

Coroners' Cases and Amendments to Coroners Act 1980

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Clinical/ Patient Services - Records

Summary Covers requirements to report deaths as well as provision of records in such cases.

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This Policy Directive may be varied, withdrawn or replaced at any time.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.

CIRCULAR

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CORONERS' CASES AND AMENDMENTS TO CORONERS ACT 1980
(1) JURISDICTION OF CORONER;
(2) OBLIGATION TO REPORT DEATH;
(3) GUIDELINES FOR NURSING STAFF AND MEDICAL OFFICERS ON CORONERS' CASES DYING IN HOSPITAL;
(4) TRANSFER OF MEDICAL RECORDS FOR POST MORTEM;
(5) DISCHARGE TYPE SUMMARIES FOR CORONIAL CASES IN HOSPITALS;
(6) OBJECTIONS TO A POST MORTEM EXAMINATION.

This Circular replaces Circular 2003/62 which replaced circular 99/57 ("**CORONERS CASES AND AMENDMENTS TO CORONERS ACT 1980**").

Amendments to section 1 of Circular 99/57 were required to incorporate amendments to the *Coroners Act 1980* found in the *Community Services Legislation Amendment Act 2002* and the *Human Tissue and Anatomy Legislation Amendment Act 2003*. The *Community Services Legislation Amendment Act 2002* amended the *Community Services (Complaints, Reviews and Monitoring) Act 1993* and other Acts with respect to the monitoring of community services, complaints about community services and the reporting and investigation of deaths of children at risk and children and persons in care; to abolish the Community Services Commission and confer its functions on the Ombudsman; and for other purposes.

The effect of the amendments is to expand the categories of deaths that should be reported to the police or a coroner. Generally, the amendments require that deaths of children or persons with a disability in care and deaths of children that may be due to abuse or neglect be reported. A chart summarising the new reporting requirements is annexed to this Circular.

Amendments to section 1 of Circular 99/57 were also required to reflect the fact that the *Prisons Act 1952* has been replaced by the *Crimes (Administration of Sentences) Act 1999*.

Distributed in accordance with circular list(s):

A	B	C	D	E
23		22		3
F	G	H	I	J
				14
K	L	M	N	P
				4

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

It is essential that the principles of the Occupational Health and Safety Act, 2000 are applied in relation to the implementation of this Circular. In particular, work practices are to be consistent with Circular 2002/45, Infection Control Policy, which sets out general infection control principles and includes guidelines for the safe handling, use and disposal of sharps.

(1) JURISDICTION OF THE CORONER

A medical practitioner must not issue a death certificate if they are of the opinion that the person died in any of the circumstances listed below. Instead, the medical practitioner should report the death, as soon as is practicable, to the police or a coroner.

- (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 having not been attended by a medical practitioner within the period of 3 months immediately preceding their death,
- (e) the person died 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 of resuscitation from apparent or impending death,

In circumstances where a patient has died during or within 24 hours of the administration of a local anaesthetic, it will be necessary to determine whether the anaesthetic was administered as part of a resuscitative measure. Further, if the death occurred in any of the other circumstances listed above, then the death will be examinable by the Coroner.

- (f) the person died within a year and a day after the date of any accident to which the cause of his or her death is or may be attributable,
- (g) the person died while in or temporarily absent from a hospital within the meaning of the *Mental Health Act 1990* and while the person was a resident at the hospital for the purpose of receiving care, treatment or assistance.
- (h) the person was a person in custody and died in any of the following circumstances:
 - (1) while in the custody of a police officer or in other lawful custody, or while escaping or attempting to escape from the custody of a police officer or other lawful custody, or
 - (2) as a result of or in the course of police operations, or
 - (3) while in, or temporarily absent from, a detention centre within the meaning of the *Children (Detention Centres) Act 1987*, a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*, or a lock-up, and of which the person was an inmate, or
 - (4) while proceeding to an institution referred to in paragraph (3), for the purpose of being admitted as an inmate of the institution and while in the

company of a police officer or other official charged with the person's care or custody.

- (i) if the person was, or there was reasonable cause to suspect that the person was, a child¹ or a person with a disability who died in any of the following circumstances:
- whilst a child in care, or
 - whilst 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
 - whilst a child who is a sibling² 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
 - as a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances, or
 - as 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 handicapped persons, or
 - as 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.

For the purposes of paragraph (i), a "child" means a person under the age of 18 years and a "child in care" means a child or young person under the age of 18 years:

- who is under the parental responsibility of the Minister administering the *Children and Young Persons (Care and Protection) Act 1998*, or
- 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
- who is a protected person within the meaning of section 135 of the *Children and Young Persons (Care and Protection) Act 1998*, or
- who is the subject of an out-of-home care arrangement under the *Children and Young Persons (Care and Protection) Act 1998*, or
- 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
- who is otherwise in the care of a service provider.

Despite the above, a medical practitioner may issue a death certificate if the medical practitioner is of the opinion that the person:

- (a) was 65 years of age or older, and

¹ Circular 2003/16: Protecting Children and Young People and the NSW Health Frontline Procedures for the Protection of Children and Young People (December 2000) provide guidance on the reporting responsibilities of health care staff.

² A sibling must share one or more parents of the child who is the subject of the report and be a member of the same household as the deceased child at the time of the deceased child's death.

- (b) died in circumstances other than those referred to in paragraphs (b), (c), (d), (e), (g) (h) or (i), and
- (c) died after sustaining an injury from an accident, being an accident, which did not occur in a hospital or nursing home, that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act or omission by another person.

Where a death certificate is issued under this provision, the death certificate must indicate that it was issued under 12B(2) of the Coroners Act.

Where doubt exists as to whether a death should be reported, contact the State Coroner's Court on (02) 8584 7777 for advice.

(2) OBLIGATION TO REPORT DEATHS

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 but has not been reported, must report the death or suspected death to the police or a coroner as soon as possible.

All reports by hospitals should be on the prescribed forms:

Form A - "*Report of Death of a Patient to the Coroner*" and Form B - "*Report of Death Associated with Anaesthesia/Sedation*". Examples are annexed to this Circular.

It is Departmental policy that deaths associated with the administration of anaesthesia must also to be notified to the NSW Special Committee Investigating Deaths Under Anaesthesia, PO Box M25, Camperdown, NSW 2050 (Circular No. 90/88). This notification is to be made by forwarding the triplicate copy of the Form B.

Where the death has been associated with Anaesthesia, Form B must be completed in addition to form A.

Reports on Form A should be prepared in triplicate, the original and duplicate copies being handed to the police for transmission to the Coroner, the triplicate copy retained by the hospital. Form B is provided in quadruplicate with the original and duplicate copies being handed to the police for transmission to the Coroner, the triplicate copy to the Special Committee Investigating Deaths Under Anaesthesia and the quadruplicate copy being retained by the hospital.

These forms can be ordered from: cmSolutions (formerly Government Printing Service), telephone: (02) 9743 8777, fax: (02) 9743 8603, address: PO Box 256, Regents Park, NSW 2143

Form A: quote "item no: 606180 – form MR39"

Form B: quote "item no: 601685 – form MR40"

(3) GUIDELINES FOR NURSING STAFF AND MEDICAL OFFICERS ON CORONERS' CASES DYING IN HOSPITAL

These guidelines should be followed by nursing and medical 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 IV 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 pieces 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. When, for instance 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 chins should 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.

Prior to death, the deceased may have had (either definitely or possibly) one of the infectious diseases listed under "List A" or "List B" (see following)³. If this is the case 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
- Human Immunodeficiency Virus Infection (HIV)

List B

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

³ As prescribed under s13 of the Public Health (Disposal of Bodies) Regulation 2002

Hospitals are also responsible for the safe custody of bodies until a Coroner's order for burial has been issued or, when directed by the Coroner, bodies are removed by members of the Police Force. This implies safe custody of the correct body in the same condition as when death occurs, i.e. no interference with incisions, dressings etc. Further, customary treatment of the body such as plugging the orifices, shall not be carried out.

If a Teaching Hospital wishes to take the opportunity with regard to a particular case for the specific purpose of teaching students, written consent must be obtained from the senior next of kin. Written application must then be made by a senior medical practitioner or hospital administrator to the Coroner for permission in each case and approval obtained.

If a hospital desires to remove surgical apparatus, written application for permission to do so must be made by a senior medical practitioner or hospital administrator to the Coroner in each case and approval obtained.

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 senior medical officer who had cared for the deceased or the Nurse Unit Manager or Acting Nurse Unit Manager in that ward.

(4) 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 should have access to the medical records. The hospital should assume responsibility for the safe delivery and collection from the coroner's court of these medical records. A circular dealing with the confidentiality of medical records was issued in February 1999 (99/18). 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:
- **Unit Number/ 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 all the statutory forms of report to the coroner have been completed. There are two main forms:

- (i) the “*Report of Death of a Patient to the Coroner*” (Form A) and
- (ii) “*Report of Death Associated with Anaesthesia/Sedation*” (Form B).

- **Police informed.** The nearest police station should be informed of all deaths falling within Part 3 of the Coroners Act 1980. The dispatch and receipt of medical records to and from the Coroner should also be noted.

- (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.
- (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.

(5) 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 Forms A, or B.

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 answer 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.

(6) OBJECTIONS TO A POST MORTEM EXAMINATION

This section provides information that should be given to the relatives of a deceased person whose death has been referred to the Coroner.

1. The senior available next of kin of a deceased person whose death has been referred to a coroner may request the coroner not to direct a post mortem examination. 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 of this decision. The post mortem examination will usually be delayed for 48 hours to enable the senior next of kin to apply to the Supreme Court for an order that the post mortem examination not proceed, or that only a partial post mortem examination proceed.
2. The “senior next of kin” is defined in the Coroners Act as:
 - a spouse of the deceased (ie a person living with the deceased immediately before their death as their spouse on a bona fide domestic basis)
 - if there is no-one in the above category or they are not available, any child of the deceased aged over 18 years
 - if there is no-one in the above categories or they are not available, either parent of the deceased
 - if there is no-one in the above categories or they are not available, any brother or sister of the deceased over the age of 18
 - if there is no one in the above categories or they are not available, an executor of the deceased person’s will or the deceased person’s personal representative immediately before their death.
3. A person other than the senior available next of kin may object to the performance of a post-mortem examination, and the objection will be referred to the Coroner. However, the special provisions regarding a right of appeal to the Supreme Court apply only to senior available next of kin.
4. If a senior next of kin or other person is considering making an objection to the post mortem examination, they should ring the Clerk of the relevant Coroner’s Court immediately to notify them of their intention, as time will be of the essence in making an objection prior to the post mortem examination taking place. They should also make their intention known to the police officer completing the relevant police form (P79A) for the Coroner.
5. The State Coroner’s Court and the Department of Forensic Medicine, Glebe have 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.

6. 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 Westmead on (02) 9845 6001. The counsellors are available to assist relatives of the deceased person. They provide the bereaved with information, support and counselling.

Robyn Kruk
Director-General

Child Death Reporting Requirements Under the Coroners Act 1980 (as amended)

REVIEWABLE DEATHS

A Medical Practitioner must not certify cause of death if the death is reportable to the Coroner. Reportable deaths now include the following:

Children and young people:

- Children in care;
- Children notified to the Department of Community Services (DoCs) within three years of their death;
- Children who are siblings of a child notified to DoCs within three years of their death;
- Children who may have died from abuse, neglect or in suspicious circumstances; and
- Children who were in detention at the time of their death.

People with a disability (whether or not a child) who at the time of their death:

- Were living in a residential care service authorised or funded under the Disability Services Act 1993; or
- Were living in a residential centre for handicapped people (a licensed boarding house).

ASCERTAINING WHETHER A DEATH IS A REVIEWABLE DEATH

- The medical practitioner makes a judgment in good faith on the information available to them at the time, which may include the medical records and information from the child's family (if appropriate) and, if in doubt, enquiries with the police. This involves consideration of child abuse and neglect indicators, which may provide reasonable grounds to suspect that the subject child or siblings have been reported to DoCS.
- If the medical practitioner suspects that a subject child or siblings have been reported to DoCS the death is reviewable.
- If a medical practitioner is aware, or suspects that the death is reviewable, s/he then refers the case to the local Police, who will confirm with DoCS whether a report has been made, investigate and refer the case to the Coroner.

i

Police then confirm with DoCS whether a report has been made to DoCs.

i

DoCs confirms whether reports have been made and reports back to police

i

State Coroner's Office determines whether an inquest is needed

HOSPITAL

FORM A

REPORT OF DEATH OF A PATIENT TO THE CORONER

Patient's Surname _____ Given Names: _____

Sex: _____ Age: _____ Marital Status: _____

Admitted: _____ at: _____ Died: _____ at: _____
Date Time Date Time

Next of Kin: _____ Relationship: _____

Address: _____

Telephone: (home) _____ (work) _____

SYNOPSIS OF CLINICAL NOTES

(Recorded in narrative form to include)

a). History (including relevant past history): _____

b). Examination on admission (including evidence of injuries, alcoholic consumption or other relevant clinical findings): _____

c). Treatment: _____

d). Subsequent progress: _____

e). Opinion as to cause of death: _____

f). Additional Remarks: _____

I, _____, Bachelor of Medicine and Bachelor of Surgery, a registered Medical Practitioner in the State of New South Wales, hereby certify that at _____ am/pm on _____ I examined the body of the abovenamed patient and pronounced life extinct.

SIGNATURE: _____ QUALIFICATIONS: _____ DATE: _____

BINDING MARGIN DO NOT WRITE

CORONERS REPORT



DEPARTMENT OF HEALTH NSW

REPORT OF DEATH ASSOCIATED WITH ANAESTHESIA/SEDATION
Coroners Act

TITLE	FAMILY NAME	M.R.N.			
GIVEN NAME/S		V.M.O.			
ADDRESS	STREET	D.O.B.	SEX	H.I.S.	
SUBURB		POSTCODE	ADMISSION DATE		

ADMISSION TO HOSPITAL _____ DEATH _____
DATE TIME DATE TIME

PLACE OF DEATH _____

DATE AND NATURE OF PREVIOUS SURGERY DURING THIS ADMISSION _____
DATE

NATURE OF THIS PROCEDURE _____

NAME OF SURGEON _____ PRE-ANAESTHETIC ASSESSMENT _____
PRINT NAME & TITLE DATE TIME

FINDINGS AT PRE-ANAESTHETIC ASSESSMENT _____

PREPARATION OF PATIENT _____

PREMEDICATION _____
DATE TIME NATURE

TYPE OF ANAESTHESIA/SEDATION GENERAL LOCAL SEDATION

INDUCTION OF ANAESTHESIA _____ CESSATION _____
DATE TIME DATE TIME

DESCRIPTION OF CLINICAL EVENTS LEADING TO DEATH _____

DESCRIPTION OF ATTEMPTED RESUSCITATION _____

OPINION AS TO CAUSE OF DEATH _____

PERSON(S) ADMINISTERING ANAESTHESIA/SEDATION

1. _____
PRINT NAME, TITLE & QUALIFICATIONS

2. _____
PRINT NAME, TITLE & QUALIFICATIONS

NAME OF MEDICAL OFFICER COMPLETING THIS REPORT _____
SIGNATURE PRINT NAME, TITLE & QUALIFICATIONS DATE

ANAESTH DEATH FORM B

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