Legal and Regulatory Services Branch

PATIENT MATTERS MANUAL FOR PUBLIC HEALTH ORGANISATIONS

AMENDMENT NO. 253(24/09/15)

Where a number appears at the bottom of an amended page [e.g. 253(24/09/15) – amendment number, date] an alteration has been made or new section included. The amendments as indicated reflect the provisions of Policy Directives/Guidelines/Information Bulletins:

- Chapter 12 PD2015_040 – Death – Verification of Death and Medical Certificate of Cause of Death
- Chapter 17 Obstetrics – Reference to PD2015_040
- Chapter 26 Tissue/Organ – Reference to PD2015_040

as notified by Strategic Relations and Communications on 24 September 2015.

The Manuals and complete amendments are available on the Internet at
http://www.health.nsw.gov.au/policies/manuals/Pages/default.aspx
If you choose to print the amendment, ensure you print it double sided.

If you are missing any amendments please email cgrm@doh.health.nsw.gov.au The amendment can be emailed to you in an electronic version.

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Appendix 5

NHMRC Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer (2005)

Post Adenoma Resection Colonoscopy Surveillance

Finding at index colonoscopy	Interval
• 2 or less tubular adenomas <10mms.	5 years
• Large adenomas ≥ 10 mms. • Advanced adenoma - high grade dysplasia/villous component. • 3 or more adenomas.	3 years
• Malignant polyps. • Piecemeal resection of large sessile polyps (>2 cms) with possible incomplete excision.	Clinician discretion for 1st surveillance (recommend within 3 months), then standard follow up as per guideline.

Family History

Finding	Interval
• 1st degree relative affected with colorectal cancer (CRC) Age <55.	Every 5 years from age 50.
• Two 1st degree relatives or 2nd degree relatives on same side of family with CRC.	10 years younger than youngest affected relative and then 5 yearly.
• Three or more 1st degree relatives on same side of the family with CRC (suspect hereditary nonpolyposis colorectal cancer (HNPCC). • Two or more 1st or 2nd degree relatives on the same side of the family with CRC and high risk features. o Multiple CRC in one person. o CRC diagnosed age <50 o At least on relative with endometrial or ovarian cancer (suspect HNPCC).	Yearly or 2nd yearly from age 25 or 5 years younger than earliest CRC.

Post Curative Resection for Colorectal Cancer

• Complete examination of the colon either pre-operatively or within 1 year of curative surgery. • Subsequent colonoscopy at 3 years and if normal 5 yearly.

Hereditary Non Polyposis Colorectal Cancer (HNPCC)

• Positive mismatch repair (MMR) gene mutation	Yearly from age 25 or 5 years younger than earliest CRC

DEATH – VERIFICATION OF DEATH AND MEDICAL CERTIFICATE OF CAUSE OF DEATH (PD2015_040)

PD2015_040 rescinds PD2012_036

PURPOSE

This policy directive outlines the processes for the assessment and documentation to verify death (previously referred to as extinction of life), and the medical certification of death of patients within the NSW Health System. It describes the roles of medical practitioners, registered nurses / registered midwives and qualified paramedics employed by NSW Health in relation to assessment and documentation when patients die within the NSW Health system.

This policy supports registered nurses and registered midwives to verify death across practice settings. The Nursing and Midwifery Board of Australia (NMBA) advises that "the extent of a nurse or midwife's scope of practice is determined by the individual's education, training and competence. The extent of an individual's scope of practice is then authorised in the practice setting by the employer's organisational policies and requirements." [1]
This policy directive does not apply to the Justice and Forensic Mental Health Network. NSW Ambulance staff may only verify death in accordance with relevant NSW Ambulance policies.

MANDATORY REQUIREMENTS

- All staff must comply with the legislative requirements in the Coroner's Act 2009 regarding the certification of death
- Medical practitioners must comply with the death certificate requirements outlined in Births, Deaths and Marriages Registration Act 1995
- In circumstances where a registered nurse / registered midwife or qualified paramedic is required to assess and document death, they must do so using the statewide Verification of Death form attached to this policy directive.

IMPLEMENTATION

Local Health District and Specialty Network Chief Executives must ensure that:

- The principles and requirements of this policy and attached procedures are applied, achieved and sustained
- All staff are made aware of their obligations in respect of this policy directive
- Training is provided to relevant staff regarding assessment and documentation of death (will be available via HETI on-line in 2015)
- There are documented procedures in place to effectively respond to and investigate alleged breaches of this policy directive.

Health Facility Managers and Staff have responsibility to:

- Understand the distinction between the procedures for Verification of Death and medical certification of death
- Understand the legislative requirements in the Births, Deaths and Marriages Registration Act 1995 and the Coroner's Act 2009 regarding certification of death.

NSW Ambulance must ensure that:

- Ambulance policies and protocols are consistent with this policy directive
- All staff are made aware of their obligations in respect of this policy directive
- Training is provided to Ambulance Officers regarding assessment and documentation of death.

[1] Nursing and Midwifery Board of Australia Fact Sheet, Context of practice for registered nurses and midwives 2015.

BACKGROUND

About this document
This policy directive supersedes PD2012_036.

This policy directive outlines the process for the assessment and documentation to verify death (previously referred as extinction of life), and the medical certification of death of patients within the NSW Health system. It describes the roles of medical practitioners, registered nurses / registered midwives and qualified paramedics employed by NSW Health in relation to assessment and documentation when patients die within the NSW Health system.

This policy directive does not apply to the Justice and Forensic Mental Health Network. NSW Ambulance staff may only verify death in accordance with NSW Ambulance Protocol A13 Verification of Death.

KEY DEFINITIONS

This policy directive makes a distinction between the procedures for assessing whether a person is deceased (**Verification of Death**) and issuing a **Medical Certificate of Cause of Death**.

Verification of Death: is a clinical assessment process undertaken to establish that a person has died. Using a standard regime of clinical assessment tools, a registered medical practitioner, registered nurse / registered midwife or qualified paramedic can establish and document that death has occurred. Verification of Death has previously been known as extinction of life in NSW Health policy.

Verification of Death is required to enable a person's body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD).

Where a death is reportable to the Coroner, Verification of Death (pronouncement of life extinct) is documented on Report of Death of a Patient to the Coroner (Form A) (SMR010.510).

For all other patients where Verification of Death is required, it must be documented using the NSW Health statewide Verification of Death form – Attachment 2.

Medical Certificate of Cause of Death: is the form issued by the Registry of Births, Deaths & Marriages in which a medical practitioner notifies the Registrar, Registry of Births, Deaths & Marriages of a death and the cause of that death, pursuant to legislative requirements in Section 39 of the Births, Deaths and Marriages Registration Act 1995.

Notification of deaths by medical practitioners to the Registrar at the Registry of Births, Deaths & Marriages: a requirement of the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death under the Births, Deaths and Marriages Registration Act 1995.
For further details please see Section 2.2.

Intention to complete and sign a Medical Certificate of Cause of Death: In circumstances where there may be a delay in completion of the Medical Certificate of Cause of Death by a medical practitioner, it may be appropriate following verification of death by a registered nurse / registered midwife or qualified paramedic, for a medical practitioner to provide a notice of intention to complete a Medical Certificate of Cause of Death which will allow a funeral director to remove the body. The certification as to the cause of death must take place within 48 hours of the death.

Public health organisations is defined in Section 7 of the Health Services Act 1997 as:

a) A local health district and specialty health network, or
b) A statutory health corporation, or
c) An affiliated health organisation in respect of its recognised establishments and recognised services.

Legal and legislative framework
NSW legislation relevant to this policy directive:

- Births, Deaths and Marriages Registration Act 1995
- Coroners Act 2009
- Human Tissue Act 1983
- Health Services Act 1997

Policy framework
NSW Health policy documents relevant to this policy directive:

- PD2010_054 Coroners Cases and the Coroners Act 2009
- PD2013_001 Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements
- PD2011_052 Conduct of Anatomical Examinations and Anatomy Licensing in NSW.

NSW Health State Forms relevant to this policy directive:

- Attending Practitioners Cremation Certificate (Public Health Regulation, 2012,
- Clause 81)
- Medical Certificate of Cause of Death (SMR010.509)
- IB2010_058 Coronial Checklist (SMR010.513)
- Verification of Death (SMR010.530)
- Death Certification Arrangements for Expected Home Death (SMR010.531)

DOCUMENTATION REQUIREMENTS WHEN A PATIENT DIES

Please see the flow chart at Attachment 1 for a summary of the process.

Reporting a death to the Coroner
To determine if a death should be reported to the coroner refer to the Coronial Checklist (State Form SMR010.513, see IB2010_058 http://www0.health.nsw.gov.au/policies/ib/2010/pdf/IB2010_058.pdf). The Coronial Checklist includes details of how to seek advice where there is uncertainty.

Nursing, midwifery and medical staff managing cases reportable to the Coroner should follow the steps outlined in PD2010_054 Coroners Cases and the Coroners Act (http://www0.health.nsw.gov.au/policies/pd/2010/pdf/PD2010_054.pdf).

For deaths reportable to the Coroner, verification of death (extinction of life) is documented within Report of a Death of a Patient to the Coroner (Form A) (State Form SMR010.510). No additional documentation relating to death is required.

Key elements of PD2010_054

- Medical practitioners must not issue a certificate as to cause of death under the Births, Death and Marriages Registration Act 1995 if the death is a reportable death (Section 6 Coroners Act 2009). Reportable deaths include where the person died a violent or unnatural death; the person died a sudden death the cause of which is unknown; the person died under suspicious or unusual circumstances; 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; the person died while in or temporarily absent from a declared mental health facility while receiving care, treatment or assistance; and/or 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.

- If a health practitioner is uncertain about whether the death is reportable they should contact the Duty Pathologist, Department of Forensic Medicine during business hours in Sydney 02 8584 7821 or Newcastle 02 4922 3700. After hours, contact the State on call Pathologist on 02 8584 7821. The Office of the NSW State Coroner may be contacted for advice during business hours on 02 8584 7777. Information is also available on the Coroners website at http://www.coroners.justice.nsw.gov.au/Pages/for_health_professionals.aspx

It is advisable to seek advice from the Coroner regarding the mandatory reporting of deaths which fall within the requirements of Section 24 of the Coroners Act 2009 which covers jurisdiction concerning deaths of children and disabled persons.

MEDICAL CERTIFICATION OF DEATH

Legal responsibilities of medical practitioners

Death certificates certify the facts and circumstances of the death of a person. Under the Births, Deaths and Marriages Registration Act 1995 the medical practitioner who was responsible for a person's medical care immediately before death, or who examines the body of a deceased person after death, **must,** within 48 hours of the death:

- "Give the Registrar of Births, Deaths and Marriages, notice of the death and cause of death, and
- If the medical practitioner is of the opinion that it is impracticable or undesirable to give notice of the cause of death of the person within that time, give the Registrar notice of the death, and of the medical practitioner's intention to sign a death certificate with the cause of death notified as soon as possible after that."

In NSW public health organisations, the Medical Certificate of Cause of Death Form (SMR010.509) must be used to give notice of death. This form asks for the date of death or range of dates where the exact date is not known.

A medical practitioner cannot give notice based on review of medical records only. The body must be viewed, or, the medical practitioner must have been treating the person prior to death.

If another medical practitioner has given notice, or the death has been reported to the Coroner under the Coroners Act 2009, a medical practitioner is not required to give repeat notice of death to the Registrar.

A medical practitioner should only certify the cause of death if a diagnosis of cause of death can be made. If the cause of death is uncertain, reasonable steps should be taken to obtain sufficient information to enable the medical practitioner to determine the cause of death. Reasonable steps

would include reviewing the medical record or contacting other health professionals involved in the recent care of the deceased person.

If the medical practitioner is unable to ascertain the cause of death the matter should be referred to the Coroner.

If the medical practitioner is a relative of the deceased they should not complete the certificate unless they are the only medical practitioner in a remote area. Medical practitioners should also disclose any property, pecuniary or other benefit(s) that they anticipate acquiring from the death.

Notification of death certificates may be requested from the Registrar of Births, Deaths and Marriages phone 1300 655 236.

Responsibilities for certification of death in NSW Health facilities
When a patient dies in a public health facility where there are medical practitioners on site, it is preferable that a medical practitioner conducts the verification of death assessment. If verification of death is completed by another health professional, a medical practitioner should certify the death as soon as practicable. In the case of facilities where there is not 24 hour medical coverage, the medical practitioner should certify death at the commencement of duties. Only a medical practitioner can complete the Medical Certificate of Cause of Death.

VERIFICATION OF DEATH

Roles of medical practitioners, registered nurses / registered midwives and qualified paramedics
A medical practitioner must conduct the verification of death assessment in situations where medical tests are required to declare death (for example, prior to organ donation).

In all other cases, where there is no medical practitioner available to verify death, registered nurses / registered midwives and qualified paramedics can do so. Qualified paramedics must only verify death as outlined in NSW Ambulance Protocol A13 Verification of Death.

Clinical procedure for verifying death[1]
This is done by demonstrating all of the following:

- No palpable carotid pulse, and
- No heart sounds heard for 2 minutes, and
- No breath sounds heard for 2 minutes, and
- Fixed and dilated pupils, and
- No response to centralised stimulus, and
- No motor (withdrawal) response or facial grimace in response to painful stimulus.

No response to centralised stimulus may be assessed by trapezius muscle squeeze, supraorbital pressure or sternal rub. No motor (withdrawal) response or facial grimace in response to painful stimulus would be assessed by pinching the inner aspect of the elbow. In cases of expected deaths at home, it may be reasonable not to complete these two tests if the person has been deceased for some time and there is the potential to distress relatives who are present. In such cases, all other criteria for the verification of death assessment must be undertaken. Any decision not to assess response to painful stimulus should be briefly documented on the form.

[1] Published by the Emergency Care Institute, Agency for Clinical Innovation (website accessed 2014)

Where a verification of death assessment has been undertaken and the practitioner is not certain if the person is deceased, they should seek the opinion of a second health professional. In a hospital setting, a medical practitioner should be called, if available. In the case of a registered nurse attending an expected death in a community setting, it is reasonable for the attending nurse to wait and repeat the verification of death assessment after a clinically appropriate time period has elapsed. A second opinion may be sought from a qualified paramedic by calling an ambulance if necessary.

Note that a different clinical procedure is conducted when a patient is certified dead for the purpose of organ donation. Such an assessment is conducted according to PD2013_001 Deceased Organ and Tissue Donation - Consent and Other Procedural Requirements http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_001.html.

In situations where the person has injuries incompatible with life (e.g. decapitation, severe incineration or extensive trauma), or has been deceased for some time (as evidenced by rigor mortis, dependent lividity or tissue decomposition) the death is considered obvious and no clinical assessment is required. This situation is most likely to occur when a body is brought to a hospital by a government contractor (see Section 2.4).

Documentation

Registered nurses / registered midwives who are assessing and documenting death must use the statewide Verification of Death form (SMR010.530) (Attachment 2). The original form is provided to the funeral director and the copy is kept in the health care record.

In remote sites, in situations where it is necessary for a funeral director or government contractor to transport the body of a deceased person to a NSW Health facility for completion of the Medical Certificate of Cause of Death and the name of the medical practitioner who will complete the Medical Certificate of Cause of Death is not known at the time the registered nurse / registered midwife completes the Verification of Death form, the registered nurse / registered midwife may write "transfer to <name of NSW Health facility>" in the Medical Certificate of Cause of Death section on the Verification of Death form. Local procedures must be in place to ensure that the Medical Certificate of Cause of Death is completed within 48 hours of the death.

Qualified paramedics should provide the funeral director with the Verification of Death form (SMR010.530) and record details of the clinical procedure to verify death in the NSW Ambulance clinical record.

Tissue or body donation for deaths outside a health facility

Tissue and body donation may be relevant for some deaths outside of a health facility.

- Tissue Donation

A potential donor of tissue for corneal, musculoskeletal and cardiac tissue (heart valve) transplantation is a deceased person for whom retrieval is possible within 24 hours after death. In order to provide opportunities for families / carers to support the donation of tissues for transplantation, the staff member who verifies the death should sensitively inquire whether the deceased had indicated their wish to be a tissue donor. If so, they should prompt the family / carer to contact the NSW Tissue Bank via the Lions NSW Eye Bank on (02) 9382 7288 (24 hours a day) to notify them of the death. For more information see PD 2013_001 Deceased Organ and Tissue Donation- Consent and Other Procedural Requirements http://www0.health.nsw.gov.au/policies/pd/2013/PD2013_001.html.

- Donation of Bodies to a School of Anatomy / Medical Science

Similarly the deceased person may have decided in their lifetime to donate their body after death to a School of Anatomy for the purposes of anatomical examination and medical research and will usually have completed a consent form during their lifetime to document this decision. Again, the family / carer should be prompted to contact the relevant School of Anatomy body donation program to notify them of the potential donor's death and make arrangements for the transfer of the body. See PD 2011_052 Conduct of Anatomical Examinations and Anatomy Licensing in NSW: Procedures and Guidelines http://www0.health.nsw.gov.au/policies/pd/2011/PD2011_052.html.

Medical certification following verification of death

A medical practitioner must complete the Medical Certificate of Cause of Death within 48 hours of death. The contact details of the medical practitioner who will complete the Medical Certificate of Cause of Death should be included in the Verification of Death form to ensure this occurs.

For patients cared for at home where death is anticipated (e.g. patients known to NSW Health palliative care and affiliated or contracted palliative care services or hospital in the home patients with a resuscitation plan in place), it is recommended that there is agreement in advance on who will complete the medical certification of death. In such cases, the patient's general practitioner may agree to this responsibility (see Section 2.5).

BODIES TRANSPORTED FOR VERIFICATION OF DEATH ASSESSMENT BY GOVERNMENT CONTRACTORS (INDIVIDUALS NOT UNDER THE CARE OF NSW HEALTH AT THE TIME OF DEATH)

In some circumstances, a body may be transported by a government contractor, ambulance or the Police to a hospital for Verification of Death. If a qualified paramedic is involved in the case prior to a decision to transport the body, it is recommended that they complete the Verification of Death form as outlined in Section 2.3. This will assist with transfer of the body to a more suitable location.

Where a qualified paramedic is not involved and the body is transported to a hospital for Verification of Death, a medical practitioner or registered nurse / registered midwife can assess death and complete the Verification of Death form. The Coroner will issue a death certificate in such cases. A copy of the signed Verification of Death form does not need to be provided to the Police.

OPTIONAL CONSIDERATIONS FOR EXPECTED HOME DEATHS IN REGIONAL AND RURAL SETTINGS

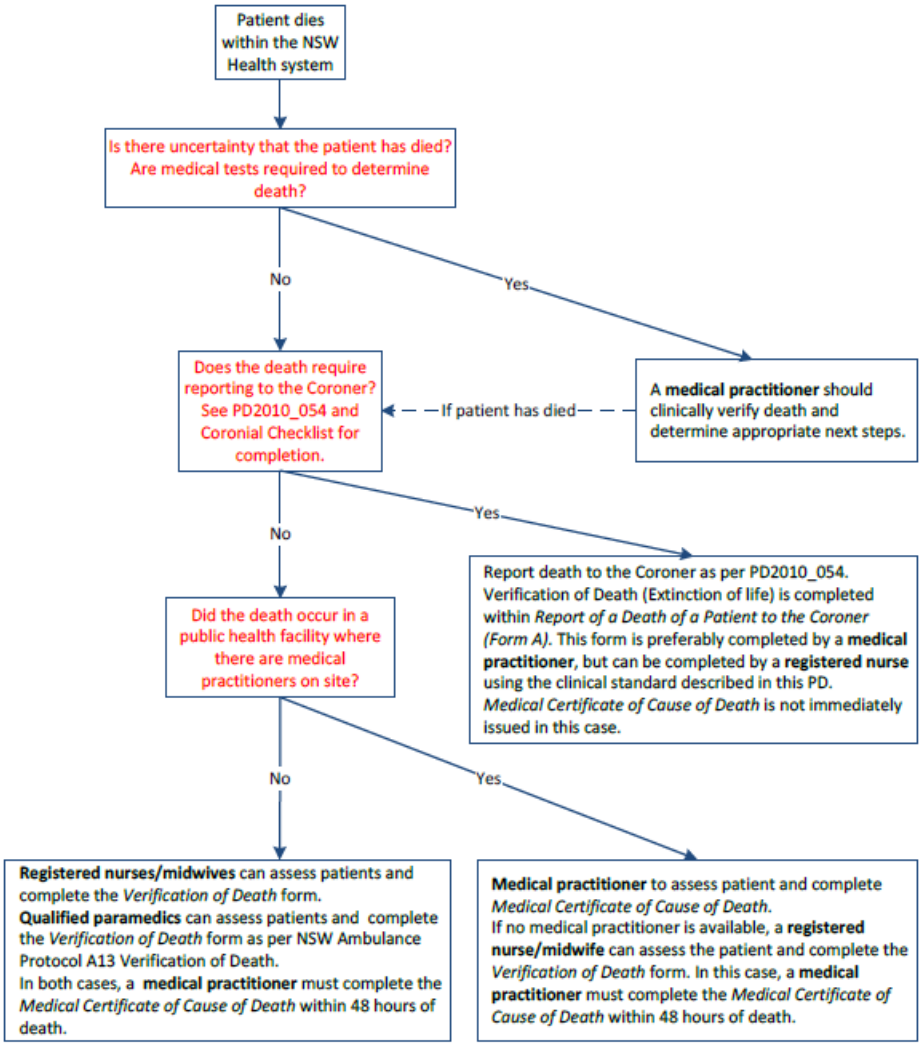
Within regional and rural settings, there may be specific challenges in organising a medical practitioner to complete the Medical Certificate of Cause of Death due to greater distances involved and limited medical workforce. Local Health Districts may elect to put in place local policy and / or procedures to designate the medical practitioner responsible for completing the Medical Certificate of Cause of Death in advance of an expected death. This approach is encouraged by the State Coroner. Local procedure or policy development should involve consultation with primary care providers, funeral directors and potentially the Police and Coroner.

In many cases the patient's general practitioner will be a key part of the healthcare team for patients approaching and reaching the end of their lives who choose to be cared for and die at home. It is recommended that general practitioners are involved in discussions about planning for completion of the Medical Certificate of Cause of Death as part of care planning. In many cases these discussions will be recorded in the patient's health record, however some Local Health Districts and Specialty Health Networks may elect to formalise the agreement. To assist with formalising this process, a model Death Certification Arrangements for Expected Home Death form (Attachment 3) has been developed and endorsed by the NSW Health State Forms Management Committee. Use of this form is encouraged, but not mandated where Local Health Districts and Specialty Health Networks have elected to develop a process for managing expected deaths in this way.

LIST OF ATTACHMENTS

1. Flowchart – Roles and responsibilities for documentation when a patient dies within the NSW Health system
2. Statewide Verification of Death form (SMR010.530) (mandatory)
3. Statewide Death Certification Arrangements for Expected Home Death form (SMR010.531) (optional)

1. ROLES AND RESPONSIBILITIES FOR DOCUMENTATION WHEN A PATIENT DIES WITHIN THE NSW HEALTH SYSTEM



2. VERIFICATION OF DEATH FORM SMR010530

NSW GOVERNMENT Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

VERIFICATION OF DEATH

SMR010530

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BINDING MARGIN - NO WRITING

Verification of Death is required to enable a person's body to be transported by a funeral director or government contractor, in circumstances where there may be a delay in completing the Medical Certificate of Cause of Death (MCCD).

Completion of this *Verification of Death* form is not required when a person's death is reportable to the Coroner (see PD2010_054) or where a MCCD has been completed.

In the absence of a medical practitioner, a registered nurse / registered midwife or qualified paramedic may complete this *Verification of Death* form.

Details of the deceased

Family name _____ Given name(s) _____

Sex _____ Age / DOB _____ MRN _____

Address _____

Place of death _____

Method of verifying identity
- ☐ Check arm band
- ☐ Patient known to health professional/service
- ☐ Information relayed by government contractor
- ☐ Other, provide details _____

Implantable devices remaining on / in body that require deactivation (eg pacemaker, implantable defibrillator)

_____

Clinical Assessment

Examination Date _____ Examination Time _____

I have completed the following assessments and there is: (all tests must be undertaken to verify death)
- ☐ No palpable carotid pulse
- ☐ No heart sounds heard for 2 minutes
- ☐ No breath sounds heard for 2 minutes
- ☐ Fixed and dilated pupils
- ☐ No response to centralised stimulus
- ☐ No motor (withdrawal) response or facial grimace in response to painful stimulus

Details of any additional assessments undertaken (eg ECG strip) _____

OR

- ☐ This is an obvious death (i.e. the person has injuries incompatible with life and/or has been deceased for some time)

AND

- ☐ I declare that the person is deceased.

Details of person verifying death

Name _____

Designation: ☐ medical practitioner ☐ registered nurse / registered midwife* ☐ qualified paramedic*

Pager/Phone _____ Employing facility _____

Signature _____ Date _____

Medical Certificate of Cause of Death (MCCD)

Details of medical practitioner who is to certify death (within 48 hours of the death)

Name _____ Contact Details _____

Has the medical practitioner been notified of patient death? ☐ Yes ☐ No

Details of arrangement with medical practitioner to complete certification _____

_____

*In the absence of a medical practitioner, a registered nurse / registered midwife or qualified paramedic may verify death.

Page 1 of 1

Original - Funeral Director Copy - Medical Record

NH7000036 260815

VERIFICATION OF DEATH

SMR010.530

3. DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH SMR010531

NSW GOVERNMENT Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. ____/____/____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

DEATH CERTIFICATION ARRANGEMENTS FOR EXPECTED HOME DEATH

SMR010531

PURPOSE:

This form is recommended for use where Local Health Districts / Specialty Health Networks have put in place local policy and/or procedures to designate the medical practitioner responsible for completing the Medical Certificate of Cause of Death (MCCD) in advance of an expected home death. This form will assist with timely removal of the body from the patient's home and give certainty about who will complete the MCCD.

- The first section of the form is for completion by Local Health District / Specialty Health Network staff.
- The second section of the form is for completion by the GP or medical practitioner who agrees to complete the Medical Certificate of Cause of Death within 48 hours of the patient death. The GP or medical practitioner should return this form to the requesting service as soon as possible.

FOR COMPLETION BY REQUESTING SERVICE

Patient details

Family name _____ Given name(s) _____

DOB _____ Phone _____ MRN _____

Address _____

Patient Contact Person: _____ Relationship: _____

Palliative or Life-limiting Diagnosis: _____

Palliative Care Phase: ☐ Deteriorating ☐ Terminal

Details of requesting service:

☐ Specialist Palliative Care Service ☐ Community Health ☐ Aged Care ☐ Multipurpose Service (MPS)

Staff member requesting form: Print Full Name: _____ Signature: _____

Designation: _____ Date: _____

Organisation: _____ Phone: _____

FOR COMPLETION BY GP OR MEDICAL PRACTITIONER WHO ACCEPTS RESPONSIBILITY TO COMPLETE MCCD FOR EXPECTED HOME DEATH

Will you make yourself available at the time of the patient's death to view the body and complete MCCD?

☐ Yes ☐ No

Comment: _____

Can you be contacted after hours? ☐ Yes ☐ No

If No, are you prepared to provide a Medical Certificate of Cause of Death (MCCD) to the Funeral Director within 48 hours if the death is not a reportable death under the Coroners Act 2009?

☐ Yes ☐ No

GP/Medical practitioner's details:

A/H or Mobile No (if available): _____ Surgery Ph: _____

Print Full Name: _____ Signature: _____ Date: _____

ON COMPLETION, RETURN COMPLETED FORM TO:

Contact person/service _____

FAX _____ or EMAIL _____

NH700037 260815

Original - Funeral Director Photocopy - Medical Record Page 1 of 1

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DEATH CERTIFICATION ARRANGMENTS FOR EXPECTED HOME DEATH

SMR010.531

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- Death - Verification of Death and Medical Certificate of Cause of Death PD2015_040
- Consent to Medical Treatment - Patient Information PD2005_406
- Human Tissue-Use/Retention Including Organ Donation, Post-Mortem Examination and Coronial Matters PD2005_341
- Infection Control PD2007_036
- Deaths - Review and Reporting of Perinatal Deaths PD2011_076
- NSW Perinatal Data Collection (PDC) Reporting and Submission Requirements PD2015_025
- Congenital Conditions Register - Reporting Requirements PD2012_055
- Health Care Records - Documentation and Management PD2012_069
- Genetic Testing PD2007_066
- Interpreters - Standard Procedures for Working with Health Care Interpreters PD2006_053.

2. LEGAL CONTEXT

The legal framework in relation to termination of pregnancy is set out below.

2.1 Criminal Law[17]

In New South Wales, the law on termination is governed by the N*SW Crimes Act 1900* as interpreted by relevant case law. In summary, termination is lawful if:

- The procedure is performed with the consent of the woman and by a registered medical practitioner.
- The medical practitioner procuring the termination has an honest belief based on reasonable grounds that the procedure is necessary to preserve the woman from serious danger to her life, or physical or mental health. These grounds may be medical, economic or social.
- In the circumstances, the operation is not out of proportion to the danger intended to be avoided.

2.2 *Births, Deaths and Marriages Registration Act*

Under the *Births, Deaths and Marriages Registration Act 1995* ("the Registration Act") there is a requirement to register all births.

2.2.1 Stillbirth

"Birth" includes "stillbirth", which means the birth of a "stillborn child" (a fetus of at least 20 weeks gestation or, if the gestational age is not known, having a body mass of at least 400 grams at birth). If the gestational age of the fetus is not accurately known, the weight of the fetus becomes relevant. When notice of a stillbirth is given, the responsible person must also give a doctor's certificate certifying the cause of fetal death. No registration of "death" is required in respect of stillborn children.

2.2.2 Neonatal birth and death

A child born alive, irrespective of gestational age, must be registered as a birth - see section 12 of the Registration Act. If the child subsequently dies it must be registered and notified to the Registrar together with the cause of death in accordance with the Registration Act or alternatively reported to the Coroner.

[17] see Sections 82 to 84 of the *Crimes Act*

2.3 Duty of Care

This section outlines the legal responsibilities in relation to both adult and child patients in the context of terminations of pregnancy. Both the civil and criminal law is relevant.

2.3.1 Adult patient

The law imposes on a medical practitioner a duty to his/her patient to exercise reasonable care and skill in the provision of professional advice and treatment. Appropriate and adequate information must be provided to patients in order for the patient to make an informed choice about treatment.

In relation to the actual performance of the termination, a duty of care is owed to the patient and the standard of reasonable care and skill required is that of a medical practitioner experienced in that area of practice. Negligence may be established where the standard of care falls below that which could be reasonably expected in the circumstances.

2.3.2 Child

For the purposes of this section "child" refers to a child who has been expelled or removed from the mother's womb alive. It should be noted that a fetus in utero is not recognised as a separate legal entity. However, once a fetus has been expelled or removed from the mother's womb, and is born alive, the child has the legal status of a person whose rights exist independently of the rights of the parents.

Where a child is born alive and a responsible body of medical opinion considers that the burden of medical treatment is such that it would not benefit the child, because of pre-viability of the child, prematurity, or the effect of a disease or condition - then a medical practitioner is under no duty to render overburdensome treatment. Healthcare professionals have an obligation to work together with families to make compassionate decisions. Conversely, where the likelihood of treatment will be of benefit, there is an obligation to render life-saving medical treatment.

2.4 Coroners Act

"Death" in the *Coroners Act 2009* should be construed in the same way as "death" in the Registration Act. The delivery of a fetus that "exhibits no sign of respiration or heartbeat, or other sign of life" which does not include a stillbirth after expulsion from the womb is not a "death" for the purposes of the *Coroners Act*. A fetus becomes a person if after expulsion or extraction from the mother and before being determined to be dead, signs of life are exhibited.

The reporting obligations are set out in the *Coroners Act* and Policy Directive *Coroners Cases and the Coroners Act 2009* (PD2010_054).

3. PRE-PROCEDURE ISSUES

3.1 Counselling

All women seeking a termination of pregnancy are to be offered counselling. This counselling does not replace but is additional to any genetic counselling that may be indicated.

USE AND RETENTION OF HUMAN TISSUE INCLUDING ORGAN DONATION, POST-MORTEM EXAMINATION AND CORONIAL MATTERS (PD2005_341)

This circular and attached procedures fully replace the following Circulars:

84/111	*Human Tissue Act - Appointment of Designated Officers and Designated Specialists*
84/130	*Human Tissue Act 1983 and Related Legislation Administrative Procedures*
84/207	*Human Tissue Act 1983 - Police Matters*
92/17	*Organ Donation*
94/82	*Designated Officers*
2000/97	*Organ Donation - Procedural Update*
2001/13	*Organ Donation - Coronial Cases*

and the Circular on *The Interim Policy On Consent Associated with Post-mortem Examination* issued on 10 October 2000.

This circular states the Department's policy in relation to the requirements of the *Human Tissue Act 1983* and the *Anatomy Act 1977* as amended by the *Human Tissue and Anatomy Legislation Amendment Act 2003*. This incorporates Departmental policy in relation to the provision of information and obtaining of consent for the use of tissue removed during a non-coronial or coronial post-mortem examination or during medical, dental or surgical treatment and its subsequent use for scientific, therapeutic or medical purposes.

This circular should be read in conjunction with the following NSW Department of Health circulars:

PD2005_406	*Patient Information and Consent to Medical Treatment*
PD2015_040	*Death - Verification of Death and Medical Certificate of Cause of Death*
2000/74	*Human Tissue Regulation 2000: Medical Certificates for Donors of Blood and Semen*
PD2010_054	*Coroners Cases and the Coroners Act 2009*
GL2006_021	*Human Tissue - Requirements of the Human Tissue Act 1983 in Relation to Research and Use of Tissue*

Health Staff should also be aware of the relevant sections of the Patient Matters Manual which will be updated with the content of this circular.

Chief Executive Officers of public health organisations and those persons in charge of private health organisations should bring the contents of this circular to the attention of all persons involved in use of human tissue, consent, post-mortems, coronial matters and administration of anatomy requirements.

This policy applies to public health organisations, as defined in the *Health Services Act 1998*. These organisations are to implement this policy as a minimum standard.

USE AND RETENTION OF HUMAN TISSUE INCLUDING ORGAN DONATION, POST-MORTEM EXAMINATION AND CORONIAL MATTERS

Introduction:

The main points of the policy are:

- Written consent must be obtained prior to the conduct of a non-coronial post-mortem and to the use and/or retention of human tissue removed during coronial or non-coronial post-mortem examinations, using a standardised consent form.
- For non-coronial post-mortems, in the absence of written consent from the deceased, written consent must be obtained from the senior available next-of-kin.
- The *Anatomy Act* requires written consent to be obtained prior to the use of a body for anatomical examination or other research purposes.
- Written consent must be obtained for the retention and use of tissue removed during medical, dental or surgical procedures and its subsequent use for scientific or medical purposes (apart from the original diagnostic/treatment purpose).
- A Designated Officer must be appointed by a Public Health Organisation Board or Governing Authority, CE of area health service and Royal Alexandra Hospital for Children to legally authorise, in writing, all non-coronial post-mortem examinations and the use of tissue removed at post-mortem for other therapeutic, medical or scientific purposes.
- The Policy establishes the minimum requirements for a process to be undertaken to obtain consent including guidance on the information to be provided to the next-of-kin in relation to consent to post-mortem examination; retention and use of tissues for therapeutic, medical and scientific purposes and disposal of any retained tissue. (Appendix 1)
- The Policy also sets out the standards for the staffing requirements considered necessary to facilitate the process. All Public Health Organisations involved in carrying out post-mortem examinations have responsibilities to ensure that staff involved with bereaved relatives are appropriately trained and able to provide information, support and assistance to the senior next-of-kin and relatives. A post-mortem co-ordinator should be appointed. This may be someone within the organisation who already works with bereavement issues such as a social worker or counsellor.
- The policy establishes minimum standards for the documentation and maintenance of confidential records and consent forms relating to post-mortems and the use of tissues, including details of the source, location, reason for removal and retention of tissue removed for the purpose of post-mortem and records of tissue used for medical and scientific research.

This policy is issued with detailed procedures attached for the reference of staff. The policy and procedures include:

Section 1 Definitions Used in the Administration of This Policy
Section 2 Staffing Requirements and Roles
Section 3 Designated Officers
Section 4 Obtaining Consent - Process and Practical Issues, Consent to the Use of Tissue Removed from Living and Deceased Person and for Post-Mortem Examination
Section 5 Organ Donation - Coronial and Non-Coronial

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