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Relevant sections of the Board Policy Manual should also be read. These are on the Intranet (Death – Reported to the Coroner; Deceased Child, Deceased Persons / Tupapaku - Release of).

**Reporting to the Coroner**

The Coroner’s Act 1988 Section 4 specifies the deaths which must be reported to the Coroner. Medical staff must notify the Coroner of the following deaths (unless already reported).

1) Every death that appears to have been without known cause, or suicide, or unnatural or violent.
2) Every death in respect of which a doctor has not given a certificate under section 37 of the Births, Deaths and Marriages Registration Act 1995.
3) Every death -
   a) that occurred while the person concerned was undergoing a medical, surgical, or dental operation or procedure or some similar operation or procedure, or
   b) that appears to have been a result of any such operation or procedure, or
   c) that occurred while the person was affected by an anaesthetic, or
   d) that appears to have been a result of the administration to the person of an anaesthetic.
5) The death of any special or compulsory patient under the Mental Health (Compulsory assessment and Treatment) Act 1992 in a hospital.
6) The death of anyone receiving care in a facility under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003.
7) The death of a child in the care of a social service agency or facility under the Children, Young Persons and Their Families Act 1989.
8) The death of a prisoner, someone in the custody of the police or under the control of a security officer.

Clinical judgment is required when interpreting which hospital deaths should be reported to the Coroner. If unsure, talk to the Coroner, who can be contacted in normal working hours on 373 5295 (mornings), 916 9250 (afternoons), or urgently by mobile phone 027 448 5309.

**Contacting the Police**

If the death is to be reported to the Coroner, the doctor pronouncing the patient dead must inform the Police as soon as possible. Nursing or clerical staff may also notify the Police, at the request of medical staff. Ring 302 6400, ask for Control.

Note that any situation where child abuse is suspected to be the cause will be a suspected homicide, and Police procedure will be different from that described in this document (see Abuse and Neglect guideline in Starship Clinical Guidelines). If possible, all such cases should be notified to the Police and Child, Youth and Family Services prior to death.
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Information Required by the Police

Name, age and date of birth of the deceased; name of the responsible consultant; brief description of the circumstances of death including location; cultural preferences; where the deceased is to be collected from; who will meet the Police (doctor, nurse, family); location of clinical records.

Documentation

The Duty Manager must be informed, and will bring the file of documents necessary for referral to the Coroner (for deaths in PICU, PICU have their own file). By definition, Starship medical staff cannot complete a death certificate for a death reported to the coroner.

The doctor must complete the NZ Police Deceased Person Certificate (POL265) and the Coroner’s Autopsy Form (CR0020). The latter must accompany the body to the mortuary or be given to the Police. Note adornments and jewellery that are not removed on the Death Notice (CR2669). The top copy is left in the file. The second copy goes with the body to the mortuary.

Complete the Starship Mortality Notification Form (Q005), the ACH/Starship Resuscitation Record (CR8545) if appropriate (both are for internal quality assurance review) and the Bereavement Service Form (CR2043). CR2043 should be faxed to 5926, to facilitate follow-up.

The original patient notes will go with the body to the mortuary, on the understanding that:
• If possible, a copy of the original documents will be made before transfer. Grafton Clinical Record Department can assist if ward staff are unable to copy the record, particularly after hours. The copy will be retained on the ward while the originals are with the pathologist.
• The post-mortem will usually be performed at 7am (Mon – Sat) unless it has been authorised by the Coroner as an urgent release autopsy. The original medical records must be available prior to this for the forensic pathologist to review prior to the post-mortem.
• The original notes will be returned to ADHB Clinical Records for scanning upon completion of the post-mortem examination, later the same day. ADHB Clinical Records department will be notified by the pathologist where a delay of more than 24 hours is envisaged.
• On return to ADHB Clinical Records, the notes will be scanned immediately. Note that the scanning service is not available overnight between 2100 – 0700 hours. Note: original documents for the last admission of deceased patients referred to the coroner are not destroyed after scanning, but held at least until the Coroner has issued a finding.
• The pathologist may request that the original notes are returned to them after scanning, and will return the file to Clinical Records in due course, without any alteration to the original record.
• Rarely, the Coroner may order retention of the original file and will inform ADHB of the reasons.

Next of Kin

The doctor pronouncing the patient dead is also responsible for informing the next of kin of the notification to the Coroner and the indications / processes involved. The doctor should also inform the child’s GP, and document in the notes that they have done so.

If available, Kaiatawhai or Pacific Family Support Unit staff should be informed as soon as possible of the death, so that they can provide support to the family if they desire it. The Chaplain should also be contacted if the family desire it.
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Whanau should be offered the option to stay until the Police arrive, so that the Police can explain the procedure to them. Parents must be given as much time as they need to be with and handle their baby or child.

**Statements to the Police**

The Police are required to obtain a positive identification of the deceased. This necessitates the completion of a ‘Statement of Identification’ form which may be completed with a nurse or doctor if no family or friends are present. The inquest sergeant carries out routine inquiries. The Police are also required to take statements regarding the death which may involve asking medical and nursing staff questions, and in particular speaking with the person(s) who last saw the deceased alive. If staff have any concern about providing a statement ADHB Legal Services should be contacted. Unless the police require information urgently staff should take time to review and correct the statement before signing it. Alternatively a report may be prepared and forwarded to the Police.

**Dealing with the Body of the Deceased**

On arrival at the Starship the Police report to Starship reception outside Children's Emergency Department. The staff phone the duty manager to notify their arrival and to confirm a private place for them to meet with the doctor, and with the family. (For deaths in PICU, the Police usually report directly to PICU). When the Police have completed their enquiries they will arrange for a funeral director to transfer the body to the Coroner's mortuary at LabPlus. If the body is to remain for a period in the Starship, the Police will identify the body, collect the Autopsy Form for Patient Referred to Coroner and arrange the transfer time with staff and the Police funeral director. Family can be responsible for care of the deceased until the transfer. If there is a suspected homicide, a detective is assigned to stay with the deceased.

**Tubes and Lines**

In all cases referred for coronial autopsy, remove lines and tubes only with the consent of the specialist or senior registrar responsible for the deceased. If there was any suggestion of a problem with the position of a tube or line that may have contributed to the death then that particular tube or line should be left in situ and not removed prior to the autopsy. **It may not be removed unless the treating clinician has obtained the consent of the Forensic Pathologist.**

If there are no objections from the senior doctor responsible for the deceased, and there is no indication of a problem with lines or tubes present within the patient, then these may be removed before the body is dispatched to the mortuary. **Any lines or tubes removed from a deceased are to be retained and forwarded with the deceased to the Mortuary.**

If the senior doctor is in any doubt about the appropriateness of removal of a particular line or tube, discuss the problem with the on-call forensic pathologist. The forensic pathologist can be contacted by mobile phone on 021 555 319 or through Auckland Central Police Control (see above).
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Urgent Release

Autopsies are routinely performed in the morning, Monday to Saturday. After hours, particularly on a Saturday, standard procedures could mean the body of a child spends up to 48 hours in the mortuary awaiting autopsy. The Coroner’s Act allows for the possibility of “urgent release” of the body where this is required by ethnic origin, social attitude, customs or spiritual beliefs. Only the Coroner has the power to authorise urgent release.

Staff may not promise families of deceased that the post-mortem will take place immediately without having obtained the Coroner's agreement to this. If there is a need for urgent release, report the death to the Coroner as soon as possible and make the request as soon as possible after death. Forensic pathologists and other mortuary staff finish work for the day at 1530 weekdays and 1230 weekends. It can be extremely difficult for the Coroner to arrange for an early postmortem and release if a request is delayed. Make the “Request for early performance of postmortem and release” (“Request”) to the Police Inquests Officer on 302 6829, who liaises with the Coroner. A forensic pathologist cannot perform an autopsy until the Police have completed their documentation. Before requests are made, arrangements must have been made for a funeral director to be available to collect the deceased after the postmortem.

It may be difficult to secure an urgent release if the deceased suffered from a complex problem (eg congenital heart disease), for which a sub-specialist paediatric pathologist is required. If you are unsure whether this is the case, discuss the situation with the forensic pathologist on call. If you cannot reach the Coroner or the Police Inquests Officer, contact the on-call pathologist directly. Out of hours, you can do this by ringing Auckland Central Police, and asking Control for the telephone number of the forensic pathologist on call (home number, mobile phone).

Nursing Care

For nursing care of the deceased patient refer to the Starship nursing guidelines.

Blessing the Room

The Chaplain or Kai Atawhai may be contacted to bless the room and equipment used by the deceased person.

Postmortem Reports

Once completed, postmortem reports may be available during working hours from extension 307 4949 extn 7517.

Follow up

All families whose child has died in Starship need emotional support and follow-up. (See Deceased Child policy on Intranet). Starship Bereavement Services may be able to facilitate this if they are notified of the death. They have resources for families such as the booklet After your child has died.
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(Skylight ISBN 0-9582325-7-1), and Writing to Remember (both available from Skylight 0800 299 100, or by email from ad@skylight-trust.org.nz).

It is good practice to arrange a follow-up appointment with the family to offer support, and to address any questions. If the child has an autopsy, a doctor should meet with the family to explain the autopsy report when it arrives. In coronial cases, the autopsy report may be delayed for a long time. If you have any concerns about the timing or appropriateness of a follow-up meeting with the family in a coroner’s case, feel free to ring the coroner and discuss the matter.