Coronial referral matters (POW ICU)

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Acknowledgement of Country

NSW Health Pathology FASS acknowledges the traditional custodians of this land, the Darug people, and pay our respects to ancestors and Elders, past, present and future.

We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

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Forensic and Analytical Science Service

- **Forensic Medicine**
- **Criminalistics:**
  - Forensic Biology/DNA
  - Illicit Drugs Analysis Unit
  - Chemical Criminalistics Unit
- **Forensic and Environmental Toxicology:**
  - Environmental Microbiology and Toxicology
  - Forensic Toxicology
  - Drugs and Driving Toxicology Unit

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Forensic Medicine in NSW

- State-wide service since 2015
- Multi-disciplinary teams at three facilities:
  - Forensic Pathologists
  - Forensic Mortuary Technicians
  - Forensic Medicine Social workers
  - Clinical Nurse Consultant
  - Administrative support
  - Radiologists/Radiographers
  - Other specialists services: Neuropathology, Odontology, Anthropology,

Forensic Medicine, Sydney

- Largest of our 3 facilities
- $91.5 million Forensic Medicine Coroners Court Complex
- Approx. 3700 Coronial death referrals annually
- Approx. 2050 post mortem examination annually

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Forensic Medicine – New and Old

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Relocation: Glebe - Lidcombe

Former NSW State Coroner's Court on Parramatta Road, Glebe

NSW Ambulance superstation will replace the former building

Forensic Medicine, Newcastle and Wollongong

- **FM Newcastle** - covers approximately 85% of the geographic area of NSW
- approximately 2500 coronial referrals annually
- approximately 1500 post mortems
- 81 jurisdictional districts

- **FM Wollongong** – relatively new service
- smallest facility with only one forensic pathologist

State Coroner

Magistrate Teresa O’Sullivan –appointed in 2019

Role of The Coroner

A Coroner must establish:

1. **Identity** of the deceased person
2. **Date** of death
3. **Place** of death
4. **Cause** of death
5. **Manner** of death

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When to Report to the Police and Coroner

In NSW, a death must be reported if the person has:

Section 6

- Died a **violent or unnatural** death
- Died a **sudden** death, the cause of which is unknown
- Died under **unusual or suspicious** circumstances
- Doctor **will not certify** cause of death
- The person's death was **not the reasonably expected outcome** of a health related procedure carried out in relation to that person
- Died whilst in, or temporarily absent from a **mental health facility** in which the person was a resident and receiving services

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When to report to the Coroner

Section 23

- Died in custody or whilst in, or temporarily absent from, a **detention or correctional facility**
- Died in the course of a **police operation**

Section 24

- Child in **care**
- Child about whom a **report was made to FACS within 3 years** preceding the child's death
- Sibling of child (above)
- Child whose death **may be due to abuse, neglect or is suspicious**
- Person (adult or child) living in or temporarily absent from **residential care home/ centre**

NSW HEALTH

Facility:

CORONIAL CHECKLIST

SMR010513

BINDING MARGIN - NO WRITING

FAMILY NAME		MRN
GIVEN NAME		☐ MALE ☐ FEMALE
D.O.B. ______/______/______		M.O.
ADDRESS		
LOCATION		

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Deaths Reportable to the Coroner – check list

This checklist is to be used to determine if a death should be reported to the coroner. It is to be completed by the officer determining extinction of life for all patients (PD 2005_488). The form is filed in the front of the medical record.

This check list is to be used in conjunction with NSW Health Policy Directive 'Coroners Cases and the Coroners Act' http://www.health.nsw.gov.au/policies/pd2010_054

Coronial Flags	YES	NO
1. Did the person die a violent or unnatural death?		
2. Did the person die a sudden death, the cause of which is unknown?		
3. Did the person die under suspicious or unusual circumstances?		
4. Did the person die 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?		
5. Did the person die in circumstances where death **WAS NOT** the reasonably expected outcome of a health related procedure carried out in relation to that person? *(see point 1 over page for further guidance)*		
6. Did the person die while in or temporarily absent from a declared mental health facility and while the person was a resident at the facility for the purpose of receiving care, treatment or assistance? (Includes admission to acute care facility whilst a patient of a Mental Health Facility)		
7. Did the person die whilst in the custody of a police officer or in other lawful custody? *(see point 2 over page for further guidance related to deaths in custody)*		
8. Did the person die whilst escaping or attempting to escape from the custody of a police officer or other lawful custody?		
9. Did the person die as a result of, or in the course of police operations?		
10. Did the person die whilst temporarily absent from an institution or place where the person was an inmate?		
11. Was the person a child in care, or a child whose death is or may be due to abuse or neglect or that occurred in suspicious circumstances? *(see point 3 over page for definitions and guidance related to death of a child)*		
12. Was the person (child or adult) living in or 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? *(see point 3 (e) over page for definitions and guidance)*		
13. Was the person disabled within the meaning of the Disability Service Act 1993 and receiving from a service provider assistance to enable them to live independently in the community? *(see over page point 3 (f) for definitions and guidance)*		

Approved Do Not Print

If answers to ALL of the questions are NO, the death is NOT required to be referred to the Coroner and a death certificate MAY be issued. Where doubt exists as to whether a death should be reported, telephone the Duty Pathologist (**Glebe:** *Business Hours (02) 8584 7821, After Hours (02) 8584 7821.* **Northern Forensic Hub, Newcastle:** *Business Hours (02) 4922 3700, After Hours (02) 49290822)* for clarification. The State Coroner's Court may also be contacted for advice on (02) 8584 7777.

If the answer is YES to ANY question the death must be referred to the Coroner using *SMR010.510 – Reporting of Death of a Patient to the Coroner* and a death certificate MUST NOT be issued.

The exception to this rule is that under S38 (2) of the Act, medical practitioners can issue a death certificate if they are of the opinion that the person:
(a) was aged 72 years or older, and
(b) died in circumstances other than in any of the circumstances referred to above, and
(c) died after sustaining an injury from an accident, being an accident that was attributable to the age of the person, contributed substantially to the cause of death and was not caused by an act or omission by any other person(this applies to accidents at home or in institutions)

However the medical practitioner **must state** on the certificate that it is given in pursuance of *S38(2) of the Coroners Act 2009*. A medical practitioner cannot certify the cause of death in accordance with this section if before the certificate is given a relative of the deceased person indicates to the medical practitioner that s/he objects to the giving of the certificate. If an objection by a relative occurs the death must be reported to a police officer who is then required to report the death to a coroner or assistant coroner as soon as possible after the report is made.

Staff Name:	Signature:	Designation:	Date:

081010

NO WRITING

CORONIAL CHECKLIST

SMR010.513

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Natural deaths and the Coroner

- Coroners focus on unnatural, violent and suspicious deaths
- Only refer natural cause deaths if the **probable** cause is unable to be identified
- Can the likely proximate cause of death be identified?
- Can issue a death certificate if the Dr has examined the body and the deceased has seen some other Doctor in the last six months
- Doctor responsible for the deceased's medical care immediately prior to the death MUST issue a cause of death certificate if he or she can identify a natural disease or condition that more likely than not caused the death

Issuing a MCCD

Record the disease or condition directly leading to death in the top row of part 1

		► Cause of death	► Time interval from onset to death
1. Report disease or condition directly leading to death on line a Report chain of events in due to order (if applicable) State the underlying cause on the lowest used line	a		
	b	Due to:	
	c	Due to:	
	d	Due to:	
2. Other significant conditions contributing to death (time intervals can be included in brackets after the condition)			

Record any antecedent causes giving rise to the above cause in subsequent rows in part 1

Record any other significant conditions contributing to the death, but not related to disease or condition causing it in part 2

The most important entry is the underlying cause of death

		Cause of death	Time interval from onset to death
1. Report disease or condition directly leading to death on line a Report chain of events in due to order (if applicable) State the underlying cause on the lowest used line	a		
	b	Due to:	
	c	Due to:	
	d	Due to:	
2. Other significant conditions contributing to death (time intervals can be included in brackets after the condition)			

The underlying cause of death is the disease or injury that *initiated* the train of events leading directly to death

- The underlying cause of death should be recorded on the lowest completed line in part 1 of the cause of death document
- The underlying cause of death:
  - is captured by Australian Bureau of Statistics; and
  - determines whether the cause is natural or unnatural*

Example of how to complete a MCCD

This sequence must make sense, both pathophysiologically and chronologically

		► Cause of death	► Time Interval from onset to death
1. Report disease or condition directly leading to death on line a Report chain of events in due to order (if applicable) State the underlying cause on the lowest used line	a	Septic shock	Hours
	b	E. Coli urinary tract infection	5 days
	c	Indwelling catheter	4 months
	d	Parkinson's disease	2 years
2. Other significant conditions contributing to death (time intervals can be included in brackets after the condition)		Diabetes Mellitus type 2	Years

Definition of health related procedure

Includes: medical, surgical, dental or other health related procedure including administration of an anaesthetic, sedative or other drug.

Does not include:

- Giving of IV or IM injection/ IV therapy/ insertion of a line or cannula/giving of subcutaneous injection or infusion
- Artificial ventilation/CPR
- Urethral catheterisation
- Insertion of NG tube
- Intra-arterial blood gas collection
- Venepuncture for blood collection for testing
- Ear syringing
- Acupuncture

Things to consider.

a) Did the health related procedure cause the death?
b) Was the death an unexpected outcome of the procedure?

Did the health procedure cause the death?

Consider:

- was the health related procedure **necessary** to improve the patient's medical condition, rather than an elective or optional procedure, and
- was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers to be **competent medical practice**?

If the answer to both of these questions is yes, then

the death may not be reportable

Was the death an unexpected outcome of the health related procedure?

Consider:

- whether the patient’s condition (factoring in age and co-morbidities) at the time they underwent the 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 that the *potential benefits of the procedure outweighed the risk.*
- was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers to be *competent medical practice*?

If in doubt ask for advice….

Duty pathologist - 9563 9000

If you need to report a death.

- Leave all lines, tubes insitu
- Do not clean the deceased or if any cleaning is attended during the course of the resuscitation ensure this is documented along with the reason why.
- Make sure you document all attempts at IV cannulation during resuscitative measures
- Complete clinical documentation
- Don’t forget the Form A
- Contact police and notify them of the death and referral to the coroner

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Police and Coronial referrals

- P79a (report to the Coroner) is completed by police
- Crime scene officers may attend in some instances to take coronial scene photos
- A detective may or may not be asked to attend to assist in establishing the nature of the death (Natural vs suspicious)
- Conduct search of body (non suspicious)
- Conduct identification of the deceased with appropriate individual
- Organise transport to Forensic Medicine or mortuary (rural) through state-wide transport service
- Recognize this can be quite distressing for families, particularly in natural deaths

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Coronial recommendations

- Medical certificate Cause of Death (MCCD)
- Coronial Certificate
- External and toxicology
- Limited
- Coronial Post-Mortem
- Forensic

Supporting a family during the process

- All social workers with various backgrounds in trauma, bereavement and counselling
- Interface between forensic and coronial systems and the families
- Every caller and every visitor has experienced a recent bereavement

Supporting a family during the process

Core functions of the Forensic Social Work team include:

- Providing psychological first aid, crisis support and early intervention to acutely bereaved and/or traumatised people;
- Providing preparation and support for the viewing and formal identification of deceased persons;
- Providing hand and footprints and locks of hair as keepsakes to parents after the death of a baby or child and mementos of other deceased persons upon the request of bereaved individuals;
- Supporting the tasks of the jurisdiction to facilitate outcomes that respect the cultural and religious needs of the bereaved;
- Liaising with the Senior Next of Kin (SNOK) or their delegate/s to provide information and support regarding grief and trauma reactions, the Coronial jurisdiction, Forensic Medicine procedures and cause of death details; and
- Performing psychosocial assessment and providing referrals (with client consent) to the Support After Suicide Program, the Homicide Victims Support Group and other support services.

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Supporting a family during the process

Do not give timeframes, let the family know a Forensic Social Worker will call on the next business day after admission.

If families wish to view their loved one, this can be discussed with the Forensic Medicine Social Work team.

If you are providing a handover, email us, we generally receive a police report within a few hours with background information.

NSWPATH-FASS-FMSYD-SocialWork@health.nsw.gov.au

Factors that influence bereavement

- Type of death, natural or traumatic
- Untimely death
- Prior experience of death
- Attachment to the deceased
- Physical and psychological health of bereaved
- Cultural and spiritual beliefs
- Socioeconomic factors

How to support a grieving person

Acknowledge for yourself that imparting difficult news or bearing witness to distress is a complex, stressful and potentially triggering experience and it's entering into suffering with others.

Listen and accept there will be strong emotions.

Using the name of the deceased.

Encouraging the family to make their own decisions where they can

What can you say,

- I don't know what to say but I'm here.
- I can see how hard this is. Do you want to talk about it?
- If you would prefer not to talk right now, that's ok.

When to seek help

Although grief can be very painful, most people (85 – 90%) find that the support of family and friends and their own resources, they gradually find ways to learn to live with their loss, and do not need professional help. However, sometimes the circumstances of the death may have been particularly distressing or the circumstances can contribute to make the grief particularly acute or complicated. If over time your client or friend seems to be finding it difficult to manage their day to day life they might benefit from a referral to a professional. 2014 Australian Centre for Grief and Bereavement

Your words matter

- What you say and do matters.
- Family members often remember every aspect of the day when their life changed forever.
- Use clear unambiguous language, avoid euphemisms and medical jargon
- Explain what will happen
- Answer questions repeatedly
- Express yourself authentically, I’m shocked, I’m sorry, I’m really sorry this happened

How to introduce the subject of brain death

- We have a difficult and sensitive conversation to have with you, is now an ok time for you?
- Would you like to have the conversation when you have another family member with you for support, we can reschedule to make that happen?
- I have difficult information to share with you, I want you to know everything so I'm going to share this information with you. I'm aware this news will be painful. If you need a break or if you have a question, please let me know.

Self care

- This work is challenging, self care is imperative
- It is important to talk together
- Take care of your physical, psychological and spiritual self.
- Take breaks, do things that are restorative.