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SYDNEY SOUTH WEST
AREA HEALTH SERVICE
NSW HEALTH

Trim ref: SSWD09/22049
File ref: SSWFC06/1618

Clinical Operations

TO Facility General Managers

CC Directors of Medical Services, Area Director Corporate Services, Designated Senior Complaints Officer

FROM Dr Teresa Anderson, Director Clinical Operations

TEL 9515 9641

DATE 23 December 2009

SUBJECT Coroner's Act 2009

The Coroner's Act 2009 comes into effect on 1 January 2010.

PD2009_083 concerning the changes was issued by the Department on the 22 December 2009 (http://www.health.nsw.gov.au/policies/pd/2009/PD2009_083.html).

The attached document from the Legal Branch of the Department of Health describes the major changes with the new Act.

One of the major changes is a requirement to report a death to the Coroner if it is not the 'reasonably expected outcome of a health related procedure'. The document gives guidance to Medical Practitioners in determining this. A health related procedure means a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug), but does not include any of the following:

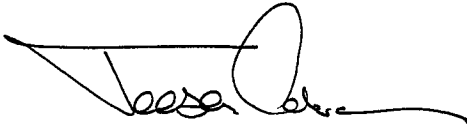
- (a) the giving of an intravenous injection
- (b) the giving of an intramuscular injection
- (c) intravenous therapy
- (d) the insertion of a line or cannula
- (e) artificial ventilation
- (f) cardio-pulmonary resuscitation
- (g) urethral catheterisation
- (h) the insertion of a naso-gastric tube
- (i) intra-arterial blood gas collection
- (j) venipuncture for blood collection for testing
- (k) the giving of subcutaneous injection or infusion
- (l) ear syringing, and
- (m) acupuncture

There is no longer an automatic requirement to refer deaths within 24 hours of an Anaesthetic. However, these deaths are to be reported to the Director General through the Special Committee Investigating Deaths Under Anaesthesia (SCIDUA).

Please ensure all relevant Medical & Nursing staff are aware of these changes. If clinical staff are unclear whether a particular case should be referred to the Coroner, the case should be discussed with the Coroner's office.

The Policy Directive also includes a new Form A, 'Report of Death of a Patient to the Coroner', and a new Form B, 'Report Of Death Associated With Anaesthesia/Sedation'.

Thank you for your assistance.

A handwritten signature in black ink, appearing to read 'Teresa Anderson', with a long horizontal flourish extending to the right.

Dr Teresa Anderson

Summary of the Coroner's Cases and Coroner's Act 2009 (PD2009_083)

This summary is a brief overview of the significant changes impacting on practitioners, health care workers and managers and is a guide. For detailed information is in the policy directive Coroner's Cases and Coroner's Act 2009 (PD2009_083) and the Act. .

Reporting of deaths to Coroner

The category of reportable deaths has been changed to require deaths to be reported to the Coroner if the death is not the 'reasonably expected outcome of a health related procedure'. The term 'health related procedure' has been defined to mean a medical, surgical or other health related procedure including the administration of an anaesthetic, sedative or drug. The policy directive outlines procedures which the Coroner has determined are not 'health related procedures'.

The term 'reasonably expected outcome of a health related procedure' has not been defined in the Act, however guidelines to assist the medical practitioner to determine whether or not the death should be reported to the coroner are below (however the examples are not exhaustive and factors individual to each case must be considered):

1. Is the death a reportable death?

Consider:

- Did the health related procedure cause the death?
- Was the death an unexpected outcome?

2. 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?
- Was the health related procedure performed in a manner, which at the time of the death, would be considered by your peers as competent professional practice?

If the answer to both of these questions is **yes**, then the death may not be reportable

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

Consider:

- Whether the patient's condition (factoring in their age and co-morbidities) at the time they underwent the health or 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; however the patient, family and/or medical practitioner believed the potential benefits of the procedure outweighed the risk.
- Whether the health related procedure was performed in a manner which at the time of the death, would be considered by your peers as competent professional practice.

If the answer to each of these questions is **yes** then the death may not be reportable.

**Comparison between the previous and the new Policy Directive: Coroners' Cases and the Coroners Act 2009
(Implementation of the new policy directive commences 1 January 2010)**

<p>Previous PD Coroners' Cases and the Coroners Act</p>	<p>PD2009_ 083 Coroners' Cases and the Coroners Act 2009 (Implementation 1 January 2010)</p>	<p>Applicable Section of the Policy Directive</p>	<p>Applicable Section of the Coroners' Act</p>
<p>Requirement to report <u>anaesthetic related deaths</u> to the Coroner within 24 hours.</p>	<p>Only requires the death to be reported to the Coroner if the death was not the 'reasonably expected outcome' of a health related procedure.</p> <p>Requirement to report <u>anaesthetic related deaths</u> to the Special committee investigating deaths under anaesthesia.</p>	<p>Section 2.4.3</p>	<p>Section 6</p>
<p>A medical practitioner can issue a death certificate if the medical practitioner has attended the person during the <u>previous three months</u> prior to the death.</p>	<p>Require <u>deaths to be reported to the Coroner</u> if the death is not the <u>reasonably expected outcome</u> of a health related procedure.</p>	<p>Section 2.2.1 PD provides a guide on <i>reasonably expected outcome</i></p>	<p>Section 6</p>
<p>Requirement that a matter be reported to the Coroner if a person died within a year and a day of an accident.</p>	<p>A medical practitioners can issue a death certificate if they are satisfied the cause of death is known and have seen the patient in the <u>previous six months</u> to the death.</p> <p>No longer applicable</p>	<p>Section 2.2.1</p>	<p>Section 6</p>
<p></p>	<p>A medical practitioner is authorised to give a death certificate concerning a cause of death of a person aged 72 <u>years old or older</u>, (in circumstances where the death is not a reportable death) who 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.</p>	<p>Section 2.3</p>	<p>Section 38(2)</p>
<p></p>	<p>A <u>medical officer undertaking a post mortem</u> is to use the least invasive procedure that is appropriate in the circumstances.</p>	<p>Section 2.5</p>	<p>Section 88</p>