SESLHD GUIDELINE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Women's and Children's Health
AUTHOR	CMC Women's and Children's Clinical Stream
POSITION RESPONSIBLE FOR DOCUMENT	CMC Women's and Children's Clinical Stream Alison.brown3@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Women and Babies Health
KEY TERMS	Coroner; unexpected death; maternal death; neonatal death
SUMMARY	A guideline for referral to the coroner in maternity services when there is a neonatal or maternal death and consideration is given regarding referral to the coroner.

Health
South Eastern Sydney
Local Health District

Referral to the Coroner

Section 1 - Background

This document can be referred to when there is a neonatal or maternal death and consideration is given regarding referral to the coroner. This is a guideline to ensure appropriate referrals to the coroner and avoid inappropriate referrals.

Section 2 - Principles

Reporting a maternal, or neonatal death to the coroner must be in conjunction with the senior medical officer in obstetrics for maternal death, and neonatology or paediatrics for neonatal death.

Refer to NSW Ministry of Health Policy Directive PD2010_054 - Coroners Cases and the Coroners Act 2009 for management of the body after death in reportable cases to the NSW Coroner, including the mechanics of arranging a coronial post-mortem.

Where there is uncertainty as to whether a maternal or perinatal death is reportable, advice can be sought from the Women's and Children's Stream Director and/or or the Medical Director of the maternity service at the facility.

If there is any doubt as to whether the death is reportable, contact must be made with a senior medical team member or senior midwifery or nurse manager or in their absence the NSW Police or the Office of the NSW State Coroner on 8584 7777 or the on duty forensic pathologist on 9563 9000 (business hours).

EXCLUSIONS

This is not a guideline for all coroner's cases.

Section 3 - Definitions

Definition:

- **Maternal death** is the death of a woman while pregnant or within 42 days of the end of pregnancy, regardless of the duration or outcome of the pregnancy.

- **Neonatal death** is the loss of a baby, who has taken a breath and/or has a heartbeat after birth irrespective of gestational age but does not live past 28 days whereby the infant dies of a sudden death.

Section 4 - Responsibilities

Chief Executives are responsible for:

- Ensuring all staff are made aware of their responsibility relating to NSW Ministry of Health Policy Directive PD2010_054 - Coroners Cases and the Coroners Act 2009.

Midwifery and Nurse Managers / Senior Medical Officers are responsible for:

- Ensuring appropriate reporting /referrals to the coroner are made.
- Providing appropriate medical records to the Coroner's Office when there has been a referral to the Coroner.
- Informing clinicians, that nothing should be done to a body after death if it is a Coroner's case.

Nursing, Midwifery and Medical staff be aware:

- All intra-venous cannulae, needles, endotracheal and intragastric tubes and drains are to remain insitu. Attached intravenous flasks, bottles and feed lines and equipment left insitu remain with the body.

Section 5 - Best Practice Principles

- Reportable deaths to the coroner which are relevant to maternity services are:
    - Violent or unnatural deaths.
    - Suspicious or unusual circumstances.
    - The woman (i.e. mother of the baby) had not attended a medical practitioner over the preceding 6 months (i.e. no antenatal care).
    - When the maternal or neonatal death was associated with a health care procedure where death was not a reasonably expected outcome or complication, i.e. the procedure caused the death and death was not the expected outcome. If, however, the procedure was necessary to improve the patient's medical condition (rather than an elective procedure), in particular if death was likely to occur if they did not undergo the procedure, and peers would consider the procedure to be consistent with competent professional practice, then the death is NOT reportable.

- It is extremely rare that a neonatal death will be referred to the coroner.
- Usually stillbirths are not coroner's cases; the baby must take an independent breath before a referral is made to the coroner. In the absence of an independent breath, life is deemed not to have occurred, and referral to the coroner is not necessary. However, there may be circumstances which arise where a stillbirth may be unusual or has resulted from a criminal action (such as violence to the mother). In these cases, autopsy should be recommended to the mother, and the autopsy should be performed by an experienced and specialised perinatal pathologist.
- Maternal and or neonatal deaths which occur as a recognised complication of pregnancy and birth and when management seemed appropriate are not coroners cases, e.g. death from prematurity, fetal anomalies, cord prolapse, placenta praevia.
- Complications of birth resulting in death, such as a subgaleal haematoma from an instrumental birth, severe hypoxia due to cord prolapse, shoulder dystocia etc are not generally reportable to the coroner if death was likely to occur if they did not undergo the procedure, and management appeared appropriate.
- The factors to consider in each particular case will be different and medical officers must use professional judgement to determine whether the death is reportable.
- An expert autopsy can be still obtained from a perinatal pathologist at NSW Pathology/SEALS if the case is not reportable to the coroner.

Potential Risks

- Inappropriate/unnecessary referral to the coroner
- Undue distress to the family

Cultural Support

- When clinical risks are identified for an Aboriginal woman, she may require additional supports. This may include Aboriginal health professionals such as Aboriginal liaison officers, health workers or other culturally specific services.
- For a Culturally and Linguistically Diverse CALD woman, notify the nominated cross-cultural health worker during Monday to Friday business hours.
- Non-English speaking culturally and linguistically diverse (CALD) women can be supported by offering appropriate interpreters using the Interpreter service NSW Health PD2017_044 Interpreters - Standard Procedures for Working with Health Care Interpreters.

Section 6 - Documentation

- Electronic medical records
    - e Maternity
    - Clinical notes
    - Complete iPM
    - K2 Guardian

- Neonatal Care Plan

Section 7 - References

- Coroners Court of NSW (2020, June. 23). *Which deaths must be reported to a Coroner* Coroners Court of New South Wales (nsw.gov.au)
- NSW Ministry of Health Policy Directive PD2010_054 - Coroners Cases and the Coroners Act 2009
- NSW Ministry of Health Policy Directive PD2017_044 - Interpreters – Standard Procedures for Working with Health Care Interpreters

Section 8 - Version and Approval History

Date	Version Number	Contact Officer (Position)
4 September 2023	2.1	Minor review to convert Business Rule SESLHDBR/007 to guideline. Inclusion of cultural support information.