroners Act 2009; and medical practitioners, nurses and midwives, health care workers and administrators with direction and guidance about reportable deaths to the NSW Coroner.

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**Distributed to** Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Private Hospitals and Day Procedure Centres

**Audience** Administration;Clinical;Nursing;Emergency Departments

### Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

## CORONERS CASES AND THE CORONERS ACT 2009

### PURPOSE

To provide:

- (a) medical practitioners, health care workers and managers in the public health system with specific information about the Coroners Act 2009; and
- (b) medical practitioners, nurses and midwives, health care workers and administrators with direction and guidance about reportable deaths to the NSW Coroner.

### MANDATORY REQUIREMENTS

Each NSW Health Agency must have effective systems and procedures in place to report deaths to the Coroner in accordance with the Coroners Act 2009 and this Policy Directive.

### IMPLEMENTATION

#### Roles and Responsibilities

**Chief Executives must ensure that:**

- the principles and requirements of this policy are applied, achieved and sustained;
- all staff are made aware of their obligations in relation to this Policy Directive;
- documented procedures are in place to support the Policy Directive;
- there are documented procedures in place to effectively respond to and investigate alleged breaches of this Policy Directive.

**Hospital Managers and Staff have responsibility to:**

- report Anaesthetic deaths to the Director-General via the Report of Death Associated with Anaesthesia/Sedation form (section 7.1);
- provide copies of medical records to the pathologist or medical officer conducting a post mortem (section 9.3);
- provide the Coroner's Office with a completed "Report of Death of a Patient to the Coroner" (form A) along with original or copies of medical records (sections 6; 9.3).

### REVISION HISTORY

Version	Approved by	Amendment notes
May 2004 (PD2005_352)	Director General	Updated to incorporate amendments to the <i>Coroners Act 1980</i>
December 2009 (PD2009_083)	Deputy Director General Population Health	Replaces PD2005_352. Updated in line with changes in the Coroner's Act 2009
September 2010 (PD2010_054)	Deputy Director General, Population Health	Replaces PD2009_083. Updated in line with provisions of the Coroners Regulation 2010

### ATTACHMENTS

1. Coroners Cases and the Coroners Act 2009: Procedures

## Coroners Cases and the Coroners Act 2009



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**Issue date:** September 2010

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## 1 BACKGROUND

### 1.1 About this document

The Policy Directive *Coroner's Cases and the Coroner's Act 2009* provides specific information about Coroners Act 2009 (the Act) and the implications for medical practitioners, health care workers and managers in the public health system.

A number of key changes have been enacted in the Coroners Act 2009 which are relevant to health care workers. These include changes in the categories of cases which must be reported to the Coroner, and changes to coronial autopsy procedures.

Current versions of the Coroners Act 2009 and the Coroners Regulation 2010 are accessible at [www.legislation.nsw.gov.au](http://www.legislation.nsw.gov.au).

## 2 DEFINITIONS

The Coroners Act 2009 Act defines the following terms that are used in this Policy Directive as follows:

**Child:** means a person who is less than 18 years old.

**Child in care** means a child or young person who is less than 18 years old:

- (a) who is under the parental responsibility of the Minister administering the [Children and Young Persons \(Care and Protection\) Act 1998](#), or
- (b) for whom the Director-General of the Department of Community Services or a designated agency has the care responsibility under section 49 of the [Children and Young Persons \(Care and Protection\) Act 1998](#), or
- (c) who is a protected person within the meaning of section 135 of the [Children and Young Persons \(Care and Protection\) Act 1998](#), or
- (d) who is the subject of an out-of-home care arrangement under the [Children and Young Persons \(Care and Protection\) Act 1998](#), or
- (e) who is the subject of a sole parental responsibility order under section 149 of the [Children and Young Persons \(Care and Protection\) Act 1998](#), or
- (f) who is otherwise in the care of a service provider.

**parental responsibility**, in relation to a child or young person, means all the duties, powers, responsibilities and authority that, by law, parents have in relation to their children.

**service provider** has the same meaning as it has in the [Community Services \(Complaints, Reviews and Monitoring\) Act 1993](#)

**Coronial proceedings:** Defined in the Act as any proceedings conducted by a Coroner or assistant Coroner for the purposes of the Coroner's Act 2009 concerning the investigation of a death, suspected death, fire or explosion. Without limiting the definition, coronial proceedings include the following:

- (a) the holding of an inquest or inquiry,
- (b) proceedings to determine whether or not to hold, or to continue to hold, an inquest or inquiry,
- (c) proceedings of an interlocutory or similar nature (including proceedings to deal with evidential matters or case management issues).

**Health related procedures:** see section 5.3; 5.3.1 & 5.3.2

**Reportable deaths:** see section 5.1

**Senior next of kin:** This is defined in section 4 of the Coroners Act to mean:

- (a) the deceased's person spouse, or
- (b) if (a) is not available, any of the deceased's adult children, or
- (c) if (a) and (b) are not available, either of the deceased's parents, or
- (d) if none of (a), (b) or (c) are available, the deceased's person's adult brothers or sisters, or
- (e) if none of the above are available, the executor named in the deceased's will or the deceased's legal representative immediately prior to death.

**Remains:** of a deceased person means the body or remains of the body (or any part of the body) of the person.

**Tissue:** includes an organ, or part, of a human body, including bodily fluids.

**Whole organ:** of a deceased person means the whole or a substantial part of a visibly recognisable structural unit of the person's body.

In the context of this Policy Directive the term Nursing Unit Manager (NUM) is interchangeable between Director of Nursing, Midwifery Unit Manager or any other nursing and midwifery position that is responsible for the management of a service or unit.

### 3 LEGAL AND LEGISLATIVE FRAMEWORK

Births, Deaths and Marriages Registration Act 1995  
Children (Detention Centres) Act 1987  
Children and Young Persons (Care and Protection) Act 1998  
Community Services (Complaints, Reviews and Monitoring) Act 1993  
Coroners Act 2009  
Coroners Regulation 2005  
Crimes (Administration of Sentences) Act 1999  
Disability Services Act 1993  
Human Tissue Act 1983 (part 7)  
Mental Health Act 2007  
Public Health (Disposal of Bodies) Regulation 2002  
Public Health Act 1991

### 4 JURISDICTION OF THE CORONER

A Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that:

- (a) the person's death is (or there is reasonable cause to suspect that the person's death is) a reportable death, or
- (b) a medical practitioner has not given (or there is reasonable cause to suspect that a medical practitioner has not given) a certificate as to the cause of death.

## 5 CIRCUMSTANCES IN WHICH A MEDICAL PRACTITIONER SHOULD NOT ISSUE A CERTIFICATE AS TO CAUSE OF DEATH

5.1 A medical practitioner must not issue a certificate as to cause of death under the Births, Death and Marriages Registration Act 1995 if the death is a **REPORTABLE** death (s6 Coroners Act 2009) i.e. :

- (a) the person died a violent or unnatural death;
- (b) the person died a sudden death the cause of which is unknown;
- (c) the person died under suspicious or unusual circumstances;
- (d) the person died in circumstances where the person had not been attended by a medical practitioner during the period of six months immediately before the person's death;
- (e) the person died in circumstances where the person's death was not the reasonably expected outcome of a health related procedure carried out in relation to the person (see below);
- (f) the person died while in or temporarily absent from a declared mental health facility within the meaning of the [Mental Health Act 2007](#) and while the person was a resident at the facility for the purpose of receiving care, treatment or assistance.

OR

if the death is a death under s 23 Coroners Act 2009 i.e.: a death in custody case where the person died:

- (a) while in the custody of a police officer or in other lawful custody, or
- (b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
- (c) as a result of, or in the course of, police operations, or
- (d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
  - (i) a detention centre within the meaning of the [Children \(Detention Centres\) Act 1987](#),
  - (ii) a correctional centre within the meaning of the [Crimes \(Administration of Sentences\) Act 1999](#),
  - (iii) a lock-up, or
- (e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

OR

if the death is a death under s 24 Coroners Act i.e.:

- (1) the death of a child who was:
  - (a) a child in care, or
  - (b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the [Children and Young Persons \(Care and Protection\) Act 1998](#) within the period of 3 years immediately preceding the child's death, or

- (c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the [Children and Young Persons \(Care and Protection\) Act 1998](#) within the period of 3 years immediately preceding the child's death, or
- (d) a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances.

OR

(2) the death of a disabled person:

- (a) a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, residential care provided by a service provider and authorised or funded under the [Disability Services Act 1993](#) or a residential centre for disabled persons, or
- (b) a person (other than a child in care) who is in a target group within the meaning of the [Disability Services Act 1993](#) who receives from a service provider assistance (of a kind prescribed by the regulations) to enable the person to live independently in the community.

## 5.2 Changes to the categories of cases that were previously reportable in the Coroners Act 1980

- (a) Deaths during, within 24 hours, or as a result of anaesthesia are no longer reportable to the Coroner unless they are captured under one of the other sections of the Act listed above. For example, if death occurred following anaesthesia and this was not a reasonable expected outcome of the procedure, the death is still reportable. (See also S7.1.)
- (b) The period where the person had not been attended by a medical practitioner for three months prior to death has been increased to six months.
- (c) The limitation whereby a death need be reported only if it occurred within a year and a day of an accident has been removed.
- (d) A death is not reportable if it follows an accident attributable to old age, if the person is older than 72 years (as opposed to 65 years in the previous legislation). The provision covers accidents that occur in a nursing home, hospital or at home. The medical practitioner **MUST STATE** on the certificate that it is given in pursuance of S38(2) of the *Coroners Act 2009*. Note that if a relative of the deceased person objects to a medical practitioner issuing a death certificate in these circumstances, the death must be reported to the Coroner (s 38(3) of the Act).

## 5.3 NSW DEPARTMENT OF HEALTH GUIDELINES FOR DETERMINING WHETHER A DEATH IS A REASONABLY EXPECTED OUTCOME OF A HEALTH-RELATED PROCEDURE

### 5.3.1 What is a health-related procedure?

For the purposes of this section, the Coroner's Act defines a health-related procedure as a medical, surgical, dental or other health-related procedure (including the administration of an



anaesthetic, sedative or other drug). Procedure in this circumstance is taken to mean health care provided to a patient.

### 5.3.2 What is meant by the term reasonably expected outcome'?

The Coroners Act 2009 does not define the term '*reasonably expected outcome*'. This is a matter for medical practitioners to decide based upon the facts of the case. Guidelines to assist the medical practitioner determine whether or not the death should be reported to the Coroner are below (however, the examples are not exhaustive and factors individual to each case must be considered):

In determining whether the death is a reportable death?

Consider:

- did the health related procedure cause the death, and
- was the death an unexpected outcome of the procedure?

**IF THE ANSWER TO BOTH OF THESE QUESTIONS IS YES, THEN THE DEATH IS REPORTABLE.**

In determining whether the health procedure caused the death consider:

- was the health related procedure necessary to improve the patient's medical condition, rather than an elective or optional procedure, and
- with regards to the death, would your peers consider the health related procedures performed to be consistent with competent professional practice?

**IF THE ANSWER TO BOTH OF THESE QUESTIONS IS YES, THEN *THE DEATH MAY NOT BE REPORTABLE*.**

In determining whether the death was an unexpected outcome of the health related procedure consider:

- whether the patient's condition (factoring in their age and co-morbidities) at the time they underwent the health or health related procedure was such that death was likely to occur if they did not undergo the procedure;
- was death recognised as being a significant risk of the procedure given the patient's medical condition, but the patient, family and/or medical practitioner believed the potential benefits of the procedure outweighed the risk;
- with regards to the death, would your peers consider the health related procedures performed to be consistent with competent professional practice?

**IF THE ANSWER TO EACH OF THESE QUESTIONS IS YES THEN THE DEATH MAY NOT BE REPORTABLE.**

**The factors to consider in each particular case will be different and doctors should use their professional judgement to determine whether the death is reportable. If the medical practitioner is uncertain about whether the death is reportable then s/he should contact the NSW State Coroner's Office on the numbers located at the end of this Policy Directive.**

## 6 OBLIGATION TO REPORT DEATHS OR SUSPECTED DEATHS THAT ARE EXAMINABLE BY THE CORONER

Under the Act, hospitals and medical practitioners or any other person, who has reasonable grounds for believing that a death or a suspected death would be examinable by the Coroner must report the death or suspected death to the police (who will then report it to the Coroner) or a Coroner or assistant Coroner as soon as possible (ss35 and 38 of the Act).

All reports by medical practitioners and hospitals to the Coroner should be on the prescribed Form "*Report of Death of a Patient to the Coroner*" annexed to this Policy Directive. Reports on this form should be prepared in triplicate; the original and a duplicate copy should be handed to the police (a copy for the police and a copy for the police to give to the Coroner), the third copy should be retained by the hospital in the medical record of the deceased patient.

### Medical, nursing and midwifery staff requiring further advice

If there is doubt as to whether the death is reportable, contact **must** be made with a senior medical team member or senior nurse manager or in their absence the NSW Police or the Office of the NSW State Coroner on 02 8584 7777 (business hours).

## 7 NSW DEPARTMENT OF HEALTH REQUIREMENT TO REPORT OTHER KINDS OF DEATHS

### 7.1 Anaesthetic deaths

The Coroners Act 2009 does not specifically identify anaesthesia related deaths as being reportable to the Coroner. The requirement of the 1980 Coroners Act to report to the Coroner deaths occurring while under, or as a result of, or within 24 hours after the administration of anaesthesia enabled these deaths to be reviewed by the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) who then ensured that policies and practices were put in place to help reduce the number of such deaths.

In order to ensure the continued monitoring of anaesthetic related deaths, the Public Health Act and Regulation have been amended to make a death occurring 'while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or procedure or an operation or procedure of a like nature (other than a local anaesthetic administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death)' ('Anaesthesia Related Deaths') a Category 1 Scheduled Medical Condition.

Category 1 Scheduled Medical Conditions must be reported to the Director-General in accordance with the Public Health Act and Regulation. In relation to Anaesthesia Related Deaths, medical practitioners are required to notify SCIDUA via the "Report of Death Associated with Anaesthesia/Sedation" ("SCIDUA Notification Form").

The SCIDUA Notification Form is annexed to this Policy Directive. Copies of the SCIDUA Notification Form are available from the Department of Anaesthesia at each hospital. The form can also be downloaded from the NSW Clinical Excellence Commission's website: <http://www.cec.health.nsw.gov.au/programs/scidua.html>

The completed Notification Forms are to be mailed to:

Secretary NSW Health,  
C/o Special Committee Investigating Deaths Under Anaesthesia  
Clinical Excellence Commission  
Locked Bag 8  
HAYMARKET NSW 1240

It should be noted that it is possible that a death might require notification to both the Coroner and SCIDUA, for example, if death occurred following anaesthesia and this was not a reasonable expected outcome of the procedure. In such cases Form A should be completed and sent to the Coroner and SCIDUA should be notified using the notification form "Report of a Death Associated with Anaesthesia/Sedation".

## 7.2 Certain other deaths

The NSW Department of Health has other Policy Directives for reporting deaths that may not be part of the Coroner's Act, such as reporting to:

- NSW Reportable Incident Review Committee
- NSW Maternal and Perinatal Committee, and
- Collaborating Hospitals Audit of Surgical Mortality (formally known as the Special Committee Investigating Deaths Associated with Surgery).

Staff should be familiar with these Policy Directives and note that they have a responsibility to report to these Committees.

# 8 GUIDELINES FOR MEDICAL, NURSING AND MIDWIFERY STAFF ON CORONERS' CASES DYING IN HOSPITAL

## 8.1 General considerations

The guidelines should be followed by medical, nursing and midwifery staff in dealing with Coroners' cases dying in hospital.

In general nothing should be done to a body after death if it is a Coroner's case.

All intra-venous cannulae, needles, endotracheal and intragastric tubes, all drains and airways should be left in situ. Attached drip bags, bottles and feed lines must accompany the body. All sharps or items of equipment left in situ should be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised. The immediate area should be checked and any sharps or equipment not required to remain in situ should be removed for disposal or reprocessing.

The body should be placed only in a plastic body bag. The body should not be washed even if the surface is soiled so that all surface contamination can be observed by the forensic pathologist and duly assessed. For instance, when death occurs shortly after injury by impact with a vehicle or by violent assault, washing may remove vital trace evidence such as an offender's blood and hairs or such things as paint flakes, glass chips or other finely divided material, which may be matched later against similar material obtained from another source.

Limbs and jaws must not be tied and orifices should not be plugged with cotton wool as these activities can leave marks, which cause problems especially about the face and neck.

Any material sucked from the stomach and/or any vomitus from suspected poisoning cases, should be retained and placed in screw-capped container(s), appropriately labelled and forwarded with the body for chemical analysis.

## 8.2 Removal of surgical apparatus

Generally, surgical and other apparatus are removed from the body during an autopsy. Such apparatus will be returned to the hospital if requested. However, not all deaths reported to the Coroner undergo an autopsy and in these circumstances surgical apparatus and similar equipment will not necessarily be removed from the body. If the hospital would like the surgical and other apparatus returned, written application should be made to the Coroner so that the equipment can be removed from the body.

## 8.3 Infectious diseases

Prior to death, if the deceased had or may have had one of the infectious diseases listed under "List A" or "List B" in section 3 of the Public Health (Disposal of Bodies) Regulation 2002, then a label stating clearly and indelibly only either "Infectious Disease List A - Handle With Care" or "Infectious Disease List B - Handle With Care" should be attached to the body and the body should be placed only in a plastic body bag. The body should then be placed in a second plastic body bag with a second label with the same information affixed outside. Neither label should specify the condition. The body should **not** be washed with antiseptic solution.

### Infectious Diseases:

#### List A

- Creutzfeldt-Jakob disease
- Hepatitis C, and
- Human Immunodeficiency Virus Infection (HIV)

#### List B

- Diphtheria
- Plague
- Respiratory Anthrax
- Smallpox
- Tuberculosis
- Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers)

## 8.4 Custody of body

The hospital in whose care the body of the deceased is, is responsible for the safe custody of the body until a Coroner's order for burial has been issued or, when directed by the Coroner, it is removed by members of the Police Force. This implies safe custody of the correct body in the same condition as when death occurred, i.e. no interference with incisions, dressings, equipment in situ etc. and orifices must not be plugged.

## 8.5 Education purposes

Occasionally, medical staff of a teaching hospital might have a coronial case that they would like to use for the specific purpose of informing clinical staff or teaching students. For

example, they might wish to conduct the post mortem at the teaching hospital in order that students can attend; alternatively, they might wish to take photographs of the body for future teaching purposes. In these cases, a senior medical practitioner or hospital administrator must first obtain the written consent of the deceased person's senior next of kin and then obtain the approval of the Coroner.

## 8.6 Relatives

Relatives are at times caused distress because they are questioned by police and asked to carry out the necessary identification formalities without having been advised in advance of the reason for police enquiries. Where deaths are reported to the Coroner, whether immediately after death or at anytime thereafter, a senior Hospital Officer should make all reasonable efforts to contact and, where possible, to interview relatives to explain to them the formalities required by the Coroner's Act.

- Access to bodies for identification purposes should be appropriately authorised and supervised by the police.
- Access to bodies for any other reason including compassionate reasons should be appropriately authorised and supervised by a staff member such as a Nursing/Midwifery Unit Manager or Acting Nursing/Midwifery Unit in the ward or manager or social worker employed by the Area Health Service.
- In any death considered suspicious or where criminal charges relating to the death are possible, any access to the body should be appropriately authorised and supervised by the police.

## 9 CORONIAL POST MORTEMS

### 9.1 Power to dispense with a post mortem

The Coroner has powers to dispense with a post mortem if after obtaining advice from police officers and medical practitioners, s/he is satisfied that the person died from natural causes and the senior next of kin (see Definitions section of PD) indicates the family does not wish to have a post mortem conducted to ascertain the precise cause of the person's death.

### 9.2 Dignity of deceased person to be respected

Under the terms of the 2009 Act the dignity of the deceased person is to be respected.

Medical practitioners undertaking post mortems are to endeavour to use the least invasive procedures that are appropriate in the circumstances. Examples of procedures that are less invasive than a full post mortem examination of the remains of a deceased person include (but are not limited to) the following:

- (a) an external examination of the remains
- (b) a radiological examination of the remains
- (c) blood and tissue sampling, and
- (d) a partial post mortem examination.

### 9.3 Transfer of medical records to forensic pathologists for post mortem

Where a post mortem is to be conducted under the direction of the Coroner, the pathologist or medical officer conducting the post mortem must have access to a copy of the medical records. The hospital is responsible for providing a copy of the medical records. The following procedure is recommended for the handling of records:

- (a) the release of all medical records should be handled by the Medical Records Section or designated responsible officer of the hospital. All hospitals must maintain a Register of Deceased Persons. It is recommended that the movement of medical records of deceased persons be recorded either in a specific register or in the Register of Deceased Persons. If a separate register is kept it should contain the following information:
- **Area Health Service Unique Patient Identifier (medical record number).** This is a registered number given to the patient.
  - **Patient's full name**
  - **Date of death**
  - **Hospital autopsy.** This column should be notated if the medical staff of the hospital are seeking to conduct a post mortem within the hospital.
  - **Report to Coroner complete.** This column should be notated to signify that the statutory form A "*Report of Death of a Patient to the Coroner*" has been completed.
  - **Report to SCIDUA.** This column should be notated to signify that the form "*Notification of Death Associated with Anaesthesia/Sedation*" has been sent to the Clinical Excellence Commission, if relevant.
- (b) Medical records may be sent with the deceased but should be collated and packaged prior to dispatch. The records should be forwarded in a sealed envelope to the Coroner. (If the original documents are forwarded to the Coroner, the hospital must retain a copy of the medical records).
- (c) A signed receipt should be obtained for all records from the Coroner's Court. The receipt may be a simple card bearing the following:

Received from.....Hospital  
Package Number:.....  
.....signed  
.....date  
The Coroner, Coroner's Court

- (d) Records should be forwarded within 24 hours of the death.  
(e) Records should be forwarded and collected by the hospital courier where practical.

Records will generally be available for collection within seven (7) days of delivery to the Coroner's Court.

Police requesting information and/or medical records from frontline staff should be advised to make a formal request to the Area Health Service Chief Executive.



#### 9.4 Discharge type summaries for coronial cases in hospitals

For coronial cases involving deaths in hospitals, it is the responsibility of hospitals to provide the Coroner's Office with originals or copies of the deceased person's medical records and completed Form A.

Hospitals should provide a discharge type summary upon the written request of the Coroner. This summary should outline the care and treatment received by the deceased person at the hospital and specifically answers the questions raised by the Coroner's Office in its request. This will enable any issues of concern to be addressed in the first instance without the intervention of the police.

#### 9.5 Information for relatives of a deceased person whose death has been referred to the Coroner

This section provides information that should be given to the relatives of a deceased person, irrespective of whether that person was a public or private patient, whose death has been referred to the Coroner.

##### 9.5.1 *The right to object to the exercise of post mortem investigative function*

The senior next of kin of a deceased person whose death has been referred to a Coroner may object in writing to the conduct of a post mortem investigation including the retention of whole organs during the conduct of such investigations. If the Coroner decides that a post mortem examination is necessary or desirable in the public interest, the Coroner must notify the senior next of kin in writing of this decision. The senior next of kin may apply to the Supreme Court within 48 hours of receiving the notice for an Order that the post mortem examination not be conducted or a whole organ not be retained.

##### 9.5.2 *Coronial Information and Support Program - Objections*

The Coronial Information and Support Program (CISP) at the Office of the NSW State Coroner manages all objections throughout New South Wales. The CISP staff are trained to deal with acutely bereaved families and will speak to the senior next of kin regarding any objection to the autopsy. Tel. 02 8584 7777.

The website for the Office of the NSW State Coroner contains important information and links to other supportive information.

The address is: <http://www.lawlink.nsw.gov.au/CORONERS>.

In addition the State Coroner's Court and the Department of Forensic Medicine, Glebe has produced an information leaflet. The leaflet provides information about the coronial system and informs next of kin of their right to object to a post mortem examination. Copies of the leaflet can be obtained from the State Coroner's Court at Glebe on (02) 8584 7777 or the Department of Forensic Medicine, Glebe on (02) 8584 7800.

##### 9.5.3 *The availability of Grief Counselling*

Forensic grief counsellors are employed on a full-time basis at the NSW Department of Forensic Medicine, Glebe on (02) 8584 7800 and at the Department of Forensic Medicine at Newcastle on (02) 49223700.

The counsellors are available to assist relatives of the deceased person (who are coronial cases). They provide the bereaved with information, support and counselling.

## 10 CORONIAL INVESTIGATIONS

### 10.1 Power to obtain documents and things for purposes of coronial investigation.

For the purposes of assisting a Coroner in her/his investigation, s53 of the Act gives the coroner the power to direct a person to produce a document or other thing. The power to give direction includes:

- (a) power to direct that a document be produced relating to the medical care or treatment of a person.
- (b) the power to direct a person to provide any tissue in the person's possession or under the person's control that was taken from the deceased before his or her death.

However, the Coroner must withdraw a direction if it appears to the Coroner that:

- (a) any person would be entitled on the grounds of privilege to refuse to produce the document or other thing in a court of law, and
- (b) the person does not consent to compliance with the direction.

The production of a copy of a document is taken to be sufficient compliance with the direction unless the direction expressly requires the production of the original document.

### 10.2 Cross border coronial assistance

Under the Act (s102) the State Coroner may request in writing that the person holding a corresponding office in another State or Territory provide assistance in relation to a matter that is the subject of an investigation. Likewise the State Coroner, at the written request of a person holding a corresponding office in another State or Territory, provide assistance in relation to that person or a Coroner of that State or Territory in connection with the exercise of power under the law of that State or Territory.

In practice this section allows the NSW State Coroner to request assistance from an Area Health Service (AHS) (this could be a request for clinical records or statements from staff) in relation to an Inquest that is been held in another State, at the request of a Coroner from another State.

## 11 CORONERS RECOMMENDATIONS

The role of the State Coroner in New South Wales is to ensure all deaths, suspected deaths, fires and explosions, which come under the Coroner's jurisdiction are properly investigated and concluded.

Where an inquest or inquiry is held, the Coroners Act allows NSW Coroners to make any recommendation that they consider necessary or desirable in relation to a death, suspected death, fire or explosion.

When a Coroner addresses a recommendation to the Minister for Health or to NSW Health, the Department's Corporate Governance and Risk Management Branch is responsible for ensuring a response is provided to the Coroner. Corporate Governance and Risk Management Branch liaise with relevant areas within the NSW Health System, particularly those areas responsible for implementing recommendations, to prepare the response.



The Department's Corporate Governance and Risk Management Branch is also responsible for reporting to the Department of Attorney-General as referred in the Department of Premier and Cabinet memorandum M2009-12 Responding to Coronial Recommendations.

The Department's Corporate Governance and Risk Management Branch can be contacted on telephone 9391 9654.

## **12 ATTACHMENTS**

1. Form - "Report of Death of a Patient to the Coroner"
2. SCIDUA notification form "Report of Death Associated with Anaesthesia/Sedation".



SMR010511

Holes Punched as per AS2828.1: 2012  
BINDING MARGIN - NO WRITING

NH601685 301014



Health

Facility:

**REPORT OF DEATH ASSOCIATED  
WITH ANAESTHESIA/SEDATION  
(PREVIOUSLY FORM B)**

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

LOCATION OF DEATH (eg, OR, ICU, HDU etc)

DATE OF DEATH

TIME OF DEATH

WEIGHT

Pre-operative diagnosis / condition

ASA classification (please tick)

☐ 1☐ 2☐ 3☐ 4☐ 5☐ E

Operation(s) / procedure(s)

Findings at operation/procedure

Induction

DATE OF INDUCTION

TIME OF INDUCTION

TIME ANAESTHETIC CEASED

Anaesthetic / Sedation  
(tick all relevant boxes)☐ GA☐ Regional☐ Local☐ SedationList of all drugs given & doses  
(including premedication if any)

Brief description of events

Likely cause(s) of death

Anaesthetist / Sedationist  
(Please print name, title and  
qualifications)

1.

2.

Contact details of Medical  
Officer completing this report  
(for feedback)

PRIVATE MAILING ADDRESS

HOSPITAL ADDRESS

Name of Medical Officer  
completing this report:

SIGNATURE

DATE

Please send completed form to:

Secretary NSW Health, c/o Special Committee Investigating Deaths Under Anaesthesia  
Clinical Excellence Commission, Locked Bag 8 HAYMARKET NSW 1240

SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA

REPORT OF DEATH ASSOCIATED WITH  
ANAESTHESIA/SEDATION (PREVIOUSLY FORM B)

SMR010.511



SMR010511

Holes Punched as per AS2828.1: 2012  
BINDING MARGIN - NO WRITING

NH601685 301014

Facility:

**REPORT OF DEATH ASSOCIATED  
WITH ANAESTHESIA/SEDATION  
(PREVIOUSLY FORM B)**

FAMILY NAME

MRN

GIVEN NAME

☐ MALE ☐ FEMALE

D.O.B. \_\_\_\_ / \_\_\_\_ / \_\_\_\_

M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

LOCATION OF DEATH (eg, OR, ICU, HDU etc)

DATE OF DEATH

TIME OF DEATH

WEIGHT

Pre-operative diagnosis / condition

ASA classification (please tick)

☐ 1☐ 2☐ 3☐ 4☐ 5☐ E

Operation(s) / procedure(s)

Findings at operation/procedure

Induction

DATE OF INDUCTION

TIME OF INDUCTION

TIME ANAESTHETIC CEASED

Anaesthetic / Sedation

(tick all relevant boxes)

☐ GA☐ Regional☐ Local☐ Sedation

List of all drugs given &amp; doses

(including premedication if any)

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Likely cause(s) of death

Anaesthetist / Sedationist

(Please print name, title and  
qualifications)

1.

2.

Contact details of Medical  
Officer completing this report  
(for feedback)

PRIVATE MAILING ADDRESS

HOSPITAL ADDRESS

Name of Medical Officer  
completing this report:

SIGNATURE

DATE

Hospital Copy

REPORT OF DEATH ASSOCIATED WITH  
ANAESTHESIA/SEDATION (PREVIOUSLY FORM B)

SMR010.511