Referral to the Coroner – Mothers and Babies - SESIAHS Business Rule

The full policy document is PD 094 – Deaths – Reports to Coroner. This is an abridged local business rule.

Initial action- confirm that this death will be referred to the coroner- see flow chart.

INFORM:

1. In hours Midwifery Unit Manager who informs the Network Manager & Nursing Co-Director. VMO/SS for neonatology or obstetrics as appropriate- it may be prudent for the issues to be discussed with the Facility Director and or the Director of Clinical Services.

2. Outside Hours After hours Senior Nurse Manager VMO/SS for neonatology or obstetrics as appropriate- it may be prudent for the issues to be discussed with the Facility Director and or the Director of Clinical Services- NB* be aware of time.

3. The duty social worker

4. Inform relatives of the baby’s/mother’s death as per usual procedures. The family should be informed that this is a Coroner’s case, and they will have to identify the body in the presence of a police officer and unfortunately at no point will they be permitted to be left alone with the body.

5a. Inform the relatives that the body will be taken to the Glebe Department of Forensic Medicine by government contractors for post-mortem to be performed.

5b. Inform Coroner of any family requests for religious considerations in relation to the body.

6. Contact the police to inform them that there is a Coroner’s case:
   - For Royal Hospital for Women contact Randwick Police: 9697 1099
   - For St George Hospital ring Kogarah Police: 8566 7499
   - For Sutherland Hospital ring Miranda Police: 9541 3899
   - For Wollongong Hospital ring Wollongong Police: 4226 7899
   - For Shoalhaven Hospital ring Nowra Police: 4421 9699
   - For Milton Ulladulla Hospital contact Ulladulla Police: 4454 2542

7. Preparation of the body:
   - All IV cannulae, needles, endotracheal and intra gastric tubes, drains and other airways are left insitu. Attached drip bags, bottles and feed lines can be disconnected and secured, but must accompany the body.
   - All sharps or pieces of equipment left insitu should be 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 insitu 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.
   - Limbs and chin should not be tied and orifices should not be packed.
   - Any material sucked from the stomach and/or vomitus from a suspected poisoning case should be retained and placed in a screw capped container, appropriate labelled and forwarded with the body.
   - If relevant/available the placenta should also be labelled appropriately and forwarded with the body.
   - In the case of infectious diseases a clear and indelible label should be attached to the body stating – Handle with Care the body should then be placed in a body bag x2 (i.e. Double bagged). A second label should then be placed on the outside of the second bag.
Neither label should specify the disease but specify an infectious disease ‘LIST A’ or ‘LIST B’ lists can be found on page 7 of SESIAHS PD 094 – Death – Reports to Coroner.

<table>
<thead>
<tr>
<th>8. Documents for completion:</th>
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<tr>
<td>– <strong>Report of a death of a patient to the Coroner.</strong></td>
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<tr>
<td>To be completed for all cases. The doctor on duty, usually the registrar, should fill in the form. Form A should be in triplicate: the original and first copy to be given to the police, the second copy should be filed in the baby’s/mother’s medical record. Copies of Form A are available in the Coroner’s folder on Delivery Suite.</td>
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<tr>
<td>– <strong>Report of a death associated with anaesthesia.</strong></td>
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| This form should only to be completed if death within 24 hours of an anaesthetic. Copies usually available on ICU at both sites.  
(see SESIAHS PD 213 – Death Screening)  
Coronial Checklist AMR 010.706 & Death Screening Form AMR010. 705 |

| 9. Photocopy all clinical documents (including results and ultrasounds) related to the current pregnancy. Place documents in a sealed envelope labelled “Attention: Coroner”. This envelope to be given to the police to accompany the body. |

| 10. The original medical record should be forwarded to: |
| In hours: Medical Administration.  
After hours: Nursing Administration via After Hours Senior Nurse Manager. |

| 11. Complete IIMS notification if not already entered onto the system. |

| References: |
| SESIAHS, 2009 | Death Screening in SESIAHS. Area Policy Directive PD 213 |

I, Professor William Walters Clinical Stream Director of SESIAHS Women’s and Babies Clinical Stream attest that this business rule is not in contravention of any legislation, industrial award or policy directive.
Maternity Department process of referral to the Coroner’s Department

The following guide is designed to assist staff when there is consideration for referral to the Coroner’s Department. This flow chart outlines the process that should be followed and is intended as a quick reference guide.

Please note: All Maternal Deaths require referral to the Coroner’s Department

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Obtaining Provisional Results from the Coroner’s Department

After a referral has been made to the Coroner’s Department the following process should be used by the relevant Midwifery Manager within 3 – 5 working days in-order for provisions results to be obtained.

Midwifery Manager and/or SS/VMO

Director of Clinical Services

Liaison with Medical and/or Nursing & Midwifery Co-Director

Department of Forensic Evidence

Discussion with

Director of Clinical Services

Liaison with Medical and/or Nursing & Midwifery Co-Director

Midwifery Manager and/or SS/VMO

December 2009

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