SA Health

Policy

Coronial Process and the Coroners Act 2003

Version 7.1

Approval date:

PDS Reference No: D0274

Government of South Australia

SA Health

1. Name of policy

Coronial Process and the Coroners Act 2003

2. Policy statement

This policy sets out the mandatory requirements and instructions that apply to all reportable deaths within SA Health. Compliance with this Policy is mandatory and includes the Mandatory Instruction included at **Appendix 1**. Failure to comply may constitute grounds for disciplinary action, including termination of employment.

3. Applicability

This policy applies to all employees of SA Health and Attached Offices; this is all employees of the Department for Health and Wellbeing, Local Health Networks (including state-wide services aligned with those Networks), SA Ambulance Service, Wellbeing SA and The Commission on Excellence and Innovation in Health.

4. Policy principles

SA Health's approach to the Coronial Process and the Coroners Act 2003 Policy is underpinned by the following principles:

- We support the principles of the reporting obligations within the Coroners Act 2003 (the Act) and the principles of the process that is involved in coronial investigations.

5. Policy requirements

5.1 Reportable Deaths

SA Health must have processes in place to ensure that the Coroner or South Australian Police (SAPOL) are immediately notified of any death that is, or may be, a reportable death.

SAAS Officers must contact SAPOL through the SAAS State Duty Manager and request police attendance at a suspected reportable death scene.

See section 8 Definitions and Appendix 1 Mandatory Instruction for further details regarding the types of reportable deaths and reporting timeframes and obligations.

5.2 Reporting Requirements

The person notifying the Coroner or SAPOL must:

- Give the Coroner or Police Officer any information that the person has in relation to the death.
- Where the person is a medical practitioner who was responsible for the medical care of the deceased person prior to death, or who examined the body of the person after death, they must give their opinion as to the cause of death.

Penalty for failing to give an opinion as to the cause of death: Maximum penalty $5,000.

5.3 Body of the deceased

- The body of the person whose death is reportable is under the exclusive control of the Coroner until the Coroner authorises the release of the body.
- Following a reportable death, the medical practitioner must NOT:

- give written notice to the Registrar of Births, Deaths and Marriages.
- perform or authorise a post mortem examination to determine the cause of death unless directed by the Coroner or the Coroner's Court and / or;

- Where the death is unexpected, unnatural or suspicious in nature the surrounding area must not be disturbed or cleared.

6. Mandatory related documents

Under this policy, all employees of SA Health and Attached Offices must comply with:

- Aged and Infirm Persons' Property Act 1940
- Births, Deaths and Marriages Registration Act 1996
- Children and Young People (Safety) Act 2017
- Consent to Medical Treatment and Palliative Cate Act 1995
- Coroners Act 2003 and Regulations
- Death (Definition) Act 1983
- Guardianship and Administration Act 1993
- Health Care Act 2008
- Health Practitioner Regulation National Law (South Australia) Act 2010
- Mental Health Act 2009
- Supported Residential Facilitates Act 1992
- Transplantation and Anatomy Act 1983
- Patient Incident Management and Open Disclosure Policy Directive
- Policy Guideline 'Police Requests for Information and Witness Statements'

7. Supporting documents

- Death Notification and Checklist Medical Record form (MR-DNC)

8. Definitions

- **Coroner** means the person holding or acting in the office of State Coroner under Part 2 Section 3 of the *Coroners Act 2003.*
- **Death in custody** means; the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person was in custody as defined in Section 2, Coroners Act 2003.
- **Delegate** means the person identified by the health site and notified to the Coroner as being the person to deal with the requests for information from the Coroner/SAPOL during business hours e.g. Clinical Risk Manager or Police Liaison Officer.
- **Designated officer** means: in relation to a hospital, a person appointed under section 6 of the *Transplantation and Anatomy Act 1983* to be designated officer for that hospital.
- **Health Site** means: refers to a specific hospital or health service of a Local Health Network or State-wide Clinical Support Service.
- **Investigator** is a police officer or a person appointed under section 9 of the *Coroner's Act 2003* to be an investigator.
- **Local Health Network (LHN)** is an incorporated hospital that provides services and facilities under the Health Care Act 2008.

- **Medical Practitioner** means a person registered under section 26 of the *Health Practitioner Regulation National Law (South Australia) Act 2010* to practice in the medical profession (other than a student).
- **Protected Person** means the person subject of a guardianship or administration order (or both) under the *Guardianship and Administration Act 1993*, or a person who or whose estate or part thereof becomes the subject of a protection order under the *Aged and Infirm Persons' Property Act 1940*.
- **Reportable death** as defined in Part 1 Section 3, Interpretation; Coroners Act 2003.
- **State Death'** means the death of a person –
  - (a) That occurred in the State; or
  - (b) Where the place of death is unknown but it is reasonably possible that the death occurred in the State; or
  - (c) Where the body of the person is in the State; or
  - (d) A cause of which occurred, or possibly occurred, in the State; or
  - (e) Where, at the time of death, the person was ordinarily a resident in the State; or
  - (f) In the case of a death on an aircraft or vessel – where flight or voyage was to a place of disembarkation in the State.

9. Compliance

The SA Health-wide compliance indicators for this policy are set out below. These indicators are required to be met across all SA Health services and Attached Offices.

Any instance of non-compliance with this policy should be reported to the Domain Custodian for the Clinical Governance, Safety and Quality Domain and the Group Director for the Risk, Audit and Compliance.

Indicator	Description
SLS Coronial notifications	Audit of compliance with reporting requirements and timeframes
Safety and Quality Accounts	LHN compliance with responding to and addressing the requirements of recommendations from the findings of inquests.

10. Document ownership

Policy owner: Executive Director, Provider Commissioning and Performance domain custodian for Clinical Governance, Safety and Quality.

Title: Coronial Process and the Coroners Act 2003 Policy

ISBN: 978-1-76083-398-5

Objective reference number: 2018-12727 - A2801579

Date published: 23 Sept 2021

Review date: 23 Sept 2023

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11. Document history

Version	Date approved	Approved by	Amendment notes
7.1	27/10/2021	DCE, Commissioning and Performance	Minor amendment to Appendix 1, Section 1.5 – clarity on organ donation contacts.
7.0	30/08/2021	DCE, Commissioning and Performance	Revised policy into new template
6.0	07/08/2013		4.1.13 – documentation and process notification changes now via Safety Learning System
5.0	08/03/2013		Update 4.2.1 and 4.2.2 to align with the protocol between the Department and SA Police regarding requests for patient records
4.0	19/10/2012		Update to reflect the restructures within the portfolio and are not material in nature
3.0	20/07/2012		Update 4.1.1 and Appendix A
2.0	06/07/2012		Updated directive to provide clarity regarding roles and responsibilities of Coroners and Health staff relating to reportable deaths
1.0	01/06/2005		Original

12. Appendices

1. *Mandatory instruction SA Health Coronial Process and Coroners Act 2003 Mandatory Instruction*

Appendix 1: SA Health Coronial Process and Coroners Act 2003 Mandatory Instruction

The following Instruction must be complied with to meet the requirements of this policy.

1. Reportable Deaths (refer to definitions, section 8 of policy)

SA Health must have processes in place to ensure that the Coroner or South Australian Police (SAPOL) are immediately notified of any death that is, or may be, a reportable death.

SAAS Officers are required to contact SAPOL through the SAAS State Duty Manager and request police attendance at a suspected reportable death scene.

1.1 Reporting Requirements

- Refer to Part 5 of The Act and 5.2 of the policy.
- In making a determination as to whether a death is a reportable death the following must be considered:
  - (a) The original admission diagnosis or provisional diagnosis,
  - (b) Treatment whilst in hospital or at the scene (SAAS officers), at a prior hospital before transfer, or in transition between hospitals (SAAS officers/MedSTAR medical practitioners); and
  - (c) The medical cause of death (medical officers only).

  *for the list of reportable deaths see section 8: definitions.
- When reporting to the Coroner after hours, the phone is diverted to Adelaide Police Station.
- The Coroner or Police Officer may ask for a Report to Coroner Medical Practitioner's Deposition' form from the notifying medical practitioner/SAAS officers/MedSTAR medical practitioner.
- For further guidance refer to the SA Health Policy Guideline 'Police Requests for Information and Witness Statements from SA Health'.
- To gain additional information relating to the notified death, the Coroner or Coroner Investigator (Police Officer) has the power to enter at any time, and by force (if necessary) to:
  - (a) inspect and remove anything in or on site;
  - (b) take photographs, films and audio, video or other recordings;
  - (c) examine, copy or take extracts from any medical records or relevant documents (see 1.10).

1.2 Body of the deceased

- See Section 32 of the Act (refer to Body of the deceased, section 5.3).

1.3 Investigations

- All deaths in custody where the deceased is the subject of a Mental Health Inpatient Treatment Order are investigated by the Criminal Investigation Branch (CIB) of SAPOL.
- If the deceased is a Department for Correctional Services (DCS) prisoner then the death is investigated by the Coronial Investigation Section.
- In the event of a death where;
  - staff believe that a criminal act may have occurred, or
  - the death involves suspicious or unnatural circumstances, or
  - the patient death is considered a death in custody,

- all equipment such as drips, tubes and drains are to be left in situ and the surrounding area must not be disturbed or cleared
- the deceased's body must NOT be moved until SAPOL/Coronial Investigator has attended
- where the death has occurred within a correctional services environment, the DCS is responsible for maintaining the chain of evidence, scene and notification to the Coroner.

1.4 Identification of the deceased

> Family or friends (18 years or older) of the deceased person, or those who have known the deceased more than 48 hours prior to death and are present at the hospital, may identify the deceased to a hospital employee or DonateLife SA coordinator.

> A staff member who has known the deceased for longer than 48 hours prior to death can confirm the identity to an independent forensic conveyor or funeral director when collecting the body, or to a SAPOL Officer. If they do not feel comfortable doing the identification, leave that section of the form blank.

> If identification occurs after the Coroner's Court Death Report to Coroner Medical Practitioner's Deposition form has been faxed to the Coroner, re-fax the form to the Coroner. The form must be filed in the patient's medical record or scanned to Electronic Medical Record (EMR).

1.5 Organ Donation

- Cases for organ donation that are reportable to the Coroner are referred for consent for donation by the Organ Donation Coordinators from DonateLife.
- Cases for tissue donation that are reportable to the Coroner are referred for consent for donation by the Donation Coordinators from the Eye Bank of South Australia.

1.6 Internal Notifications

> If a medical practitioner is uncertain of the cause of death, or identifies issues that have the potential to be litigious, and/or believes a criminal act may have occurred, they are to notify the relevant Chief Medical Officer, Executive Officer, Director of Nursing and Midwifery or Medical Director (or delegate), Clinical Risk Manager or Director of Safety and Quality/Clinical Governance (or similar) within the LHN.

> If a SAAS Officer is uncertain of the nature of the death, or identifies issues that have the potential to be litigious, and/or believes that a criminal act may have occurred, they are to notify the State Duty Manager immediately who will notify the CEO.

1.7 SLS Reporting

> Separate to the requirement to report a notifiable death directly to the Coroner, the death must be reported in the Safety Learning System (SLS) Notifications module by the LHN (commonly Clinical Risk Managers or Risk Managers, or SAAS).

> A confirmation email is then sent from the individual SLS notification to the Insurance Services Unit (ISU) and the DHW Clinical Governance Unit at the time of entering the notification.

> Notifications into SLS are to be made:

  - within 72 hours of a death being notified to the Coroner's Office (health sites must have local processes that define who is responsible for this e.g. Clinical Risk Management); or
  - within 72 hours of the LHN being notified of a death by the Coroner's Officer or the delegated investigating police officer (at a time when the Coroner will request material from an LHN of a past patient, who died in the preceding months).

- Once a Coroner's Direction is received it must be uploaded to the Notification module in SLS.
- Where the death meets the definition of an adverse incident as per the South Australian Government Gazette (11 July 2019, page 2683) a patient incident must also be reported through the SLS Patient Incident module.

1.8 Notification of Relatives:

- Relatives of the deceased person must be advised by the Medical Practitioner or SAAS Officer of the Health Site's requirements to report the death to the State Coroner's Office or SAPOL as soon as possible.

1.9 Inquest – Investigations

- All health site personnel are to ensure the medical/clinical records of the deceased are up to date, including all pathology reports, x-rays, all electronic health records and medical and nursing notes, so that they are available for further discussion or review by the Coroner.
- Medical records must not be sent to the Coroner unless requested. Under Section 22 of the *Coroners Act 2003*, the State Coroner has the power to seize any records or documents. This power can be exercised by police officers or investigators appointed by the Coroner.
- Health site personnel must photocopy the medical records of a deceased person before releasing the original to the Coroner. The protocol that the DHW has with SAPOL states that:
    - Where a patient/client's medical records are required for a Coroner's Investigation, the health site must ensure that it has a copy of the records prior to delivering the original records to SAPOL. If a copy of the medical records cannot be readily obtained (e.g. the request for medical records occurs outside normal business hours), efforts need to be taken to negotiate a time to enable the health site to copy the records.
    - For sites using EMR, the medical record must be downloaded and presented to the State Coroner in a printed version.
    - In the event of a dispute the State Duty Police Officer must be contacted (ph. 0417 800 902). Medical records include the formal record, EMR, OACIS health material including laboratory reports, patient related material held on any other digital system that the LHN uses, and any other material that relates to the patient, which may include video footage.
- NOTE: in some instances it may be possible to negotiate providing a copy of the medical records to the Coroner's Officer or SAPOL. The Coroner (or delegate) may request a witness statement from staff to determine what had transpired leading up to the death of a patient.
- NOTE: The Chief Executive, DHW has provided written authorisation to disclose information to the Coroner, a South Australian Police Officer investigating a death on behalf of the Coroner and any other Investigator appointed pursuant to the Act during the investigation stage.

1.10 Coroners Finding of Inquest and Recommendations

- When the Coroner addresses the recommendations to the Minister for Health and Wellbeing and/or the Chief Executive, DHW, the SA Health Clinical Governance Unit is responsible for preparing a response on behalf of DHW. The Minister provides the response to the Coroner.
- As per section 25(5) of the Act the Minister must cause a report to be tabled in Parliament (within 6 months and 8 sitting days after the release of the findings).

1.11 Findings of Inquests

- As detailed in the *Coroner's Act 2003* – Part 4, Section 25, items 4 & 5:

- (4) *The Coroner's Court must, as soon as practicable after the completion of the inquest, forward a copy of its findings and any recommendations –*

- The DHW Clinical Governance Unit liaises with areas within SA Health, particularly those responsible for responding to the recommendations. These responses are used to prepare a report for the Minister who submits it to the Coroner.

2. Roles and responsibilities

- The following roles within SA Health have specific responsibilities in implementing this Policy and Mandatory Instruction, as summarised in Table 1 below:

Table 1. Roles and responsibilities for the implementation of the *SA Health Coronial Process and Coroners Act 2003 Policy*

Role/s	Responsibilities
SA Health Chief Executive/Deputy Chief Executive / LHN Chief Executive Officers / and other Health Services procured to deliver health services on behalf of SA Health	> adherence to this policy and appropriate reporting and record keeping > internal processes are in place to investigate 'reportable deaths' > all medical officers undertake MANDATORY e-learning course on Reporting a Death to the Coroner > staff are made aware of their obligation to report deaths in accordance with this policy and The Act and the penalties in failing to do so > that the Findings of Inquest recommendations that are relevant to the LHN are addressed, and any proposed actions are completed.
LHN Director of Safety and Quality/Clinical Governance Units / Divisional Directors	> maintaining and reviewing the SA Health Coroners Reporting System, this policy and associated processes > providing advice to SA Health in response to specific queries about the Policy > responding to Media and Communications Team regarding Coronial matters > providing briefings to the Chief Executive and the Minister for Health and Wellbeing about Coroners' Inquests and other Coronial matters.
Senior Insurance Officer, Insurance Services Corporate Affairs	> appointing legal representation for Coroners' investigations or inquests when required or requested by staff; > liaising with LHNs, SAAS and the DHW regarding requests received from appointed solicitors in relation to the Coroners' investigations or inquests > notifying the Minister's Office, relevant departmental and LHN staff when: o an Inquest is to be held and providing background summary into death; findings of Inquest are to be delivered; o distributing copies of Findings of Inquest to the Minister's Office and relevant departmental and LHN staff; > notifying the Media and Communications Branch when issues of a sensitive nature arise during an Inquest.
Medical Practitioners (Post Graduate Year 2+ and above)	> ensuring that any death that is or may be a reportable death, is promptly notified to the Coroner's Office within or after hours > providing the Coroner's Office or their delegate (out of office hours) with all relevant information in relation to the death

Role/s	Responsibilities
	> ensuring that they provide their opinion on the cause of death if they provided care to the person prior to their death or examined the person after their death > ensuring that a death certificate is not issued if the death is or may be reportable to the Coroner > completing the Coroner's Court Death Report to Coroner Medical Practitioner's Deposition' form if the death is reportable.
South Australian Ambulance Services (SAAS) Safety and Quality Lead	> ensuring staff are educated on their reporting obligations in accordance with The Act using e-learning course and other resources > responding to requests from the DHW Clinical Governance Unit for information relevant to a Coroner's Inquest or Safety Assessment Code (SAC) 1 death related incidents.
All other staff	> Keep informed of the requirements of this Policy.