CHAPTER 19 - PATHOLOGY

TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Table Title</th>
<th>PD/IB/GL NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institute of Clinical Pathology and Medical Research – Services</td>
<td></td>
</tr>
<tr>
<td>Blood - Management of Fresh Blood Components</td>
<td>PD2012_016</td>
</tr>
<tr>
<td>Cord Blood - Public And Private Cord Blood Banking</td>
<td>PD2015_048</td>
</tr>
<tr>
<td>Responsibilities of Medical Officers with Regard to Drivers</td>
<td>IB2013_059</td>
</tr>
<tr>
<td>Blood and Urine Testing of Drivers Apparently Under the Influence of Drugs</td>
<td>PD2005_029</td>
</tr>
<tr>
<td>Collecting Blood and Urine Samples in Emergency Departments – Changes to</td>
<td>IB2015_033</td>
</tr>
<tr>
<td>Governing Legislation</td>
<td></td>
</tr>
<tr>
<td>Interim Drug Driving Blood Testing Arrangements in NSW Emergency Departments</td>
<td>IB2007_003</td>
</tr>
<tr>
<td>Client Registration Policy</td>
<td>PD2007_094</td>
</tr>
<tr>
<td>Handling of Bodies</td>
<td></td>
</tr>
<tr>
<td>Procedures for Post Mortem of SIDS Cases (Coroner’s Circular)</td>
<td></td>
</tr>
<tr>
<td>Multiple Injury Due to Child Abuse</td>
<td></td>
</tr>
<tr>
<td>Suggested Protocol in Relation to Bodies Being Brought to Sydney for Post</td>
<td></td>
</tr>
<tr>
<td>Mortem (Coroner’s Circular No 22)</td>
<td></td>
</tr>
<tr>
<td>Non-Coronial Post Mortems</td>
<td>PD2013_051</td>
</tr>
<tr>
<td>Destitute Persons - Cremation or Burial</td>
<td>PD2008_012</td>
</tr>
<tr>
<td>Burials – Exhumation of Human Remains</td>
<td>PD2013_046</td>
</tr>
<tr>
<td>Burials on Private Land – Approval by Local Authority</td>
<td>GL2013_016</td>
</tr>
<tr>
<td>Shallow Burial</td>
<td>PD2013_045</td>
</tr>
<tr>
<td>Burials – Exemptions from Public Health (Disposal of Bodies) Regulation 2012 for Community and Religious Reasons</td>
<td>PD2013_048</td>
</tr>
<tr>
<td>Body Parts Burial/Cremation</td>
<td></td>
</tr>
<tr>
<td>Disposal of Bodies</td>
<td></td>
</tr>
<tr>
<td>Cremation of More Than One Body Simultaneously</td>
<td>GL2013_014</td>
</tr>
<tr>
<td>Canvassing by Representatives of Funeral Directors at Public Hospitals</td>
<td></td>
</tr>
<tr>
<td>Coroners’ Cases and the Coroners Act 2009</td>
<td>PD2010_054</td>
</tr>
<tr>
<td>Coronial Checklist</td>
<td>IB2010_058</td>
</tr>
<tr>
<td>Testing for Fatal Anaphylaxis</td>
<td></td>
</tr>
<tr>
<td>Retention of Bodies – Approval to Retain Bodies for Longer than Permitted</td>
<td>GL2013_015</td>
</tr>
<tr>
<td>Accreditation of NSW Health Pathology Laboratories</td>
<td>PD2006_064</td>
</tr>
<tr>
<td>Code of Practice and Performance Standards for Forensic Pathology in NSW</td>
<td>PD2012_049</td>
</tr>
<tr>
<td>Point of Care Testing (PoCT) Policy</td>
<td>PD2015_028</td>
</tr>
</tbody>
</table>
INSTITUTE OF CLINICAL PATHOLOGY AND MEDICAL RESEARCH - SERVICES

The Institute of Clinical Pathology and Medical Research, Westmead, provides a comprehensive referral service for either primary diagnosis and assessment or confirmation in the following areas: Virology, Bacteriology, Syphilis Serology, Chemical Pathology, Immunopathology, Exfoliative Cytology, Histopathology (including electron microscopy) and Haematology.

Material for examination should be accompanied by a completed request form, pads of which are obtainable from the Institute.

General enquiries regarding the preparation of specimens should be directed to the Laboratory Superintendent, telephone 0409 846 157. Specimens should be forwarded by courier or by mail to: The Institute of Clinical Pathology and Medical Research, PO Box 533, Wentworthville, 2145.

Some details of procedures in the areas of Exfoliative Cytology, Bacteriology and Virology are as follows:

EXFOLIATIVE CYTOLOGY

Detection of Cancer of the Cervix

The Department of Exfoliative Cytology at the Institute of Clinical Pathology and Medical Research, Westmead, accepts specimens for the early detection of cancer of the cervix by the Papanicolaou smear technique. Kits for this purpose are provided by the Institute on request.

BACTERIOLOGY

Appendix “A” shows how the Department may help other laboratories in the diagnosis of some infectious diseases.

In general for the identification of cultures a viable pure culture is required on a slope of appropriate medium inside a leak-proof screw-capped container. The container’s top should be well screwed and the container then safely packed for transport. Sera should similarly be contained in leak-proof containers which are well packed in case accidental leakage does occur.

For any further details please telephone 9633-6255.

VIROLOGY

SPECIMENS REQUIRED FOR LABORATORY DIAGNOSIS OF VIRAL & RICKETTSIAL INFECTIONS

ALL SPECIMENS MUST BE SUBMITTED IN LEAK-PROOF CONTAINERS AND ALL SPECIMEN CONTAINERS SHOULD BE ENCLOSED IN SEALED PLASTIC BAGS WITH THE REQUEST FORM IN THE OPEN SECTION OF THE BAG.

Appendix “B” lists infective agents for which diagnosis can be provided, the major diseases they cause and the types of specimens which should be submitted for cultivation or identification of the agent.

Specimens for virus isolation listed in Appendix “B” should be collected during the acute stage of the disease and sent to the Institute with the minimum of delay. If a delay of more than two or three hours is unavoidable, specimens should be stored in a refrigerator and transported to the Institute on ice in a thermosflask.
Fluid for throat gargling is supplied by the laboratory on request. However, gargling can be carried out with 10 to 15 ml of 10% broth in normal saline or if this is not available, plain normal saline can be used. The fluid can be stored in MacCartney bottles until required. The patient should draw it up into his mouth, through a short (100mm to 150mm) piece of glass tubing, gargle and then return the fluid to the bottle through the tube. In the case of babies or young children where garglings cannot be obtained, a swab may be submitted. Viral transport medium for swabs, tissues, etc. is available from the laboratory on request. In general, swabs sent in Stuart’s transport medium are not suitable for viral isolation. Rapid diagnosis of some respiratory infections can be achieved by immunofluorescent methods but aspirates are required for this technique.

In suspected cases of Trachoma or Inclusion Conjunctivitis a portion of the scrapings should be smeared on a clean glass slide and fixed with methyl alcohol for five minutes. This should be done by the ophthalmologist.

Electron microscopy can be used for the rapid diagnosis of skin lesions resulting from vaccinia, or, Herpes simplex or Varicella/Zoster infections. Swabs are not satisfactory for this technique and undiluted vesicle or pustular fluid, or crusts should be submitted.

The laboratory is also able to investigate suspected infections of Mycoplasma pneumoniae. Sputum, and acute and convalescent blood specimens for serology, should be submitted.

In certain instances such as congenital rubella, cytomegalovirus and respiratory syncytial virus, the collection of specimens on three successive days greatly increases chances of isolation.

Viruses are extremely labile and their identification is time consuming and costly. It is essential therefore that specimens are carefully collected at a stage of the illness when there is still a likelihood of their being present and that they be properly stored and transported.

VIRAL SEROLOGY

For serological investigations clotted blood or serum should be sent in a sterile tube. It is rarely that a diagnosis can be established from a single blood specimen, and two specimens (acute and convalescent), are required for comparison of antibody titres. One specimen should be collected during the acute stage, i.e. before the fifth day, and the other 14 to 21 days after the onset of symptoms.

With the large number of virus serotypes now recognised, diagnosis by sero-logical methods alone has become impracticable in many instances. This applies particularly to the Coxsackie A and Echovirus groups where large numbers of serotypes are known. With these groups it is necessary to rely on isolation of the organism. Serological diagnosis is the method of choice in Hepatitis A, Hepatitis B, HIV (AIDS) Psittacosis, Q fever, Rubella, E-B virus, Arbovirus. Typhus and M. pneumoniae infections and is useful in cases of Influenza and Mumps, Adenovirus, Cytomegalovirus, Poliomyelitis and Coxsackie B, but with most other infections, isolation of the virus is the most practical approach.

SINGLE SERUM

A separate publication entitled “A Guide to the Interpretation of the Haemagglutination Inhibition (HAI) Test for Rubella in Pregnant Women” is also available from this laboratory.

The virology laboratory will provide any further information, if required, and will, if necessary, make available refrigerated containers for the transport of specimens from the referring hospital or doctor to the Institute (telephone 9633-6233).
### APPENDIX “A”

<table>
<thead>
<tr>
<th>DISEASE OR INFECTION</th>
<th>TEST PERFORMED AT ICPMR</th>
<th>SPECIMEN OR CULTURE REQUIRED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoebiases</td>
<td>Indirect haemagglutination</td>
<td>Serum</td>
</tr>
<tr>
<td>Anaerobic infections</td>
<td>Identification of cultures</td>
<td>Culture in Robertson’s cooked meat medium. (Please check viability.)</td>
</tr>
<tr>
<td>Antibiotic-associate colitis</td>
<td>Assay of Clostridium difficile toxin</td>
<td>Faeces</td>
</tr>
<tr>
<td>Aspergillosis</td>
<td>Immunodiffusion</td>
<td>Serum</td>
</tr>
<tr>
<td>Blastomycosis</td>
<td>Immunodiffusion</td>
<td>Serum</td>
</tr>
<tr>
<td>Brucellosis</td>
<td>Agglutination Complement fixation</td>
<td>Serum</td>
</tr>
<tr>
<td>Coccidioidomycosis</td>
<td>Immunodiffusion</td>
<td>Serum</td>
</tr>
<tr>
<td>Cryptococcosis</td>
<td>Detection of antigen (quantitative)</td>
<td>Cerebrospinal fluid and/or serum</td>
</tr>
<tr>
<td>Enteropathogenic E. coli</td>
<td>Serotyping of cultures</td>
<td>Culture on nutrient agar slope</td>
</tr>
<tr>
<td>Fungal infections, especially by dermatophytes</td>
<td>a) Skin scrapings, hairs or nails</td>
<td>Specimen in a paper envelope</td>
</tr>
<tr>
<td></td>
<td>b) Identification of culture</td>
<td>Culture on a slope of a suitable medium such as DTM (CSL)</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Identification of cultures and sensitivity testing</td>
<td>Pure culture on chocolate agar, incubated for 48 hours and then sent as soon as possible.</td>
</tr>
<tr>
<td>Histoplasmosis</td>
<td>Immunodiffusion</td>
<td>Serum</td>
</tr>
<tr>
<td>Meningitis, suspected of being bacterial in origin but with inconclusive laboratory results.</td>
<td>Detection of antigen (of Neisseria meningitidis, Haemophilus influenzae, or Streptococcus pneumoniae) by counter-current immunoelectrophoresis.</td>
<td>Cerebrospinal fluid</td>
</tr>
<tr>
<td>Meningitis, cases or carriers</td>
<td>Typing of Neisseria meningitidis and Haemophilus influenzae</td>
<td>Culture on chocolate agar slope</td>
</tr>
<tr>
<td>VIRUS</td>
<td>DISEASE</td>
<td>SPECIMEN</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Adenovirus</td>
<td>Acute respiratory disease Pharyngitis,</td>
<td>Throat gargling.</td>
</tr>
<tr>
<td></td>
<td>Pneumonia.</td>
<td>Throat swab.</td>
</tr>
<tr>
<td></td>
<td>Keratoconjunctivitis.</td>
<td>Eye Swab.</td>
</tr>
<tr>
<td>Influenza A B and C</td>
<td>URTI, Influenza, Pneumonia</td>
<td>Throat gargling.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lung tissue (post mortem).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nasopharyngeal mucous aspirate.</td>
</tr>
<tr>
<td>Mumps</td>
<td>Parotitis.</td>
<td>Saliva. CSF</td>
</tr>
<tr>
<td>Respiratory Syncytial Virus</td>
<td>Bronchitis.</td>
<td>Throat gargling.</td>
</tr>
<tr>
<td>Rhinovirus</td>
<td>Common Cold</td>
<td>Nasal swab or washing.</td>
</tr>
<tr>
<td>Poliovirus</td>
<td>Poliomyelitis</td>
<td>Faeces, throat gargling. Brain, spinal cord (post mortem).</td>
</tr>
<tr>
<td>Coxsackie A</td>
<td>Herpangina.</td>
<td>Throat gargling.</td>
</tr>
<tr>
<td></td>
<td>Aseptic meningitis.</td>
<td>Faeces. CSF</td>
</tr>
<tr>
<td></td>
<td>Febrile illness with rash.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hand, foot and mouth disease</td>
<td></td>
</tr>
<tr>
<td>Mycoplasma pneumoniae infection</td>
<td>Isolation of organism</td>
<td>Sputum</td>
</tr>
<tr>
<td>Salmonella and Shigella infections</td>
<td>Identification of cultures</td>
<td>Cultures on nutrient agar slopes in screw-capped bottles with lids sealed with paraffin wax. <strong>NOTE:</strong> We will arrange for despatch of culture of Salmonella typhimurium for phage typing to the Microbiological Diagnostic Unit, University of Melbourne.</td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td>Indirect haemagglutination</td>
<td>Serum</td>
</tr>
<tr>
<td>Streptococcal infections</td>
<td>a) Lancefield grouping)</td>
<td>Culture on blood agar slope</td>
</tr>
<tr>
<td></td>
<td>b) Griffith (T-antigen) serotyping of</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Streptococcus pyogen</td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Anti-streptolysin 0 titre</td>
<td></td>
</tr>
<tr>
<td>Toxoplasmosis</td>
<td>a) Indirect haemagglutination</td>
<td>Serum</td>
</tr>
<tr>
<td></td>
<td>Complement fixation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Isolation of Toxoplasma gondii in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>laboratory mice</td>
<td></td>
</tr>
</tbody>
</table>
### 19. PATHOLOGY

<table>
<thead>
<tr>
<th>Disease</th>
<th>Method 1</th>
<th>Method 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Tuberculosis</em></td>
<td>a) Isolation of Mycobacterium tuberculosis</td>
<td>Sputum—three separate early morning specimens.</td>
</tr>
<tr>
<td></td>
<td>b) Identification and drug sensitivity testing of Mycobacteria.</td>
<td>Gastric contents—preserved by the addition of an equal volume of a sterilised 23% solution of trisodium phosphate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urine—at least 100 ml. of each of three early morning specimens collected on successive days.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tissues—in sterile containers without any additives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Culture on a slope of Lowenstein—Jensen medium; in a strongly built container, with top well screwed up. Container to be safely packed for transport.</td>
</tr>
<tr>
<td><em>Typhoid and paratyphoid</em></td>
<td>a) Identification of cultures</td>
<td>Culture on nutrient agar slope as described above under “Salmonella and Shigella infections”</td>
</tr>
<tr>
<td></td>
<td>b) Widal</td>
<td>Serum</td>
</tr>
<tr>
<td><em>Typhus</em></td>
<td>Weil—Felix reaction</td>
<td>Serum</td>
</tr>
<tr>
<td><em>Echovirus</em></td>
<td>Aseptic meningitis. Mild paralysis. Febrile illness with rash. Diarrhoea of infants and children.</td>
<td>CSF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Faeces</td>
</tr>
<tr>
<td><em>Rotavirus</em></td>
<td>Gastroenteritis of infants and young children</td>
<td>Throat gargling</td>
</tr>
<tr>
<td><em>Ross River (Alphavirus)</em></td>
<td>Polyarthritis with rash</td>
<td>Blood</td>
</tr>
<tr>
<td><em>Murray Valley Encephalitis</em></td>
<td>Encephalitis</td>
<td>Blood</td>
</tr>
<tr>
<td>(Flavivirus)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Dengue</em> (Flavivirus)</td>
<td>Fever with rash</td>
<td>Blood</td>
</tr>
<tr>
<td></td>
<td>Congenital Rubella Syndrome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Herpes labialis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Vesicles at other sites</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Keratoconjunctivitis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meningoencephalitis</td>
<td></td>
</tr>
<tr>
<td><em>Varicella/Zoste</em></td>
<td>Chickenpox</td>
<td>Vescicle fluid. Crusts.</td>
</tr>
<tr>
<td></td>
<td>Herpes zoster</td>
<td></td>
</tr>
<tr>
<td><em>Epstein-Barr (EB)</em></td>
<td>Infectious mononucleosis</td>
<td>Blood (serology only)</td>
</tr>
<tr>
<td><em>Variola</em></td>
<td>Smallpox</td>
<td>Vescicle fluid. Crusts.</td>
</tr>
<tr>
<td><em>Vaccinia</em></td>
<td>Generalised vaccinia</td>
<td>Vescicular or Pustular fluid. Granulomatous tissue.</td>
</tr>
<tr>
<td><em>Cowpox</em></td>
<td>Cowpox</td>
<td></td>
</tr>
<tr>
<td><em>Paravaccinia</em></td>
<td>Orf. Milkers nodes</td>
<td></td>
</tr>
</tbody>
</table>

Rickettsia prowazekii | Epidemic typhus Brill’s disease | Blood.

Rickettsia Mooseri | Murine or Endemic Typhus | Blood.

Coxiella burnetti | Q fever | Sputum, Blood.

Hepatitis A | Hepatitis A | Faeces.

Hepatitis B | Hepatitis B (Australia Antigen) | Blood.

Mycoplasma pneumoniae | Primary atypical pneumonia | Sputum.

*Arbovirus serology specimens are sent to the Laboratory of Pathology and Microbiology, George Street, Brisbane, 4000, for testing.

OBSTETRIC/PATHOLOGY

LABORATORY FACILITIES: MINIMUM REQUIREMENTS FOR OBSTETRIC CARE

To achieve high quality obstetric care, certain minimum laboratory facilities must be available. Some investigations are complicated procedures requiring special technical skill, and are only suitable for performing at central laboratories in each State. Even more important are those simple tests which are required urgently on a 24 hour/day basis. Some of these are life saving for mother and foetus, (e.g. blood transfusion) others may be important in preventing permanent damage to the newborn child. It is to be regretted that these latter tests cannot be made available at all maternity hospitals; the object of the following table is to indicate an immediate practical objective which will allow coverage of as much of obstetric practice as possible.

The laboratory equipment required for the tests listed below (a), (b), is quite small, and almost all items are routinely available in a hospital pathology laboratory. A major problem is the availability of trained technical staff, competent to deal with all procedures. Large hospital laboratories operate in divisions, so that technicians from biochemistry, haematology and bacteriology divisions would need to be organised on an on-call roster. In smaller hospitals senior technicians have to be competent in many areas of work, and on-call rostering would be more demanding. Nevertheless, the quality of modern obstetric care is dependent on ancillary services, and laboratory establishments must be adjusted to provide these essential services.

It is proposed that the following estimations should be provided at all hospitals where a substantial number of confinements take place. In addition, they should be available at base hospitals, and at central laboratories in metropolitan areas, to provide a service for smaller hospitals. Generally, these services should be available wherever the number of confinements exceeds 1000/annum in the immediate district surrounding a group laboratory. In addition, the more common items in (i), (ii), (iii), below should be available where confinements exceed 500.

(a) Services required 24 hours/day

i. Haematology
   Blood grouping including Rh typing
   Cross matching
   Haemoglobin
   Coombs Test
   Fibrinogen and degradation products
19. PATHOLOGY

ii. **Biochemistry**
- Blood urea nitrogen
- Blood glucose
- Electrolytes
- Serum bilirubin

iii. **Microbiology**
- Microscopic examination of urine
- Routine facilities for identification of organisms (aerobic/anaerobic) and their sensitivity to antibiotics. Routine equipment only is required.

iv. **Radiology and Ultrasound**
- Plain abdomen
- Pelvimetry
- Ultrasonic placentography

(b) **In addition to the above the following should be available working hours**

i. **Haematology**
- Complete blood picture and interpretation of findings, and identification of immune antibodies.
- Coagulation studies

ii. **Biochemistry**
- Serum albumin
- Urinary protein

(c) **In addition to one and two above the following should be available at central laboratories**

i. **Haematology**
- Investigation of haemoglobinopathies.

ii. **Biochemistry**
- Oestriol assay
- Spectrophotometry of liquor amnii for assessment of Rh Antibodies
- Determination of L/S ratio or similar test for foetal lung condition
- Alphafetoprotein estimation

iii. **Microbiology**
- Syphilis serology - VDRL, etc. together with fluorescent antibody test and treponema pallidum immobilisation test
- Rubella serology - haemagglutination antibody inhibition Virus identification by isolation and/or serology.

iv. **Cytogenetics**
- Chromosome studies.

v. **Micro studies on neonatal or foetal blood**
- pH, PCO2, PO2
- Blood gas analysis required - operator needs special training; officer requires experience in interpreting results.

**EQUIPMENT**

The equipment necessary for group laboratories are:

i. **Biochemistry**
- Colorimeter
- Flame photometer
- Standard glassware
- Centrifuge
- Blood gas analyser
ii. **Haematology**
- Centrifuge
- Incubator
- Water bath incubator
- Binocular microscope
- Haematocrit centrifuge
- Basic glassware, pippettes, counting chambers, etc

iii. **Bacteriology**
- 37° incubator
- Refrigerator
- Standard media
- Binocular microscope
- Counting chamber and basic glassware
- Anaerobic jar
PURPOSE

The purpose of this Policy Directive is to provide clinicians (medical practitioners, nurses and midwives), hospital transfusion service staff, hospital blood bank staff, pathology providers and health service managers who are involved with the collection, storage and transfusion of fresh blood and blood components with guidance in areas central to the provision of transfusion therapy.

MANDATORY REQUIREMENTS

- All staff involved with the provision of transfusion therapy must adhere to the provisions of this Policy Directive. It is recognised that some of the requirements in this policy such as the role of the Local Health Districts are not applicable to private health facilities. However, private health facilities are expected to comply with the general principles described in the Policy Directive in compliance with the Private Health Facilities Act 2007 and Regulation 2010.

- Each health facility in NSW that provides transfusion therapy must have effective systems and procedures in place to enable compliance with this Policy Directive. In particular, the facility must have a process for the review of transfusion issues. This may be through an existing committee or through the establishment of a specific hospital transfusion committee. The process must include monitoring, quality improvement in the care of blood and transfusion practices and staff education. As a minimum requirement, all staff who are involved in transfusion-related activities must have completed the BloodSafe e-Learning program (www.BloodSafelearning.org.au).

IMPLEMENTATION

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 the Policy Directive;
- all staff receive appropriate training to enable them to carry out their obligations in relation to this Policy Directive; and
- documented procedures are in place to support the Policy Directive.

Clinicians (medical practitioners, nurses and midwives), Hospital Blood Bank staff, Pathology Providers and Hospital Transfusion Service staff

- must comply with this Policy Directive.

INTRODUCTION

In line with the Australian Health Ministers’ Conference Statement on National Stewardship Expectations for the Supply of Blood and Blood Products¹ (Attachment A), this Policy Directive provides clinicians (medical practitioners, nurses and midwives), hospital transfusion service staff, hospital blood bank staff, pathology providers, and health service managers who are involved with the collection, storage and transfusion of fresh blood and blood components with guidance in areas central to the provision of transfusion therapy.

---

¹ Statement endorsed by the Australian Health Ministers’ Conference, 12 November 2010
19. PATHOLOGY

1. TRANSFUSION-RELATED ISSUES

1.1 Safe and effective transfusion therapy

Safe and effective transfusion therapy requires the following elements:

- a clearly defined indication and evidence for the likely benefit of transfusion;
- the accurate identification of the patient for compatibility testing;
- a request for the appropriate blood component and quantity required;
- the identification of possible transfusion hazards and the likelihood of their occurrence;
- communication of the benefits and risks to the patient and/or family/carers;
- identification and appropriate management of high risk patients;
- appropriate handling, administration and monitoring of transfused components;
- early recognition and prompt action in relation to adverse events of transfusion, including feedback to the hospital transfusion service;
- appropriate documentation; and
- participation in quality improvement programs.

1.2 Blood components – Clinical Practice Guidelines

Compliance with the current and any subsequent National Health & Medical Research Council/Australasian Society of Blood Transfusion Clinical Practice Guidelines on the Use of Blood Components and summary Clinical Practice Guidelines is required.

1.3 Consent for treatment

As part of the informed consent to medical treatment, a patient must be given a clear explanation of the potential risks and benefits of blood component therapy, and the patient’s consent to receiving a blood transfusion must be obtained and documented. Where treatment involves the administration of blood components/products over a period of time or a series of patient visits, e.g. administration of clotting products to patients with haemophilia, the patient should be provided with advice about the treatment together with advice about material risks and benefits and consent should be obtained and documented in the normal way prior to commencing the treatment. It is not necessary to seek the patient’s consent for each of the subsequent stages of the treatment program. However, the patient’s consent is required and should be documented if a new treatment is proposed which was not previously explained to the patient or where alternative treatments become available or if new risks associated with the treatment are identified.

1.4 Pre-transfusion sample collection and labelling of blood specimens

The staff member collecting the blood sample must be trained in collection procedures. The person collecting the sample must label the specimen tube at the time the blood is collected from the patient. At the time of collection, two people, one of whom may be the patient, must check the name of the person from whom the sample was collected against the name written on the specimen tube to ensure that they are identical. If the patient is unconscious, irrational or unable to respond to direct questioning, the patient’s responsible person (as defined in the NSW Ministry for Health’s Policy Directive (PD2005 – 406) - Consent to Medical Treatment – Patient Information or a second staff member must confirm the patient’s identity.

---

2NHMRC/ANZSBT, Clinical Practice Guidelines on the Use of Blood Components (red blood cells, platelets, fresh frozen plasma, cryoprecipitate), 2001 at: www.nhmrc.gov.au
3NSW Health, Policy Directive (PD2005 – 406) - Consent to Medical Treatment – Patient Information
4ANZSBT Royal College of Nursing Guidelines for the Administration of Blood Products, 2011
5ANZSBT Guidelines for Pretransfusion Laboratory Practice 2007
Labelling procedures in the laboratory must ensure that the correct sample is being tested. All blood tubes must be adequately labelled and laboratory staff must check the label each time the tube is handled.

1.5 Transfusion verification procedure

In the presence of the patient two people must independently check the details of the patient’s identity, the blood pack and the accompanying documentation when the transfusion is being set up. The two people must have knowledge of the transfusion verification procedure and the patient must be involved, if appropriate.

1.6 Reason for transfusion to be recorded

The reason for a patient requiring a blood transfusion should be recorded in the records relating to the patient.

1.7 Blood for Rh (D) - negative patients

Rh (D)-negative patients requiring blood transfusion must normally be given Rh (D)-negative blood. If there is a shortage of Rh (D)-negative blood, Rh (D)-positive blood may be given to Rh (D)-negative males and post menopausal females who have no anti-D antibodies. If large quantities of O Rh (D)-negative blood are required, irrespective of the patient’s age, Rh (D)-positive blood may have to be given.

Small health care facilities must not store O Rh (D)-negative blood. If local clinicians believe that blood is warranted at these sites, O Rh (D)-positive blood must be stored instead.

In this Policy Directive a small health care facility is defined in the public health system as a facility that is a member of one of the following groups - community acute, community non-acute facilities, multi-purpose services and hospices.

If usage of O Rh (D)-negative blood is very low at any health care facility the Australian Red Cross Blood Service (Blood Service) may consider providing O Rh (D)-positive blood in place of O Rh (D)-negative blood to that facility.

2. TRANSPORTATION AND STORAGE OF BLOOD AND BLOOD COMPONENTS

The transportation and storage of blood components must comply with the relevant Australian Standards and ANZSBT Guidelines for the Administration of Blood Products.

2.1 Transportation

Blood products must be transported according to the specifications of the supplier and the receiving facility. The acceptance of products into the inventory of the receiving facility should be conditional on evidence of suitable storage and handling whilst in transit. Products should not be used for transfusion if there is any doubt regarding the conditions of storage during transport. Table 1 sets out the requirements for the safe transportation of blood and blood components.
Table 1

<table>
<thead>
<tr>
<th>Step</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Service delivery to designated point</td>
<td>Use a validated transport vehicle or validated transport system.</td>
</tr>
</tbody>
</table>
| Transport between sites a regional health centre to a health facility| Use a validated transport vehicle or a validated transport system. **Transport products at the following temperature range**  
Red blood cells: 2 to 6°C  
Fresh frozen plasma, cryoprecipitate: at or below -25°C  
Platelets: 20 to 24°C (with gentle agitation) |
| Transport to patient                                                | FFP and platelets should be commenced as soon as possible after receipt in the clinical setting.  
The transfusion of red blood cells must commence within 30 minutes of removal from storage. The procedures set out in the ANZSBT Guidelines for the Administration of Blood Products 2011 should be followed where:  
(1) red cells have been out of controlled storage for less than 30 minutes and not transfused \(^9\) or  
(2) where red blood cells are out of controlled storage for longer than 30 minutes \(^{10}\) |

2.2 Storage – minimum requirements

Storage equipment for blood and blood products must comply with the relevant provisions of Australian Standard AS 3864-1997 *Medical refrigeration equipment - For the storage of blood and blood products*. Table 2 sets out the storage temperature and shelf life for blood and blood components stored under optimal conditions Table 2.

<table>
<thead>
<tr>
<th>Blood component</th>
<th>Temperature range and conditions</th>
<th>Shelf life</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whole Blood</td>
<td>2 to 6°C</td>
<td>35 days</td>
<td>Refrigerators must comply with AS 3864 (1997) (^{11})</td>
</tr>
<tr>
<td>Red Cells</td>
<td>2 to 6°C</td>
<td>42 days</td>
<td>Refrigerators must comply with AS 3864 (1997) (^{12})</td>
</tr>
<tr>
<td>Platelet</td>
<td>20 to 24°C</td>
<td>5 days</td>
<td>Must be stored on a reciprocating concentrate rocker</td>
</tr>
<tr>
<td>Frozen Plasma</td>
<td>At or below -25°C</td>
<td>365 days</td>
<td>Refrigerators must comply with AS 3864 (1997) (^{13})</td>
</tr>
<tr>
<td>Cryoprecipitate</td>
<td>At or below -25°C</td>
<td>365 days</td>
<td>Refrigerators must comply with AS 3864 (1997) (^{14})</td>
</tr>
</tbody>
</table>

\(^9\)Ibid (see section 5.5.1)  
\(^{10}\)Ibid (see section 5.5.2)  
\(^{11}\)Australian Standard AS 3864, Medical Refrigeration Equipment – for the storage of blood and blood products (1997) or any Standard that supersedes this.  
\(^{12}\)Ibid.  
\(^{13}\)Ibid.  
\(^{14}\)Ibid.
19. PATHOLOGY

2.3 Labelling of blood components

Labelling procedures in the laboratory must ensure that the correct sample is being tested. All blood tubes must be adequately labelled and laboratory staff must check the label each time the tube is handled, in accordance with National Pathology Accreditation Advisory Council Requirements for Transfusion Laboratory Practice.15

Sometime in the future, in line with international practice, the Australian Red Cross Blood Service (the Blood Service) will be changing its bar coding system for blood components to the ISBT Code 128 bar code. Under this system donation identification numbers will be unique, as the year of collection will be encoded into the donation number. This will eliminate the problems associated with the recycling of donation numbers under the previous ABC Codabar system. During the change over period the barcode readers will be expected to be able to read both the ABC Codabar and the Code 128 bar code formats.

3. CLINICAL GOVERNANCE ISSUES

The following sets out the respective roles of the Blood Service and Local Health Districts in the provision and follow up of transfusions in health care facilities across the state.

3.1 Role of the Blood Service

The Blood Service provides various blood components to the NSW health system. The Blood Service operates a 24 hour, 7 day a week phone line (Tel.1300 478 348) for advice and consultation on urgent clinical matters including untoward transfusion reactions.

Significant reactions and near-miss incidents relating to the use of fresh blood components must be reported (1) via the Incident Information Management System (IIMS) in accordance with NSW Ministry for Health Policy Directive (PD2014_004) - Incident Management Policy and (2) to the Blood Service. Examples of matters to be reported include:

• ABO incompatibility;
• wrong blood in tube;
• incorrect blood component transfused;
• transfusion-associated graft versus host disease (GVHD);
• transfusion related acute lung injury (TRALI);
• suspected bacterial contamination;
• anaphylaxis;
• post transfusion purpura;
• other suspected transfusion transmitted infections.

3.2 Role of the Local Health Districts

Establishing and implementing a quality improvement system for the clinical use of blood and blood components requires the commitment and cooperation of executive staff, health service managers, hospital transfusion service staff, hospital blood bank staff, pathology providers, quality improvement staff, clinicians and patients. The recommendations for a quality management system are set out in the NHMRC/ANZSBT, Clinical Practice Guidelines on the Use of Blood Components16.

16NHMRC/ANZSBT, Clinical Practice Guidelines on the Use of Blood Components (red blood cells, platelets, fresh frozen plasma, cryoprecipitate), 2001 at: www.nhmrc.gov.au
Each health care facility that undertakes transfusion therapy must establish a process for the review of transfusion issues. This may be through an existing committee or through the establishment of a specific committee such as a hospital transfusion committee. The process should ensure clear arrangements for responsibility for education (including training in relation to the transfusion verification procedure), monitoring and quality improvement in the care of blood/blood components and transfusion practices.

The Local Health District must ensure that each of its health care facilities has appropriate arrangements in place to enable the development of local transfusion therapy policies that are consistent with state-wide policies and which address any problems that have been identified. Specific matters to be addressed include the following:

- monitoring the safety, adequacy and reliability of the supply of blood, blood components and alternatives to transfusion;
- monitoring the usage of blood components in the health care facility;
- reviewing incidents of severe adverse effects or errors associated with transfusion;
- developing systems and procedures for the implementation of the policy within the health care facility;
- promoting the effective implementation of the policy through the education and training of clinicians and blood bank staff involved in the transfusion process;
- monitoring the implementation of the policy in the health care facility and take appropriate action to overcome any factors hindering its effective implementation.

Each health care facility must have clear lines of reporting blood and blood transfusion issues to the authority responsible for blood transfusion. In particular, all adverse events relating to blood or blood transfusion must be reported. In the NSW public health system the relevant authority must report to the Local Health District Clinical Governance Unit.

3.3 Reporting of infections

Local Health Districts must notify the local Public Health Unit and the Blood Service whenever a patient is suspected of having developed a transfusion-transmitted infection. Local Health Districts must allow Blood Service staff access to patients’ records to enable the Blood Service to collect and assess data relating to the units of blood and/or blood components that may be implicated in the transmission of infectious agents.

4. RETENTION OF RECORDS

It is essential that health records be retained for designated periods of time to facilitate both donor and patient follow up.

Health facilities in the public sector should follow the requirements for the retention of records set out in the General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17) 2004 of the State Records Authority of New South Wales. In particular health facilities should refer to:

4.4.0 Blood Bank and blood collection services (includes autologous and homologous);
4.4.2 Laboratory records of blood donations and administration of blood & blood products;
4.4.3 Registers of blood products. Recorded details of fresh and pooled blood products.
19. PATHOLOGY

4.1 Patient and component information

The following information must be retained for a minimum of 20 years:17,18

• donation or batch number and description of all blood components and manufactured blood
  components;
• ABO/Rh (D) group if relevant;
• date and time received;
• expiry date and time;
• fate of the component or blood component (issued, expired, transferred);
• patient’s family name, given name/s in full, hospital record or national health number or date of
  birth;
• date and time of transfusion.

4.2 Donor records

The Human Tissue Regulation 201019 sets out the period for the retention of a donor’s records as not
less than 10 years from the date on which the record relating to the medical suitability of the donor
was signed.

17General Retention and Disposal Authority - Public Health Services: Patient /Client Records (GDA 17) 2004
18National Pathology Accreditation Advisory Council, Requirements for the Retention of Laboratory Records and Diagnostic Material, 2009
at: www.health.gov.au
5. ATTACHMENT

ATTACHMENT A

AUSTRALIAN HEALTH MINISTERS’ CONFERENCE STATEMENT ON NATIONAL STEWARDSHIP EXPECTATIONS FOR THE SUPPLY OF BLOOD AND BLOOD PRODUCTS

The Australian Health Ministers’ Conference (AHMC) has determined that a clear statement is needed on governments’ stewardship expectations for the providers of blood and blood products within the health sector. Stewardship, in this context, means responsible, sustainable and appropriate use of blood and blood products.

Blood and blood products are provided under the National Blood Agreement 2003 to which all Commonwealth, State and Territory Governments are signatories. Achieving a blood supply that can meet the growing needs of an ageing population at an affordable cost requires the commitment from blood donors to be matched by an equal commitment from other parties in the supply chain.

All governments are committed to:

• Providing an adequate, safe, secure and affordable supply of blood products, blood related products and blood related services; and
• Promoting safe, high quality management and use of blood products, blood related products and blood related services in Australia.

A key component of the blood sector and one which plays an invaluable part is that of the health providers of blood and blood products. Hospitals, doctors, laboratories and other health providers serve a vital role in ensuring these key resources reach the patients in need.

In fulfilling this role, Ministers expect that these health providers will contribute to the sustainability of the blood supply by adopting these stewardship measures for their own organisation and requiring their adoption by any other party to whom they supply blood.

Blood Stewardship Principles

Blood should be managed in ways that ensure:

• All blood products are used in a clinically appropriate manner in accord with relevant professional guidelines and standards;
• Informed patient consent procedures are implemented for all patients;
• Processes, programs and facilities are in place to minimise the wastage of blood products;
• Facilities are accredited with the appropriate bodies to meet all quality and safety obligations; and
• Transfusion related adverse event information is collected and managed according to jurisdictional requirements.

National blood product planning, management and governance are supported by:

• Health providers having an ordering and receipt verification process in place which provides adequate financial accountability as required by governments; and
• Inventory data is provided on a regular and timely basis to assist in supply and demand planning, especially in times of national shortages.

Governments and the National Blood Authority will continue to manage the Australian blood supply to meet the needs of the community. Health providers play a vital role in making sure that products are available to meet clinical need, when and where required. The contribution of these health providers to safe and appropriate use, including minimisation of cost and wastage in the supply, is equally important. Ministers look to health providers to increase their efforts in these areas to ensure that Australia has a sustainable and affordable blood supply into the future.

Statement Approved by the Australian Health Ministers’ Conference, 12 November 2010.
CORD BLOOD - PUBLIC AND PRIVATE CORD BLOOD BANKING (PD2015_048)

PD2015_048 rescinds PD2005_394

PURPOSE

Collection, storage and processing of cord blood in NSW is governed by the NSW Human Tissue Act 1983 and regulated by the requirements of the Therapeutic Goods Administration. This document provides direction to health services regarding public and private cord blood banking. It outlines the procedures to be followed by NSW Health staff for obtaining a woman’s consent for and collection of cord blood for either donation to a public cord blood bank, directed donation to a family member requiring a haemopoietic stem cell transplant or for private storage for future personal use. Failure to comply with the requirements of the NSW Human Tissue Act 1983 may constitute an offence.

There are a number of options for cord blood banking available to women in NSW. It is important that women have access to relevant information on these options preferably in the antenatal period so that an informed choice can be made.

MANDATORY REQUIREMENTS

1. All consents to the donation of cord blood for its use in transplantation or other medical, scientific or therapeutic purposes (including research) must meet the requirements of the NSW Human Tissue Act 1983.
2. The collection of cord blood must not interfere with the delivery of the baby or placenta or any emergency procedure required.
3. If public or private patients in public hospitals wish to utilise a private cord blood bank, they must make their own arrangements for the collection of cord blood.
4. As a condition of permitting a private cord blood bank to undertake the collection of cord blood in a Public Health Organisation’s premises, a mother is required to sign the request form provided at Attachment 1.
5. No employee of a Public Health Organisation may be involved in the collection of cord blood for private blood banking. Public Health Organisations must not be involved in the collection, storage or transplantation of cord blood for private blood banks.

IMPLEMENTATION

Chief Executives of Local Health Districts are responsible for:

- Ensuring that the contents of this policy are brought to the attention of relevant staff.

Cord blood bank collection staff (both public and private) must:

- Obtain consent to the collection and/or donation of cord blood by the woman (preferably in the antenatal period) and provide a copy to be placed on the woman’s medical record at the commencement of labour
- Make their presence known to hospital staff when attending for collection and satisfy the Public Health Organisation’s (PHO’s) security requirements by presenting their company employee identification on arrival and
19. **PATHOLOGY**

- Await the instruction of the doctor / midwife conducting the delivery for an indication that cord blood collection can proceed.

Individual patients who wish to have private collection of cord blood are responsible for:

- Making arrangements for the collection, storage and transfer of cord blood, with a collector from the private cord blood bank, a private obstetrician with visiting practitioner appointment to the hospital or another suitably qualified person and
- Ensuring that the private cord blood bank collection staff are notified of the commencement of labour.

Individual medical practitioners exercising their rights of private practice:

- May make arrangements with a private cord blood bank for the collection of cord blood at the request of their patients.

Private cord blood bank staff are responsible for:

- Ensuring that women complete the Request for Private Cord Blood Banking form (Attachment 1) antenatally and providing a copy to be included in the woman’s medical record before the commencement of labour.

1 **BACKGROUND**

1.1 **About this document**

This document relates to cord blood banking. Cord blood is the blood remaining in the umbilical cord vessels and placenta after the umbilical cord has been cut after the birth of a baby. Normally, the umbilical cord and placenta, together with the approximately 100 millilitres of cord blood, are disposed of after birth. Cord blood collection is the collection of cord blood from the umbilical vein after birth. Cord blood is rich in stem cells and can be frozen and banked for many years and subsequently used as an alternate source of stem cells to bone marrow.

Requests for cord blood collection and / or banking are not routine but are becoming more common. Currently, in NSW, there are three circumstances in which cord blood collection may take place:

1. Public donation
2. Family donation or
3. Private collection and use / banking.

1.2 **Key definitions**

Public cord blood donation: the collection of cord blood for anonymous donation through the Sydney Cord Blood Bank (SCBB) at one of its collection centres. The SCBB has collection centres at a number of hospitals in NSW including Royal Hospital for Women Randwick and Royal Prince Alfred Mothers and Babies Hospital, Camperdown.

Family cord blood donation: the collection of cord blood for donation and use where there is a family member (e.g. a biological sibling) with a disease such as leukaemia who is in immediate need of a bone marrow transplant.

Private use cord blood banking: the collection of cord blood for storage for private use either for the child following whose birth the cord was collected or for another family member in case there is ever a medical need in the future.
1.3 Legal and legislative framework

The Human Tissue Act 1983 regulates the process by which consent can be given to the donation of human tissue such as cord blood for the purpose of its transplantation into the body of another person or for medical, therapeutic or scientific purposes.

The Human Tissue Act 1983 expressly prohibits trade in donated human tissue. This includes any agreement or offer to enter into any agreement for any valuable consideration to the sale or supply of tissue from a person’s body.

Failure to comply with the requirements of the Human Tissue Act 1983 may constitute an offence.

All public and private cord blood banks must meet TGA regulatory and / or manufacturing licensing requirements to operate as cord blood banks.

2 Public Cord Blood Donation

2.1 The Sydney Cord Blood Bank (SCBB)

In NSW public donation of cord blood is managed through the SCBB located at the Sydney Children’s Hospital Randwick. The SCBB is part of a national network of public cord blood banks. NSW Health supports the activities of the SCBB which collects and stores cord blood for the use of all patients, free of charge, on the basis of need.

This network collects and banks cord blood from voluntary donors for anonymous use by patients needing a stem cell transplant. Donating mothers give informed consent and are screened for blood borne viruses and for any historical risk of transmitting genetic disorders.

Collected cord blood that meets strict acceptance criteria is processed, frozen, stored and distributed for transplant and is identified only by a unit number so that the donor remains anonymous.

The SCBB arranges for cord blood to be collected by its own staff, or obstetricians and midwives who have been trained and accredited by the SCBB.

Public cord blood donations can only be collected in facilities licensed by the Therapeutic Goods Administration. Information on current collection sites for public cord blood donation is available at www.abmdr.org.au

2.2 Information on Public Cord Blood Collection and Banking

Public and private patients attending maternity units in hospitals with public bank collection sites should be informed that public cord blood donation is available. Information should be made available to expectant parents in the antenatal period about the option to collect and donate their cord to the public cord blood bank. If parents wish to donate the woman should be encouraged to discuss this intention with her midwife or obstetrician in the antenatal period.

2.3 Procedures for Public Cord Blood Banking in NSW Public Health Organisations

The following procedures apply for public cord blood collection and banking:
2.3.1 Informed consent to the collection of cord blood for the purpose of public cord blood banking should be obtained preferably during the antenatal period. The consent is archived by the SCBB and a copy of the consent will be provided to the public health facility. A copy of the consent is also given to the woman intending to donate.

2.3.2 It is important to confirm that the woman understands she is consenting to public cord blood donation for anonymous use by anyone in need of a stem cell transplant and that the cord will not be available and / or released for uses other than for purposes for which it has been banked (stem cell transplantation).

2.3.3 All SCBB staff employed to collect cord blood at designated collection sites must satisfy the PHO’s requirements for identification and must be clearly identifiable and make their presence known to hospital staff. SCBB visitors will act in accordance with the PHO’s work health and safety policies at all times whilst present.

2.3.4 Obstetricians and midwives of the public health organisation may be involved in the collection of cord blood for public cord blood banks upon voluntary completion of training and accreditation offered by the SCBB.

2.3.5 Facilities of public health organisations (i.e. materials, documents or staff) may be provided as part of a contractual arrangement with the SCBB for the purpose of cord blood collection and temporary storage.

2.3.6 The collection of cord blood must not interfere with the delivery of the baby or placenta or any emergency procedure required. The doctor / midwife conducting the delivery will indicate if the collection can proceed.

3 FAMILY CORD BLOOD COLLECTION AND DONATION

A family cord blood donation (also known as directed cord blood donation) is the donation of cord blood for use where there is an identified sibling with a disease that may require a bone marrow transplant. In NSW directed cord blood donation is only available through the Sydney Children’s Hospitals Network.

A decision to use a directed donation of cord blood for transplantation will be made by the treating doctor of the family member needing a transplant.

As with all cord blood donation the consent of the mother to the donation, collection, screening and testing of the cord blood unit will be required.

If the decision is to proceed with directed donation, the donating mother will be responsible for the making the arrangements for the collection and transportation of the cord blood in collaboration with her obstetric team.

For further information on family (directed) cord blood donation contact the Sydney Children’s Hospital Bone Marrow Transplant Unit.

4 PRIVATE USE CORD BLOOD BANKING

The following procedures apply for private cord blood collection and banking:
4.1.1 If a patient (either a public patient or a private patient in a public hospital) wishes to utilise a private cord blood bank for the collection of cord blood, they must make their own arrangements with a private cord blood bank representative for the collection.

4.1.2 Informed consent to the collection of cord blood for the purpose of private cord blood banking must be obtained by the private cord blood representative during the mother’s antenatal period. A copy of this consent should be provided to the hospital where the woman plans to give birth and should be placed on the woman’s medical record prior to the commencement of labour.

4.1.3 The mother must make a private arrangement for the collection, storage and transfer of cord blood with a collector from the private cord bank, a private obstetrician holding a visiting practitioner appointment to the hospital or another suitably qualified person.

4.1.4 No employee of the public health organisation may be involved in the collection of cord blood for private blood banks.

4.1.5 It is a matter for individual medical practitioners, exercising their rights of private practice, as to whether they make arrangements with a private cord blood bank for the collection of cord blood at the request of their patients.

4.1.6 Facilities (i.e. materials, documents or staff) of public health organisations are not to be used for the collection, storage or transplantation of cord blood for private blood banks.

4.1.7 As a condition of permitting a private blood bank to undertake the collection of cord blood in a public health organisation’s premises, a mother is required to sign a request form (Attachment 1) in the antenatal period. The form is to be placed on the medical record prior to the commencement of labour. This form confirms that she understands that the cord blood service is not provided by the public health organisation or its employees and that the hospital is not responsible for the collection, transport and storage of the cord blood.

4.1.8 The woman seeking private cord blood banking services is responsible for ensuring that the private cord blood banking service is notified when she commences labour.

4.1.9 Private Cord Blood Bank visitors to the delivery suite involved in cord blood collection must satisfy the PHO’s requirements for identification and must be clearly identifiable and make their presence known to hospital staff. Private Cord Blood Bank visitors will act in accordance with directions by PHO staff and otherwise in accordance with the PHO’s work health and safety policies at all times whilst present.

4.1.10 The doctor / midwife conducting the delivery will indicate if and when the cord blood collection can proceed. Cord blood collections undertaken by private cord blood bank collectors must take place after the delivery of the baby and placenta (ex-utero).
5 LIST OF ATTACHMENTS

Request and Release for Private Cord Blood Banking

Attachment 1: Request and Release for Private Cord Blood Donation

---

REQUEST FOR PRIVATE CORD BLOOD BANKING

Request for Private Cord Blood Banking

Patient declaration

[Print name]

[Print address]

have made arrangements with [Name of private cord blood bank representative/private obstetrician collecting the cord blood]

I understand that the cord blood banking service is provided by the bank named above and is not provided, approved or endorsed by this hospital and that this hospital and its staff have no responsibility for and no involvement with the private cord blood bank.

I understand and accept that a condition of permitting my arrangement with the private cord blood bank for collection of the cord blood to occur on this hospital premises is that this hospital and its employees are absolved from all liability, however arising including any breach of contract, breach of duty and or negligent act or omission on the part of this hospital and its employees arising from loss, injury or damage arising directly or indirectly in connection with the collection, handling, transportation or storage of the cord blood.

I understand that the attending medical practitioner or midwife, as the case may be, will ultimately determine whether the collection of the cord blood can proceed having regard to the medical condition of myself and my child.

Signature of patient

[Date (dd/mm/yyyy)]

Print name of witness

Signature of witness

---

This space for form information, notations, благодар, etc.

295(10/12/15)
RESPONSIBILITIES OF MEDICAL OFFICERS WITH REGARD TO DRIVERS
(IB2013_059)


PURPOSE

This information bulletin summarises the responsibilities of medical practitioners working in NSW Health with regard to drivers, and outlines the relevant legislation that permits reporting by medical officers of concerns about drivers directly to Roads and Maritime Services (RMS).

This information bulletin replaces PD2005_028 Drivers – Medical Officers Responsibilities with Regard to Drivers.

KEY INFORMATION

The Ministry of Health’s policy, based on common law and ethical principles, is that the duty of confidentiality owed by medical practitioners to their patients must be preserved except where disclosure of health information occurs with the consent of the patient or where there is a lawful justification for disclosing the information without the consent of the patient.

One context in which disclosure of health information to third parties arises is medical assessment of patients for fitness to hold a licence to drive. This is generally done to assist the relevant licensing authority (Roads and Maritime Services in NSW) to determine whether or not a patient is fit to hold a licence or to hold a conditional licence.

Information regarding this process can be found on the RMS website, which includes a standard “Medical Condition Notification Form”. This form can be completed by the medical practitioner in consultation with the patient, and submitted to RMS.

There may be circumstances in which a medical practitioner may hold concerns about a patient’s fitness to drive and/or that the patient is a potential danger to the public if permitted to drive in any circumstances, or is permitted to drive without being subject to conditions. In this event where possible medical practitioners should encourage patients to either self-notify the medical condition to RMS or to consent to the medical practitioner notifying RMS of the practitioner’s concerns via the submission of a completed “Medical Condition Notification Form”.

Where the patient does not comply with the medical practitioner’s advice, legislation in NSW provides protections for medical practitioners who directly report the matter to RMS.

Section 275(4) of the Road Transport Act 2013 (NSW) provides as follows:

An individual does not incur civil or criminal liability for reporting to the Authority [ie RMS], in good faith, information that discloses or suggests that:

(a) Another person is or may be unfit to drive
(b) It may be dangerous to allow another person to hold, to be issued or to have renewed, a driver licence or a variation of a driver licence.

The above provisions are discretionary reporting requirements only. There is no mandatory reporting requirement for medical practitioners in relation to drivers who may present a risk to the public. In considering whether to make report directly to RMS, medical practitioners should ensure that:
19. PATHOLOGY

- They are acting in good faith – that is, they are acting out of a bona fide concern for safety concerns regarding the driver concerned.
- The health information they disclose to RMS is limited to information that is relevant to the issue of the driver’s fitness to drive or that allowing the person to hold a licence may be dangerous.

Situations that may result in a medical practitioner reporting a patient to the RMS include where the patient is:
- Unable to appreciate the impact of their condition.
- Unable to take notice of the health professional’s recommendations due to cognitive impairment.
- Continues driving despite appropriate advice and is considered likely to endanger the public.

In the event that the medical practitioner decides to directly report a patient to RMS, it is good practice to advise the patient that the practitioner is doing so.

Medical practitioners may, if they wish, when directly reporting a patient to RMS, use a copy of the approved “Medical Condition Notification Form”. A copy of the form, and more information from RMS, can be found at: http://www.rms.nsw.gov.au/licensing/healthmedicals/health_professionals.html

BLOOD AND URINE TESTING OF DRIVERS APPARENTLY UNDER THE INFLUENCE OF DRUGS (PD2005_029)

The Traffic Act 1909 has been amended, with effect from 1 December 1987 to provide for testing of blood and urine of drivers whose driving gives reasonable cause for belief that they are under the influence of alcohol or other drugs, but whose breath test indicates that they do not have a prescribed concentration of alcohol in their blood. This section sets out the requirements in such cases.

This position, however, must be qualified in light of certain provisions of the Traffic Act 1909, which were inserted into that Act in 1983 and which expressly exonerate medical practitioners from common law and statute liability in respect of potential civil or criminal actions arising from, inter alia, breaches of confidentiality in certain prescribed cases.

A motor vehicle driver who appears to be under the influence of alcohol or another drug, but whose breath test for alcohol is negative, may be arrested by a member of the police force and taken to a hospital for blood and urine sampling for the purpose of analysis for the presence of drugs likely to impair driving ability.

Where an arrested driver is brought by a member of the police force to a hospital for blood and urine sampling for drug testing purposes, the samples must be taken as soon as practicable and in any case not more than 2 hours after the event which led to the arrest.

The samples are required to be taken by a medical practitioner or a person acting under the supervision or direction of a medical practitioner. Sampling is deemed to have been performed by the medical practitioner. The medical practitioner taking or supervising or directing the taking of the samples is protected against civil or criminal liability for anything properly and necessarily done in taking the samples in conformity with the Act.

Each sample must be divided into 2 parts, of which:
- one part is to be handed to the driver or someone acting for the driver;
- one part is to be handed to the member of the police force for forwarding to the Government Analyst.
A medical certificate must be filled out by the medical practitioner who performed or supervised or directed the performance of the sampling. Medical certificate forms are provided in quadruplicate on special carbonless paper. After the certificate is completed, the fourth (pink) copy should be detached and given to the driver or person acting on behalf of the driver. The other three (white, yellow and blue) copies should be kept intact and handed to the member of the police force.

An approved sampling kit for blood and urine testing for the presence of drugs must be used for collecting samples and recording the necessary details. Each kit contains all equipment needed for sampling, packaging and identification of samples and certification by the medical practitioner. Full instructions are included in each kit.

Approved kits are available in cartons of 2 kits from the Government Supply Department. Order should specify:

- Drug driving sampling kit (cartons of 2)
- Item No. 841 620

One carton will be supplied and invoiced to each public hospital. Orders for additional supplies should be submitted in the usual way.

Orders may be submitted to the Government Supply Department by facsimile [Fax (02) 360 1991].

No charge is to be raised for collection of blood and urine samples for drug analysis under the Traffic Act 1909.

COLLECTING BLOOD AND URINE SAMPLES IN EMERGENCY DEPARTMENTS – CHANGES TO GOVERNING LEGISLATION (IB2015_033)

PURPOSE

This Information Bulletin highlights recent changes to the legislation governing the requirements for collecting blood and urine samples in Emergency Departments and the impact on NSW Health policy and patients under this Legislation.

This Information Bulletin is to be read in conjunction with the following policies and provides corrected requirements under the new Legislation:

- PD2005_495 Blood Alcohol Sampling by Hospital Staff
- PD2005_029 Blood and Urine Testing of Drivers Apparently Under the Influence of Drugs

KEY INFORMATION


The Marine (Boating and Safety - Alcohol and Drugs) Act 1991 has been repealed; all requirements for the taking of blood and urine samples in ED for persons involved in an accident whilst operating a vessel are contained within the Marine Safety Act 1998, Schedule 1.

A full review of the two existing policies detailed above has been delayed as operational changes are still being made to the system which may require additional legislative changes. However, in the interim, it is apparent that additional information is required for Health Services and EDS to support use of the existing policies until a full review is completed.

246(30/07/15)
Please note: where the policy’s existing information is not mentioned below, the information contained in the policy remains consistent with the new Legislation.

Updates to information in PD2005_495 - Blood Alcohol Sampling by Hospital Staff
- Clause 11 of Schedule 3 of the Road Transport Act provides the requirements relating to the taking of blood samples on patients presenting to EDs who may have been involved in a road accident.
- The Marine Safety Act 1998, Schedule 1, Clause 9 provides the requirements relating to the taking of blood samples on patients presenting to EDs who may have been involved in an accident whilst operating a vessel.
- The blood alcohol sampling procedure no longer requires the sample to be divided into two approximately equal portions. A sample of the blood is not given to the patient. The single sealed and labelled blood sample is placed in the blue Police Security Box as normal with the relevant evidentiary certificates and the pink copy of the certificate must still be given to the patient.
- Sampling should occur as soon as possible and must be undertaken within 12 hours of the accident.

Updates to Information in PD2005_029 - Blood and Urine Testing of Drivers Apparently Under the Influence of Drugs
- Road Transport Act 2013, Schedule 3, clause 5 replaces the Motor Traffic Act 1909 and allows for blood and urine sampling at hospital from persons arrested by police following a failed sobriety test with the suspicion of being under the influence of drugs.
- The Marine Safety Act 1998, Schedule 1 Clause 20 also allows for blood and urine sampling at hospital from persons arrested by police following a failed sobriety test with the suspicion of being under the influence of drugs.
- Sampling must occur within 4 hours (instead of 2 hours) from the occurrence of the event that entitled the police officer to bring the person to Hospital for the sample to be taken.
- Samples can be taken by any authorised sample taker. Specifically this includes:
  - Medical Practitioners
  - Registered Nurses
  - A person (or a person belonging to a class or description of persons) prescribed by the statutory rules as being authorised to take samples for the purposes of Schedule 3 in the Road Transport Act (referred to throughout as authorised sample taker). Currently this includes Enrolled Nurses and a person employed to work at a hospital, whose duties include taking blood samples or other specimens for laboratory testing.
- The urine drug sampling procedure no longer requires the sample to be divided into two approximately equal portions. A sample of the urine is not given to the patient. The single sealed and labelled urine sample together with single blood alcohol sample is placed in the blue Police Security Box as normal with the relevant evidentiary certificates and the pink copy of the certificate must still be given to the patient.
- Approved kits with serial number that starts with ‘D’ are available as imprest items and can be ordered as per local process for imprest stock.
- Any blood and/or urine sampling taken under the provisions of the Marine Safety Act 1998 must use the blood and urine kit with the serial number starting with ‘D’ and the box indicating the sample has been collected under Clause 27 and 29 of the Schedule 1 to the Marine Safety Act 1998 must be ticked.
Additional Legislation where persons may be bought to ED by Police to request blood and urine sampling

- **Road Transport Act 2013** Schedule 3 Part 2 Division 3 Clauses 5A and 9 and **Marine Safety Act 1998**, Schedule 1 Clause 4A – police may arrest a person and bring them to the ED for blood and urine tests if the person:
  I. Has attempted to provide a breath test for alcohol or an oral fluid sample to test for illicit drugs but
  II. Has been physically unable to comply with that direction (for example, because no oral fluid was physically able to be produced)

- **Road Transport Act 2013** Schedule 3 Part 2 Division 4 Clause 12 and **Marine Safety Act 1998**, Schedule 1 Clause 14 – police may arrest a person and bring them to the ED for blood and urine tests if the person is the driver in an accident and the police officer believes that:
  I. The accident is a fatal accident, or
  II. It is more likely than not that a person involved in the accident will die within 30 days as a consequence of the accident

- **Road Transport Act 2013** Schedule 3 Part 3 Clause 21 and **Marine Safety Act 1998**, Schedule 1 Clause 7 – police may bring an unarrested person to the ED at the person’s request if, during the course of being requested to submit to a breath analysis, the person requests that a sample of blood be taken for analysis. The testing of this sample will be done at the person’s own expense. Police will bring a ‘B’ testing kit with them to the ED for samples taken under this clause.

- **Crimes Act 1900** Section 25A – police may bring an arrested person over the age of 18 years to the ED for blood and urine testing if the person:
  I. Is under arrest for Assault Causing Death of another person
  II. Is under arrest for the assault of another person and the police officer has a reasonable belief that the person would be liable to be charged with an offence under section 25A (2) of the Crimes Act 1900 if the other person dies.

**The Rail Safety (Adoption of National Law) Regulation 2012**

Clause 13 of the [Rail Safety (Adoption of National Law) Regulation 2012](#) provides that where a rail worker attends the hospital following an accident, a blood or urine sample must be taken by a medical practitioner or registered nurse, however the taking of a blood sample is preferred by the National Rail Safety Regulator. The blood sample should be taken by a medical practitioner, or if a medical practitioner is not available, a registered nurse.

Clause 14 provides additional circumstances where a rail worker may be required to provide a blood sample such as if there is a reasonable belief that the worker might be under the influence of alcohol and has not been able to be breathalysed or is under the influence of a drug. In such circumstances the blood sample may be taken by any “authorised sample taker” as defined in the Road Transport Act 2013.

Contrary to the Road Transport Act, if a urine sample is taken instead of the blood sample, the Rail Safety Law states that two samples are still required; both samples are sent to the laboratory for testing. The second urine jar should be taken from a second sampling kit; however the duplicate serial number stickers to seal the urine containers must be used from the first kit.

If urine sampling occurs, the samples are **not put in the blue Police Security Box**. Samples are to be given to the Rail Authorised Person, who will send them to the correct laboratory for testing.

The kit with serial number that starts with ‘D’ should be used for any Rail Safety Regulation testing and the box indicating the sample has been collected under Clause 29 (2) of the Rail Safety (Adoption of National Law) Regulation 2012 must be ticked.
INTERIM DRUG DRIVING BLOOD TESTING ARRANGEMENTS IN NSW EMERGENCY DEPARTMENTS (IB2007_003)

This purpose of this information bulletin is to advise Area Health Service employees of changes to processes and procedures in taking blood samples from uninjured arrested drivers under the Road Transport (Safety and Traffic Management) 1999 Act.

This information bulletin does not change procedures to be followed when taking blood samples for traffic matters other than to amend the manner in which information is recorded on the Blood Sampling for Drugs Certificate by Police Officers. All other procedures detailed in the circular Blood Alcohol Sampling by Hospital Staff (PD2005_495) and Blood and Urine Testing of Drivers Apparently under the influence of drugs (PD2005_029) still apply to the actual taking of blood samples.

Summary
The Road Transport Legislation Amendment (Drug Testing) Bill 2006 requires police to conduct compulsory drug testing after fatal traffic crashes.

In relation to hospitals:
- There will be no changes to procedures for taking blood samples at hospitals.
- There will be one additional scenario when blood sampling at a hospital is required; for surviving drivers involved in a fatal road accident. This will have a small impact on individual hospitals.
- Extra resources have been provided to NSW health to outsource the blood sampling for existing and new traffic matters.

Additional blood sampling requirements
All drivers (injured and uninjured) involved in a fatal traffic crash will be required to provide a blood sample for drug testing. This will result in approximately 200 uninjured drivers each year having blood samples taken at hospitals across the state.

Police officers will be required to make hand-written amendments to the Blood Sampling for Drugs Certificate to note the new legislative provision under which the sample was taken from uninjured drivers. This is an interim measure only from 15 December 2006. See the attached example certificate for an illustration of the hand-written changes Police Officers will be required to make.

Certificates with the new provisions will eventually be placed in all blood-sampling kits. After a specific date previous blood sampling certificates will be redundant. It is anticipated these new certificates will be available by March/April 2007.

There are no changes to the existing blood-sampling regime for injured drivers.

Random Roadside Drug Testing
Random roadside drug testing will not ordinarily involve hospitals at any point. Involvement may occur if a driver is unable to provide the required oral fluid sample. Police may then take the driver to a hospital to provide a blood sample.

As with the fatal crash scenario Police officers will be required to make hand-written amendments to the Blood Sampling for Drugs Certificate to note the new legislative provision under which the sample was taken.

Future reduction in workload for Emergency Departments
The NSW Government has allocated funding to NSW Health to allow for the contracting of pathology service providers to conduct blood sampling at hospitals for all traffic matters for uninjured drivers. This will alleviate the current and future workload of many NSW hospital emergency departments when taking blood samples from uninjured arrested drivers. This not only relates to the new drug testing requirements, but also to the pre-existing blood alcohol testing regime. This program is only likely to be viable in the greater Sydney basin, Newcastle and Wollongong areas initially, with a possibility of extending to other regional centres in the future.

NSW Health is currently in discussions with the Department of Commerce to conduct a tender to provide these services. Notification about any changes will be issued in due course, and well before implementation begins.
NSW BLOOD / URINE TESTING CERTIFICATES FOR DRUGS

Certificate by medical practitioner / registered nurse pursuant to the provisions of:
Section 35 of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Clause 26 (2) of the Rail Safety (Drug and Alcohol Testing) Regulation 2003
☐ Clause 17 of Schedule 1 of the Marine Safety Act 1998

I, __________________________________________ (name of medical practitioner / registered nurse acting under direction of medical practitioner)
a medical practitioner / nurse certify that at __________________________________________ on ____________
(time) ____________________________ (date) ____________________________
I attended __________________________________________ (patient's name)
of __________________________________________ (patient's address)
who attended __________________________________________ (name of hospital / prescribed place)
In accordance with:
Division 4A of Part 2 of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Rail Safety (Drug and Alcohol Testing) Regulation 2003
☐ Schedule 1 of the Marine Safety Act 1998

At __________________________________________ on ____________________________ I then took a sample of blood and a sample of urine from that person.
(time of sampling) ____________________________ (date of sampling)
I then dealt with the sample of blood in accordance with:
Division 6 of Part 2 of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Clause 15A of the Rail Safety (Drug and Alcohol Testing) Regulation 2003
Division 4A ☐ Clause 8 of Schedule 1 of the Marine Safety Act 1998
The container was sealed and labelled with the serial number __________________________________________ (serial number on seal / label)
I then dealt with the sample of urine in accordance with:
Division 6 of Part 2 of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Clause 17 of the Rail Safety (Drug and Alcohol Testing) Regulation 2003
Division 4A ☐ Clause 8 of Schedule 1 of the Marine Safety Act 1998
Each of the containers was sealed and labelled with the same serial number __________________________________________ (serial number on seal / label)
(%signature of medical practitioner / nurse) __________________________________________ (date of signature)

Certificate by Police / Authorised Officer pursuant to the provisions of:
Section 35 (2) of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Clause 26 (3) of the Rail Safety (Drug and Alcohol Testing) Regulation 2003
☐ Clause 17 of Schedule 1 of the Marine Safety Act 1998

I, __________________________________________ (name and rank of Officer)
of __________________________________________ (Officer's work place)
hereby certify that:
I received a sample of the blood and / or a sample of the urine of __________________________________________ (subject's name)
taken in accordance with:
Division 6 of Part 2 of the Road Transport (Safety and Traffic Management) Act 1999 OR
(Tick box if other Act is applicable) ☐ Rail Safety (Drug and Alcohol Testing) Regulation 2003
Division 4A ☐ Schedule 1 of the Marine Safety Act 1998
I arranged for the sample / s to be submitted for analysis by an analyst to determine whether any drug was present in the sample / s.
The container of blood was sealed and labelled with the serial number __________________________________________ (serial number on label / seal)
The container of urine was sealed and labelled with the serial number __________________________________________ (serial number on label / seal)
(%signature of Officer) __________________________________________ (date of signature)
1. Introduction

1.1 What is client registration?

Client registration is the process of identifying and collecting data on an individual and recording of that data within an Area Health Service-wide client registration database for the purpose of uniquely identifying that individual. The allocation of an Area Health Service unique patient identifier, to be used as a unique key for that client/patient, is a product of this process.

The intent of client registration is to be able to link information held on a client/patient and thereby, support the delivery of services to that client/patient and the management and understanding of services and service needs.

Client registration involves all of the following:

- **Gathering minimum standard information** about a client/patient of a health service to ensure that the client/patient is properly identified.
- **Searching** the Area Health Service-wide client registration database to determine if the client/patient has already been registered.
- **Recording mandatory information** about the client/patient or **updating existing information** in the Area Health Service-wide client registration database, and populating any other copies of this information with the updated information, ensuring that information held by the health service is correct and up-to-date.
- **Allocating an Area Health Service unique patient identifier** to new clients/patients.

Registration is for the purpose of providing health care to the client/patient or other related functions.

1.2 Purpose of this policy directive

The purpose of this policy directive is to specify NSW Health policy in relation to the registration of clients, patients and other related people.

Standardised client registration leads to more effective health care in that it enables information relating to any previous care, including screenings, tests, medications, and alerts, to be readily accessible by health professionals, allowing them to provide the best possible care to each client/patient. This includes improving the quality and safety of health care by better targeting tests, investigative procedures and prescriptions, and reducing any duplication of these that may occur.

Standardised client registration also reduces the costs associated with disparate holdings of client/patient registration details within an Area Health Service.

1.3 Target audiences

This policy directive applies to all NSW public sector health services as follows:

- Public hospitals
- Multi-purpose services
- Residential care facilities
- Supported living services
- Outreach services
- Community health services
19. PATHOLOGY

- Public psychiatric hospitals
- Pathology, imaging, pharmacy and other support services located in a public health facility
- Ambulance Service of New South Wales
- Justice Health services.

The policy covers health care provided by these services in any mode (e.g., telehealth) and any location (e.g., outreach).

Services that are not part of NSW Health and are not delivered in NSW Health facilities (e.g. Aboriginal Medical Services, the Royal Flying Doctor Service) are not subject to this policy.

The staff for which this policy is intended includes any staff involved in registering clients/patients, including:
- client services or registration staff
- support staff such as medical record staff, ward clerks or secretarial staff
- intake officers
- admission managers
- health information managers
- Area information system departments
- clinicians

1.4 Replaced policy directives

This policy replaces the following policy directives:
- Client Registration Policy (PD2007_094)

2. Client Registration Process

2.1 Which services must register clients/patients?

The following NSW Health services must register clients/patients:

1. Public hospitals and public psychiatric hospitals, including:
   - admitted patient services
   - outpatient services
   - residential and transitional aged care services
   - emergency department services
   - allied health services
   - outreach services
   - confused and disturbed elderly services

2. Residential care facilities, including:
   - residential aged care services
   - brain injury rehabilitation/transitional living services
   - hostel services
   - group home services
   - supported living services
19. PATHOLOGY

3 Community health services, including:
   • centre/campus based services
   • home based services
   • mobile services
   • outreach services

4 Multi-purpose services

5 Ancillary health services, including pathology, radiology and pharmacy

6 Community acute and post acute care services (including hospital in the home)

7 Ambulance Service of New South Wales

8 Justice Health services

9 HealthOne NSW services.

2.2 Who must be registered?

Mandatory registrations

The following clients/patients who receive a health care service, or who are booked to receive a health service, including those added to a waiting list, must be registered:

- Patients who are admitted or are planned to be admitted to a health facility, including hospital-in-the-home patients.
- Patients who receive services or are planned to receive services in an outpatient department of a hospital.
- Patients who present to an emergency department, including those who do not wait to receive the service and those who are dead on arrival.
- Community health clients or those that are planned to receive these services, including those receiving services off-campus, e.g., at home.
- Clients receiving pathology, radiology or pharmacy services from a public health service, including those who receive a service as a result of a request from an external and/or private health service provider.
- All babies born in public hospitals or a NSW Health birthing facility. Each baby in a multiple birth must be registered separately.
- Stillborn babies of 20 weeks gestation or more, or, if the period of gestation cannot be determined, with a body mass of 400 grams or more. This applies regardless of the delivery location of the stillborn (that is whether it occurs in hospital or prior to arrival).
- Babies up to 9 days old accompanying their mother during her admission to hospital, even if they are well. For this purpose, determine the baby’s age at the time of admission of the mother, calculating the day of birth as zero (0). If the baby’s age is less than or equal to 9 days old at this time, then the baby must be registered. Babies older than 9 days accompanying their mother to hospital who do not require clinical care should be classified as boarders. See ‘Optional registrations’ below for guidelines relating to boarders.
- Organ donors (dead or alive), but only within the Area Health Service in which the organ is harvested.
- Clients/patients who are residents in NSW Health facilities, including but not limited to: residential aged care, hostels, group homes, transitional and assisted living, brain injury rehabilitation, and facilities for confused and disturbed elderly.
- Clients/patients receiving respite care.
- Clients/patients receiving a service within a group situation where clinical notes need to be recorded in the individual client’s/patient’s health record, including clients/patients who may join the group for one or a limited number of sessions.
• Clients/patients who are located in one Area Health Service but who are provided a service by staff in another Area Health Service using telecommunication service contact modes, such as telehealth. In these instances, clients/patients should be registered at each health service.

• Clients of call-centre based services where identification and/or registration would not inhibit participation in the service. (See ‘Optional registrations’ below for call-centre based services where registration may inhibit participation in the service.)

• People receiving individual immunisation or screening services, e.g., breast screening.

• Clients/patients whose identity is unknown at the time of receiving a health care service. (See Section 2.3 for further guidance on this.)

• Clients/patients who wish to have their identity restricted. (See Section 2.3 for further guidance on this.)

• People who are certified as dead prior to arrival to hospital taken directly to the hospital morgue. (See section 3.5 for minimum data requirements for dead people.)

Optional registrations

It is not mandatory to register the following clients, patients and other people who have contact with NSW Health services:

People receiving group immunisation or screening services (though a record including details of the people receiving these services needs to be kept for medico-legal and follow-up purposes).

• Recipients of health promotion services.

• Clients/patients of the NSW public health system receiving a service that has been contracted out to a private sector or non-government organisation.

• Clients of a needle exchange service or a supervised injecting room.

• Clients of a service where identification and/or registration may inhibit participation in the service and where it is lawful and practicable to provide the service without identifying the client (e.g., crisis counselling, sexual health).

• A family member, carer or support person who receives a service directly related to a client/patient, but who is not deemed clinically as being a client/patient in his/her own right.

• A family member, carer or support person with whom the health service provider communicates regarding the client/patient.

• People making general enquiries of a health service, e.g., about a health condition or about the nature of services available.

• Boarders or other people receiving food and/or accommodation by the health service but who are not receiving treatment (e.g., a parent accompanying their sick child during a hospital admission). While there is no requirement under this policy directive to register these people, individual Area Health Services may set local policies that require registration for purposes such as delivery of meals or for accounting for hospital occupants in disaster or emergency situations.

2.3 Special circumstances

Unidentified clients/patients: Unidentified clients/patients are people for whom no registration details can be collected because the client/patient is unable to provide those details (e.g., the person is unconscious) and there is no other person (such as a relative or carer) who can provide this information. Unidentified clients/patients must be registered and assigned an Area Health Service unique patient identifier. Procedures for registering unidentified clients/patients detailed in the Client Registration Guideline (GL2007_024) must be followed, and attempts should be made to obtain the client/patient registration details from alternative sources, such as relatives or carers, where possible. People in Justice Health under a witness protection program are considered to be unidentified clients/patients for the purpose of this policy but in these instances no attempts should be made to obtain the client/patient registration details from alternative sources.
Identity-restricted clients/patients: An identity-restricted client/patient is one whose identity can be ascertained but there is a requirement to mask it in the registration system because the client/patient requests it, or for legal or other reasons. Identity-restricted clients/patients may include staff of a service; Very Important Persons (VIPs); or people receiving services of a sensitive nature. Clients/patients who wish to have their identity restricted or are required to have their identity restricted must still be registered and allocated an Area Health Service unique patient identifier. This should be managed by policies developed by the Area Health Service. See Client Registration Guideline (GL2007_024) for further guidance on the registration of identity-restricted clients/patients. Also, see the Privacy Manual for Health Information (March 2015).

Telephone information, assessment and intake: Clients/patients may or may not be registered in these instances, depending on the nature of the call. For example, if the call is purely a request for publicly accessible information (e.g., opening times or contact details for a service), registration is not required. However, if the call involves intake (e.g., screening or assessment for the provision of a service), or for an appointment for a service, client registration needs to occur and at least the minimum registration data items recorded (see section 3.2). See Section 2.2 for guidelines on crisis-lines.

2.4 When to register

Client registration must occur at the first point of contact with a health service, or as early as possible in the process of providing a service. The first point of contact may be at the time of booking or, in the case of drop-in services, at the time of first presentation. For people who are certified as dead prior to arrival to hospital, the first point of contact is when the hospital takes responsibility for the body.

If it is not possible to obtain all client registration details at the time the client/patient is being booked for a service, effort should be made to obtain as many of the mandatory registration items as possible and then to record the remaining mandatory items at the time that the service is actually provided. This practice also applies in instances when the Area Health Service-wide client registration database is not accessible, in which case local policies should be developed and followed to ensure that the minimum mandatory data items are collected and the remainder followed up later. See Section 3 for a listing of mandatory client registration data items.

2.5 How to register clients/patients and update details

Client registrations must be recorded electronically in a single Area Health Service-wide client registration database. Each client/patient must be assigned an Area Health Service unique patient identifier.

Prior to adding a new client/patient to the Area Health Service-wide client registration database, it is mandatory to search for an existing registration of the client/patient within that database using a variety of search criteria. The search criteria should be defined in an Area Health Service policy and should align with the criteria described in the Client Registration Guideline (GL2007_024) and section 3.1 of this policy directive.

Updates to client registration details must always be made in the Area Health Service-wide client registration database.

Where client registration details are required in applications other than the Area Health Service-wide client registration database, an electronic HL7 message should flow outbound from Area Health
Service-wide client registration database to the other system when a client’s details are added, updated or requested by that system. For systems that are not compliant with HL7 messaging standards, the registration details will need to be entered manually into both the Area Health Service-wide client registration database and the non-HL7 compliant system - both sources must be kept consistent and up-to-date.

All alternative local identifiers (e.g. medical record numbers) assigned to the patient by other electronic systems, or by manual methods, must be stored in the Area Health Service-wide client registration database. This is required so that information from all source systems can be linked. Where functionality is available, the Area Health Service unique patient identifier must also be stored in the other source systems that hold a copy of client registration details, and transcribed onto all paper based medical records.

A ‘Privacy leaflet for patients’, as described in the NSW Health Privacy Manual, or similar, must be made available to clients/patients at every site performing client registration. This information should be prominently displayed (e.g. in admission areas, community health and hospital outpatient reception areas, emergency departments and hospital wards) and readily accessible to patients.

2.6 When to update client registration details

Client/patient details should be checked and confirmed or updated, as appropriate, each time a client presents for a new phase of treatment.

A phase of treatment may involve a number of service events that occur within weeks or months. Where a phase of treatment goes beyond three months, the currency of client registration details should be checked and confirmed with the client/patient every three months at minimum.

On re-presentation, or at the time a new service is booked or scheduled, special consideration must be given to the currency of:
- Address of usual residence
- Mailing address
- Telephone number(s)
- Preferred language
- Interpreter required
- Medicare eligibility and Medicare number (if eligibility for Medicare is a factor in service provision or billing)
- Health fund and health fund membership number (if a claim is to be made for the client/patient).
- General practitioner details
- Person to contact

Under privacy laws it is a requirement to keep personal health information up-to-date and accurate. Corrections or updates to client registration details made following a request by a client/patient, or his/her authorised representative, must be actioned in the Area Health Service-wide client registration database and in all copies of that information. For further guidance on clients’ requests to make changes to their personal health information, see section 12.7 of the NSW Health Privacy Manual.

2.7 Area Health Service responsibilities

It is a mandatory requirement that each Area Health Service defines standard criteria for searching for client registrations that align with those described in the Client Registration Guideline (GL2007_024) and section 3.1 of this policy directive and to distribute them to all staff responsible for registering clients.
Area Health Services must ensure that all staff responsible for registering clients are trained in all aspects of registration (e.g., gathering of information from the client/patient, searching, recording information and assigning an Area Health Service unique patient identifier) before they are allowed to register clients/patients. Training should cover relevant policies and procedures, consequences and risks to patient health care and health service liability arising from duplicate registration and incorrect identification and matching of individuals.

Follow up training and education should be available for all relevant staff and procedures implemented to monitor the quality of registrations. Staff identified as having issues meeting the expected client registration standards, e.g., creating duplicate registrations or incorrectly matching clients/patients, should undergo structured remedial training and further monitoring to ensure that the training has been effective. Subsequent ongoing issues with registration should be addressed in accord with the local performance management framework and the staff member’s continued involvement in client registration examined.

Area Health Services should have a client registration policy that addresses the following:
- standard methodology for searching for existing registrations in the Area Health service-wide client registration database;
- training staff prior to allowing them to register clients;
- follow-up training for client registration staff;
- material to be covered in client registration training;
- methods used to reduce duplicate registrations;
- procedures to resolve potential duplicates;
- how to register identity-restricted clients.

2.8 When to implement

It is recognised that implementation of this policy directive may require changes to local business processes and, as such, will be introduced in a staged manner across NSW. The policy should be implemented across all services by 1 September 2008.

3. Client Registration Data to Collect

There are four groups of client registration data:
1. minimum data for searching for an existing registration;
2. minimum data for booking or scheduling the first service within the Area Health Service;
3. minimum data for provision of the first service within the Area Health Service;
4. additional data mandated for specific encounter types.

The NSW Health Data Dictionary is the authoritative source for data and classification standards for NSW Health. It also provides some business rules. Compliance with the dictionary is mandatory.

3.1 Information required to search for an existing registration

A search of the Area Health Service-wide client registration database must be conducted prior to registering a new client. This applies regardless of whether or not the patient states that they have previously been a client/patient of the service.
The priority information to be used for searching and matching is:
• Family name
• Initial of given name/given name
• Date of birth
• Sex

Highly desirable information for searching and confirming identity when results for a search have been returned are:
• Middle name(s)
• Alias name(s) (including maiden name and any other name used at any time)
• Address of usual residence

Where only part of the information above can be obtained (e.g., in emergency situations), the search should use what information is available and reviewed at a later time when further information is available.

### 3.2 Information required for booking the first service

When a booking is made for the first service it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:
• Family name
• Given name
• Date of birth
• Sex
• Middle name(s)
• Alias name(s) (including maiden name and any other name used at any time)
• Address of usual residence
• Mailing address (if different from Address of usual residence)
• Telephone number(s) - home, work and/or mobile
• Preferred language
• Interpreter required

This information is required to enable the client/patient to be contacted when a planned service needs to be rescheduled, and for scheduling interpreter services if required.

In addition to these items, services may choose to record the extra items in section 3.3 to save having to enter them at the time of first service provision.

### 3.3 Information required at time of service provision

At the time the first service is provided, it is mandatory that the following information is recorded in the Area Health Service-wide client registration database:
• Family name
• Given name
• Date of birth
• Sex
• Middle name(s)
• Alias name(s) (including maiden name and any other name used at any time)
19. PATHOLOGY

- Address of usual residence
- Mailing address (if different from Address of usual residence)
- Telephone number(s) - home, work and/or mobile
- Preferred language
- Interpreter required
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Medicare eligibility and Medicare Number (if eligibility for Medicare is a factor in service provision or billing)
- Department of Veterans’ Affairs (DVA) file number and card type (if a DVA card holder)
- Health fund and health fund membership number (if the health service intends to make a claim against a private fund for services provided)
- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients under 16 years of age

It is highly desirable that the following information is also recorded in the Area Health Service-wide client registration database:

- Person to contact (name, address, telephone numbers, relationship to client/patient) - for clients/patients 16 years of age or older.
- General practitioner name, address, telephone, email and facsimile numbers (for the purpose of corresponding with general practitioner about the client’s/patient’s ongoing care).

3.4 Additional data mandated for newborns

A baby born at or on the way to the hospital/birth centre must be registered as soon as possible after the birth. The information required for newborns is the same as the information required for other clients/patients, however the following additional information is also mandatory:

- Full name of mother
- Mother’s medical record number/Area Health Service unique patient identifier

It is also highly desirable to record:

- Full name of father

Some details, such as address of usual residence, may be inherited (copied) from the mother’s registration details. However, Aboriginal or Torres Strait Islander origin of the baby should not be assumed to be the same as that of the mother. Staff should especially not assume that the newborn baby is not of Aboriginal or Torres Strait Islander origin when the mother has not identified as being Indigenous. The mother should be asked as to the status of the baby.

3.5 Information required for dead people

All hospitals must register, in the Area Health Service-wide client registration database, all people who die in hospital and those who are already dead who are brought to hospital. Specific information, outlined below, is required for the management of deceased people, and an additional register will need to be maintained where the Area Health Service wide client registration database does not accommodate all that information.

With respect to deaths, this policy directive should be read in conjunction with the following Acts and Policy Directives:

70(2/09)
Hospitals should ensure that proper procedures are followed at all times with respect to the identification of dead people as well as the subsequent removal of bodies from hospital premises.

When the body of a person who dies outside the hospital is brought to the hospital, the Area Health Service-wide client registration database should be searched in the same way as for all other clients/patients of the health service.

Information about the person’s identity and other details should, if possible, be obtained from the next of kin, other family members or friends. If this is not possible, then information should be obtained from the person bringing the body to the hospital and any documentation in relation to the person (e.g., death certificate).

Where only part of the information required for searching is available, the search should use what information is available and reviewed when further information is available.

If the person has not been registered in the Area Health Service-wide client registration database, data items that must be recorded for them in that database are as follows:

- Family name
- Given name
- Date of birth
- Sex
- Middle name(s)
- Alias name(s) (including maiden name and any other name used at any time)
- Country of birth
- Aboriginal or Torres Strait Islander origin
- Person to contact (name, address, telephone numbers, relationship to client/patient)

Other mandatory information required specifically for the management of dead people includes:

- Where the body came from
- Whether a death certificate was issued or the death has been reported to Coroner
- Whether an autopsy has been authorised
- Who the body is claimed by
- That an authority for removal of the body has been sighted
- Date and time of removal
- Signature of the person removing the body

If this additional mandatory information cannot be accommodated in the Area Health Service-wide client registration database, an additional register to record this information must be maintained. The Area Health Service unique patient identifier must be used in that register to enable the information in that register to be linked to the record in the Area Health Service-wide client registration database.

When a person is dead, it is also important to record this on the Area Health Service-wide client registration database. This is necessary for people that die in hospital, for people who die outside of hospital and are brought to the hospital (e.g., to the emergency department or to the morgue), and for other people when the health service obtains notice and confirmation of their death.
Recording that a person is dead will ensure that any outstanding appointments across the Area Health Service can be cancelled, and can prevent further activity in relation to the client/patient (such as automatically generated letters) where information systems check the deceased flag in the Area Health Service-wide client registration database before initiating such activity.

If the death of a client/patient is known, the following information fields must be updated on the client’s/patient’s registration record:

- Date of death
- Date of death estimation flag

Standards for recording date of death where it is unknown are described in the *NSW Health Data Dictionary*.

4. Related Documents and Definitions

4.1 Related policies

This policy directive should be read in conjunction with NSW information privacy policies, legislation and other relevant policy directives to ensure the proper collection, storage, use and disclosure of health information. Such policies and legislation currently include:

4. *PD2010_054 Coroners’ Cases and the Coroners Act 2009*, and

4.2 Related standards

The following standards and guidelines have been referenced in developing this policy directive:


Information contained in the Area Health Service-wide client registration database should be maintained according to guidelines in the current General Retention and Disposal Authority - Public Health Services: Patient/Client Records (GDA 17), NSW Department of Health Information Bulletin 2004/20.

4.3 Definition of a health service

In the context of this policy directive a health service is defined as a service that provides any of the following:

- Initial health care needs identification
- Comprehensive or specialist health assessment
- Therapy or clinical intervention, symptom control
- Pain management
19. PATHOLOGY

- Palliative care
- Spiritual, personal and/or social support or care
- Case management and/or care coordination
- Follow up, monitoring, evaluation, review
- Provision of aids and appliances (including in the home)
- Preventative care
- Radiology, pharmacy or pathology services
- Supported living
- Education about health issues

4.4 Definition of an Area Health Service unique patient identifier

A unique identifier within the Area Health Service assigned to a client/patient to distinguish them from other clients/patients.

For The Children’s Hospital at Westmead, The Ambulance Service of New South Wales, and Justice Health, the Area Health Service unique patient identifier is the unique client/patient identifier assigned by those organisations respectively.

HANDLING OF BODIES

In accordance with Public Health (Disposal of Bodies) Regulation 2002 the following procedures must be complied with.

Premises for handling of bodies

5. (1) A person must not, without the approval of the Director-General, use any premises other than a mortuary approved under the Local Government Act 1993 for the embalming, or other preparation, of bodies for burial or cremation or for the placing of bodies in coffins for burial or cremation.

(2) A person must not, without the approval of the Director-General, use any premises other than a holding room or a mortuary for the storage of bodies for burial or cremation.

(3) A person must not store a body in a vehicle except during the transport of the body or with the approval of the Director-General.

(4) A person must not use a holding room for any purpose other than the storage of bodies.

(5) A person must not, without the approval of the Director-General, use the facilities of a hospital for the purpose of the business of a funeral director or of the operator of a mortuary transport service except for the removal of bodies of persons who died in the hospital.

(6) The Director-General may give approval:
   (a) under subclause (1), (2) or (3) - either generally or in a particular case, or
   (b) under subclause (5) - in a particular case.

Embalming of bodies

11. (1) A person must not embalm a body unless that person has a certificate of proficiency of, or equivalent to, Certificate IV standard, issued by an institute approved by the Director-General.

(2) A person must not embalm a body that the person has reason to believe is infected with a List B disease.
19. PATHOLOGY

Definitions - Clause 3

**List A disease** means any one or more of the following conditions:
- Creutzfeldt-Jakob disease
- Hepatitis C
- Human immunodeficiency virus infection (HIV)

**List B disease** means any one or more of the following diseases:
- Diphtheria
- Plague
- Respiratory anthrax
- Smallpox
- Tuberculosis
- Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers);

Bodies to be placed in body bags

13. (1) A person must not remove the body of a dead person from a place unless:
   (a) the body has been placed and secured in a bag approved by the Director-General or a wrapping so approved in such a manner as to prevent the leakage of any body exudate or substance, and
   (b) the name of, or an identification of, the dead person is clearly and indelibly written on the top outer surface of the bag or wrapping, and
   (c) if subclause (3) or (4) applies - that subclause has also been complied with.

(2) The body bag or wrapping referred to in subclause (1):
   (a) is to be made of low density polyethylene film of not less than 150 micrometres in thickness, and
   (b) if the bag is used for enclosing the body of an adult it is to be (when flat) not less than 2.4 metres in length and 1 metre in width, or if for enclosing the body of a child, not less than 1.5 metres in length, and
   (c) if a wrapping is used for enclosing the body of an adult it is to be (when opened and flat) not less than 2.4 metres in length and 2 metres in width, or if for enclosing the body of a child, not less than 1.5 metres in length.

(3) If a person has reason to believe that a body is infected with a List A disease, the person must ensure that the bag or wrapping referred to in subclause (1) (a), and any bag or wrapping used to replace that bag or wrapping, is clearly and indelibly marked with the words “INFECTIOUS DISEASE - LIST A - HANDLE WITH CARE”.

(4) If a person has reason to believe that a body is infected with a List B disease, the person must ensure that the bag or wrapping referred to in subclause (1) (a), and any bag or wrapping used to replace that bag or wrapping, is clearly and indelibly marked with the words “INFECTIOUS DISEASE - LIST B - HANDLE WITH CARE”.

(5) The person responsible for complying with this clause is:
   (a) if the body is at a hospital - the chief executive officer, or
   (b) if the body is at any other premises or place - the funeral director or other person removing the body.

Protective clothing

14. (1) A person engaged in placing in a plastic bag or wrapping a body that the person has reason to believe is infected with an infectious disease must wear:
   (a) a clean protective outer garment such as a gown, overalls or jumpsuit; and
   (b) a clean pair of disposable gloves; and
   (c) a disposable mask and appropriate eye protection.
(2) The person who wears those items must ensure that they are placed, immediately after use, in a clean plastic bag and then laundered as soon as practicable or, if disposable, disposed of as soon as practicable as contaminated waste.

PROCEDURES FOR POST MORTEM OF SIDS CASES (CORONER’S CIRCULAR)

The post mortem of all apparent SIDS cases in the State, are performed in Sydney.

The plan is that apart from the Westmead cases, SIDS post mortems are performed at the one place at the Glebe Morgue, so as to ensure there is uniformity in forensic investigation and to assist with SIDS research objectives. It would appear that some confusion has arisen with some country coroners concerning authorisation, such as permitting the release of the body and the issue of the burial order. In addition some coroners have requested that firm guidelines be issued to be followed in all SIDS deaths.

Coroners in country areas, that is the local coroner, are therefore to particularly note the following protocol which is to be followed in the case of an apparent SIDS deaths:
(1) Any death of the baby should be attended to as a matter of urgency.
(2) When such a death occurs, either the local coroner or the police should notify the duty pathologist at Glebe by telephone and advise him/her of the circumstances.
(3) The body will be transported to Glebe by government contractor with identification tags attached, after life has been pronounced extinct by a registered medical practitioner.
(4) The wrist bands are to be attached to the body, including name, date of death and the signature of the person effecting the identification, that is the police officer.
(5) The local coroner is to make certain that a copy of the P.79A report and the order for post mortem examination, signed by him/her, is sent with the body or is promptly sent by fax to the Glebe morgue office.
(6) The local coroner is to ensure that the police officer in charge of the death obtains relevant hospital records/medical history (if any) and that these records be sent to Glebe for the information of the forensic pathologist. These documents, wherever possible should he placed in a sealed envelope and are to accompany the body.
(7) A copy of the P.79A report is to be sent at the same time to the State Coroner.
(8) It is important that the local coroner provide the Glebe morgue office with details of his/her fax number or nearest contact fax number.
(9) Upon completion of the post mortem examination, an interim report will be sent to the local coroner from the morgue office at Glebe, indicating whether the body is held for further examination or is ready for release.
(10) As some post mortem examinations at Glebe occur at weekends and on public holidays, local coroners should be sure that their fax facilities are operating during this period.
(11) In the case of a clearly established SIDS death, the government contractor will return the body to the country for burial.
(12) In normal circumstances, any decision for release of the body and the issue of the burial order, will be made by the local coroner, following receipt of the interim post mortem report.
(13) Any police enquiries concerning the death should be made through the local coroner.
(14) If necessary, the local coroner can liaise with the Institute of Forensic Medicine/Morgue at Glebe.
(15) It would be advisable for any local coroner in country areas to prepare all the forms in duplicate.
(16) The fax number of the NSW Institute of Forensic Medicine/Morgue at Glebe is 9552-1613.

The telephone number of the Institute/Morgue is 8584 7800.
The address of the Institute is:

42 Parramatta Road
Glebe  NSW  2037

Entrance to the Morgue is at the rear of the Institute at 52 Arundel Street, Glebe, 2037.

MULTIPLE INJURY DUE TO CHILD ABUSE

These cases should all be referred to the NSW Institute of Forensic Medicine (02) 8584 7800 examination.

SUGGESTED PROTOCOL IN RELATION TO BODIES BEING BROUGHT TO SYDNEY FOR POST MORTEM (State Coroner’s Circ. No. 22)

UNDER WHAT CIRCUMSTANCES ARE BODIES BROUGHT TO SYDNEY FOR PM

Aircraft fatalities, ultralight fatalities, hang gliding fatalities, and helium balloon fatalities.  (Except Newcastle and Westmead.)

Country major accidents resulting in multiple deaths.

A suspicious death (includes infant non SIDS) which would require a specialist pathologist to perform the autopsy.  (Except Newcastle and Westmead.)

A death by homicide.  (Except Newcastle and Westmead.)

Deaths in custody.  (Except Newcastle and Westmead areas.)

SIDS babies.  (Established protocol in place already.)

Any other death that the Local Coroner feels should NOT be handled by the local GMO.  In some instances the deceased may have been the Local GMO’s patient and it would not be appropriate to have the Local GMO perform an autopsy in this case.  These cases can sometimes be dealt with locally by another GMO in a nearby district, however a phone call to the Institute of Forensic Medicine would be beneficial in these circumstances if the problem cannot be solved locally, or if further advice is required.

WHAT TO DO:

1. As soon as a report of a death is received (orally or in written form) by the Local Coroner and it is established that the body should be sent to Sydney for post mortem the first contact made by the Coroner is to the number one doctor on call at the Institute of Forensic Medicine, Glebe, (Phone (02) 8584 7800) to discuss the case, firstly to establish the necessity of the body being brought to Sydney, and secondly to alert the staff that a body will be arriving down and thirdly to discuss identification procedures.

2. Homicides and suspicious deaths will usually require a police escort to Sydney.  In other cases ID bands are used and the body is identified by the Police to the contractors delivering the body who then identify the body upon its arrival to the morgue staff or the doctor if they are available.  It is important that the chain of identification is not broken in any way.
3. All the paperwork should either be faxed to the Institute of Forensic Medicine and the Office of
the State Coroner or accompany the body including any medical records relating to the
deceased.

4. Your next phone call is to the Office of the State Coroner advising the State Coroner or his
Deputy of the body coming down and the reasons. We then alert the Sergeant Assisting the
Coroner at Glebe that a body will be forthcoming from a rural area.

5. It is important that the local coroners advise the families of the deceased the reason the body has
to be brought to Sydney and the likely time they may expect the body to be returned so as to
assist them with the funeral arrangements.

6. In addition, the Coroner should ascertain if the family require the body returned to the same
area. In many outlying areas the family do not always arrange for the funeral to be held in the
same district from whence the body came. The contractors will need to be informed which area
the body is to be delivered.

7. Many of the contracts held by funeral directors in outlying districts do not include the return of
the body. The State Contracts Board have undertaken to address this situation and a number of
Government Contractors based in Sydney will be available to return bodies to a country location
or to the airport at Mascot or Bankstown.

8. The Coroner, when arranging for a body to arrive at the IOFM at Glebe for post mortem
examination should request the OIC Police assisting him to enquire of the Government
contractors whether there will be any difficulties in returning the body from Sydney to a country
location. If there are difficulties, police attached to the Office of the State Coroner should be
suitably informed and requested to arrange for the return transportation of the body.

HOW DOES IT GET HERE?

In one of our past circulars the Local Coroners were advised never to use the police air wing unless
prior approval is given by head office. Transport by road is encouraged to be used as much as
possible. Occasionally this method proves more expensive than arranging a domestic flight. In recent
times there have been problems with decomposition of bodies who have been transported here by road
in unrefrigerated vehicles. In these cases the post mortem can prove worthless because of the
condition the body upon arrival at Glebe and in one instance just recently a cause of death could not be
determined which now necessitates an Inquest hearing.

The present Government contract involving funeral companies falls short of the ideal in many respects
and this is cause for concern. After a meeting between a representative of the State Contracts Board,
head office, the State Coroner and Professor Hilton it was indicated the government contracts for
removal of bodies will be reviewed as soon as possible so as to address the problems that have arisen.

In the event of a funeral contractor, particularly those “on call” in country areas becoming unavailable
for any reason then the contractor must inform the local coroner and local police so that alternate
arrangements can be made in the event of a death occurring.

GENERAL CONSIDERATIONS:

The autopsy will be carried out at the Institute of Forensic Medicine, Glebe and the Office of the State
Coroner will issue the burial order and any cremation orders that are received. We also advise the
Principal Registrar of the death.
When the “Provisional Post Mortem Report” (a grey coloured form) is received we will return the file to the local coroner so that he/she can pursue the investigation into the death if necessary.

The completed post mortem report (a blue coloured form) will be forwarded to you direct when the report is complete. These reports take some time to finalise.

**BODIES TO BE EXAMINED IN SITU BY A FORENSIC PATHOLOGIST FROM GLEBE WESTMEAD OR NEWCASTLE**

Recently a problem arose following an aircraft crash where bodies were removed from the scene without the forensic pathologist examining them in situ. As a consequence the chances of determining a medical cause of death is very much reduced.

Whilst the medical examination of a body, in situ, is not usually required there is a need to develop some guidelines to identify the situations where such must occur. A police instruction has been drafted to assist police officers decide whether to request the attendance of a forensic pathologist at a scene.

The police instructions, developed in consultation with this office and Forensic Medicine, listed several situations where the forensic pathologist should be requested to examine a body prior to removal from the scene. They are as follows:

- homicides
- death in custody (police and gaol)
- aviation death (aircraft)
- multiple deaths
- skeletal remains

Other situations where either the police, coroner or forensic pathologist considers that an in situ examination of the body is desirable.

The reasons for calling a specialist forensic pathologist to the scene are fairly obvious. Body removal may have quite an effect particularly if the body is decomposed or skeletal. Loose teeth may dislodge and prejudice identification, bones may separate, wounds may change their features, marks may be added to the body etc. The position and posture of the body is important particularly in an aviation death and homicide. The body temperature, rigor mortis and lividity are also matters of importance. The geography and physical environment in which the body is found can also assist the forensic pathologist arrive at a medical cause of death and further the coronial investigation generally.

Coroners must do everything possible to assist the forensic pathologist provide medical answers. This will include being very aware of the need for an in situ examination. The police instruction includes an invitation to seek the guidance of the State Coroner. Coroners and police share a joint responsibility in the early stages of an investigation as such may involve criminal as well as coronial considerations. It is therefore necessary that the coroner and police understand the need for and collaborate.

Ideally the forensic pathologist should examine all coronial bodies in situ but this is not practical or possible with the resources available. However, there are those circumstances where the trouble and cost must not be considered ahead of the principle coronial function of establishing the medical cause of death.

**WORK RELATED FATALITIES**

The Workcover Authority approached me in relation to the provision of reliable data relating to alcohol and other drugs in work place fatalities.
After some general enquiries were made with the Institute of Forensic Medicine, Glebe and the Westmead complex it became obvious that no uniform protocol is followed in relation to what tests are asked for at post mortem.

I believe it would be beneficial to have appropriate screening tests for alcohol and other drugs ordered in ALL work related fatalities and industrial accidents.

State Coroners Circular No. 7 detailed what tests should be ordered in particular types of death. It is now felt that the appropriate tests to order in work related deaths should be:

**Blood for Alcohol**

Samples of Unpreserved Blood and Preserved Blood, Urine, Liver, Stomach contents and Bile in all cases.

Lung (for inhaled solvents), hair, nail clippings and bone (for heavy metal testing) must be taken in cases of possible exposure to heavy metals, solvents and other industrial chemicals.

I would ask you to notify your Government Medical Officer of the additional tests that must be ordered in these types of deaths. It is hoped that all work related deaths across NSW will commence with uniform testing from the 1st January 1994.

**NON-CORONIAL POST MORTEMS (PD2013_051)**

PD2013_051 rescinds PD2005_008.

**PURPOSE**

Non-coronial post-mortems are governed by the *Human Tissue Act 1983* (the Act) which makes specific provisions for obtaining consent and authorisation for the conduct of a non-coronial post mortem and the subsequent use of organs and tissues removed at post mortem and retained for other purposes (eg. for scientific research or teaching purposes).

This Policy Directive provides guidance for Local Health Districts (LHDs) Speciality networks and NSW Health Pathology Services on the procedures that must be in place to support families and clinicians in:

- Providing information to families regarding non-coronial post mortems.
- Obtaining written consent and the authorisation of a designated officer for a non-coronial post mortem and the retention and subsequent use of organs and tissue removed at post mortem for other purposes.
- Disposing of, or returning tissue removed at post mortem to the next of kin for disposal.
- Determining attribution of the costs of post mortems.
- Meeting the requirements relating to the post mortem report including the retention periods for post mortem records.

**MANDATORY REQUIREMENTS**

Facilities where non-coronial post mortems are undertaken must ensure:

- Compliance with the requirements of the Act in relation to obtaining consent and authorisation prior to post mortem being undertaken and in relation to using tissue taken at post mortem for other purposes (such as scientific research or teaching).
One or more designated officers are available for authorising the post mortem and/or the subsequent use of tissues removed.

- That staff who approach families for consent for the above procedures have appropriate knowledge about the post mortem process and the training to provide that information in a clear and sensitive manner.
- That the standard state-wide forms attached to this policy directive are used wherever indicated by this policy directive.

**IMPLEMENTATION**

Chief Executives of LHDs and Specialty Networks must ensure that:

- All relevant staff are made aware of their obligations in relation to this Policy Directive.
- Documented procedures are in place to support the Policy Directive.

**Staff involved with non-coronial post mortems:**

- Must comply with this policy statement as it relates to the work they undertake.

**1. BACKGROUND**

**1.1 About this document**

Non-coronial post mortems are performed in a hospital or a forensic pathology facility at the request of a treating clinician, or occasionally at the request of the deceased person’s family, when the cause of death is known but there is an interest in determining, for example, the extent of the condition/disease that caused the death, the effects of therapy or whether any undiagnosed disease of interest might have contributed to the death. These post mortems must not be performed on a person who has, or is suspected of having a prescribed infectious disease as defined in Clause 53 of the *Public Health Regulation 2012*.


Unlike coronial post mortems, a non-coronial post mortem can only be conducted if the deceased or his/her senior available next of kin has consented to it and it has been authorised by a designated officer. The Policy Directive outlines the legal requirements relating to consent and authorization, together with the principles applicable to obtaining consent. It should be read in conjunction with the NSW Ministry of Health *PD2013_002 Designated Officer Policy and Procedures*. The Policy also addresses a number of administrative matters relating to hospital post mortems.

For information about post mortem following stillbirth, see the NSW Ministry of Health’s Policy Directive *PD2007_025 Stillbirth - Management and Investigation*.

**1.2 Definitions**

**Authorised/Delegated person:** A person who has been authorised in writing by a deceased person’s senior available next of kin to exercise his/her functions under the *Human Tissue Act 1983*.
Child: A person who has not attained the age of 18 years and who is not married.

**Designated officer** means:
(a) In relation to a hospital, a person appointed under s5 (1) (a) of the *Human Tissue Act 1983*, to be a Designated Officer for the hospital.
(b) In relation to a forensic institution, a person appointed under s 5 (1)(a) of the *Human Tissue Act 1983*, to be a Designated Officer for the forensic institution.
(c) In relation to a private hospital within the meaning of the *Private Health Facilities Act 2007* a person appointed by the governing body (defined in the Human Tissue Act as the licensee) of the hospital.

**Post mortem (non-coronial):** A non-coronial post mortem is a medical examination of the body performed after death to:
(a) Confirm the nature of the illness and/or the extent of the disease.
(b) Identify other conditions that may not have been diagnosed.
(c) Assess the effects of treatments and drugs, and identify any complications or side-effects.

**Full post mortem:** A full post mortem entails a detailed external examination of the body and a gross and histological examination of organs and tissues contained in the abdominal, thoracic and cranial body cavities.

**Limited post mortem:** A limited post mortem is one in which restrictions are placed on the examination for example, limited to an external examination only with X-rays, computed tomography or magnetic resonance imaging or restricted to an examination of the tissues in only one or two body cavities.

**Records:** The term record includes consent forms, registers of tissue/organ sources and their disposal. Records may include cards/charts, registers, files, microfilm and microfiche, electronic records including electronic media and photographs, x-rays, scans, film, video, audio and audio-visual recordings. It is expected that the medium or format in which the record is stored will support its retention and maintenance for as long as the record is required.

**Senior available next of kin:** The order of senior available next of kin is defined in the *Human Tissue Act 1983* in relation to a deceased child as:
(a) Parent of the child.
(b) Sibling of child who is 18 years of age or over where a parent is not available.
(c) Guardian of the child at the time of death where none of the above is available.

and in relation to **any other deceased person** as:
(a) Spouse (which can include a de facto spouse and same sex partner).
(b) Son or daughter of the deceased person (18 years of age or over) where above is not available.
(c) Parent where none of the above is available.
(d) Sibling of the deceased person (18 years of age or over), where none of the above is available.

It should be noted that the list of senior available next of kin for both adults and children is exhaustive and cannot be extended to include other people.

**Tissue:** In this Policy Directive, the term tissue refers to an organ or part of a human body and any substance extracted from a human body or from part of a human body.

**Valid consent:** For consent to be valid the following conditions must be met:
(a) The consent must be in writing.
(b) The person giving the consent must be fully informed of the procedures to be undertaken.
(c) The person giving consent must have the capacity to do so.
(d) Consent must be given freely.
(e) Consent must be specific to the procedure.

(see NSW PD2005_406 Consent to Medical Treatment - Patient Information).

1.3 Legal, Ethical and Policy Framework

Legislation
*Human Tissue Act 1983* (NSW)
*Public Health Regulation 2012* (NSW)

National Guidelines and Standards
*Requirements for the Packaging and Transport of Pathology Specimens and Associated Materials* (2007 Edition); and

NSW Policy and Guidelines
NSW Ministry of Health PD2005_406 Consent to Medical Treatment - Patient Information.
NSW Ministry of Health PD2013_002: Designated Officer Policy and Procedures.

2. CONSENT

Valid consents are required for (1) the conduct of a non-coronial post mortem and (2) the retention of tissue taken at post mortem for subsequent use for research or education and training purposes i.e. purposes that are unrelated to the post mortem examination. Consent must be informed and in writing. If the tissue is to be used for research purposes, the proposed research project must have the approval of a properly constituted Human Research Ethics Committee.

2.1 Who can provide consent?

2.1.1 Where the deceased is an adult

Consent may be given by the deceased during his/her lifetime or posthumously by the deceased’s senior available next of kin or their delegate.

2.1.2 Where the deceased is a child

The child’s senior available next of kin (usually a parent of the child) is required to provide the consent. *The Human Tissue Act 1983* only requires the written consent of one parent; however, if both
parents are alive and one refuses to give consent or objects to a post mortem being conducted, a
designated officer must not authorise the post mortem (see NSW Ministry of Health PD2013_002
Designated Officer Policy and Procedures).

2.2 Delegation of responsibilities of the senior available next of kin

In some cultures and communities, for example, Aboriginal and Torres Strait Islander cultures, it is
usual for responsibilities relating to death to be undertaken by a person who is not the deceased’s
senior available next of kin. The Human Tissue Act 1983 provides for this situation by allowing the
deceased’s senior available next of kin to authorise another person (known as a delegate), to exercise
their functions. Authorisation must be in writing. The form “Authorisation to delegate responsibilities
of next of kin” must be used for this purpose (Appendix 2).

If responsibilities of the senior available next of kin have been delegated, it is the delegate who is
included in discussions in which consent is being sought.

2.3 The consent process

The overarching principle for consent for post mortem is that the family of the deceased must be
consulted. In relation to non-coronial post mortems the deceased’s family has the right to:
• Refuse a post mortem being performed.
• Limit both the extent of the examination and the organs and tissues retained for diagnostic
  purposes, understanding that such limitations may compromise the information obtained at post
  mortem.
• Determine the method of disposal of retained tissues.
• Agree or refuse to tissues taken during the post mortem for being subsequently used for
  therapeutic, medical or scientific purposes.

In hospitals, consent to perform a post mortem should be sought by a senior clinician supported by a
staff member with appropriate skills in grief and bereavement counselling. An interpreter should be
present, if required. If not readily available, an interpreter can be accessed over the telephone (see
NSW Ministry for Health PD2006_053 Interpreters – Standard Procedures for Working with Health
Care Interpreters).

If the consent of Aboriginal and Torres Strait Islander families is being sought, it is useful to have an
Aboriginal Liaison Officer or Aboriginal Health Care Worker present to assist with the discussions.

The consent seeking process should involve an initial discussion about the reason for wanting to
perform a post mortem. If the deceased’s family raises no objection to a post mortem the discussion
should be broadened to include information about:
• Who will perform the post mortem.
• What it involves.
• The option of a limited post mortem.
• The option to agree to tissues removed for the purpose of the post mortem being subsequently
  used for research purposes.
• Information about costs.
• Viewing arrangements.
• Information about the post mortem report.

The senior next of kin/delegate should also be advised that:
(1) small pieces of tissue taken during the post mortem and prepared as blocks and slides for
microscopic examination will be retained.
19. PATHOLOGY

(2) whole organs removed from the body during the course of the examination will be returned to
the body unless further diagnostic testing is required. In the latter case the family have the
option, once the tests are completed, of having the organ(s):

• Returned to the body prior to the funeral (which may result in the funeral being delayed).
• Returned to them after the funeral for separate burial/cremation as required by the family.
• Disposed by the institution.

At the end of the discussions the senior available next of kin or the delegate should be provided with
an information sheet (see example provided in Appendix 5) in an appropriate language outlining all
the matters discussed and an opportunity to ask questions before signing the consent form (Appendix 1
Consent and Authorisation Form).

2.4 Refusal to have a post mortem conducted

If a deceased’s senior available next of kin/delegate refuses to give consent to a post mortem, the
requesting clinician must not instead refer the case to the Coroner.

In cases where a post mortem is requested for the purpose of determining compensation entitlement, as
in the case of persons who contract dust diseases as a result of their employment, not conducting a
post mortem may result in the lack of essential medical evidence required to make a compensation
award to dependents of the deceased.

3. AUTHORIZATION

Once consent has been obtained, a post mortem MUST NOT be carried out until it has been
authorised in writing by a designated officer of the facility in which the body is located ie. hospital or
forensic institution. The designated officer can only authorise what was consented.

Prior to authorizing a post mortem, a designated officer must be satisfied as to the following:

3.1 In relation to Adults

Where an adult consented during their lifetime, the designated officer must be satisfied that

• Written consent had been given and
• The deceased person had not withdrawn their consent before he/she died.

Where the senior available next of kin of a deceased adult has consented, the designated officer must
be satisfied that:

• Written consent had been given and
• While the deceased was alive he/she had never expressed an objection to having a post mortem
  or tissue being used for non-diagnostic purposes (if applicable) when they died and
• No next of kin of the same or higher order than the senior available next of kin has objected to a
  post mortem being carried out or tissue used for non-diagnostic purposes.

3.2 In relation to Children

Before a designated officer can authorise a post mortem on a child or a neonate and, where applicable,
the use of tissue for subsequent non-diagnostic purposes, they must be satisfied that:

• The child had not during their lifetime expressed an objection to having an post mortem when
  they died or their tissue being used for non-diagnostic purposes such as teaching and research
  and
19. PATHOLOGY

4. DISPOSAL OF TISSUE

Disposal of tissue removed for the purposes of the post mortem examination must be carried out in accordance with what was consented.

4.1 Procedure to follow where a request had been made for return of tissue for burial/cremation

If a senior available next of kin or their delegate requests that tissue/body parts be returned to them for cremation or burial, the deceased persons clinician or a senior health officer must establish the grounds for the request and explain the relevant public health requirements (see Public Health Regulation 2012), the safe handling of human tissue including the requirement that it must not be packed on dry ice, and any of the facility’s policy requirements that they must comply with. The hospital should obtain a signed statement from the senior available next of kin/delegate stating that they have had the requirements explained to them and that they have understood the requirements and agree to them. If the request is made for the return of a fetus, the meeting should include a staff member with skills in grief and bereavement counselling and an interpreter if required consistent with the principles outlined in section 2.3.

Once a decision has been made to allow release of the human tissue for disposal, the hospital authorities should provide written instructions for the senior available next of kin/delegate specifying the conditions under which release of the tissue is permitted (including the agreed method of final disposal) and waiving the responsibility of the organisation and its employees if the tissue is subsequently managed in an unauthorised manner. It should be made clear to the person who signs the Tissue Release Form (see Appendix 5) for the receipt of the tissue that they are responsible for the safe and secure storage of the transferred tissue.

The senior available next of kin/delegate should be provided with a copy of a Tissue Release Form (Appendix 5) and a letter (see example Appendix 6) should be given to the person collecting the tissue certifying that they are travelling with human tissue in their possession by the authority of the organisation (in case of accidents etc.).

Tissue that is returned to the senior next of kin or their delegate for separate burial/cremation should be triple packed as required by the National Pathology Accreditation Advisory Council Guidelines for Approved Pathology Collection Centres (2012).

4.2 Disposal of the tissue by the institution

If the senior available next of kin or delegate requests that retained organs be disposed of by the institution, the National Code of Ethical Autopsy Practice 2002 states that the organs must be disposed of by cremation rather than incinerated with surgical waste. Co-cremation of retained organs requires approval from the Director-General, NSW Ministry of Health (Public Health Regulation 2012).

21 In some cultures tissues expelled from the body such as placentas or tissue removed during treatment such as limbs are similarly required to be returned for cremation or burial and the same principles that apply to tissues returned following post mortem apply in these cases.
5. GENERAL ADMINISTRATIVE MATTERS RELATING TO POST MORTEM EXAMINATIONS

5.1 General matters

Once a post mortem has been authorised, all reasonable efforts should be made to minimise delays in proceeding with it.

At the completion of the post mortem examination, the senior available next of kin/delegate should be contacted and provided with information about the outcome of the post mortem and any associated investigations.

If the post mortem shows a different outcome to that listed on the initial certificate as to cause of death, the clinician who provided the initial certificate should prepare a new one and send it to the NSW Registry of Births, Deaths and Marriages together with an explanatory letter.

5.2 Forms

In NSW standardised State Forms must be used for recording of the consent and authority for non-coronial post mortem examination and the delegation of authority of the senior available next of kin. All forms required by this policy may be obtained from Fuji Xerox (previously SALMAT) Electronic Print on Demand (ePOD) at fujixerox.com.au.

5.3 Costs associated with a post mortem

The costs of a post mortem performed at the request of a treating clinician will be borne by the relevant Local Health District. Where a post mortem is requested by the deceased’s family, the full costs associated with the post mortem are borne by the deceased’s estate. These costs include transport, the post mortem examination and the costs of any tests conducted.

If a post mortem has been requested by the NSW Workers Compensation Dust Diseases Board, the Board will bear the full costs associated with the post mortem.

The full cost of a post mortem on a deceased person who has, or is suspected of having Creutzfeldt-Jakob Disease is borne by the Department of Forensic Medicine, Glebe.

5.4 The post mortem report

In the case of non-coronial post mortems the senior available next of kin/delegate has a right to receive a copy of the post mortem report. During the initial consent discussions, the senior available next of kin/delegate should be advised of this together with an explanation that the report is a technical document which they should discuss with the deceased’s GP, a GP of their choice or the deceased’s hospital treating clinician. Once the post mortem report is available the health facility should post a copy of the report to the address provided by the senior available next of kin/delegate.

In the event that the senior available next of kin/delegate initially declined to have a copy of the report and subsequently changed his/her mind, they should contact the Clinical Information Department of the hospital or facility where the post mortem was conducted to seek a copy.

5.5 Post mortem records

The following documents should be placed on the deceased’s medical record file and where relevant or requested a copy given to the senior next of kin/delegate:
19. PATHOLOGY

- Records of the original discussions that took place between the senior available next of kin/delegate and family members.
- The post mortem report.
- Signed consent and authorisation forms for the post mortem and any subsequent use of tissue for purposes other than diagnostic purposes.
- A copy of the Delegation of Authority form (if relevant).
- Details of any tissues retained and records relating to method of disposal of tissue including date(s) on which disposed.
- Copies of correspondence, statements and tissue release forms relating to the release of tissue to the senior available next of kin/delegate if applicable (see section 6.1).

5.6 Retention period for tissues and records

The National Pathology Accreditation Advisory Council (NPAAC) Requirements for the Retention of Laboratory Records and Diagnostic Materials (Fifth Edition 2009) represent the minimum standards for the retention of tissues. Paraffin blocks and slides prepared from adult tissue should be kept for a minimum of 10 years. In the case of children, the retention time of paraffin blocks and slides is the age of majority (18 years) PLUS 7 years. There are specific retention times for samples used for genetic tests/investigations and the NPAAC guidelines should be consulted in relation to these.

The NPAAC guidelines and the State Records Authority of NSW General Retention and Disposal Authority for Public Health Services: Patient/Client Records require that records of post mortem examinations should be retained for a minimum of 20 years and that genetic reports/records should be kept for a minimum of 100 years. If tissue is retained at post mortem, the records should be kept for a period of 20 years from the date the tissue was disposed of/returned to the senior available next of kin/delegate.

Facilities that maintain integrated patient records should keep the complete record for the longest period required for any part of the record. Electronic records must be accessible for the relevant period (see above) so it is important that the records are migrated across systems if they are changed during that period.

Facilities that keep electronic records rather than hard copy records should ensure that the records are protected so that data cannot be amended without creating an audit trail.

6. ATTACHMENTS

Appendix 1: Consent and Authorisation Form.
Appendix 2: Authorisation to Delegate Responsibilities of Senior Available Next of Kin.
Appendix 3: Authorisation of the Release of Human Tissue Form.
Appendix 4: Example of letter to be issued to a person travelling with human tissue in their possession.
Appendix 5: Information for families about non-coronial post mortems (to print as a folded brochure printer settings should be set to double sided and flipped on short edge).

Appendix 1, 2, and 3 should be obtained from Fuji Xerox (previously SALMAT) Electronic Print on Demand (ePOD) at fujixerox.com.au
APPENDIX 1 - CONSENT AND AUTHORISATION FORM

NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

FAMILY NAME

GIVEN NAME

MRN

SEX

DOB

ADDRESS

ADDITIONAL DETAILS OF THE DECEASED

Date of death of the deceased ______ / ______

Optional: Is the deceased an Aboriginal person or Torres Strait Islander? [Tick as appropriate]

☐ YES
☐ NO
☐ UNKNOWN

SECTION 2: PERSON GIVING THE CONSENT

[Tick relevant box and complete as appropriate]

☐ PERSON GIVING THEIR CONSENT DURING THEIR LIFE TIME TO A POST MORTEM EXAMINATION OF THEIR BODY AFTER DEATH

______________________________ (insert name) consent to a post mortem examination of my body after I have died as detailed in Section 3.
NON-CORONIAL POST MORTEM CONSENT & AUTHORISATION

☐ SENIOR AVAILABLE NEXT OF KIN

Details of senior available next of kin

Family name ____________________________ Given name ____________________________
of: __________________________________________ [Insert address]
Post code: __________

Relationship of senior available next of kin to deceased: ____________________________

☐ A DELEGATE OF THE SENIOR AVAILABLE NEXT OF KIN

Details of delegate of the senior available next of kin

Family name ____________________________ Given name ____________________________
of: __________________________________________ [Insert address and postcode]
Telephone Number: ____________________________

Attach written authorisation of delegate

SECTION 3: THE CONSENT

I CONSENT TO THE FOLLOWING BEING CARRIED OUT ON THE ABOVE NAMED DECEASED: [Tick appropriate box]

☐ a full post mortem examination of the deceased

☐ a post mortem examination of the deceased LIMITED to the following organs, body parts or body cavities:

________________________________________________________

________________________________________________________

________________________________________________________
Non-Coronal Post Mortem Consent & Authorisation

I also consent to: [Tick where applicable]

☐ The retention of organs and other body parts for diagnostic testing.
   The following organs or body parts CAN be retained: ____________________________

☐ The retention of organs and other body parts for scientific, therapeutic and medical purposes
   The following organs or body parts CAN be retained: ____________________________

☐ The retention of ______________________ [Specify organs or body parts]
   for ___________________________ [Specify research study]

I request that any organs and other body parts be: [Tick as applicable]

☐ Reunited with the body prior to burial/cremation;
   Name of nominated person: ____________________________
   Address of nominated person: ____________________________
   Relationship to nominated person: ____________________________
   Disposed of in a lawful manner by the hospital

☐ I also request that:
   a copy of the post mortem report be sent to: ____________________________
   Address: ____________________________
   The body is ready for the funeral which takes place: Date: _______/_____/______ Time: ____________

I have no reason to believe that the deceased had expressed any objection to this post mortem examination or any use of tissue noted above.

THE NATURE OF THE POST MORTEM EXAMINATION and the way in which the tissue from the deceased’s body will be dealt with have been explained to me.
I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

SIGNATURE of the person giving consent in their lifetime

SIGNATURE of the senior available next of kin or authorised delegate

SIGNATURE of doctor/health professional: __________________________ Date: _____/_____/____

INTERPRETER present: NO/YES  SIGNATURE of interpreter: __________________________

**AUTHORISATION BY A DESIGNATED OFFICER**

I, __________________________ hereby authorise: [Tick where applicable]

- [ ] the full post mortem examination of the deceased’s body
- [ ] the limited post mortem examination of the deceased’s body
- [ ] the retention of organs or other body parts for diagnostic testing
- [ ] the retention of tissue, organs and body parts removed for the purposes of the post-mortem examination for scientific, therapeutic, and medical purposes as set out in the above consent.

I, __________________________ declare that I do not have a personal interest in the deceased and I have not had a clinical involvement with the deceased.

SIGNATURE of the Designated Officer: __________________________

DATE: _____/_____/_____
APPENDIX 3 - AUTHORISATION OF THE RELEASE OF HUMAN TISSUE FORM

Note:
- The completed form must be retained as part of the deceased's Medical Record.
- The person collecting the tissue must complete the form. The person could be the senior available next of kin or their authorised delegate at a funeral director if the tissue is to be buried or cremated under the management of a contracted funeral director.

A. ADDITIONAL DETAILS OF THE DECEASED AND ORGAN(S) / TISSUE(S) TO BE RELEASED

Date of death: __/__/____
Organ(s)/Tissue(s) to be released: ____________________________________________________________________________________

B. DETAILS OF PERSON COLLECTING ORGAN(S) / TISSUE(S) (tick applicable option)

☐ Senior available next of kin or delegate
☐ Funeral Director arranging funeral services on behalf of the senior available next of kin

Name (print): ____________________________________________________________________________________
Address: ______________________________________________________________________________________
Company (if Funeral Director): __________________________________________________________________________

This is to confirm that:
☐ I have provided the deceased's organ(s):
☐ I understand the instructions for the safe handling of human tissues;
☐ I have been made aware of my obligations under the Public Health Regulation 2012 for the disposal of body parts or tissue(s) and agree to abide by them.

I am not aware of any other person with an interest in the tissue(s) who does not agree with this decision.

Signature of person collecting tissue: ______________________________ Date: __/__/____

C. PERSON AUTHORISING RELEASE OF ORGAN(S) / TISSUE(S)

Name (print): ____________________________________________________________________________________
Position: ______________________________________________________________________________________
Hospital extension/pagenumber/mobile: ________________________________________________________________________________

Signature of person authorising release: ______________________________ Date: __/__/____

NO WRITING
APPENDIX 4 - EXAMPLE OF LETTER TO BE ISSUED TO PERSON TRAVELLING WITH HUMAN TISSUE IN THEIR POSSESSION

To whom it may concern,

This is to certify that ______________________________________________
(Name of person authorised to travel with human tissue in their possession)

Is travelling with human tissue in their possession.

The tissue is hermetically sealed inside a container and there is no risk associated with transporting the tissue stored in this manner.

Person certifying the packaging of the tissue:

Name: _____________________________________________________________

Designation: ________________________________________________________

Institution/Hospital: __________________________________________________

Contact: ____________________________________________________________

Signature of authorising person: ______________________

Date: ____/_____/_____

197(19/12/13)
Can I consent to retaining organs for use for other (therapeutic, medical and scientific) purposes?
When you are asked to give consent for a post mortem, you may also be asked to consider allowing the use of your deceased relative’s organs or tissue for other purposes that are not an essential part of the post mortem examination. This includes research and teaching.

You do not have to consent to the use of organs or tissue for these other purposes. A post mortem can still be carried out.

What about training?
Medical students and specialists in training need to attend and sometimes assist in performing post mortems as part of their ongoing medical education. In these circumstances the post mortem is always supervised by a fully qualified pathologist.

Will I have to pay for a post mortem examination?
There may be costs associated with the post mortem examination. It is important you discuss this with your doctor or hospital representative before you give consent.

What happens after consent is given for a post mortem?
The post mortem will be carried out as soon as possible after consent has been given. If you wish to see the body prior to the post mortem, let the doctor know and arrangements will be made.

When and how will I find out the results of the post mortem?
A preliminary post mortem report will be available within a few days of the examination but the final report will be prepared only after all test results are returned and may take some months. You can decide whether you want the report to be sent to you, your family doctor or the doctor(s) who cared for your loved one. As the report contains technical language, you should make a time with one of these doctors to discuss the report and any implications it may have for you or your family.

If you have any further questions please contact:
Name: ........................................................................
Phone: .................................................... Pager: .................

NON-CORONIAL POST MORTEMS
Deciding about a post mortem for your deceased family member can be very difficult. After reading this information, you may find it helpful to discuss the examination with a doctor who has cared for your relative or hospital social worker.

What issues should be considered?
It is important that you make the decision that is right for you and your family. It can be helpful to consider what the deceased person would have wished in the circumstances. It may also help to think about whether a post mortem would help you and your family understand and come to terms with your loved one’s death.

What is a post mortem?
A post mortem (also known as an autopsy) is a medical examination of a body after death by a doctor who is a pathologist or by a doctor training in pathology under the supervision of a pathologist. Pathologists are doctors who specialise in the study of disease.

A post mortem can be a full or limited post mortem.

A full post mortem will involve:
• an external and internal examination of the organs and tissues within the head, abdomen and chest cavities
• taking of small samples of tissues from the major organs for later testing
• possible retention of some specific organs for more detailed analysis

A limited post mortem means that you, as the next of kin, may set limits on the extent of the post mortem examination, for example:
• an external examination only;
• an external examination and some testing on small samples of tissue or
• an internal examination limited to certain areas of the body.

A post mortem examination does not always provide all the answers about a person’s death.

What information can a post mortem provide?
• More information about the medical conditions that may have caused or contributed to your relative’s death
• Information that may confirm or rule out a suspected or unsuspected medical condition. This may be important for you or other members of your family, for example, if the condition might be inherited; and
• Information that may help improve care of people in the future

When is consent needed for a post mortem?
A non coronial post mortem is a post mortem that is not legally required by the Coroner. It is either recommended to you by a doctor or sometimes requested by the family in order to find out, for example, the extent of the condition that caused the death or whether any undiagnosed disease might have contributed to the death. These are non-coronial or hospital post mortems and they require written consent from either the deceased (given when they were alive) or from the deceased’s senior available next of kin (which is determined by the Human Tissue Act 1983) after death.

Who can consent to a post mortem?
As the senior available next of kin, you may be approached by a health care worker and asked for your consent to the post mortem examination. You are free to choose whether or not to give your consent for the post mortem examination. Your consent must be given in writing.

I am the senior next of kin but in my culture it is not my role to make these decisions. Can someone else do it for me?
It is recognised that in some cultures arrangements around the death of a person may traditionally be performed by someone other than the senior available next of kin. The Human Tissue Act allows a senior available next of kin to authorise another person, in writing, to exercise their functions. This ‘authorised person’ also known as a ‘Delegate’ can then give written consent for a non-coronial post mortem. There is a form you will be asked to complete if you wish to authorise someone to be your delegate.

What happens at a post mortem?
The pathologist who will be performing or supervising the post mortem will review the deceased’s medical records before undertaking a thorough examination of the body. A full post mortem will include:
• an examination of the outside of the person’s body looking for marks or other abnormalities that might indicate injury or disease;
• an internal examination which is a surgical procedure like a large operation. The pathologist will usually make two incisions, one across the back of the head and another on the front of the body. This allows the pathologist to examine all the major organs including the brain if necessary. Small samples of tissue or body fluids will usually be taken for later microscopic examination.
• a laboratory examination, which may involve microscopic examination of the tissue samples taken during the internal examination or other testing looking for evidence of disease.

What happens after the post mortem?
Once the examination is complete the incisions are closed like a surgical operation and the body cleaned. In most cases, once the body has been clothed, the effects of the post mortem are not very noticeable. Normally, you will be able to see the body after the post mortem.

Why would the Pathologist need to retain organs?
It is often important for the pathologist to retain an organ (usually the brain or heart) in order to test for signs of disease or injury that are not immediately apparent. Usually this will be discussed as part of the consent but the need to retain a particular organ may not be known until the post mortem has begun.

If the pathologist does need to retain organs you may be able to delay the funeral arrangements for a short time so these organs can be returned to the body before it is released for burial or cremation. If this is not possible, you can decide whether you would like the organs returned to you or your funeral director for separate burial or cremation or disposed of by the facility where the post mortem was conducted (usually by cremation). Small samples of tissue and fluids taken during the internal examination will not be returned to the body.
19. PATHOLOGY 19.60

DESTITUTE PERSONS - CREMATION OR BURIAL (PD2008_012)

PD2008_012 rescinds PD2007_051.

1. Introduction

This policy directive rescinds Policy Directive PD2007_051 due to the inclusion in that Policy Directive of Police forms, and references to them, which are no longer to be used. This Policy Directive deals with the cremation or burial of the bodies of deceased destitute persons in the State of New South Wales for services as set out in this document.

Definitions:

For the purposes of this policy directive the following terms mean:

“Destitute Persons” - deceased persons with no money or assets and whose relatives and friends are unable to pay the costs of cremation or burial.

“Still Birth” - means the birth of a child that exhibits no sign of respiration or heartbeat, or other signs of life, after birth and that:
   a) is at least 20 weeks’ gestation; or
   b) if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.

“Public Health Unit” - please see the attached list (attachment I).

2. Cremation/Burial generally

Funeral procedures and rites are helpful for the resolution of grief and the bereavement process. This is no less true for the families and friends of people who are destitute when they die. The conditions for the cremation or burial of deceased destitute persons should take equal account of the emotional needs of any relatives or friends of the deceased.

Cremation will generally be the preferred method of disposal, provided that:
   • there is no objection set out in the Will of the deceased;
   • there is a written agreement of any known relatives or friends;
   • it is not contrary to the direction of the State Coroner;
   • all necessary cremation certificates have been completed.

In all Areas Health Services and Public health facilities it should be noted that only the contracted funeral director will be contacted to provide the service. A list of these can be obtained from the Department of Commerce, Office of Government Business and Procurement.

3. Responsibility for Burial or Cremation of Destitute Persons

Public Health Units are responsible for the administration of the process related to the cremation and burial of destitute persons within their Area Health Service boundaries and are to provide assistance and advice to interested parties to ensure all requirements are adhered to.

The cost of cremation or burial of deceased destitute persons is the responsibility of the Area Health Service.

67(5/08)
4. Procedure for Burial or Cremation

4.1 Where the death occurs in a public hospital, State Government nursing home, or other facility under the control of a public health organisation under the Health Services Act (in this policy referred to as a ‘public health facility’) and a medical practitioner has issued a death certificate:

- The social worker at that facility shall make all reasonable inquiries to locate any relatives, friends or members of organisations that may wish to arrange for a cremation or burial of the body at their own expense.
- Where no one is able to pay for the cremation or burial of the body:
  1. issue an order to the contracted funeral director for a funeral and cremation or burial to be conducted in accordance with the contract requirements;
  2. arrange for an officer of the public health facility to attend the service;
  3. forward the duly certified invoice to the Area Health Service for payment.

The assistance of the Police may be obtained if the facility’s own enquiries fail to locate any relatives, friends, or others who may wish to arrange a cremation or burial at their own expense. This will help to avoid causing unnecessary distress to people who may have wished to make other funeral arrangements and been willing to pay the funeral costs.

4.2 Where the death of a destitute person occurs outside of a public health facility, does not fall within the Coroner’s jurisdiction, a medical certificate as to the cause of death has been issued, and the Police have determined that the State is ultimately responsible for the burial or cremation then:

- Police will complete forms P372 (attachment 2);
- the form is then forwarded to the Director of the Public Health Unit for the relevant Area Health Service;
- an Environmental Health Officer will complete form HEALTH373 (attachment 3) and contact the contracted funeral director to arrange for the burial or cremation; and
- after the burial or cremation, the contracted funeral director will forward the invoice to the Public Health Unit to arrange payment by the appropriate Area Health Service.

4.3 Where the death of a person comes within the Coroner’s jurisdiction, or when a medical certificate as to the cause of death has not been issued, and the Police have determined that the State is ultimately responsible for the burial or cremation then:

- Police will complete form P372 (attachment 2) and forward it to the Coroner;
- in all cases the Coroner will issue an Order for Disposal of a Destitute Person;
- the Coroner will forward the form to the Director of the appropriate Public Health Unit and request the burial or cremation to be conducted; and
- an Environmental Health Officer will complete Form HEALTH 373 (attachment 3), contact the contracted funeral director and request to arrange the burial or cremation.

5. Contracts for Destitute Cremation and Burial

Contracts for the cremation or burial of deceased destitute persons are under the control of the Department of Commerce, Office of Government Business and Procurement. Contract details and information about them may be obtained from the Office of Business and Procurement. Such contracts are generally reviewed every three years.

Each contract may cover one or more police regions/local areas/towns, and includes services to all public health facilities in that police region/local area/town. Public health facilities and Area Health Services must use the contracted funeral director for all funerals, cremations or burials paid for by Area Health Service under these arrangements.
Contracts generally provide for separate rates of payment, whether it is a burial or cremation, for:

- adult - burial including ground fee and burial rites and relevant certificates;
- child under 1.1 metres - burial including ground fee and burial rites and relevant certificates;
- still-born neo-nate (not less than 20 weeks gestation or 400 grams in weight) - burial including ground fee and burial rites and relevant certificates;
- adult - cremation including cremation fee and relevant certificates;
- child under 1.1 metres - cremation including cremation fee and relevant certificates; and
- still-born neo-nate - cremation including cremation fee and relevant certificates.

6. **Complaints about Contractors**

Any complaints by family or friends about the performance of a contracted funeral director should be taken up in the first instance with the Department of Commerce, Office of Business and Procurement which has the primary responsibility for contracted funeral directors.

7. **Responsibility of the Police**

The Police are responsible in all cases for:

- determining whether a death is reportable to the Coroner and whether any person is able to pay for the cost of the burial or cremation;
- determining whether the deceased has any assets or estate.
- completion of Forms P372 (attachment 2) and forwarding the form to the Public Health Unit (or to the Coroner in coroner’s cases) as is appropriate and required in the particular case.

8. **Records of Burial or Cremation**

Under the Public Health (Disposal of Bodies) Regulation the cemetery or cremation authority is required to maintain records of the name, date, location of the grave, section and record number, or the location of the ashes, of the deceased. The ultimate burial/cremation site location details will generally also form part of the information recorded by the Registrar of Births, Deaths and Marriages. Public Health Units are also required to keep records of the name of the deceased, and place of burial/cremation and the contracted funeral director used.

9. **Assistance to Relatives and Friends of the Deceased**

Appropriate staff in the public health facilities should be made aware of this policy to enable information to be supplied to relatives of destitute persons where there is an obvious need of assistance with funeral expenses. Family members should be directed to the social worker who will assess the situation and provide appropriate advice.

A register is to be maintained at the Public Health Unit and notation made in that register in the event that relatives, after being provided details of destitute burial/cremation, decline the service. Any subsequent ex gratia request for contribution to the funeral arrangements for that particular person will then not be accepted (see Section 12 for ex gratia payments generally).

Where an ex gratia claim is made from non-family members the hospital is to examine carefully the bona fides of the claim as generally the full cost of the funeral is the responsibility of those persons.

Bereaved relatives and friends of a destitute person should, regardless of their inability to meet the cost of cremation or burial, be informed of funeral arrangements by the contracted funeral director and encouraged to attend the funeral service. They will, however, be entirely responsible for their own transportation to and from the service.
10. **Death in a Hospital Remote from Residence**

When the deceased destitute person has been transported from their normal area of residence to a “remote hospital” for treatment not available at their local hospital, and has died at the remote hospital, the reasonable costs of returning the body to the area of residence may be paid if:

- the burial/cremation in their local area is requested by relatives of the deceased; and
- approval was arranged prior to the transfer of the body.

In these cases, the cost of transport back to the local area will be met by the remote hospital where the person dies. The costs of the actual destitute funeral will be met by the local Area Health Service covering the deceased’s normal place of residence.

11. **Australian Ex-Service Man or Woman**

The Department of Veterans’ Affairs will pay a certain amount towards the funeral expenses of an Australian ex-service man or woman who dies in destitute circumstances. The Department of Veterans Affairs should be contacted for the current details of the benefit payable in a particular case.

12. **Requests for Financial Assistance after the Funeral has been performed**

Where the funeral service has already been conducted, and persons otherwise responsible for the funeral arrangements claim financial difficulty, a petition may be submitted to the relevant Area Health Service for an ex gratia contribution to that cost. Chief Executives have limited delegation to approve the provision of financial aid to impoverished families to assist with already incurred burial costs of relatives. All other ex gratia payments are to be referred to the Department of Health.

The petition should take the form of a covering letter requesting assistance and the circumstances for the request. In addition all petitioners must supply a signed statutory declaration witnessed by a Justice of the Peace, which states:

- a complete listing of the assets of the deceased;
- a complete listing of assets, income, expenditure of the remaining relatives;
- a copy of the funeral director’s invoice. If the invoice has been fully paid, it would be in very exceptional circumstances that any assistance would be offered;
- a copy of the death certificate;
- details of any financial assistance provided by charities, Centrelink or any other source; and
- details of any arrangement made with the funeral director to pay off the debt.

It should be noted, as per the Combined Delegations Manual (Delegation F91), that the Chief Executives of all Area Health Services are authorised to approve of ex gratia payments under this delegation within specified limits. Chief Executives are required to submit an annual return each financial year of the actual payments made to the Chief Financial Officer, Department of Health. The return for each year must include the following details:

- recipient;
- value of ex gratia payment;
- full cost of funeral as claimed by recipient; and
- number of claims rejected without any ex gratia payment made.

The Department will therefore no longer have primary administrative and financial liabilities associated with destitute burials and ex gratia payments. To facilitate the management by Area Health Services of all future claims for destitute burials and ex gratia payments the Department is providing annualised budget supplementation to Area Health Services from 1 July 2007 based on average annual costs over the previous 3 years.

67(5/08)
### Public Health Unit Addresses and Contacts

<table>
<thead>
<tr>
<th>Public Health Unit</th>
<th>Mailing Address</th>
<th>Phone contact (work hours)</th>
<th>Fax contact (work hours)</th>
<th>After hours contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Greater Southern AHS</strong></td>
<td><strong>Goulburn Office</strong></td>
<td>02 4824 1837</td>
<td>02 4824 1831</td>
<td>02 6021 4799 (diverts to Albury Base Hospital) - ask for the Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>Locked Bag 11 Goulburn 2580</td>
<td>02 4824 1838 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Queanbeyan Office</strong></td>
<td>02 6124 9934</td>
<td>02 6124 9946</td>
<td>02 6021 4799 (diverts to Albury Base Hospital) - ask for the Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 1845 Queanbeyan 2620</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Albury Office</strong></td>
<td>02 6021 4799</td>
<td>02 6021 4899</td>
<td>02 6021 4799 (diverts to Albury Base Hospital) - ask the Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 3095 Albury 2640</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Wagga Wagga</strong></td>
<td></td>
<td></td>
<td>02 6021 4799 (diverts to Albury Base Hospital) - ask the Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 201 Wagga Wagga 2650</td>
<td>02 6923 5755</td>
<td>03 6923 5751</td>
<td></td>
</tr>
<tr>
<td><strong>Greater Western AHS</strong></td>
<td><strong>Broken Hill Office</strong></td>
<td>08 8080 1499</td>
<td>08 8080 1683</td>
<td>08 8080 1333 (Broken Hill Base Hospital) - ask for the Senior Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>Centre for Population Health</td>
<td>PO Box 457 Broken Hill 2880</td>
<td>08 8080 1196 (secure)</td>
<td>or on call mobile 0417 685 259</td>
</tr>
<tr>
<td></td>
<td><strong>Dubbo Office</strong></td>
<td>02 6841 5569</td>
<td>02 6841 5571 (secure)</td>
<td>02 6885 8666 (Dubbo Base Hospital) - ask for the Senior Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 739 Dubbo 2830</td>
<td></td>
<td></td>
<td>or call 0418 866 397 - ask for the Senior Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td><strong>Bathurst Office</strong></td>
<td>02 6339 5601</td>
<td>02 6339 5173 (secure)</td>
<td>0428 400 526 - ask for the Senior Environmental Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 143 Bathurst 2795</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hunter/New England AHS</strong></td>
<td><strong>Newcastle Office</strong></td>
<td>02 4924 6477</td>
<td>02 4924 6490 (secure)</td>
<td>02 4924 6477 (diverts to John Hunter Hospital) - ask for Public Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>Hunter Population Health</td>
<td>Locked Bag 10 Wallsend 2287</td>
<td></td>
<td>if no answer, phone 016301965 and ask for Public Health Physician on call</td>
</tr>
<tr>
<td></td>
<td><strong>Tamworth Office</strong></td>
<td>02 6767 8630</td>
<td>02 6766 3003</td>
<td>02 6767 8630 (diverts to Tamworth Base Hospital) - ask for Public Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>PO Box 597 Tamworth 2340</td>
<td></td>
<td></td>
<td>if no answer, phone 016301965 and ask for Public Health Physician on call</td>
</tr>
<tr>
<td><strong>Justice Health Service</strong></td>
<td>PO Box 35 Matraville 2036</td>
<td>02 9214 6229</td>
<td>02 9289 2494 (secure)</td>
<td>02 9311 2707 - ask for Nurse Manager</td>
</tr>
<tr>
<td></td>
<td>Public Health Unit (Public Health coordinator/CNC)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>North Coast AHS</strong></td>
<td><strong>Port Macquarie Office</strong></td>
<td>02 6588 2750</td>
<td>02 6588 2837</td>
<td>0407 271 498 - ask for Public Health Officer on call</td>
</tr>
<tr>
<td></td>
<td>Public Health Unit</td>
<td>PO Box 126 Port Macquarie 2444</td>
<td></td>
<td>if no answer, phone 0417 244 966</td>
</tr>
<tr>
<td></td>
<td><strong>Lismore Office</strong></td>
<td>02 6620 7500</td>
<td>02 6622 2151</td>
<td>132222 pager number 397635</td>
</tr>
<tr>
<td></td>
<td>PO Box 498 Lismore 2480</td>
<td>02 6620 2252 (secure)</td>
<td></td>
<td>if no answer, phone 0417 244 966</td>
</tr>
<tr>
<td>Area</td>
<td>Location</td>
<td>Phone Numbers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
<td>------------------------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Sydney/Central Coast AHS</td>
<td>Hornsby Office</td>
<td>02 9477 9400 02 9482 1650</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Unit</td>
<td>e/- Hornsby Hospital Palmerston Rd Hornsby 2077</td>
<td>02 9482 1358 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gosford Office</td>
<td>02 4349 4845 02 4349 4850 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 361</td>
<td>02 9482 1311 (Gosford Hospital) - ask for the Environmental Health Officer on call</td>
<td></td>
<td></td>
</tr>
<tr>
<td>South Eastern Sydney/ Illawarra AHS</td>
<td>Randwick Office</td>
<td>02 9382 8332 02 9382 8334</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Unit</td>
<td>Locked Bag 88 Randwick 2031</td>
<td>02 9382 8314 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wollongong Office</td>
<td>02 4221 6700 02 4221 6722</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Locked Bag 9 Unanderra 2526</td>
<td>02 4221 6759 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney South West AHS</td>
<td>Eastern Zone</td>
<td>02 9515 9420 02 9515 9440</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public Health Unit</td>
<td>(Camperdown Office)</td>
<td>02 9515 9467 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PO Box 374</td>
<td>02 9515 9470 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Western Zone</td>
<td>02 9828 5944 02 9828 5955</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Liverpool Office)</td>
<td>02 9828 3000 (Liverpool Hospital) - ask for Public Health Officer on call</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Locked Mail Bag 7017 Liverpool BC 1871</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sydney West AHS</td>
<td>Penrith Office</td>
<td>02 4734 2022 02 4734 3300</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre for Population Health</td>
<td>PO Box 63 Penrith 2751</td>
<td>02 4734 3444 (secure)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parramatta Office</td>
<td>02 9840 3603 02 9840 3608</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Locked Bag 7118 Parramatta BC 2150</td>
<td>02 9840 3591 (secure)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
BURIAL/CREMATION OF A DECEASED DESTITUTE PERSON

Police Station

Full name of deceased ____________________________  _______________________________
(Surname)                          (Christian or given name/s

Address ________________________________________________________________________

Age __________   Date of Birth  _____________  Native of _______________________________

Date of Death ___________Time am/pm _________ Place ________________________________

Circumstances of death ____________________________________________________________
________________________________________________________________________________

Death certificate issued by Dr _____________________

Was the deceased -

(a) a pensioner/ ** YES/NO. If yes, type of pension _________________________________
(Repatriation, Invalid,Age, etc)

(b) a returned or an ex-serviceman or woman? ** YES/NO

(c) a member of any trade union, friendly society or other organisation
   Interested in defraying burial expenses? **YES/NO

(d) insured? **YES/NO

Did the deceased have any -

(e) money? **YES/NO  Details _________________________________________________

(f) property? ** YES/NO  Details ________________________________________________
   (If insufficient space attach report)

Religion of deceased ____________________________

Name and address of next of kin _______________________________________________________
________________________________________________________________________________

Next of kin notified of the death by ______________________________________________________

Will the next of kin or other person defray burial expenses? **YES/NO

Does the next of kin desire -

(g) a religious ceremony? *YES/NO If yes, details ______________________________________

(h) the body to be interred or cremated? * INTERRED/CREMATED

__________________________Signature
__________________________     Name
__________________________     Rank

THIS FORM IS TO BE COMPLETED IN DUPLICATE AND SUBMITTED TO THE PUBLIC HEALTH UNIT, OR THE CORONER (IF
A CORONER CASE)

*CROSS OUT WORDS WHICH DO NOT APPLY
** CROSS OUT WORDS WHICH DO NOT APPLY. IF ANSWER TO ANY QUESTION IS ‘YES’ ATTACH A REPORT GIVING
DETAILS

67(5/08)
AUTHORITY FOR BURIAL/CREMATION
OF DECEASED DESTITUTE PERSON

Public Health Unit: ………………………………………… Phone No …………………………………………
Report Date: …………………………………………
Police Officer: ………………………………………… Morgue Register/Book No: …………….
------------------------------------------------------------------------------------------------------------------------

The Authority given for Cremation/Burial indicated below is based on
Information received by the NSW Police Service.

To: ………………………………………………………………………..……….(Undertaker’s Name)

You are hereby requested to provide a coffin and conveyance of the body of a ……………(sex)
person, named ……………………………………… lying dead at ………………………………..(morgue),
and to arrange for ……………………………………….(Cremation/Interment) without delay.

The account for the Department of Health is to be delivered to ………………………………………
(Director, Public Health Unit) of ………………………………………………………………………...
………………………………………………………….(Area Health Service).

Authorised: …………………………………………..(Signature)
(Senior Environmental Health Officer)

Payment of Account No: …………………………………………..
Approved: ………………………………………….. Not Approved: …………………………………………..

-----------------------------------------------------------------------------------------------------------------------------------

Note: This Authority must be returned to the Director, Public Health Unit as shown above.

I hereby certify that the remains of the late ……………………………………………………………
were buried/cremated on ………………………………..(date) and place in Grave No: ………………
OR …………………………………………..(other).

Signature: …………………………………………………….. Date: …………………………………………..
Address: …………………………………………………………………………………………………..
EXHUMATION OF HUMAN REMAINS (PD2013_046)

PD2013_046 rescinds PD2008_022.

PURPOSE

This document provides the policy to be observed by Public Health Units located in Local Health Districts, on receipt of an application to seek permission for approval of the exhumation of human remains under the Public Health Regulation 2012. Common reasons for exhuming bodies include to repatriate the remains overseas or to relocate the body to another cemetery plot or vault.

MANDATORY REQUIREMENTS

Under Clause 69 of the Public Health Regulation 2012 a person must not exhume a body unless the exhumation of the remains has been approved by the Director-General.

An application for approval to exhume the remains of the body of a dead person may be made to the Director-General by:

- An executor of the estate of the dead person.
- The nearest surviving relative of the dead person.
- If there is no such executor or relative available to make the application a person who, in the opinion of the Director-General, is a proper person may make the application.

An application is to be made in the approved form and it is to be accompanied by:

- A certified copy of the death certificate relating to the dead person.
- A statutory declaration as to the relationship of the applicant to the dead person and the dead persons wishes, if any, regarding the disposal of his or her bodyAn application fee.

Under Clause 71 of the Public Health Regulation 2012 the Director-General may:

- Grant an approval to exhume the remains of a body.
- Refuse the application.

Under Clause 72, an exhumation cannot take place without an authorised officer or a Ministry of Health staff member present. A person must not proceed with an exhumation if the authorised officer or Ministry of Health staff member who is present at the exhumation, orders the exhumation to stop.

Under Clause 78, if the applicant seeks to have the exhumed body cremated a separate application can be made for an exemption from providing the required cremation documentation, provided the body has been buried for longer than 10 years. The minimum 10 year period is strictly enforced. An application under this clause is to be accompanied by a fee of $100.

IMPLEMENTATION

Authorised officers in Public Health Units of Local Health Districts are responsible for assessing applications for exhumation of human remains and either approving with a set of conditions or rejecting the application. Authorised officers should ensure that all of the required document has been submitted with the application fee and that an appropriate person has applied for the application. The approval granted is valid for a period of three months after the approval is granted.
1. BACKGROUND

1.1 Introduction

Exhumation of human remains may occur for a number of reasons, including:
- To satisfy family wishes, where the family of the deceased person may want the remains to be moved to another burial ground, to another part of the state or country or abroad, or even to have the remains cremated.
- To obey Coronial orders requiring exhumation for forensic (criminal) investigation.
- To enable the use of closed cemeteries for redevelopment or for the construction of new infrastructure such as a road or airport.

A variety of people, including authorised officers, cemetery authorities, and funeral directors are involved at different stages of exhumation procedures.

Public Health Units (PHUs) of Local Health Districts (LHDs) in NSW facilitate the approval for an exhumation however there is no obligation to proceed with an exhumation once it has been approved.

The objectives of this document are:
- To assist authorised officers with processing applications to exhume.
- To standardise the management of an exhumation so as to prevent a public health risk and protect community amenity in the handling of remains.

1.2 Key definitions

These definitions are repeated from the Public Health Act 2010 and Public Health Regulation 2012 for clarity:

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body</td>
<td>Means the body of a dead person, but does not include the cremated remains of the person.</td>
</tr>
<tr>
<td>Burial</td>
<td>Includes putting the body in a vault.</td>
</tr>
<tr>
<td>Cemetery Authority</td>
<td>Means the person or body that directs the operations of a cemetery.</td>
</tr>
<tr>
<td>Coroner</td>
<td>Means a person who exercises or performs the functions of a coroner in accordance with the Coroners Act 2009.</td>
</tr>
<tr>
<td>Dead person</td>
<td>Includes a still-born child (see definition of Still birth).</td>
</tr>
<tr>
<td>Exhumation</td>
<td>Means the removal of a dead person’s remains (not being cremated remains) from a grave or vault, but does not include their removal from one vault for immediate transfer to another vault in the same cemetery or their temporary removal for the purposes of reburial in the same grave or vault.</td>
</tr>
<tr>
<td>Funeral director</td>
<td>Means a person (other than the operator of a mortuary transport service) who, in the conduct of the person’s business, engages, for the purpose of burial, cremation or transport, in the collection, transport, storage, preparation or embalming of bodies or engages in the conduct of exhumations.</td>
</tr>
<tr>
<td>Prescribed infectious diseases</td>
<td>Means any one of the following diseases: avian influenza in humans, diphtheria; plague, respiratory anthrax; smallpox; severe acute respiratory syndrome, tuberculosis and any viral haemorrhagic fever (including Lassa, Marburg, Ebola, and Congo-Crimean fevers).</td>
</tr>
<tr>
<td>Proper person</td>
<td>The Director-General has the power to decide whether a person is a ‘proper person’ to make an application to exhume the remains of a dead person.</td>
</tr>
</tbody>
</table>
19. PATHOLOGY

<table>
<thead>
<tr>
<th>Nearest surviving relative</th>
<th>Means:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) In relation to a still-born child a parent, or sibling at or above the age of 16 years, of the child.</td>
<td></td>
</tr>
<tr>
<td>(b) In relation to a dead person who is not a still-born child – the spouse or de facto partner of the dead person immediately before death, a parent of the dead person, a child at or above the age of 16 years of the dead person or any relative of the dead person who was residing with the dead person when he or she died.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Still-birth</th>
<th>Consistent with the Births, Deaths &amp; Marriages Act 1995, means the birth of a child that exhibits no sign of respiration or heartbeat, or other sign of life, after birth and that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Is of at least 20 weeks’ gestation.</td>
<td></td>
</tr>
<tr>
<td>(b) If it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.</td>
<td></td>
</tr>
</tbody>
</table>

1.3 Legal and legislative framework

Public Health Regulation 2012

Division 4 of Part 8 of the Public Health Regulation 2012 provides specific regulation for the exhumation of bodies.

Clause 69 Exhumation without approval prohibited

(1) A person must not exhume the remains of a body unless the exhumation of those remains has been:
   (a) Ordered by a coroner
   (b) Approved by the Director-General.

(2) However, a funeral director may, without a coroner’s order or Director-General’s approval, transfer a coffin from a vault in a cemetery to a mortuary for the purpose of the coffin being immediately repaired and returned to the vault.

(3) A funeral director must return the coffin to the cemetery within 24 hours of its transfer.

Clause 70 Application to exhume remains

(1) An application for approval to exhume the remains of the body of a dead person may be made to the Director-General by:
   (a) An executor of the estate of the dead person.
   (b) The nearest surviving relative of the dead person.
   (c) If there is no such executor or relative available to make the application a person who, in the opinion of the Director-General, is a proper person in all the circumstances may make the application.

(2) An application is to be made in the approved form and is to be accompanied by:
   (a) A certified copy of the death certificate relating to the dead person.
   (b) A statutory declaration as to the relationship of the applicant to the dead person and the dead person’s wishes, if any, regarding the disposal of his or her body (so far as any such wishes are known to the applicant).
   (c) An application fee (please check with the PHU for the current fee).

(3) In this clause, death certificate means a certificate given by a medical practitioner as to the cause of death or issued under the Births, Deaths and Marriages Registration Act 1995.

All applications to exhume remains must be made in writing using an approved form to the Director of the local Public Health Unit that acts on behalf of the Director-General of the NSW Ministry of Health. The application fee may increase periodically in line with the Consumer Price Index.
Clause 71 Approval to exhume remains

(1) The Director-General may:
   (a) Grant an approval to exhume the remains of a body, subject to any conditions specified in the approval.
   (b) Refuse the application.

(2) An approval granted under this clause remains valid for three months from the date of the approval or for a period agreed to by the Director-General.

The PHU is not bound to approve the application. The PHU may approve, subject to conditions, or refuse the application. An approval is normally given for 3 calendar months and this date will be specified in a schedule of conditions attached to the approval document. Any further extension of time may require re-application and re-approval. An approval initially for longer than three calendar months should be negotiated with the PHU.

Clause 72 Exhumation not to take place without authorised officer present

(1) A person must not proceed with an exhumation unless an authorised officer or a member of staff of the Ministry of Health is present at the exhumation.

(2) A person must not proceed with an exhumation if the authorised officer or Ministry staff member who is present at the exhumation orders the exhumation to stop.

The grave may be excavated to the lid of the coffin but nothing must be disturbed until the arrival of the authorised officer. An authorised officer must be present at the exhumation to ensure that the correct interment is opened, to ensure that all of the remains are exhumed and to enforce the protection of public health should this be necessary. The authorised officer has the power to order that the exhumation be stopped immediately under adverse circumstances. An example of where this may occur is where the weather is very poor with heavy rain. The initial order to stop is to be given verbally and then confirmed in writing to all parties involved, within 24 hours.

Division 5 of Part 8 of the Public Health Regulation 2012 provides for cremation of deceased persons.

Clause 78 No cremation without documentation

Clause 78 does not apply to a cremation of the body of a dead person that has been buried for at least 10 years if the cremation is carried out in accordance with an exemption granted by the Director-General following an application by:
1) An executor of the estate of the dead person.
2) The nearest surviving relative of the dead person.
3) If there is no such executor or relative available to make the application a person who, in the opinion of the Director-General, is a proper person in all the circumstances to make the application.

This is a new addition to the Exhumation section of the Regulation that may be used where a person makes a separate application to have the exhumed body cremated following the exhumation.

Note: The Director-General’s authority under Clause 78 (4) of the Public Health Regulation 2012 (Delegations Manual page 8.66, delegation (PH590)) is the power to decide whether a person is a “proper person” to make an application in the absence of an executor or surviving relative.
19. PATHOLOGY

Work Health and Safety Act 2011


WH&S matters are enforced by WorkCover NSW. More information on safe work practices is available at http://www.workcover.nsw.gov.au or by contacting Workcover NSW direct on 13 10 50.

Heritage Act 1977

The Heritage Act 1977 and Guidelines for the Management of Human Skeletal Remains under the Heritage Act 1977 applies to relic burials. Any burial site over 50 years old is considered to be relic under the Heritage Act. If the site is listed on the State Heritage Register then approval is required from the Heritage Council of NSW.

An application must be made to the Heritage Office before any disturbance, removal or work commences on the site. Approval for an exhumation under the Public Health Regulation 2012 does not obviate the necessity to obtain approval under the Heritage Act 1977. For further information contact the Heritage Office of NSW or visit: http://www.heritage.nsw.gov.au.

Coroner’s Act 2009

A coroner may order an exhumation for the purposes of forensic investigation or a criminal investigation. Such an order is outside the ambit of the Public Health Regulation 2012. The Police may request that an authorised officer from the Ministry of Health or the local Public Health Unit be present at the coronial exhumation.

Births, Deaths and Marriages Registration Act 1995

Section 41(2) of the Births, Deaths and Marriages Registration Act 1995 requires that if human remains (other than cremated remains) are removed from NSW, the funeral director or other person who arranges for the removal of the remains from NSW must, within 28 days of disposal of the remains outside NSW, give the Registrar notice of the new location of interment. The act is available at: http://www.austlii.edu.au/au/legis/nsw/consol_act/bdamra1995383/. The Registry of Births, Deaths and Marriages may be contacted via: http://www.bdm.nsw.gov.au.

2. APPLICATION REQUIREMENTS

An application for permission to exhume the remains of a deceased person is to be made to the PHU on the approved form which is contained at the NSW Ministry of Health website at http://www.health.nsw.gov.au/environment/dotd/Documents/form-c70-application-to-exhume.pdf

The application must be made by either:

- An executor of the estate of the deceased.
- The nearest surviving relative.
- If there is no such executor or relative available to make the application a person who, in the opinion of the Director-General, is a proper person in all the circumstances to make the application.
The application must be accompanied by:

- A certified copy of the death certificate (death certificate issued by the Registry of Births, Deaths and Marriages).
- A statutory declaration that states:
  - The relationship between the applicant and the deceased or the reason the applicant is the proper person to make the application.
  - If the deceased left any instructions regarding the disposal of their body/remains if known.
  - In addition to the above an applicant should declare that he or she has consulted each nearest surviving relative and that they have no objection to the proposed exhumation.
- An application fee (please check with the PHU for the current fee).

Note: If there is no agreement amongst nearest surviving relatives, the applicant should seek independent legal advice regarding this issue. The applicant should advise if there is an intention to cremate the body following the body being exhumed, and the appropriate form completed.

3. APPROVAL BY PUBLIC HEALTH UNITS

Approval by PHUs for an exhumation must be given by formal correspondence.

3.1 Delegation

The Director-General’s authority under clauses 69(1), 70(1)(c) and 71 of the Public Health Regulation 2012 has been delegated to the Chief Health Officer, Director Health Protection, Public Health Officer or Public Health Unit Director as appointed under Section 121 of the Act (delegation PH/308, PH/309).

3.2 Special Considerations on Exhumation Approval

Special consideration should be given to the approval of an exhumation if the deceased was infected with a prescribed infectious disease. For example if the deceased was infected with diphtheria or tuberculosis, exhumation should not permitted in the first year of interment.

Although not prohibited, an exhumation of the remains of a body that was buried without a coffin will be approved only where the cemetery authority and funeral director have agreed to proceed with the exhumation, especially during the first three years of interment.

3.3 Conditions of Approval

After due consideration of the application and the statutory declaration(s), the PHU should then consider applying appropriate conditions to facilitate an approval.

There are two standard sets of approval conditions which can be applied as appropriate:

- Appendix 2 – Schedule A - Conditions of Approval for Exhumation from a Grave.
- Appendix 3 – Schedule B - Conditions of Approval for Exhumation from an Above Ground Structure.

Any other additional conditions that are deemed necessary to permit the exhumation may be added to schedule A or B based on the individual circumstances of the exhumation. If some conditions are unwarranted they may be removed from the relevant schedule.
3.4 Approval Instrument

An approval must be in writing and must be signed by the Director-General or their delegate. A template to assist in the approval process can be found at Appendix 4. This template is to be completed by the Authorised Officer in order to facilitate approval by the delegate.

3.5 Notification of Approval

The approval instrument is retained on file as a record that approval was granted by the Director-General or their delegate. Therefore it is necessary to advise the applicant, the cemetery authority and the funeral director of the approval.

The attached letter templates may be used for approval notification of the exhumation to the applicant, funeral director and Cemetery Authority.

- Appendix 5 – Sample Letter to Applicant.
- Appendix 6 – Sample Letter to the Cemetery Authority and Funeral Director.

3.6 Refusals

If after due consideration the application is to be refused then the applicant should be notified in writing specifying the reasons for refusal. Ideally the applicant should consult the PHU in the first instance to discuss the requirements and possible restrictions on an application to exhume.

3.7 Cremation of Remains

Division 5 of Part 8 of the Public Health Regulation 2012 sets out the requirements for documentation for cremations in NSW and includes the requirement for a cremation application form, a cremation certificate and the cremation permit. The documentation confirms the identity of the body to be cremated and the cause of death and ensures that a coroner’s investigation has been conducted where necessary.

After the body is exhumed the next of kin may wish to have the body cremated. However there may be cases whereby the body does not have the required paperwork necessary for cremation. Clause 78 of the Public Health Regulation 2012 provides an exemption for the required documentation for cremation where the body has been buried for longer than 10 years. An application under this clause is to be accompanied by a fee.

The Director-General has the power to approve an exemption and the executor or the nearest surviving relative or another proper person may make application on form ‘Application for Exemption by the Director-General to the Requirement for Documentation for Cremation to Proceed: Permission for Cremation of Exhumed Remains of a Body Buried more than 10 years ago with statutory declaration’. The minimum 10 year period will be strictly enforced and this matter should be clarified prior to any exhumation approval where it is planned for the remains to be subsequently cremated. The application form is available at: http://www.health.nsw.gov.au/environment/dotd/Documents/form-c78-application-for-exemption.pdf
19. PATHOLOGY

APPENDIX 1

Schedule A

CONDITIONS OF APPROVAL FOR EXHUMATION FROM GRAVE

1. The exhumation is to be carried out in the presence of a Public Health Unit’s authorised officer or other authorised officer of the NSW Ministry of Health or Local Council authorised Officer and person appointed by Cemetery Authority.

2. At least 48 hours notice of the exhumation arrangements shall be given to the Public Health Unit.

3. Day and time of the exhumation shall be arranged by the participating parties and agreed to by the Public Health Unit.

4. The approval granted is valid for a period of three months and shall lapse on ___ /____ /_____, unless a further approval is granted.

5. The presence of any relative of the deceased at the exhumation is strictly prohibited.

6. No animals are to be permitted within the exhumation site.

7. The cemetery authority and funeral director shall be responsible for the work health and safety of all persons involved in the exhumation and shall ensure that all NSW WorkCover requirements are complied with.

8. If, during the course of the exhumation, it is determined necessary to stop the exhumation by either the exhumation supervisor/cemetery manager or authorised Officer, for any valid reason e.g. work health and/or public health risk, then the exhumation must cease.

9. The remains of the deceased shall be enclosed in a body bag and placed into a new coffin with a name plate attached inscribed with the name of the deceased.

10. The remains of the original coffin are to be placed in the new coffin where possible. Where there is an excess of remains of the original coffin, these remains should be disposed in a sanitary and agreed manner.

11. Excavated soil should be back filled. The soil that was removed from immediately above and around the coffin should be replaced first.

12. If the exhumed remains are to be transferred to another cemetery, a funeral director shall be contracted to transfer the remains from the cemetery grounds or carry out preparatory work for the safe reinterment of the remains.

13. The exhumation will not proceed during or following a period of heavy rainfall within the preceding 24 hours of the appointed time of exhumation. The cemetery manager is to confirm that satisfactory conditions exist for the exhumation to proceed two hours prior to the commencement of the exhumation.

14. Used disposable protective equipment and materials are to be placed in a sealed plastic bag and disposed of in a sanitary manner.
APPENDIX 2

Schedule B

CONDITIONS OF APPROVAL FOR EXHUMATION FROM ABOVE GROUND STRUCTURE

1. The exhumation is to be carried out in presence of a Public Health Unit authorised officer or other authorised officer of the NSW Ministry of Health or Local Council authorised Officer and person appointed by Cemetery Authority.

2. At least 48 hours notice of the exhumation arrangements shall be given to the Public Health Unit.

3. Date and time of the exhumation shall be arranged by the participating parties and agreed to by the Public Health Unit.

4. An approval granted is valid for a period of three months and shall lapse on ___ / ____ / ______, unless a further approval is granted.

5. The cemetery authority and funeral director shall be responsible for the work health and safety of all persons involved in the exhumation and shall ensure that all NSW WorkCover requirements are complied with.

6. If, during the course of the exhumation, it is determined necessary to stop the exhumation by either the exhumation supervisor/Cemetery Manager or authorised officer, if for any valid reason e.g. worker health and/or public health risks, then the exhumation must cease.

7. Used disposable protective equipment and materials are to be placed in a sealed plastic bag and disposed in a sanitary manner.
APPROVAL INSTRUMENT TEMPLATE

Public Health Unit
Environmental Health Section

File Number: [XXXXX]

PURPOSE: To approve of the exhumation of the late ________________

RECOMMENDATION:

Approval is granted by the Director-General pursuant to clause 71(1)(a) Public Health Regulation 2012 to [NAME OF APPLICANT] to exhume the remains of the late [NAME OF DECEASED].

KEY ISSUES:

[DETAILS OF THE APPLICATION, STATUTORY DECLARATION, RELEVANT ISSUES, MANAGEMENT PLAN AND JUSTIFICATION OF SUGGESTED CONDITIONS ARE TO BE INCLUDED HERE]

BACKGROUND: (TO BE COMPLETED BY PHU)

CONSULTATION: (TO BE COMPLETED BY PHU WHERE APPROPRIATE)

The approval be subject to compliance with the conditions specified in *Schedule A/Schedule B and to expire on _______/____/_____.

Signature: Authorised officer

Author: Authorised officer
Telephone: Date:

1 Authorised officer
2 Public Health Unit Director/Public Health Officer [SIGN AND DATE]:
   Approved via delegation from the Director-General PH308, PH309 page 8.63 Public Health Delegations Manual under clause 69(1) and 70(1) (C) Public Health Regulation 2012.
3 Authorised officer

196(12/12/13)
SAMPLE LETTER TO APPLICANT

[APPLICANT’S NAME]
[ADDRESS]

Dear [APPLICANT’S NAME]

Reference is made to your application of [DATE] requesting approval to exhume the remains of late [NAME OF DECEASED] from *grave/vault/crypt No: ____ , Section ____ , [NAME OF PLACE OF INTERMENT OR CEMETERY] for the purpose of re-interment to [NAME OF PLACE FOR RE-INTERMENT].

Approval has been granted by the Director-General pursuant to clause 71 (1) (a) Public Health Regulation 2012, subject to compliance with the conditions specified in *Schedule A/Schedule B attached.

The funeral director and cemetery authority have been advised of the approval.

Should you have any inquiries please contact the authorised officer [EHO] on [TELEPHONE] or (EMAIL ADDRESS).

Yours sincerely,

[NAME]
Public Health Unit Director/Public Health Officer
SAMPLE LETTER TO CEMETERY AUTHORITY AND FUNERAL DIRECTORS

[NAME]
[ADDRESS]

[DATE]

Dear [NAME]

EXHUMATION OF THE REMAINS OF THE LATE [NAME OF DECEASED]

Approval has been granted for the exhumation of the late [NAME OF DECEASED] from *grave/vault/crypt No: ______, Section ______, [NAME OF PLACE OF INTERMENT OR CEMETERY] in accordance with clause 71(1)(a) of the Public Health Regulation 2012, and subject to compliance with the conditions specified in Schedule A/Schedule B attached.

A copy of the approval letter is attached for your information.

Should you have any inquiries please contact [Authorised Officer) on [TELEPHONE] or email address.

Yours sincerely,

[NAME]

Public Health Unit Director/Public Health Officer
GUIDANCE ON BURYING A BODY ON PRIVATE LAND – PUBLIC HEALTH REGULATION 2012 (GL2013_016)

GL2013_016 rescinds GL2006_008.

PURPOSE

This document provides guidance to local authorities in their role as the approval authority under the Public Health Regulation 2012 and explains the conditions under which approvals may be granted for burials on private land to those wishing to bury the dead on private land and to Public Health Units of Local Health Districts involved in the process.

KEY PRINCIPLES

Clause 66 (1) (c) of the Public Health Regulation 2012 provides that “A person must not place a body in any grave or vault unless that grave or vault is located on private land where the area of landholding is 5 hectares or more and the location has been approved for that purpose by the local authority.

Clause 66(2) states “A person must not bury a body in or on any land if to do so would make likely the contamination of a drinking water supply or a domestic water supply.”

USE OF THE GUIDELINE

For burials on private land other than a private cemetery, the following requirements need to be met:

- The total landholding must be equal to or exceed five hectares.
- Bodies must be buried at a minimum depth of 900 millimetres.
- Bodies must be placed in a coffin prior to burial.
- A geotechnical investigation may be considered if there is any likelihood of the contamination of ground waters and/or surface waters.

The Guideline also contains, as an attachment, a list of further considerations for local government authorities under other relevant legislation for the burial of a body on private land.


SHALLOW BURIAL (PD2013_045)

PD2013_045 rescinds PD2006_051.

PURPOSE

This document provides the procedures to be followed by Local Health District Public Health Units in receipt of an application to bury a body in a grave shallower than that permitted by Clause 64 Public Health Regulation 2012.

The design, structure and materials used for a shallow burial need to avoid subsidence when the coffin deteriorates, prevent feral animals from entering the grave and prevent the escape of decomposition odours.

MANDATORY REQUIREMENTS

- A person who wishes to bury the body of a deceased person in a shallow grave must seek the approval of the Director-General or delegate.
• A grave liner must be constructed when the depth of burial is reduced from the required 900 millimetres below the natural surface level.
• The body of the deceased person must be contained in a coffin or casket.
• The distance from the top of the lid of the grave liner to the natural ground surface shall not be less than 400 millimetres.
• A person requesting to bury the body of a deceased person in a shallow grave must complete an Application for Shallow Burial, provided at Attachment 2 of the Shallow Burial: Procedures, and is required to provide their personal details, their relationship to the deceased, the deceased date of death, the reason for the shallow burial, the material covering the shallow burial, plans and methodology, proposed date of interment and name and contact details of the cemetery where the burial is to take place.
• The Authorised Officer in the Local Health District Public Health Unit is responsible for assessing the application in relation to any public health risk and approval or rejection of the application.
• The Council or Cemetery Authority must record satisfactory compliance and shall notify the public health unit within 14 days of the interment. The ‘mandatory requirements’ section of the policy statement articulates what must be undertaken to achieve the objectives of the policy.

IMPLEMENTATION

Authorised Officers in Local Health District Public Health Units are responsible for:
• Assessing an application to bury a body at less than 900 millimetres.
• Ensuring that the body of the deceased person is in a coffin or casket.
• Ensuring that the distance from the top of the lid of the grave liner to the natural surface is not less than 400 millimetres.

1. BACKGROUND

1.1 About this document

This document provides procedures to be followed by Local Health District’s Public Health Units upon receipt of an application to bury a body in a grave shallower than permitted by clause 64 of the Public Health Regulation 2012.

This document provides information on the circumstances that may lead to a shallow burial, the design requirements including examples of material and methods for a shallow burial and provides application and approval templates for both Public Health Units and Councils and Cemetery Authorities.

1.2 Key definitions

Authorised Officer – means a person who is appointed as an authorised officer under section 126 of the Public Health Act 2010.

Body – means the body of a dead person but does not include the cremated remains of the person, (Clause 49 of the Public Health Regulation 2012).

Cemetery Authority – means the person or body that directs the operation of a cemetery, (Clause 49 of the Public Health Regulation 2012).
1.3 Legal and legislative framework

This Policy Directive is underpinned by Clause 64 of the *Public Health Regulation 2012* which provides that ‘unless otherwise approved a person who buries a body contained in a coffin must place that coffin so that its upper surface is not less than 900 millimetres below the natural surface level of soil where it is buried.’

A person who wishes to bury the body of a deceased person in a shallow grave must seek the approval from the Director-General, or delegate. The Director-General’s authority under Clause 64 *Public Health Regulation 2012* has been delegated (PH306 page 8.60) including to a Local Health District’s Public Health Unit Director or Public Health Officer.

2. CIRCUMSTANCES THAT MAY LEAD TO A SHALLOW BURIAL

Circumstances leading to a shallow burial may include:

- A reduction in overall depth of burial due to a geographical feature of the land.
- A second or third burial: when a grave is opened for a second or third burial the excavation shall be made so as to leave a layer of undisturbed earth at a level to be determined at the time.
- The land has been filled and a reduction in burial depth is needed to allow burial in the fill: the fill material needs to be suitable for the operation of a cemetery in that a grave could be prepared without it collapsing. The soil and its use as fill should not permit decomposition leachate to percolate to the surface of slopes or enter any streams or intermittent water courses.

3. DESIGN REQUIREMENTS

The design, structure and materials used for a shallow burial need to avoid subsidence when the coffin deteriorates, prevent feral animals entering the grave, or prevent the escape of decomposition odours.

A grave liner must be constructed when the depth of burial is reduced from the mandatory 900mm. The materials used for this purpose should be impervious. A typical example of materials and method of a shallow burial grave lining construction are compressed cement sheeting liners, which is outlined in Attachment 1 together with other alternatives.

The body of the deceased person must be contained in a coffin or casket.

The distance from the top of the lid of the grave liner to the natural ground surface shall not be less than 400mm, and should be as deep as possible.

4. APPROVAL PROCESS

Approval by the appropriate authority for a shallow burial under the *Public Health Regulation 2012* may be given by an exchange of facsimile, email or formal mail. The appropriate authority in this instance is the Public Health Unit in the area in which the body of the deceased will be buried.

Contact details for Public Health Units are provided on the NSW Health website at: http://www.health.nsw.gov.au/Infectious/Pages/phus.aspx

The applicant should provide the information requested in the application form and plan and methodology of the interment.

Additionally, within fourteen days of the interment, the Council or Cemetery Authority, is to record satisfactory compliance with the requirement, and shall forward notification to the Public Health Unit. A plan shall also be kept by the Council or the Cemetery Authority as appropriate to record all shallow burials.
5. LIST OF ATTACHMENTS

The following documents are attached:

**Attachment 1** Typical use of compressed cement sheeting liners for shallow burial.
**Attachment 2** Application form Shallow Burial Clause 64 *Public Health Regulation 2012*.
**Attachment 3** Example briefing note to request approval of the Shallow Burial of a body.
**Attachment 4** Example letter to applicant.
**Attachment 5** Example letter to Cemetery Authority.
**Attachment 6** Example of letter to record satisfactory compliance with the requirements which may be used by the Cemetery Authority.
**Attachment 7** Diagram 1 – Example – Grave liner for a shallow burial.
**Attachment 8** Diagram 2 – Example – Grave liner for a shallow burial.
Attachment 1 - Typical use of compressed cement sheeting liners for shallow burial

Compressed cement sheeting liners are the most commonly used method for shallow burial, see Attachment 7- Diagram 1 and Attachment 8- Diagram 2. The material required is described as 18mm compressed cement sheeting with two smooth faces and precision trimmed edges. Joining shall be with 8mm diameter cadmium plated, brass or galvanised bolts of suitable length. A total of eight bolts (two per cleat) are required.

The calculation of the dimensions of the two (2) sides, two (2) ends, one (1) lid and four (4) cleats shall be as follows:

- **Sides:**
  - the length of the coffin plus 300mm
  - the height of the coffin plus 75mm
- **Ends:**
  - the width of the coffin plus 100mm
  - the height of the coffin plus 75mm
- **Lid:**
  - the length of the coffin plus 300mm
  - the width of the coffin plus 172mm plus sufficient to allow for an overhang to assist in final placing
  - the lid may be in two sections
- **Cleats:**
  - the height of the coffin plus 75mm, and
  - 50mm wide

A cleat shall be attached at the end of each side section. Each cleat shall be set 18mm in from the outer edge. A masonry drill shall be used to form all bolt holes and the bolt holes shall not be less than 6mm from edge of the sheet.

Alternatively, angle brackets may be used top and bottom to secure the sides and ends together to prevent shifting or collapse of the liner during backfilling. The angle brackets must be secured with bolts in a similar manner as the cleats.

**Procedure of placement**

The side of the liner (with cleats attached) shall be installed and levelled. The ends shall be positioned so that they butt against the cleats and separate the sides and the structure shall be square.

The voids between the grave sides and grave liner shall be backfilled with compacted earth to the level of the liner wall prior to the placement of the coffin.

After the placement of the coffin, the voids within the liner shall be similarly filled prior to the fitting of the lid.

**Encasing the Coffin in Concrete**

This process would entail lowering the coffin in to the required depth and then pouring concrete around and over it. The covering layer should be no less than 50mm.

**Encasing the Coffin in a mix of road-base and cement**

This process would entail lowering the coffin to the required level and then compacting the mix around and over it. The mix is hosed with water causing it to harden. The covering layer of road base/cement mix should be no less than 75mm. It has been observed that a very durable and almost impenetrable protective layer is formed. This is a low cost method relative to other methods outlined.
APPLICATION FOR SHALLOW BURIAL
Clause 64 Public Health Regulation 2012

Name of applicant of applicant: ....................................................................................................................
Contact number: (H) .....................................(W) ..................................(M) ........................................
Relationship to deceased: .................................................................................................................................
Name of deceased: ...........................................................................................................................................
Deceased’s date of death: ……/ ……/……
Reason for shallow burial: .................................................................................................................................
Material of covering shallow burial: (tick one which is appropriate)
☐ Compressed Cement Sheeting
☐ Concrete
☐ Other, specify ..................................................................................................................................................
Plans and methodology are attached: ☐ Yes ☐ No
Proposed date of interment: ……/……/……
Name and address of the cemetery where burial will take place: ....................................................................
Name of contact person of the cemetery: .........................................................................................................
Contact number: ..............................................................................................................................................

Signature of applicant............................................. Date …../…../…..
Attachment 3 - Example briefing note to request approval of the shallow burial of a body

(LOGO)

Public Health Unit
Environmental Health Section

File Number: XXXXX

PURPOSE: To approve the shallow burial of a body

RECOMMENDATION: That approval be granted by the Director-General pursuant to Clause 64 Public Health Regulation 2012 to [NAME OF APPLICANT] to conduct a shallow burial of the body of [NAME OF DECEASED] subject to the condition that the burial shall comply with “Shallow Burial” policy and requirements of the approved plan and methodology.

KEY ISSUES: [TO BE COMPLETED BY PHU]

BACKGROUND [TO BE COMPLETED BY PHU]

CONSULTATION [TO BE COMPLETED BY PHU WHERE APPROPRIATE]

Signature: [SIGN]

Author: [SIGN]  Telephone:  Date:
Authorised Officer

1 Public Health Unit Director

Approved vide delegation from the Director-General (PH306 page 8.60) Public Health Delegations Manual under Clause 64 Public Health Regulation 2012. [SIGN]

2 Author
Attachment 4 - Example letter to applicant

(LOGO)

LETTER TO APPLICANT

(LETTERHEAD)

[Applicant’s name]
[Applicant’s address]

Dear [applicant’s name]

Reference is made to your application of [DATE] in regard to the shallow burial of the body of [NAME OF DECEASED] in [NAME OF CEMETERY OR PLACE OF INTERMENT].

Approval has been granted by an authorised delegate of the Director-General pursuant to Clause 64 Public Health Regulation 2012 to reduce the depth of grave to not less than 400mm between the top of the lid of the grave liner and the natural ground level.

The approval is subject to compliance with the matters set out in the “Shallow Burial” NSW Health Policy Directive, requirements of the Public Health Regulation 2012 and to the conditions of the approved plans and methodology.

Should you have any inquiries please contact the [EHO] on [TELEPHONE] or email at (email address).

Yours sincerely,


[NAME]
Public Health Unit Director

[Date]
LETTER TO LOCAL CEMETERY AUTHORITY

(LETTERHEAD)

[Name]
[Address]

Dear [Name]

RE: SHALLOW BURIAL OF THE LATE [NAME OF DECEASED]
IN THE [NAME OF CEMETERY]

Approval has been granted to [Name of applicant] to conduct a shallow burial in accordance to Clause 64 Public Health Regulation 2012.

A copy of the approval letter and Policy Directive is attached for your information.

Please note this matter in your records and ensure that the interment complies with the relevant requirements.

Advice would be appreciated when the shallow burial has been completed by using the attached form.

Should you have any inquiries please contact [authorised officer] on [TELEPHONE] or email at (address).

Yours sincerely,

[NAME]
Public Health Unit Director

Enclosed (Attach form Appendix 6)

[Date]
Attachment 6 - Example of letter to record satisfactory compliance with the requirements which may be used by the Cemetery Authority.

LETTER FROM CEMETERY TO PUBLIC HEALTH UNIT

[CEMETERY LETTERHEAD]

[Director Name]
[Name of Public Health Unit]
[Address]

[Date]

Dear [Director Name]


In accordance with Clause 64 Public Health Regulation 2012 I wish to advise that the above interment was conducted in compliance with the matters set out in accordance with the NSW Health Policy Directive “Shallow Burial” and the requirements of the Regulation.

Method of covering Shallow Burial (tick one which is appropriate):

- [ ] Compressed Cement Sheeting
- [ ] Concrete
- [ ] Other, specify ……………………………………………………………………………………………………………………………
  …………………………………………………………………………………………………………………………………………………
  …………………………………………………………………………………………………………………………………………………

Date of interment: ……/…../…….

Yours sincerely,

[Signature of manager]
[Name of manager]
Example - Grave Liner for a Shallow Burial (Diagram 1)
Attachment 8 - Diagram 2 – Example – Grave liner for a shallow burial
BURIALS - EXEMPTIONS FROM PUBLIC HEALTH REGULATION 2012 FOR COMMUNITY AND RELIGIOUS REASONS (PD2013_048)

PD2013_048 rescinds PD2007_004.

PURPOSE

This document provides the policy direction to be observed by NSW Ministry of Health and Local Health District Public Health Units in receipt of an application to seek permission for exemption from clause 63 Public Health Regulation 2012 and enables approval for either generally or for a particular case.

Clause 63 of the Public Health Regulation 2012 provides that unless otherwise approved by the Director-General of Health the body of a deceased person must not be buried or cremated unless their body had been placed in a coffin and the lid of the coffin securely sealed.

In some communities or religious groups, religious beliefs are such that the body of a deceased person needs to be wrapped in a shroud and placed in direct contact with the earth without the use of a coffin.

In a general case the request is to be made on behalf of the community or religious group by the recognised leader and in a particular case approval needs to be obtained by an appropriately close relative, funeral director or cemetery authority.

MANDATORY REQUIREMENTS

- A person who wishes to bury the body of a deceased person without a coffin or casket in a general case or in a particular case must seek the approval of the Chief Health Officer or delegates including the Director Health Protection or the Public Health Unit Director or Public Health Officer of the Public Health Unit of the Local Health District.
- Applicants must submit an application on the prescribed template (Attachment 1) and clearly identify if they are applying for exemption in a general or a particular case; the relationship to the deceased or position in the community; reason for the exemption; whether an agreement has been negotiated and the name of the cemetery and cemetery manager where the body is to be buried.
- Wrapping of the body must be in at least four layers of cotton/linen sheeting which is able to prevent the leakage of any body exudates or substances.
- The body must be contained in a coffin until the body is placed into a grave.
- The body of a deceased person who is known or is reasonably believed to be infected with a prescribed infectious disease must be buried in a coffin for public health reasons.
- The body must be prepared in a mortuary registered with the NSW Ministry of Health.

IMPLEMENTATION

This Policy Directive must be implemented in all NSW cemeteries.

Authorised Officers are responsible for the assessment and approval of all requests for exemptions under clause 63 of the Public Health Regulation 2012, in all particular cases. The Chief Health Officer, Director Health Protection or Public Health Unit Director or Public Health Officer is responsible for approval of the request.
1. **BACKGROUND**

1.1 **About this document**

This document provides the policy direction to be observed by the NSW Ministry of Health or the Public Health Unit at the Local Health District upon receipt of an application to seek permission for exemption from clause 63 of the *Public Health Regulation 2012*.

In some communities or religious groups, religious beliefs and traditions are such that the body of a deceased person needs to be wrapped in a shroud (cotton/linen sheeting) and placed in direct contact with the earth without the use of a coffin.

This document provides information on the approval process, conditions of consent for the approval and provides templates for approval, internal briefs and letter of response to the applicant.

### Key definitions

<table>
<thead>
<tr>
<th><strong>Authorised Office</strong></th>
<th>Means a person who is appointed under Section 126 of the <em>Public Health Act 2010</em>.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body</strong></td>
<td>Means the body of a dead person but does not include the cremated remains of the person, (Clause 49 of the <em>Public Health Regulation 2012</em>).</td>
</tr>
<tr>
<td><strong>Cemetery Authority</strong></td>
<td>Means the person or body that directs the operation of a cemetery, (Clause 49 of the <em>Public Health Regulation 2012</em>).</td>
</tr>
<tr>
<td><strong>Approval in a General Case</strong></td>
<td>Means exemption from the requirement to bury a body in a coffin across multiple cemeteries, a particular cemetery or a section in a cemetery.</td>
</tr>
<tr>
<td><strong>Approval in a Particular Case</strong></td>
<td>Means exemption from the requirement to bury a body in a coffin for an individual burial.</td>
</tr>
</tbody>
</table>

1.3 **Legal and legislative framework**

Clause 63 of the *Public Health Regulation 2012* provides that unless otherwise approved by the Director-General of NSW Ministry of Health the body of a deceased person must not be buried or cremated unless their body had been placed in a coffin and the lid of the coffin securely sealed.

A person who wishes to bury a person without a coffin must seek the approval of the Director-General, or delegate. The Director-General’s authority under clause 63 of the *Public Health Regulation 2012* has been delegated (PH305 page 8.59) at the Local Health District to the Public Health Unit Director or Public Health Officer.

2. **APPROVAL BY AUTHORITY**

An approval by the Director-General or delegate for burial where the body of a deceased is to be wrapped in a shroud and not placed in a coffin or casket can be obtained generally or in a particular instance. Applicants should identify on the application form if they are applying for approval for a particular case or are seeking a general approval.

2.1 **General Applications**

In a general case the request is to be made on behalf of the community or religious group by the recognised leader. The community leader shall submit a detailed document clearly identifying the process or mechanism to protect the community from any public health risk while still achieving their objective.
An application for exemption from the requirement to bury a body in a coffin in a general case may include reference to multiple cemeteries, a particular cemetery or a section in a cemetery.

Approval in a general case can be given under delegation by the Chief Health Officer, Director of Health Protection or a Public Health Officer as appointed under section 121 of the Public Health Act 2010.

All general applications need to be forwarded to the appropriate Public Health Unit where the nominated cemetery authority is located. Where an application is received in a general case which covers multiple cemetery authorities across Local Health District boundaries the application can be processed by the Public Health Unit who have received the application or forwarded to the Environmental Health Branch for further assessment.

2.2 Individual Applications

An application for exemption from the requirement to bury a body in a coffin in a particular case would include reference to an individual burial. In a particular instance an approval needs to be obtained for an individual burial by an appropriate person legally able to represent the family.

Following approval the applicant should advise the funeral director and/or the cemetery authority in order that appropriate conditions of approval can be put into place.

3. CONDITIONS OF APPROVAL

Generally the following conditions would be attached to an approval granting an exemption under Clauses 63 of the Public Health Regulation 2012:

I. The Cemetery Authority has agreed to carry out the burial of a body that has not been placed in a coffin, in particular the handling of bodies on cemetery grounds.

II. Wrapping of the body of a deceased must be in at least four layers of cotton/linen sheeting which is able to prevent the leakage of any body exudates or substances.

III. The body is to be contained in a coffin until the body is placed into a grave.

IV. A non-reusable coffin is to be dismantled and placed within the grave prior to commencement of backfilling. If a re-usable coffin is used, at the completion of the burial the re-usable coffin is to be steam cleaned and disinfected.

V. The name plate is to be removed from the coffin and placed near the body in the grave.

VI. The body of a deceased person who is known or is reasonably believed not to be infected with a prescribed infectious disease. They shall otherwise be buried in a body bag and coffin.

VII. The body has been prepared in a mortuary notified to the NSW Ministry of Health.

4. FORMAL APPROVAL

Formal approval by the appropriate authority for an exemption from clause 63 of the Public Health Regulation 2012 must be given using the attached template instrument of approval and this must be communicated to the applicant using the attached letter. For further information contact the local Public Health Unit (see www.health.nsw.gov.au for a list of Public Health Units).

5. LIST OF ATTACHMENTS

The following templates are attached:

Attachment 1 – Application form which may be used by the person, community or religious group and cemetery authority seeking approval.

Attachment 2 – Approval brief.

Attachment 3 – Conditions of approval schedule.

Attachment 4 – Reply letter which may be used by the Public Health Unit.
APPLICATION FOR:
Burial of a body which is not been placed in a coffin - exemption from
Clause 63 Public Health Regulation 2012

Name of applicant: ....................................................................................................................................
Address of applicant: ..................................................................................................................................
..................................................................................................................................................................
Contact number: (H) ....................................... .....(W)..............................(M)
....................................................................... ...............
Is this request for a particular case or a general exemption...................... ☐ Yes  ☐ No
Relationship to deceased in a particular case: .................................................................
Relationship to the community in a general case..............................................................................
Name of deceased (In particular instance): ..........................................................................................
Reason for exemption: ..............................................................................................................................
..................................................................................................................................................................
Have you negotiated and reached agreement with the cemetery authority which has agreed to carry out
the burial in a particular case.............................................................................................................. ☐ Yes  ☐ No ....
Have you negotiated and reached agreement with the cemetery authority for a general
exemption..................................................................................................................................................... ☐ Yes  ☐ No
If yes, provide a copy of the agreement reached with the cemetery authority

Name of Cemetery Authority: ....................................................................................................................
Name of Manager: ......................................................................................................................................
Address of Cemetery Authority: ................................................................................................................
..................................................................................................................................................................
Contact Number: ........................................................................................................................................
Applicants Signature:..................................................................................................................................
Date ....../....../....

196(12/12/13)
Attachment 2 - Approval Brief Template

(LETTERHEAD)

Public Health Unit
Environmental Health Section

File Number: XXXXX

PURPOSE: To approve the exemption from Clause 63 Public Health Regulation 2012

RECOMMENDATION: Approval is granted by the Director-General pursuant to clause 63 Public Health Regulation 2012 to [NAME OF APPLICANT] to allow exemptions from this section of the Regulation in the specific instance of the burial of [NAME OF DECEASED] or in a general case in accordance with applicant’s custom and injunction. It is permitted that the removal of a body in at least four layers of cotton/linen sheeting and subsequent burial of a body that has not been placed in a coffin.

KEY ISSUES: [TO BE COMPLETED BY PHU]

BACKGROUND: [TO BE COMPLETED BY PHU]

CONSULTATION: [TO BE COMPLETED BY PHU WHERE APPROPRIATE]

The approval is subject to compliance with the conditions set out in the attached Schedule 1.

Signature: [SIGN]

Author: Telephone: Date:

3 Public Health Unit Director or Public Health Officer (SIGN)

Approved vide delegation from the Director-General PH305 page 8.59 Public Health Delegations Manual under clause 63 Public Health Regulation 2012.

4 Author
Attachment 3 - Conditions of approval Schedule

I. The Cemetery Authority has agreed to carry out the burial of a body that has not been placed in a coffin, in particular the handling of bodies on cemetery grounds.

II. Wrapping of the body of a deceased must be in at least four layers of cotton/linen sheeting which is able to prevent the leakage of any body exudates or substances.

III. The body is to be contained in a coffin until the body is placed into a grave.

IV. The coffin is to be dismantled and placed within the grave prior to commencement of backfilling. If a re-usable coffin is used, at the completion of the burial the re-usable coffin is to be steam cleaned and disinfected.

V. The name plate is to be removed from the coffin and placed near the body in the grave.

VI. The body of a deceased person who is known or is reasonably believed not to be infected with a prescribed infectious disease. They shall otherwise be buried in a body bag and coffin.

VII. The body has been prepared in a mortuary registered by NSW Ministry of Health.
Attachment 4 - Reply letter template for Public Health Units

(LETTERHEAD)

LETTER TO APPLICANT

[APPLICANT'S NAME]
[ADDRESS]

Dear [APPLICANT’S NAME]

Reference is made to your application of [DATE] in regard to the approval for an exemption from Clause 63 Public Health Regulation 2012.

Approval has been granted by the Director-General pursuant to Clause 63 of the Public Health Regulation 2012 to [NAME OF APPLICANT] to allow exemptions to the regulation in a particular case regarding burial of [NAME OF DECEASED] or in a general case to (CEMETERY WHERE THIS IS TO OCCUR).

The approval is subject to compliance with the following conditions:

a. The Cemetery Authority has agreed to carry out the burial, particularly the handling of bodies on cemetery grounds.

b. Wrapping of the body of the deceased must be at least four layers of cotton/linen sheeting which is able to prevent the leakage of any body exudates or substance.

c. The body is to be contained in a coffin until the body is placed into a grave.

d. The coffin is to be dismantled and placed within the grave prior to commencement of backfilling. If a re-usable coffin is used for this purpose, the re-usable coffin is to be steam cleaned and disinfected at the completion of burial.

e. The name plate is to be removed from the coffin and placed near the body in the grave.

f. The body of a deceased person who is known or is reasonably believed not to be infected with a prescribed infectious disease. They shall otherwise be buried in a body bag and coffin

g. The body has been prepared in a mortuary registered by the NSW Ministry of Health.

Should you have any inquiries please contact the authorised officer on [TELEPHONE] or email.

Yours sincerely,

Public Health Unit Director/Officer

Approval date....................

196(12/12/13)
BODY PARTS BURIAL/CREMATION

At present ex-gratia payments are made, at the discretion of the Minister, to families seeking assistance in burial or cremation of body parts of loved ones that were retained during post-mortem examinations. Costs per case are usually below $500, with the majority less than $200. The number of requests has been small, with less than ten such requests being processed by the Department of Health to date.

In his report to the Inquiry into Matters Arising from the Post-mortem and Anatomical Examination practices of the Institute of Forensic Medicine, Bret Walker SC recommended that organs retained at post-mortem should, where requested, be returned to the family and disposed of at State expense. The principle on which this recommendation is made, that families should not incur additional expenses in funeral costs due to retention of body parts following post-mortem examination, applies equally to coronial and non-coronial post-mortem examinations.

As of 1 January 2002, area health services should have a policy in place to meet additional funeral costs associated with burial or cremation of body parts retained at both coronial and non-coronial post-mortem examination, where the family requests this. These payments should be reasonable, equitable and accessible to families in need, and apply in a prospective manner to post-mortems carried out from 1 January 2002. The Department of Health will continue to be the point of contact for requests for assistance relating to costs associated with post-mortems carried out prior to 1 January 2002. Any additional funeral costs to re-unite body parts retained from post-mortem examination with the other remains of the deceased should be discussed with the next-of-kin prior to obtaining their consent for a non-coronial post-mortem examination, and families should be made aware that assistance with these costs is available. Payment of costs associated with burial or cremation of body parts retained at coronial post-mortem examination for purposes associated only with the coronial investigation should be discussed with the coroner.

DISPOSAL OF BODIES

Cremation of human remains may only be lawfully carried out in a crematorium, of which notice of opening has been given to the Minister for Health. Crematoria have been established at the following centres within New South Wales:

Metropolitan
- Eastern Suburbs (Botany)
- Eastern Creek (Blacktown)
- Castlebrook Memorial Gardens and Crematorium
- Leppington (near Camden)
- Northern Suburbs (Lane Cove)
- Rookwood
- Rouse Hill (Blacktown)
- Woronora (near Sutherland)

Country
- Albury
- Kanahooka (near Wollongong)
- Lismore
- Newcastle
- Orange
- Palmdale Memorial Park, Ourimbah
- Tamworth
- Tweed Heads South
- Unanderra (near Wollongong)
Hospitals must not undertake the cremation or burial of the remains of any deceased persons. (This includes not only persons who have lived, but also a still-born child, which is now defined as any child of twenty weeks or more gestation or at least 400 grammes weight, at delivery, that has not breathed after delivery.) It is only where the parents or relatives of the deceased are unable, by reason of their financial circumstances, to arrange for the appropriate disposal of the remains of a deceased person or still-born child, that hospitals should undertake arrangements for burial, (see section 19.7.6 in the case of still-born children or neonatal deaths, the Maternity Allowance should be available and should cover the full cost of burial of a still-born child).
CREMATION OF MORE THAN ONE BODY SIMULTANEOUSLY (GL2013_014)

GL2013_014 rescinds GL2006_018.

PURPOSE

This document is a guide to Public Health Unit authorised officers in receipt of an application for exemption under Clause 75 (1) of the Public Health Regulation 2012 to cremate more than one body simultaneously.

KEY PRINCIPLES

Generally the cremation retort (furnace) is not large enough to accommodate two adult size coffins at the same time, and requests to cremate two adult size coffins at the same time are uncommon.

However, this Guideline allows for an exemption to be given under special circumstances where a family requests that more than one body be cremated together. Examples of the special circumstances could be where two sibling children died under the same circumstances or a mother and baby whom died during childbirth.

Under these circumstances the person who applies to cremate two bodies simultaneously in the same cremator retort must have the approval from the Director-General or delegate.

USE OF THE GUIDELINE

This Guideline provides protocols to Public Health Units for approving the simultaneous cremation of more than one body at a time.

The approval process to be followed includes:
- An Application for Cremation of More than One Body Simultaneously (Appendix 1) by the same person who made and signed the application for cremation.
- Requires the applicant to provide information on their relationship to the deceased; the relationship between the deceased persons and the reasons for the bodies to be cremated together.

The guideline also contains a draft internal approval instrument to be completed by the Public Health Unit (Appendix 2) and a draft letter of approval to the applicant (Appendix 3).

Public Health Units should retain a copy of the approval on an internal file.

19. PATHOLOGY

19.102

CANVASSING BY REPRESENTATIVES OF FUNERAL DIRECTORS AT PUBLIC HOSPITALS (1.7.5.4)

The Department’s attention has been drawn to the activities of certain Funeral Directors’ representatives who were alleged to be canvassing for funeral business at public hospitals.

The Department expects hospital authorities to exercise whatever control is reasonable and practicable in the particular circumstances. The aim should be to prevent activities on hospital premises which would harass or inconvenience deceased patients’ relatives or friends or would give the appearance of any particular funeral director receiving favoured treatment by the hospital, or by any member of its staff.

CORONER’S CASES AND THE CORONERS ACT 2009 (PD2010_054)

PD2010_054 rescinds PD2009_083.

PURPOSE

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.

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 regarding this Policy Directive;
- documented procedures are in place supporting 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).
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.


2. DEFINITIONS

The *Coroners Act 2009* 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 a 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 non of (a), (b) or (c) are available, the deceased 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 terms 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

A medical practitioner must not issue a certificate as to the cause of the death under the *Births, Deaths 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 s23 _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 correction 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 s24 _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
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.

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 (s38(3) of the Act).

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

What is a health-related procedure?

For the purposes of this section, the Coroners 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.

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).

1. NSW DEPARTMENT OF HEALTH REQUIREMENT TO REPORT OTHER KINDS OF DEATHS

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 (SCIDUAA) 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

The completed Notification Forms are to be mailed to:

**Director-General**
C/o Special Committee Investigating Deaths Under Anaesthesia
Clinical Excellence Commission
Locked Bag A4062
SYDNEY SOUTH NSW 1235

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”.

**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.

2. **GUIDELINES FOR MEDICAL, NURSING AND MIDWIFERY STAFF ON CORONERS’ CASES DYING IN HOSPITAL**

**General considerations**

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

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.

Lims 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.

**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.

**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

102(02/09/10)
19. PATHOLOGY

- Tuberculosis
- Any viral haemorrhagic fever (including Lassa, Marburg, Ebola and Congo-Crimean fevers)

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.

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.

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.

3. CORONIAL POST MORTEMS

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.

Dignity of deceased person to be respected

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

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.

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.
19. PATHOLOGY

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.

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.

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.

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.

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.coroners.justice.nsw.gov.au/.

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.
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

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.

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.


CORONIAL CHECKLIST (IB2010_058)

PURPOSE

To advise the NSW Health system of a checklist that has been drawn up for use in determining whether a death should be reported to the coroner.

KEY INFORMATION

The NSW Health Department has recently issued Policy Directive PD2010_054 Coroners Cases and the Coroners Act 2009. A Coronial Checklist has been developed for optional use as an aid in determining whether a death should be reported to the coroner. All forms (those annexed to the Policy Directive PD2010_054 and the Coronial Checklist) can be obtained from SALMAT either by Electronic Print On Demand (ePOD) or by purchase order from Health Support Services, Better Health Centre.


TESTING FOR FATAL ANAPHYLAXIS

Test highly reliable if:

Patient survives longer than 30-60 minutes. (But dies within 6 hours of administration.)

1. Blood taken up to three days after death.

Serum required – 5mls

Prefer the blood separated (as best it can be with post mortem blood).

Frozen? (Not mandatory) but if frozen can do, IgE antibodies.

To advise delivery to Royal North Shore Hospital:

Contact Professor Fisher, North Shore Hospital, ph. 9926-8656.

Prefer delivery to: Professor Fisher
Head of Intensive Therapy
6th Level, Royal North Shore Hospital
Pacific Highway
St Leonards

113(02/12/10)
19. PATHOLOGY

Package to be marked all over: “CONTACT PROF FISHER URGENT, EXTENSION 8656”.

History to accompany blood, e.g. P79A, form “A” and/or “B” if applicable. If unsure as to history required refer Professor Fisher or Coronial Investigation Unit.

COST

In metro area: Nil initial cost. (Once blood sample is at the morgue arrangements will be made for transport to North Shore Hospital.) (Refer Professor John Hilton, Director, Glebe.)

Country and semi country areas: Blood travels with other samples through normal channels and then as per no 1.

The testing itself is done under a state government grant therefore no actual cost incurred to perform test.

Whilst this testing will assist coroners in these types of matters it will also be assisting with further research into this medical phenomenon.

RETENTION OF BODIES – APPROVAL TO RETAIN BODIES FOR LONGER THAN PERMITTED (GL2013_015)

GL2013_015 rescinds GL2006_006.

PURPOSE

This document is intended as a guide to Public Health Unit authorised officers in receipt of an application to retain bodies longer than permitted under Clause 54 of the Public Health Regulation 2012. The Guideline also provides information to funeral directors about the retention of bodies in their premises.

KEY PRINCIPLES

A person who is not a funeral director is able to seek approval to retain a body for longer than the permitted time under the Public Health Regulation 2012, namely 5 days, by applying to the local Public Health Unit for an exemption. A person who is not a funeral director includes the operators of hospitals, private health care facilities and aged care facilities.

The approval process ensures that there is no public health risk associated with the retention of bodies beyond the prescribed 5 day period.

The Guideline does not apply to a body that is stored at premises licensed under the Anatomy Act 1977 or the subject of an inquest under the Coroners Act 2009.

USE OF THE GUIDELINE

The Guideline outlines the protocols for an applicant, who is not a funeral director to apply to retain a body longer than 5 days.

An application to retain a body (Attachment 1) is required to be completed by the nearest surviving relative of the deceased (or by a person who is acting on behalf of the deceased family) and the information required to support the application is:
19. PATHOLOGY

- Reasons for retaining the body longer than the 5 day period.
- The condition of the body.
- Whether the body has been embalmed.
- A description of the premises where the body will be kept.
- The body storage facilities under which the body will be kept.
- Proposed date of interment.
- Transportation – under what conditions the body will be transported.

The Guideline also contains a draft approval instrument to be completed by the Public Health Unit (Attachment 2) and a draft letter of reply to the applicant (Attachment 3) whereby the Public Health Unit is either able to approve or reject the application. The Public Health Unit if approving the exemption is to include conditions on which the approval is granted and should the application be rejected the reasons for the rejection.

Public Health Units should retain a copy of the approval on an internal file.

The Guideline provides information on Clause 55 of the Public Health Regulation 2012 which provides that a funeral director must retain a body in a (a) refrigerated body storage facility and (b) in a mortuary or a holding room. Clause 55 (2) provides the circumstances under which a funeral director may remove a body from a refrigerated body storage facility and to another part of the mortuary for a maximum of 8 hours per day for the purposes of preparing the body for cremation or burial, embalming the body, viewing of the body by mourners or for the purpose of transporting the body to another mortuary or for burial, interment or cremation.

19. PATHOLOGY

ACCREDITATION OF NSW HEALTH PATHOLOGY LABORATORIES (PD2006_064)

The Commonwealth requires that for a pathology service to attract Medicare benefits the pathology laboratory is to be accredited for the kinds of services that are being provided. The standards used to assess accreditation for pathology laboratories are Standards for Pathology Laboratories developed by the National Pathology Accreditation Advisory Council (“NPAAC”). These set out the minimum standards acceptable for good pathology practice in Australia. It should be noted that these Standards also require the laboratory to be certified to ISO 15189:2003 and AS4633-2004. The Commonwealth has chosen the National Association of Testing Authorities (NATA) to act on its behalf to undertake the accreditation and certification of laboratories. For full information of the Commonwealth’s requirements for obtaining accreditation refer to the Medical Benefits Schedule Category 6 - Pathology Services which can be obtained from http://www.medicareaustralia.gov.au/public/claims/what-cover.jsp

NSW Area Health Services are to ensure that the accreditation of pathology laboratories is maintained. By maintaining accreditation it is expected that laboratories will meet uniform standards of practice, competently perform tests/examinations, and produce accurate and reliable results for the tests for which they are accredited.

CODE OF PRACTICE AND PERFORMANCE STANDARDS FOR FORENSIC PATHOLOGY IN NEW SOUTH WALES (PD2012_049)

PURPOSE

The purpose of this Policy Directive is to support all health practitioners requested to perform post-mortem examinations on behalf of the Coroners in NSW within the NSW Health System. It refers to the management of activities of medical practitioners (or other practitioners) under the Coroner’s Act 2009 – specifically where medical practitioners are deemed to be an appropriate medical investigator and given a post-mortem investigation direction for examination of the remains.

MANDATORY REQUIREMENTS

In relation to Coronial Matters:

1. Generally, only appointed Coronial Medical Officers and specialist Forensic Pathologists (or their supervised trainees) should perform post-mortem procedures (including ordering radiology or taking specimens for testing) associated with the Coroners Act 2009 unless this is first discussed with a specialist forensic pathology unit (Glebe or Newcastle).

2. All autopsies, investigations, reports and any other aspects relating to death investigations are to be conducted in accordance with the requirements of the Expert Witness Code of Conduct in Schedule 7 of the NSW Uniform Civil Procedure Rules 2005.

3. Complex cases must be discussed with a Specialist Forensic Pathologist and will usually be referred to the appropriate Department of Forensic Medicine. Such cases include:
   • All homicides and suspicious deaths.
   • Deaths requiring attendance by police at the autopsy.
   • High profile deaths or deaths which are a matter of public interest.
   • Cases with identification issues.
   • Skeletal remains.
   • Accidents involving aviation, marine transport, trains and buses.
   • Multiple-death incidents and mass fatalities.

162(06/09/12)
• Any case requiring disaster victim identification procedures.
• Workplace-related deaths.
• Diving and scuba-related deaths.
• Sudden unexpected infant deaths (see PD2008_070) and deaths of children under the age of 15 years.
• Maternal deaths.
• Infectious deaths requiring specific protocols (e.g., HIV, active tuberculosis, Creutzfeldt-Jakob disease).
• Deaths where the person died in circumstances where the person’s death was not the reasonably expected outcome of a health procedure carried out in relation to that person.
• Deaths of foreign nationals or tourists.
• All deaths in custody, or police action-related deaths.
• Any death outside the practitioner’s normal scope of practice.

Education and training
Any staff directed to perform actions under the Coroners Act 2009 should carefully consider the level of their competency and their ability to provide an appropriate post-mortem report (including interpretation of tests performed post-mortem rather than ante-mortem) according to the Expert Witness Code of Conduct in Schedule 7 of the NSW Uniform Civil Procedure Rules 2005.

Practitioners requested to perform duties outside their competency are advised to inform the Coroner of this as undertaking such duties may breach other ethical requirements of their work.

IMPLEMENTATION
Chief Executives must ensure:
• Local protocols are developed based on the Code of Practice and Performance Standards for Forensic Pathology in New South Wales.
• Local protocols are in place in all hospitals and facilities likely to be required to assist in the management of Coroners’ cases.
• Ensure that all staff who may be appointed as appropriate medical investigators by local Coroners are aware of this code of practice and the performance standards.
• Medical Officers are appropriately credentialled to perform the various types of autopsies listed in the document.

POINT OF CARE TESTING (PoCT) POLICY (PD2015_028)

PD2015_028 rescinds PD2014_003.

PURPOSE

For the purpose of the Policy, *A Point of Care Testing (PoCT) Service* is defined as “A Quality Assured Pathology Service Using Devices Located near the Patient”.

More rapid access to test results provided by use of PoCT devices can increase clinical effectiveness and contribute to improved patient outcomes, but the result provided by the device must be accurate, reliable and relevant.

This Policy Directive provides guidance for safe, effective management and use of PoCT, using devices that are fit for their intended purpose and used by competent individuals on the correct patient, giving results which must become part of the patient record.

The major risks to patient safety of the PoCT service are:
- Inappropriate utilisation.
- Failure to maintain devices appropriately.
- Failure to monitor device performance through quality assurance programs.
- Misinterpretation of results.
- Uncertainty on how to act on results.

The expected outcomes for this policy are:
- To ensure that where point-of-care pathology testing (PoCT) is deployed in NSW Health facilities, it is accurate, effective and clinically reliable in supporting safe and optimal care for patients.
- To provide clear standards for the introduction and management of PoCT that maximise patient care and patient safety.
- To minimise any associated medico-legal and financial risks, by supporting all operators (but in particular those without a laboratory background) in implementing PoCT appropriately.
- To ensure that patients do not suffer any avoidable harm or loss.
- To ensure that staff do not suffer any avoidable harm or loss.
- To ensure that staff using PoCT are competent and use safe work practices and that equipment including in vitro diagnostic devices, facilities and environmental conditions are safe.
- To ensure compliance with International Standards ISO 15189 and ISO 22870 and any other relevant regulatory requirements so that supervising laboratories achieve and maintain National Association of Testing Authorities, Australia (NATA) accreditation for PoCT.
- To ensure principles of quality management and continuous improvement for PoCT are applied.

MANDATORY REQUIREMENTS

Mandatory requirements for this policy are described in Policy for Managed Point of Care Testing (PoCT) Service: Procedures (Attachment 1).

The mandatory requirements are described according to the following sections:
- General requirements.
- Service introduction.
- Accreditation.
- Patient results.
19. PATHOLOGY

- Networking.
- Supporting documentation.
- Safety.
- Quality Control and External Quality Assurance.
- Device maintenance.
- Training and Competency Assessment
- Incident Reporting.

IMPLEMENTATION

Effective clinical governance is an essential component of PoCT. To achieve this, this Policy describes a co-operative framework involving both NSW Health Pathology Services and Networks and local healthcare facility staff. This governance is overseen on a state-wide basis by a multidisciplinary PoCT Management Committee. The day-to-day operational oversight for PoCT services, and specifically the laboratory assigned supervising responsibilities, is the responsibility of the Pathology Network which provides pathology services to the facilities where the PoCT devices are situated. Performance of testing at the point of care is the responsibility of the local healthcare facility. Measures for compliance with the requirements of this Policy and any other relevant requirements must be specified in service level agreements.

Details about the roles and responsibilities for managing the PoCT service and appropriate use of devices is provided in the Service Level Agreement template (Attachment to Point of Care Testing (PoCT) Policy: Procedures).

An electronic management solution for PoCT devices will be provided by NSW Health Pathology as a part of this framework to support clinical governance and accreditation objectives by:
- Electronically transmitting a patient’s results to laboratory information systems in which they then become part of that patient’s medical record.
- Monitoring both operator and device performance.
- Allowing for remote management of devices, including preventing device operation, if operator competency has not been assessed or reassessed within appropriate intervals.
- Supporting e-learning for ongoing competency assessment.

Public Health Organisations (PHOs) and NSW Health Pathology must ensure that this policy directive is brought to the attention of all relevant staff of the organisation and all relevant staff must comply with its requirements.

1. BACKGROUND

1.1 About this document

The Policy applies to all approved PoCT services and equipment incorporated into NSW Health Pathology’s Managed PoCT Service and covers the management and use of these devices irrespective of who performs the test.

While NSW Health Pathology’s Managed PoCT service will apply initially to PoCT services and devices with defined scope situated in Emergency Departments in NSW Health facilities, it is expected that other PoCT services and devices will be progressively integrated as a result of a formal application and approval process.

The process for approval is detailed in the PoCT Commissioning Flowchart (Attachment 1).

248(13/08/15)
Point of Care Testing (PoCT) is performed in many locations throughout NSW Health facilities including Emergency and ICU departments, clinics and other settings.

The main driving forces for increasing the demand for PoCT include clinician demand for best practice treatments prescribed by formal guidelines/protocols, requirements for more rapid results and by advances in technology which have produced restricted menu devices.

Advantages of PoCT include:
- Improved equity of access and greater satisfaction for patients who require care in rural and remote communities or for those unable to travel from home.
- Improved patient compliance with testing from greater convenience and, in some instances, more simple sample collection.
- More rapid provision test results particularly from reduced time between collection and analysis ensuring more timely treatment leading to reducing the risk of harm and increasing the likelihood of more effective healthcare outcomes.

Disadvantages of PoCT include:
- Compromised safety and quality of patient care from defective testing in an unmanaged ad-hoc system without a robust quality framework which includes device control, supervision, training, maintenance and support.
- Its use without clinical pathway amendment or development.
- Its introduction without proper evaluation of clinical need or effectiveness.
- Increased workload for clinical staff which may compromise other patient care activities.
- Uncertainty about the performance of particular devices.
- Inadequate expertise or failure of compliance with procedure resulting in errors of performance or interpretation; inadequate quality control measures to assure operators of result precision and accuracy.
- Problems of interpretation arising from differences in results for the same analyte by PoCT and those in the laboratory arising from differences both in method and instrument technology.
- Increased costs per test without clearly identifiable offsetting benefits.
- Inadequate documentation of results and, in particular, failure to include them in the patient’s permanent medical record.

If clinical decisions are based upon non-accredited and/or poorly supervised systems there is significant patient safety risk and medico-legal risk for clinicians and healthcare facilities. A managed PoCT service reduces and may eliminate risk associated arising from the disadvantages listed above.

To achieve patient and service benefit PoCT must demonstrate clear benefits for clinical decision making and pathways.

1.2 Key definitions

PoCT is defined as pathology testing performed in close proximity to a patient by a healthcare worker and usually outside the precincts of a traditional laboratory. Other terms commonly used to describe PoCT include:
- Near patient testing (NPT).
- Bedside testing.
- Physician office testing.
- Extra-laboratory testing.
- Disseminated laboratory testing.
19. PATHOLOGY

**Managed PoCT Service** is defined as an organisational framework that delivers an integrated PoCT service according to defined standards and to provide results in a short period of time because of clinical urgency.

**Operator** refers to Registered Medical Practitioners, Nurses, Midwives, and other Healthcare workers including laboratory staff.

**Quality Assurance** is the process of assuring that diagnostic services have been performed in an appropriate and approved manner adequate to meet an agreed standard of medical care.

1.3 Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>APA</td>
<td>Approved Pathology Authority.</td>
</tr>
<tr>
<td>APP</td>
<td>Approved Pathology Provider.</td>
</tr>
<tr>
<td>ARTG</td>
<td>Australian Register of Therapeutic Goods.</td>
</tr>
<tr>
<td>eMR</td>
<td>Electronic Medical Record.</td>
</tr>
<tr>
<td>EQA</td>
<td>External Quality Assurance.</td>
</tr>
<tr>
<td>ISO</td>
<td>International Organization for Standardization.</td>
</tr>
<tr>
<td>ISO 15189</td>
<td>International Standard - Medical Laboratories - Particular requirements for quality and competence - Requirements for quality and competence.</td>
</tr>
<tr>
<td>ISO 22870</td>
<td>International Standard - Point-of-care testing (POCT) - Requirements for quality and competence.</td>
</tr>
<tr>
<td>IT</td>
<td>Information Technology.</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator.</td>
</tr>
<tr>
<td>LIS</td>
<td>Laboratory Information System.</td>
</tr>
<tr>
<td>NATA</td>
<td>National Association of Testing Authorities, Australia.</td>
</tr>
<tr>
<td>NPAAC</td>
<td>National Pathology Accreditation Advisory Council.</td>
</tr>
<tr>
<td>NPT</td>
<td>Near patient testing.</td>
</tr>
<tr>
<td>NSWHP</td>
<td>New South Wales Health Pathology.</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Organisation.</td>
</tr>
<tr>
<td>PoCT</td>
<td>Point of Care Testing.</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance.</td>
</tr>
<tr>
<td>QC</td>
<td>Quality Control.</td>
</tr>
<tr>
<td>RCPA</td>
<td>Royal College of Pathologists of Australasia.</td>
</tr>
<tr>
<td>SLA</td>
<td>Service Level Agreement.</td>
</tr>
<tr>
<td>TGA</td>
<td>Therapeutic Goods Administration.</td>
</tr>
<tr>
<td>WH&amp;S</td>
<td>Workplace Health &amp; Safety.</td>
</tr>
</tbody>
</table>

1.4 Regulatory framework

NSW Ministry of Health requires that NSW Health staff and facilities comply with all approved jurisdictional policies and legislation regulating and assuring quality of pathology results. NSW Health policy [PD2006_064 Pathology Laboratories – Accreditation in NSW Health](#) states that Accreditation of NSW Health Pathology Laboratories is required by the Commonwealth to meet uniform standards of practice, competently perform tests and examinations, and produce accurate and reliable results in order to attract Medicare benefits.

2. MANDATORY REQUIREMENTS FOR A MANAGED PoCT SERVICE

2.1 General

2.1.1 Pathology testing that is performed on approved PoCT devices must conform to this policy.
2.1.2 PoCT will only be approved for use as an alternative to a laboratory based service if there is a significant demonstrable benefit to patient care or clinical outcomes.

2.1.3 The Managed PoCT Service must comply with all relevant NPAAC Standards and must operate under a clinical governance framework based on International Organisation for Standardisation (ISO) documents 15189 and ISO 22870. That Service must review all requests to establish Point-of-Care Testing and must approve all such services and the devices to be used before PoCT is implemented.

2.1.4 All testing locations performing PoCT must be authorized for this purpose.

2.1.5 For each test performed each member of staff performing PoCT must be trained and assessed as competent. This training and assessment must occur before commencing testing for individual patient care.

2.1.6 Each PoCT device must be periodically re-evaluated for its ongoing suitability.

2.1.7 PoCT devices may be withdrawn and PoCT services suspended if:
   - PoCT service testing locations fail to comply with this policy.
   - A significant safety issue has occurred.
   - There is a performance problem including misuse of instrumentation or a deficiency in either operator accreditation or certification.
   - There are persistent doubts about accuracy of results.
   - There is a lack of clinical effectiveness.

Services may be reinstated if evidence of remediation or resolution is provided.

2.2 Service Introduction

2.2.1 Applications to introduce, modify or change PoCT services or devices must be made in writing using the Request for PoCT Service form (NSW Health Pathology’s Application Form – please ask supporting NSW Health Pathology laboratory for the latest template).

2.2.2 Implementation of PoCT must be in collaboration with the LHD or relevant clinical service team and the supporting Pathology Network and must be integrated into the clinical framework of the health service.

2.2.3 The application must identify if PoCT will replace, or will be in addition to laboratory testing, and must also identify how PoCT will be integrated into clinical pathways and guidelines.

2.2.4 PoCT service applications must clearly address the benefits to clinical need and effectiveness and have defined quality key performance indicators (KPIs).

2.2.5 Only approved devices will be endorsed and supported by this strategy, irrespective of how the devices are financed, e.g. purchased, loaned, gifted, leased, etc.

2.2.6 Devices will not be commissioned until adequate numbers of competent operators have been trained, assessed and accredited. ‘Adequate numbers’ of operators will be determined by the requesting test location’s management.

2.2.7 A Service level Agreement (SLA) must be agreed and signed before implementation of PoCT services. (NSW Health Pathology’s Service Agreement Template – please ask supporting laboratory for the latest template).
19. PATHOLOGY

2.3 Accreditation

2.3.1 All PoCT services must be accredited by National Association of Testing Authorities, Australia (NATA).

2.3.2 Under Australian Legislation, all PoCT devices must be approved for use by the Therapeutic Goods Administration’s (TGA).

2.4 Patient Results

2.4.1 All patient results must be entered into the appropriate laboratory information system (LIS) so they become part of the electronic medical record (eMR).

2.4.2 Results from PoCT devices must be clearly distinguishable in the LIS and eMR from results derived from laboratory analysers.

2.5 Networking

2.5.1 All new PoCT devices included in the Managed PoCT service must be capable of transferring patient results electronically to the LIS.

2.5.2 All new PoCT devices included in the Managed PoCT service must be linked to NSW Health Pathology’s PoCT Management System.

2.6 Supporting documentation

2.6.1 A copy of the operational procedure for each device must be readily available near the PoCT instrument.

2.6.2 The procedure must contain:
   • Principle of examination.
   • Sample requirements.
   • Reagent storage.
   • Calibration procedure (if appropriate).
   • Testing procedure and use of all related equipment.
   • Maintenance and troubleshooting procedures including device error messages.
   • Result interpretation including critical alert limits and reference ranges.
   • Competency assessment criteria.
   • Response to abnormal or unexpected results.
   • Limitations of procedure including known interferences and limits of detection.
   • Quality control (QC) and external quality assurance (EQA) procedures and Quality Control Record Sheets.
   • Safe work practice and infection control information.
   • Requirements and processes for recording results.
   • Storage of documentation relating to testing ie printed test results.

2.7 Safety

2.7.1 Only PoCT devices and associated equipment that have satisfied all Workplace Health & Safety (WH&S) requirements can be commissioned.

248(13/08/15)
2.7.2 Specimens, reagents and other consumables supplies must be handled and disposed of according to safe work practices.

2.7.3 Devices and associated equipment must be located/stored, used and managed according to safe work practices.

2.8 **Quality Control and External Quality Assurance**

2.8.1 Adequate and appropriate quality control and quality assurance must be performed on all devices, for all analytes as per NATA/RCPA requirements, or as specified by the Managed PoCT service. Refer to Attachment 3 - Service Level Agreement template including roles and responsibilities.

2.8.2 All devices must be enrolled in an EQA program for every analyte/test performed (if available).

2.8.3 Quality control and external quality assurance must be performed by operators. It is recommended that there be participation in the EQA program by a representative of staff using the device. All results must be recorded and retained for a period according to NPAAC\textsuperscript{14} Requirements (link below).


2.9 **Device Maintenance**

2.9.1 Maintenance of devices is the responsibility of staff employed at the testing location performing PoCT.

2.10 **Training and Competency Assessment**

2.10.1 Initial training for devices must include ‘face-to-face’ training.

2.10.2 Training must be undertaken by an approved trainer. Knowledge/skill training requirements must include:

- The ability to demonstrate appropriate use of the device.
- Theory of measurement system.
- Pre-analytical requirements such as sample collection, reagent storage requirements, safety and infection control practices.
- Clinical interpretation of results that fall outside of reference ranges.
- Device maintenance.
- Quality control (QC) and external quality assurance (EQA) program participation and documentation.
- Other requirements that may become apparent from time to time.

2.10.3 All staff performing PoCT must be initially assessed for competence by an approved trainer for all devices they use.

2.10.4 All staff performing PoCT must be reassessed for competence periodically. The interval between re-certification of competency will be dependent on the device type, testing frequency and may be varied if there is any deficiency in performance of PoCT at the testing location. Minimum intervals for re-certification are to be specified in service level agreements. Subsequent scheduling and re-certification of competency may be managed using the online e-learning module of the PoCT Management software.

248(13/08/15)
2.10.5 All training will be followed by competency assessment.

2.10.6 Competency certificates will be provided to the operator; these must be retained in their training records.

2.10.7 Competency assessment records must be retained in accordance with NPAAC Requirements (links below).

2.11 Incident Reporting

2.11.1 Any clinical incident involving PoCT devices must be reported in the NSW Health incident monitoring system.

2.11.2 Any non-clinical issue relating to reagents, devices, quality control, EQA must be reported to the testing location’s management and be made the subject of a corrective action report in accordance with current standards.

2.12 Internal and External Audit

2.12.1 PoCT Services are subject to internal and external audits as part of accreditation requirements.

3. LIST OF ATTACHMENTS

3.1 Attachment 1 - PoCT Commissioning Flowchart
3.1 Attachment 1: PoCT Device Commissioning Flowchart

Process for Managing Requests for Point of Care Testing in NSW Health Pathology Networks

<table>
<thead>
<tr>
<th>Step</th>
<th>Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Request</td>
<td>Testing location requests pathology service for a test or tests</td>
</tr>
<tr>
<td>2 Principle check</td>
<td>Site and LHD notified by Pathology Network</td>
</tr>
<tr>
<td>3 Approved test/device check</td>
<td>Device available on approved register</td>
</tr>
<tr>
<td>4 Complete application</td>
<td>Request for test registered for review by PoCT Clinical Stream (Pathology) and NSW Health Specialty Network</td>
</tr>
<tr>
<td>5 NSW Health Pathology application review</td>
<td>Pathology Network PoCT Coordinator assists requesting location to complete application form (includes business case)</td>
</tr>
<tr>
<td>6 Application finalised and sent to LHD</td>
<td>Site and LHD notified by Pathology Network</td>
</tr>
<tr>
<td>7 LHD review</td>
<td>Pathology Network PoCT Coordinator assists requesting location to complete application form (includes business case)</td>
</tr>
<tr>
<td>8 Implementation</td>
<td>Review for appropriateness</td>
</tr>
<tr>
<td>9 LHD review of benefits</td>
<td>PoCT appropriate</td>
</tr>
</tbody>
</table>

Notes:
- PoCT: Point of Care Testing
- LHD: Local Health District
- NSWHP: NSW Health Pathology