Coroners Cases and Coroners Act 2009

Summary Updates following changes to the Coroners Act 2009 (NSW) since the publication of PD2010_054. It also updates associated State Forms including the Coronial Checklist and Report of a Patient's Death to the Coroner forms. The updated Policy Directive also provides new guidance on Voluntary Assisted Dying deaths.

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Distributed to Ministry of Health, Public Health System, Divisions of General Practice, Government Medical Officers, NSW Ambulance Service, Private Hospitals and Day Procedure Centres

Audience Administration;Clinical;Medical;Nursing and Midwifery;Paramedic;Allied Health Staff

Secretary, NSW Health

NSW Health

Policy Directive

Coroners Cases and the Coroners Act 2009

Policy Statement

NSW Health is committed to ensuring that there is appropriate reporting of deaths to the Coroner and support for the deceased person's family and friends.

This updated Policy Directive is in line with changes in the *Coroners Act 2009* (NSW) and *Coroners Regulation 2021* (NSW).

Summary of Policy Requirements

The *Coroners Act 2009* (NSW) provides that certain deaths are reportable to the Coroner.

This updated Policy Directive provides specific information about the Coroners Act to medical and other health practitioners and managers in the public health system.

It also provides:

- guidance in determining which deaths should be reported to the Coroner and the procedures for reporting.
- guidance and information for health practitioners to support the family and friends of the deceased person whose death is reported to the Coroner.

This updated Policy Directive provides new guidance on specific issues such as Voluntary Assisted Dying deaths and reporting deaths of children whose deaths fall within section 24 of the *Coroners Act 2009* (NSW), except where the death is a palliative care death.

The Policy Directive includes an updated *Coronial Checklist* and *Report of a Patient's Death to the Coroner* form.

Revision History

Version	Approved By	Amendment Notes
PD2024_036 December-2024	Deputy Secretary, Population and Public Health & Chief Health Officer	Updated in line with amendments to the *Coroners Act 2009* (NSW) and *Coroners Regulation 2021* (NSW) in addition to the following updates: • Inserted new guidance about Voluntary Assisted Dying deaths • Inserted new guidance about children's deaths where they are reviewable under section 24 of the Coroner's Act. • Inserted new information about support for Aboriginal families and the Coroner's First Nations Protocol. Updated the following associated State Forms: • *Coronial Checklist* (SMR010513) • *Report of Death of a Patient to the Coroner* (SMR010510).
IB2010_054 November-2010		
PD2010_054 September-2010	Deputy Director General, Population Health	Replaces PD2009_083. Updated in line with provisions of the Coroners Regulation 2010.
PD2009_083 December 2009	Deputy Director General Population Health	Replaces PD2005_032. Updated in line with changes in the Coroners Act 2009.
PD2005_352 May 2004	Director General	Updated to incorporate amendments to the Coroners Act 1980

Contents

1. Background

1.1. About this document

This Policy Directive provides specific information about the *Coroners Act 2009* (NSW) (**the Act**) and the implications for medical practitioners, health care workers and managers in the public health system. It relates to deaths that occur within the NSW public health system.

Current versions of the *Coroners Act 2009* (NSW) and the *Coroners Regulation 2021* (NSW) are accessible at www.legislation.nsw.gov.au.

1.2. Key contact details – Forensic Medicine and Coroner

For medical practitioners/health service staff:

Duty Forensic Pathologist, Forensic Medicine, NSW Health Pathology: 02 9563 9000

When contacting Forensic Medicine please advise the administration officer receiving your call, which hospital and/or location you are from. This will assist in ensuring your call is directed to the appropriate Duty Forensic Pathologist.

Office of NSW Coroner/Registry: 02 8584 7777 (business hours)

For the bereaved family/friends:

Coronial Information and Support Program (CISP): 02 8584 7777 or lidcombe.coroners@justice.nsw.gov.au

Forensic Medicine Social Work, Sydney: 02 9563 9000

Forensic Medicine Social Work, Newcastle: 02 4935 9700

Forensic Medicine Social Work, Wollongong: 02 4222 5466

Griefline Helpline 1300 845 745 or https://griefline.org.au/

Mental Health Telephone Access Line: 1800 011 511

Suicide call back Service: 1300 659 467

1.3. Key definitions

Assisted Boarding House	A premises providing beds to 2 or more residents who are persons with additional needs or declared to be an Assisted Boarding House. A person with additional needs is defined as a person who has a permanent age-related frailty, a mental illness within the meaning of the *Mental Health Act 2007* (NSW), or a disability and as a result of the permanent condition, requires assistance or supervision with activities of daily living [section 36 and 37 *Boarding Houses Act 2012* (NSW)]. However, this excludes persons with additional needs who reside with their competent

	relatives.
Child	As defined in section 24 the Act, a child means a person who is less than 18 years old.
Child in care	As defined in section 24 of the Act, a child in care means a child or young person who is less than 18 years old: • who is under the parental responsibility of the Minister administering the *Children and Young Persons (Care and Protection) Act 1998* (NSW), or • for whom the Secretary of the Department of Communities and Justice or a designated agency has the care responsibility under section 49 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), or • who is a protected person within the meaning of section 135A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), or • who is the subject of an out-of-home care arrangement under the *Children and Young Persons (Care and Protection) Act 1998* (NSW) or the *Children's Guardian Act 2019* (NSW), or • who is in specialised substitute residential care within the meaning of the *Children's Guardian Act 2019* (NSW), or • who is the subject of a sole parental responsibility order under section 149 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW), or • who is otherwise in the care of a service provider.
Coroner's Certificate	A Coroner's Certificate may be issued where a Coroner is satisfied, after obtaining relevant advice from Police and medical practitioners and after consulting with the senior next of kin, that the deceased person died of natural causes (whether or not the precise cause of death is known). It records the date, place and cause of death. A Coroner's Certificate may be issued before or after a post-mortem examination is performed (either under section 25 or 89(6) of the Act).

Coronial proceedings	Section 46 of the Act defines coronial proceedings as any proceedings conducted by a Coroner or assistant Coroner for the purposes of the Act concerning the investigation of a death, suspected death, fire or explosion. Without limiting the definition, coronial proceedings include the following: • the holding of an inquest into a death or suspected death • the holding of an inquiry concerning a fire or explosion • proceedings to determine whether or not to hold, or to continue to hold, an inquest or inquiry • proceedings of an interlocutory (interim or provisional) or similar nature (including proceedings to deal with evidential matters or case management issues).
Designated Officer	A Designated Officer's role is to authorise, in accordance with relevant legislation: • the release of a body for anatomical examination, a non-coronial post-mortem examination • the use of tissue removed for the purposes of a non-coronial post-mortem, or • removal and use of tissue from a body for transplant or other therapeutic, medical or scientific purpose. Under section 5 of the *Human Tissue Act 1983* (NSW), a Designated Officer is: • in relation to a public hospital, a person appointed in writing by the governing body of a hospital to be a Designated Officer for the hospital • in relation to a private hospital, a person appointed in writing by the governing body of the private hospital, or • in relation to a forensic institution, a person appointed in writing by the governing body to be a Designated Officer for the forensic institution. For more information, see NSW Health Policy Directive *Designated Officer* (PD2024_023).
Disposal Order	Under Chapter 9 of the Act, a Coroner may authorise disposal of human remains (bury, cremate or place in a mausoleum or other permanent resting place) by written disposal order. A disposal order may be made by a Coroner who is holding, has held or is intending to hold an inquest, or has dispensed with an inquest.

Forensic Medicine Facility	A NSW Health Pathology Forensic Medicine facility in Sydney, Newcastle or Wollongong.
Health related procedures	Broadly defined in section 6(3) of the Act as a medical, surgical, dental or other health-related procedure, including the administration of anaesthetics, sedatives and other drugs. See section 3.5.1 of this Policy Directive for guidance.
Medical Certificate of Cause of Death (MCCD)	The form issued by the NSW Registry of Births, Deaths & Marriages used by a medical practitioner to notify the Registrar, Registry of Births, Deaths & Marriages within 48 hours of a death and the cause of that death, pursuant to section 39 of the *Births, Deaths and Marriages Registration Act 1995* (NSW). See section 3 of this Policy Directive in relation to deaths for which an MCCD should not be completed.
National Disability Insurance Scheme (NDIS)	The NDIS provides funding to eligible people with disability. The NDIS also connects anyone with disability to services in their community.
Neonatal death	A liveborn baby who dies within the first 28 days of life.
Parental Responsibility	In relation to a child or young person, parental responsibility means all the duties, powers, responsibilities and authority that, by law, parents have in relation to their children.
Relative	For the purposes of section 5 of the Act, a relative of a deceased person is an adult who is the spouse, parent, person with parental responsibility, guardian or child of the deceased person. If there is no one in the categories above, a relative is the brother or sister of the deceased person.
Relevant group (in relation to disabled person)	For the purpose of section 24(1)(f) of the Act, a person in a relevant group is a person who has a disability, whether chronic or episodic, that is: (a) attributable to an intellectual, cognitive, neurological, psychiatric, sensory or physical impairment (or combination); and (b) is permanent or likely to be permanent; and (c) results in significant reduction in the person's functional capacity in one or more areas of major life activity; and (d) results in the need for support, whether or not of an ongoing nature.

Remains	Means the body or remains of the body (or any part of the body) of the deceased person.
Reportable deaths	Deaths that must be reported to the Coroner are reportable deaths, according to sections 6(1), 23 and 24 of the Act. See section 3 of this Policy Directive for detailed information.
Senior next of kin (SNOK)	As defined in section 6A of the Act, the SNOK of a deceased person is: (a) the deceased's spouse, or (b) if the deceased person did not have a spouse or a spouse is not available, any of the deceased's adult children, or (c) if the deceased person did not have a spouse or child or a spouse or child is not available, either of the deceased's parents, or (d) if the deceased person did not have a spouse, child or living parent or none are available, the deceased's person's adult brothers or sisters, or (e) if the deceased person did not have a spouse, child, brother or sister or none are available, the executor named in the deceased's will, or the deceased's personal legal representative immediately prior to death. See section 7.2 of this Policy Directive.
Specialist disability accommodation	Under clause 4A of the *Coroners Regulation 2021* (NSW) and for the purposes of section 24(1)(e) of the Act, residential premises under the control, direction or management of a registered NDIS provider and where the registered NDIS provider provides supported independent living at the premises. It does not include nursing homes.
Stillbirth and stillborn child	Defined in the *Births, Deaths and Marriages Registration Act 1995* (NSW), a stillborn child is a child that exhibits no sign of respiration or heartbeat or other sign of life, after birth, and that is of at least 20 weeks' gestation, or if that cannot be determined, at least 400 grams at birth. See section 4.3 of this Policy Directive for more information.

Tissue	As defined in section 4 of the *Human Tissue Act 1983* (NSW), tissue includes an organ, or part, of a human body and a substance extracted from, or part of, the human body, including bodily fluids, blood, ova, semen and foetal tissue.
Whole organ	Of a deceased person, means the whole or a substantial part of a visibly recognisable structural unit of the person's body.

1.4. Legal and legislative framework

Births, Deaths and Marriages Registration Act 1995 (NSW)

Boarding Houses Act 2012 (NSW)

Children (Detention Centres) Act 1987 (NSW)

Children and Young Persons (Care and Protection) Act 1998 (NSW)

Children's Guardian Act 2019 (NSW)

Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)

Coroners Act 2009 (NSW)

Coroners Regulation 2021 (NSW)

Crimes (Administration of Sentences) Act 1999 (NSW)

Drug and Alcohol Treatment Act 2007 (NSW)

Human Tissue Act 1983 (NSW)

Mental Health Act 2007 (NSW)

Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW)

National Disability Insurance Scheme Act 2013 (Cth)

National Disability Insurance Scheme (Specialist Disability Accommodation) Rules 2020 (Cth)

Public Health Act 2010 (NSW)

Public Health Regulation 2022 (NSW)

Voluntary Assisted Dying Act 2022 (NSW)

1.5. Related Policies

NSW Health Policy Directives:

- *Designated Officer* (PD2024_023)
- *Incident Management* (PD2020_047)
- *Investigation, Review and Reporting of Perinatal Deaths* (PD2022_046)
- *Management of Sudden Unexpected Death in Infancy (SUDI)* (PD2019_035)

- *Open Disclosure* (PD2023_034)
- *Organ and Tissue Donation, Use and Retention* https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2022_035(PD2024_022)
- *Reporting of Maternal Deaths to the NSW Clinical Excellence Commission* (PD2021_006)
- *Significant Legal Matters and Management of Legal Services* (PD2017_003)
- *Verification of death and medical certificate of cause of death* (PD2023_014)
- *Voluntary Assisted Dying* (PD2023_037).

2. Jurisdiction of the Coroner

A Coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the Coroner that:

- the person's death is (or there is reasonable cause to suspect that the person's death is) a reportable death, or
- a medical practitioner has not given (or there is reasonable cause to suspect that a medical practitioner has not given) a certificate as to the cause of death.

3. Circumstances when a medical practitioner must not issue a certificate as to the cause of death

A medical practitioner must not issue a medical certificate as to the cause of death (MCCD) under the *Births, Deaths and Marriages Registration Act 1995* (NSW) if the death is a **REPORTABLE** death or a **REVIEWABLE** death, as described below.

3.1. Death reportable under section 6 of the Coroners Act

Section 6(1) of the *Coroners Act 2009* (NSW) [the Act] defines a reportable death as a:

- violent or unnatural death – see section 3.6 for guidance
- sudden death the cause of which is unknown
- death in unusual or suspicious circumstances see section 3.7 for guidance
- death that was not the reasonably expected outcome of a health-related procedure carried out on the person – see section 3.5 for guidance
- death of a patient who is in, or temporarily absent from, a declared mental health facility within the meaning of the *Mental Health Act 2007* (NSW) and while the person was a patient at the facility for the purpose of receiving care, treatment or assistance under the *Mental Health Act 2007* (NSW) or *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW).

- Note: The Act does not currently require that the death of a patient detained under *the Drug and Alcohol Treatment Act 2007* (NSW) must be reported to the Coroner. However, any such death should be treated as a death that was not the reasonably expected outcome of a health-related procedure and reported to the Coroner.

3.2. Reviewable death under section 23 of the Coroners Act (death in state or federal custody or involving a state or federal police operation)

Section 23(1) of the Act provides that the death is reviewable by a senior coroner where the person died:

(a) while in the custody of a police officer or in other lawful custody, or

(b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or

(c) as a result of police operations, or

(d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:

i. a detention centre within the meaning of the *Children (Detention Centres) Act 1987* (NSW),

ii. a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW),

iii. a lock-up, or

(e) while proceeding to any of the institutions or places above, for the purpose of being admitted as an inmate and while in the company of a police officer or other official charged with the person's care or custody.

3.3. Reviewable death under section 24 of the Coroners Act (death of a child or disabled person in certain circumstances)

Section 24(1) of the Act provides that the death is reviewable by a senior coroner where the person who died was:

(a) a child in care, or

(b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) within the period of 3 years immediately preceding the child's death, or

(c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) within the period of 3 years immediately preceding the child's death, or

(d) a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances, or

(e) a person (whether or not a child) who, at the time of death was living in, or temporarily absent from, specialist disability accommodation or an assisted boarding house (see definitions in section 1.2), or

(f) a person (other than a child in care) who is a person in 'the relevant group' (a person with a disability resulting in a significant reduction in functional capacity, requiring support), and who receives assistance of a kind prescribed by the regulations from a service provider to enable the person to live independently in the community.

- **Note: there are currently no prescribed kinds of assistance by service providers, therefore currently no requirement to report these deaths based solely on the person being in the 'relevant group'/receiving National Disability Service Scheme (NDIS) services in the community**.

3.3.1. Death involves a child or sibling of child in respect of whom a report was made within 3 years under the Children and Young Persons (Care and Protection) Act

If the death is reviewable under sections 24(1) (b) and (c) of the Act (as set out above), clinicians should contact NSW Health's Child and Wellbeing Unit (business hours) on 1300 480 420 or the Child Protection Helpline (after hours) on 13 21 11 to seek advice under Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) about a child (or sibling's) protection history and assist with determining whether any Risk of Serious Harm Reports were made.

3.3.2. Child palliative care death that falls within section 24(1)

The Coroner's Office has developed an "Alternative Pathway" for reporting deaths of children whose deaths are only reportable because they fall within the ambit of sections 24(1)(a), (b) or (c) of the Act as set out above.

The Alternative Pathway allows a senior coroner to review an expected death of a child who is receiving palliative care/comfort care measures, where:

(a) The death is expected;

(b) It is due to a known natural cause; and

(c) There are no concerns about the child's care and treatment or any suggestion of neglect or other issues which should be brought to the Coroner's or Police attention.

The procedures enable the death to be reported to the Coroner and for the coronial file to be finalised without involving Police or transporting the child's body to a mortuary for post-mortem examination.

Prior to the anticipated death, the treating medical practitioner can apply to the Coroner's Court Coronial Case Management Unit Coordinator (see contact details below) requesting that the Duty Coroner review the death under the Alternate Pathway procedures rather than

the usual procedures for the reporting of the death to the Coroner. The application should be in writing and set out:

(a) The child's full name and date of birth;

(b) The full names and contact details of the parents, guardians and carers;

(c) A summary of the child's medical history; the condition which is expected to lead to his/her death and the expected cause of death;

(d) Confirmation that the child's natural parents and the child's guardians do not wish a coronial autopsy to be undertaken; and

(e) The names and contact details of the principal medical practitioner involved in the child's care or the palliative care team leader

If the Alternative Pathway is approved by the Duty Coroner, there are steps for reporting the death when it occurs.

Where the Duty Coroner does not approve the Alternative Pathway, the death must be reported to the Coroner in the usual way.

Contact the Coroner's Court Coronial Case Management Unit Coordinator on ccmu@justice.nsw.gov.au, phone 02 8584 7778 for guidance with the Alternative Pathway.

3.4. Coronial Checklist to determine if death is reportable

Under the Act, hospitals and medical practitioners or any other person, who has reasonable grounds for believing that a death or a suspected death (such as a disappearance) is a reportable death or examinable/reviewable, they must report the death or suspected death to the Police (who will then report it to the Coroner) or a Coroner or assistant Coroner as soon as possible (see section 35 and 38 of the Act).

The Coronial Checklist (Appendix 2) is to be used to determine if a death should be reported to the Coroner.

The Coronial Checklist should be completed as soon as possible after verification of death.

The Coronial Checklist must be completed by a medical practitioner prior to completion of the Medical Certificate of Cause of Death (MCCD).

If the death is reportable to the Coroner, the MCCD must not be completed (section 38 of the Act).

The Coronial Checklist (see Appendix 2) is available in hard copy, on-site at all public hospitals/services. Forms can be obtained by purchase order by authorised staff via the State Forms printing contractor's website.

3.5. Determining whether a death is a reasonably expected outcome of a health-related procedure

A death is reportable where the death was not a reasonably expected outcome of a health-related procedure.

3.5.1. What is a health-related procedure?

A health-related procedure is broadly defined in section 6(3) of the Act as a medical, surgical, dental or other health-related procedure. It includes the administration of an anaesthetic, sedative or other drug. Procedure in this circumstance is taken to mean health care provided to a patient.

3.5.2. What is meant by the term 'reasonably expected outcome'?

The Act does not define the term 'reasonably expected outcome'. This is a matter for medical practitioners to decide based upon the facts of the case. It requires consideration of what was known or anticipated prior to the health procedure.

3.5.3. Considerations to determine if death should be reported

Considerations 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.

In determining whether the death is a reportable death, consider:

- did the health-related procedure cause death, and
- was the death an unexpected outcome of the procedure?

If the answer to both of the above questions is *yes*, then *the death is reportable*.

In determining whether the health procedure caused to 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 the above questions is *yes*, then *the death may not* be reportable.

In determining whether the death was an unexpected outcome of the health-related procedure, consider factors in the particular case based on clinician professional judgment:

- was the patient's condition (factoring in their age and co-morbidities) at the time they underwent the health-related procedure 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 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 as competent professional practice?

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

3.5.4. Where there is doubt – seek advice

If there is any doubt about whether the death is reportable then contact **must** be made with the Hospital Manager or a senior medical team member or senior nurse manager.

Advice should be sought from the the duty forensic pathologist or their delegate, Forensic Medicine, NSW Health Pathology: 02 9563 9000 – advise the administration officer receiving your call, which hospital and/or location you are from. This will ensure your call is directed to the appropriate duty pathologist.

Generally, advice from the forensic pathologist should be sought during business hours. If a death occurs outside business hours and it is uncertain whether it needs to be reported to the Coroner, after family have been afforded time to view the deceased person, the deceased person can be moved to the hospital mortuary pending forensic pathologist advice.

A detailed file note of the discussion with the forensic pathologist should be kept. Junior staff should discuss the forensic pathologist's advice with a senior clinician before deciding whether or not to report the death to the Coroner.

3.6. Unnatural death compared to natural death?

Section 6(1)(a) of the Act requires that violent or unnatural deaths are reported to the Coroner.

A natural death is a death that more likely than not was caused by a disease or condition.

An unnatural death is a death for which there is no identified underlying disease or condition that directly caused the death.

Natural deaths need only be reported if the probable cause of death cannot be determined.

It is not necessary that a medical practitioner considering issuing a MCCD, has a complete understanding of the mechanism by which the condition progressed to be fatal. The question is whether the likely proximate or probable cause of death can be identified.

It is no longer necessary that the medical practitioner had seen the deceased person within a prescribed timeframe prior to the death in order to complete the MCCD. However, if the medical practitioner completing the MCCD was not responsible for that person immediately preceding death, then the medical practitioner is required to the review the health record and examine the body.

3.7. Deaths that are unusual or in suspicious circumstances

A death is reportable under section 6(1)(c) of the Act where it occurred in unusual or suspicious circumstances. This should be considered where there is concern the patient died as a result of suspected neglect or abuse, whether a child or adult - noting a child whose death is or may be due to abuse or neglect or that occurs in suspicious circumstances is reportable under section 24(1) of the Act.

This should be considered for vulnerable patients, including elderly or disabled patients whose injuries suggest physical abuse or neglect by carers. Such deaths must be reported to the Coroner.

4. Deaths that are not necessarily reportable to the Coroner

4.1. Voluntary Assisted Dying deaths

The *Voluntary Assisted Dying Act 2022* (NSW) [VAD Act] establishes a framework that allows an eligible person to legally access a voluntary assisted dying substance that will cause their death.

A person can only access voluntary assisted dying if all requirements of the VAD Act have been met, including that a substance authority has been issued by the Voluntary Assisted Dying Board in relation to the person. The voluntary assisted dying substance may be self-administered or administered by an authorised practitioner.

Where a person has died from the administration of a voluntary assisted dying substance in accordance with the VAD Act, the person's death is not a reportable death unless the death comes under section 23 or 24 of the *Coroners Act 2009* (NSW) [the Act] – see below.

However, if there is uncertainty about whether the person has died in accordance with the VAD Act, clinicians should consider whether the death is a reportable death as outlined in section 3 of this Policy Directive.

Where a VAD death is reviewable by a senior coroner under section 23 or 24 of the Act (see section 3.2 and section 3.3 of this Policy Directive), that death remains reviewable regardless of whether the death was in accordance with the VAD Act.

However, where the VAD death is reportable only because it falls within the ambit of section 24 of the Coroner's Act, the Coroner's Court should be contacted in advance of the anticipated VAD death for advice on procedures to follow to avoid unnecessary Police involvement or transport of the deceased person's body to a forensic medicine facility for a post-mortem examination. Contact the Coroner's Court Coronial Case Management Unit Coordinator on ccmu@justice.nsw.gov.au for guidance on reporting requirements.

4.2. Where the person aged 72 years or older dies as a result of an accident attributable to their age

Under section 38(2) of the Act, if a person aged 72 or older died as a result of trauma or an accident, the death may not be reportable and a Medical Certificate of Cause of Death (MCCD) may be issued if:

- the person was 72 years of age or older
- they died after sustaining an accidental injury that was attributable to the deceased's age and not caused by the act or omission of another person

- they did not die in circumstances that would otherwise be reportable to the Coroner under section 6(1)(b) to (f) or section 23 or 24(1) of the Act (as outlined in section 3 of this Policy Directive).
- no relative objects to the MCCD being issued, and
- the MCCD must be marked 'Yes' to question 8 if the MCCD is given pursuant to section 38(2) of the Act.

4.3. Stillbirths

A stillborn baby is defined as a baby that exhibits no sign of respiration or heartbeat or other sign of life, after birth, and that:

- is of at least 20 weeks' gestation, or
- if it cannot be reliably established whether the period of gestation is more or less than 20 weeks, has a body mass of at least 400 grams at birth.

A stillbirth is not a 'death' for the purposes of the Act or the *Births, Deaths and Marriages Registration Act 1995* (NSW), therefore it need not be reported to the Coroner. The Coroner will have no jurisdiction to investigate a stillbirth.

However, if there is uncertainty about whether the child was stillborn, the Coroner may give a post-mortem investigation direction to an appropriate medical investigator that directs the investigator to conduct, or arrange to be conducted, an examination to determine whether the remains are those of a stillborn child under section 89(2) of the Act.

Although not reportable to the Coroner, there is a requirement to report stillbirths to the NSW Health Clinical Excellence Commission's (CEC) Perinatal Mortality Review Committee (PMRC), as set out in section 11 of this Policy Directive.

There is also a requirement to register the birth of a stillbirth (as defined above) which includes recording the cause of foetal death using the Medical Certificate of Cause of Perinatal Death (MCCPD) form.

4.4. Neonatal deaths

If a baby dies after birth due to prematurity or congenital abnormality, the death is not reportable as it is not an unexpected, unnatural death. However, if the death was likely due to sub-optimal care or the cause of death is not known, it may be reportable.

The baby's death is also a reportable death if it falls within the circumstances outlined in section 24 of the Act (see section 3.3 of this Policy Directive).

Even if not reportable to the Coroner, neonatal deaths are reportable to the CEC's Perinatal Mortality Review Committee (PMRC(see section 11 of this Policy Directive).

Where the neonatal death is not reportable to the Coroner, a MCCPD form must be completed.

If the neonate's death is a sudden unexpected death in infancy (SUDI) this is a reportable death under section 6 of the Act and management is per the NSW Health Policy Directive *Management of Sudden Unexpected Death in Infancy (SUDI)* (PD2019_035)

5. Reporting deaths or suspected deaths to the Coroner

5.1. Procedure for reporting deaths or suspected deaths that are reportable to the Coroner

Under the *Coroners Act 2009* (NSW) [the Act], hospitals and medical practitioners or any other person, who has reasonable grounds for believing that a death or a suspected death (such as a disappearance) would be reportable to the Coroner must report the death or suspected death to the Police (who will then report it to the Coroner) or a Coroner or assistant Coroner as soon as possible (see sections 35 and 38 of the Act).

A report of death to the Coroner should still be made where information only later becomes available that the death should be reported. This is regardless of whether a Medical Certificate of Cause of Death (MCCD) had previously been issued. For example, delayed pathology reports may indicate a violent or suspicious death, or it may become known that the deceased child was a sibling of a child who was subject of a Risk of Significant Harm Report.

The procedure is as follows:

- The Coronial Checklist (see Appendix 2 in this Policy Directive) will assist in determining whether a death should be reported to the Coroner.
- If it is decided that the death is a reportable death, the Hospital/Service Manager or their delegate should immediately notify Police to provide details of a reportable death.
- Where the death is reportable, a medical practitioner must complete the '*Report of Death of a Patient to the Coroner'* (formally known as 'Form A') [see Appendix 1 in this Policy Directive]. Reports on this form are to be prepared in triplicate; the original goes with the body, the duplicate copy is handed to Police, the third copy is retained by the hospital in the health record of the deceased patient. Copies of this form are available in hard copy on-site at all public hospitals/services. Forms can be obtained by purchase order by authorised staff via the State Forms printing contractor's website.
- If known, the deceased person's relatives/next of kin should also be notified and, where possible, a senior hospital officer should arrange to meet with them to explain to them the formalities required by the Act. Aboriginal health staff should be included when engaging with Aboriginal families/next of kin. See section 8 of this Policy Directive for more information on supporting families.
- In addition to reporting the death to the Coroner, it may also be necessary to report the death to the NSW Ministry of Health, for example deaths following anaesthesia or sedation. See section 11 of this Policy Directive for further information on the requirement to report certain deaths to the Ministry of Health.

5.2. Where there is doubt - Medical, nursing, midwifery and paramedic staff requiring further advice

If there is any doubt about whether the death is reportable then contact **must** be made with the Hospital Manager, a senior medical team member, senior nurse manager or senior paramedic. Advice should be sought from the the duty forensic pathologist or their delegate, Forensic Medicine, NSW Health Pathology by contacting:

- 02 9563 9000

Please advise the administration officer receiving your call, which hospital and/or location you are from. This will ensure your call is directed to the appropriate duty pathologist.

Forensic Medicine will maintain a record of this 'clinical consultation' during which you may be asked to provide the following information to assist the duty pathologist or their delegate with providing a response:

- Your name, position and contact details
- Patient details (such as name and medical record number [MRN])
- Your availability and an alternative contact if you are not available for future follow up.

Generally, advice from the forensic pathologist should be sought during business hours. If a death occurs outside business hours and it is uncertain whether it needs to be reported, after family have been afforded time to view the body, the deceased person can be moved to the hospital mortuary pending forensic pathologist advice.

A detailed file note of the discussion with the forensic pathologist should be kept. Junior staff should discuss the forensic pathologist's advice with a senior clinician before deciding whether or not to report the death to the Coroner.

6. Where death is reportable: Instruction for medical, nursing and midwifery staff for dealing with deaths in hospital

Following the reporting procedure above at section 5.1, these instructions should be followed by medical, nursing and midwifery staff when dealing with deaths in hospital that are reportable deaths.

6.1. Location and death and preservation of evidence

The Hospital Manager should take all reasonable steps to ensure that the physical location where the reportable death occurred is preserved for forensic analysis by NSW Police Forensic Evidence and Technical Services Command (if required by Police). This includes the physical location of the death and other evidence such as bedding, medical equipment and any other relevant objects (such as a cord used in a suicide) must remain in place.

In determining whether the physical location of the death can be preserved, the following matters should be considered and negotiated with Police to balance any conflict between the competing interests of NSW Health and Police:

- The nature and circumstances of the reportable death, for example, whether there are suspicious circumstances, or whether the circumstances are relatively routine.
- The likely timeframe within which Police can complete their investigation.
- The disruption that would be caused to the hospital's operational requirements, including the need to continue to provide emergency services. This is particularly relevant if, for example, the death occurs in an operating theatre, or in an intensive care bed which may be required for use by another patient, or where the death occurs in an open area, and leaving the body in situ is likely to cause distress to other patients.
- Whether it compromises other patients' care.

6.2. Requirement for Coroner's consent to remove tissue for donation

Where the Coroner has jurisdiction to hold an inquest (death is a reportable death), the Designated Officer (see section 1.2 of this Policy Directive for definition) must not authorise removal of tissue from the body unless a Coroner has given consent (see section 25 of the *Human Tissue Act 1983* (NSW) and NSW Health Policy Directive *Designated Officer* [PD2024_023]).

The *Human Tissue Act 1983* (NSW) allows coronial consent for the removal of tissue to be given before a person's death if the Coroner reasonably believes there will be a coronial inquest into the death.

It is important to note that although gametes are a type of tissue, authorisation for removal of gametes is a complex area involving additional safeguards (refer to section 4.5 of the NSW Health Policy Directive *Designated Officer* [PD2024_023]).

The treating team is responsible for reporting the death to the Coroner by completing *Report of Death of a patient to the Coroner* (Form A) [see Appendix 1] and contacting the local police.

The Donation Specialist or Tissue Donor Coordinator is to liaise directly with the duty forensic pathologist and the Coroner (refer to NSW Health Policy Directive *Organ and Tissue Donation, Use and Retention* (PD2024_022) for more information).

6.3. Preservation of the body, equipment and samples

The hospital responsible for the deceased is also responsible for the safe custody of the body until a Coroner's disposal order has been issued or (under Chapter 9 of the *Coroners Act 2009* [the Act]), when directed by the Coroner, the body is removed by NSW Police.

This implies safe custody of the correct body and, irrespective of whether the physical location of the death is preserved or not, the body should be kept in the same condition as when death occurred.

Equipment attached to/entering the body such as drains, intra-venous cannulae, endotracheal and intragastric tubes and single use/disposable items attached to these, such as IV fluid bags, syringes, drainage bottles and so on, must be left in situ.

However, equipment used to operate/drive these such as IV pumps, syringe drivers, Extra Corporeal Membrane Oxygenation equipment and so on, can be detached and retained at the hospital.

The body must not be washed even if the surface is soiled so that all surface contamination can be observed by the forensic pathologist and duly assessed. For instance, when death occurs shortly after injury by impact with a vehicle or by violent assault, washing may remove vital trace evidence such as an offender's blood and hairs or such things as paint flakes, glass chips or other finely divided material, which may be matched later against similar material obtained from another source.

Limbs and jaws must not be tied and orifices must not be plugged with cotton wool as these activities can leave marks, which cause problems especially about the face and neck.

Any material that may have been sucked from the stomach and/or any vomitus from suspected poisoning cases, must be retained and placed in screw-capped container(s), appropriately labelled and provided to the Police for forwarding to the Coroner for chemical analysis.

Any blood or urine collected from the patient, including that collected for point-of-care analysis should be stored in appropriate containers and labelled and forwarded with the body for chemical analysis.

6.4. Safe disposal of drugs

Forensic Medicine does not have authorisation under the Poisons and Therapeutic Goods legislation to dispose of Schedule 4 or Schedule 8 drugs. Where possible, it is preferable these restricted drugs be removed and disposed of by hospital staff (leaving the IV sites intact for potential post-mortem examination) prior to the body being transferred to a Forensic Medicine facility.

Where a body has remained in the hospital/morgue and the Coroner subsequently dispenses with a post-mortem examination or directs that a Medical Certificate of Cause of Death (MCCD) or issues a Coroner's Certificate, hospital staff must appropriately remove and dispose of any Schedule 4 and Schedule 8 drugs from any intra-venous lines prior to release of the body.

In either case, removal and disposal of any Schedule 4 or 8 drugs must be done by hospital staff in accordance with NSW Health Policy Directive *Medication Handling* (PD2022_032).

6.5. Provision of health records

Police requesting information and/or health records from frontline staff should be advised to make a formal request to the Hospital Manager/Service Manager or their delegate, by way of an Order for Production under section 53 of the Act (Order for Production). The Order for Production should state what documentation is required. Some services, such as NSW Ambulance may specify processes/portals for Police to lodge requests.

Upon receipt of an Order for Production, the Hospital/Service Manager or their delegate **must** arrange for a copy of the clinical record to be sent to the Coroner's Court, in compliance with the Order/Court's instructions. Staff must ensure the records are complete, including any pathology, imaging and reports. Generally, electronic records are acceptable and any records sent by electronic means must be via secure file transfer. Police may be copied on the email to the Coroner's Court.

Where the Coroner directs that a post-mortem investigation be undertaken, a copy of the records must be provided to the forensic pathologist. An Order for Production is not necessary to provide the records to the forensic pathologist. See section 7.5 of this Policy Directive for further information on provision of records to forensic pathologists.

6.6. Viewing the body of a reportable death while still at hospital

Viewing the deceased's body at the hospital is to be appropriately authorised and supervised by NSW Police for the following purposes:

6.6.1. Identification purposes

Viewing should be appropriately authorised and supervised by Police. However, in all suspicious or homicide cases, once the body has been sealed, the body bag should not be opened at all prior to the post-mortem examination with the forensic pathologist and Police present. Identification in these cases can occur after the post-mortem examination.

6.6.2. Compassionate purposes

Viewing for compassionate reasons may be arranged. NSW Health staff must consult with NSW Police to determine whether access is appropriate. In this case, access may need to be supervised by NSW Police and/or NSW Health staff, such as the nurse unit manager or grief counsellor in order to properly preserve evidence.

6.7. Viewing the body at a Forensic Medicine facility

When the body is at a NSW Health Pathology (NSWHP) Forensic Medicine facility, viewing the body is generally only possible prior to commencement of the post-mortem examination and requires consultation and permission of the forensic pathologist.

Viewings of the deceased at a Forensic Medicine facility may be permitted at the discretion of the forensic pathologist in consultation with NSW Police. Subject to permission being granted, arrangements can be made by contacting the Forensic Medicine Social Work team, contact details are listed in section 1.2 above.

6.8. Awaiting Coroner's direction for investigations

When Police are notified of a reportable death, Police submit a *Report of death to the coroner* (P79A Form) to the Coroner. This provides the Coroner with a summary of the case and any relevant information the Police have gathered.

Generally, in metropolitan areas, bodies are transferred to NSWHP Forensic Medicine facilities before the Coroner makes a decision about post-mortem examination or otherwise. The Forensic Medicine duty pathologist reviews the medical history and P79A Form, and makes a recommendation to the Coroner.

The Forensic Medicine Social Work team liaise with the Senior Next of Kin to explain the examination process and provide the Coroner with the views of the Senior Next of Kin. The Coroner reviews the medical recommendation and family information and makes a direction.

In non-metropolitan cases the deceased person may remain at a hospital mortuary pending further Coronial directions including transfer to a Forensic Medicine Facility.

Under section 89 of the Act, the Coroner may direct:

- a coronial post-mortem/autopsy be performed
- an external examination of the body
- the taking or testing of blood or tissue samples for toxicological analysis
- the taking and testing of tissue samples for microscopic examination
- a review of the health records.

Recommendation for some type of post-mortem examination will not be made in every case.

Where an inquest is not mandatory, the Coroner may dispense with an inquest.

Where the Coroner decides that an MCCD or a Coroner's Certificate may be issued, it will not be necessary to transfer the deceased person to a Forensic Medicine facility.

6.9. Where the body is held in an LHD facility awaiting Coroner's direction

In some cases, such as regional areas, a body may remain in a hospital mortuary whilst awaiting the Coroner's direction about a post-mortem or otherwise.

Under the *Public Health Regulation 2022* (NSW), a body is allowed to remain in a hospital mortuary for up to 21-days after death, after which the Secretary, NSW Ministry of Health, may approve the body to be kept for a longer period. In such cases, the hospital/local health district (LHD) will need to apply to the local Public Health Unit for approval to keep the body for longer than allowed in the *Public Health Regulation 2022* (NSW). For further information, see NSW Health Fact Sheet: *Approval to keep the body of a deceased person for longer than permitted*.

If hospital staff are concerned that there is a delay in being notified of a determination as to whether the body is to be transferred to a Forensic Medicine facility or that a MCCD or Coroner's Certificate can be issued, it is incumbent upon them to follow-up with Police to ensure that Police lodged the P79A Form in a timely manner.

6.10. Transfer of the body to the Coroner

If the Coroner directs that the body be transferred to a Forensic Medicine facility, the body must not be washed (see section 6.3 of this Policy Directive). The body must be placed only

in a plastic body bag. All sharps or items of equipment left in situ must be firmly taped or secured to the body in such a way that the risk of sharps injury or leakage is minimised. Attached drip bags, bottles and feed lines and bedding must accompany the body. The name of the deceased person should be clearly and indelibly written on the top outer surface of the bag.

6.11. Infectious disease prior to death

Prior to death, if the deceased had or may have had a prescribed infectious disease as listed under clause 79 of the *Public Health Regulation 2022* (NSW), then a label stating clearly and indelibly "Prescribed Infectious Disease - Handle With Care" (stock code NH606645), available from the State Forms Catalogue must be attached to the body and the body must be placed only in a plastic body bag. The body must then be placed in a second plastic body bag with a second label with the same information affixed outside. Neither label should specify the condition. The body must not be washed with antiseptic solution.

Prescribed infectious disease means the following diseases—

- avian influenza in humans
- diphtheria
- Middle East Respiratory Syndrome Coronavirus
- plague
- respiratory anthrax
- Severe Acute Respiratory Syndrome
- smallpox
- tuberculosis
- a viral haemorrhagic fever, including Lassa, Marburg, Ebola and Crimean-Congo fevers.

6.12. Return of surgical and other equipment

Generally, surgical and other equipment are removed from the body during a post-mortem. If the hospital would like such equipment returned, request in writing should be made to the Coroner.

6.13. Witness statements and legal representation

Police or the Coroner investigating a reportable death may request statements from staff witnesses.

Requests for statements must be referred to the Hospital/Service Manager or their delegate. There may be local processes in place for notifying management that should be followed.

Staff witnesses are to be given the opportunity to obtain legal advice and assistance through their own professional/industrial association or private medical defence organisation, if available.

If the Coroner issues a letter of sufficient interest and there is advice from the Coroner's Court that the death will proceed to a Coronial inquest hearing, the LHD, speciality network (network) or health entity will require legal representation. In this case, a request for legal representation should be sent to the NSW Ministry of Health Legal and Regulatory Services Branch and a legal panel firm will be appointed to act on behalf of the LHD/network/health entity. See NSW Health Policy Directive *Significant Legal Matters and Management of Legal Services* (PD2017_003) about notifying the Legal and Regulatory Services Branch of coronial matters and appointing panel firms to assist.

The legal panel firm will represent the organisation's interests. It can generally assist all relevant staff except where the legal representative identifies a conflict of interest. If staff receive an individual 'Notice of Sufficient Interest', they should advise their manager and seek legal advice from their own professional/industrial association or private medical defence organisation.

The Legal and Regulatory Services Branch can advise on managing any conflicts of interest and issues with legal representation.

6.14. Education purposes

Occasionally, medical staff of a teaching hospital might have a coronial case that they would like to use for the specific purpose of informing clinical staff or teaching students. For example, they might wish to conduct the post-mortem at the teaching hospital so students can attend. Alternatively, they might wish to take photographs of the body for future teaching purposes. In these cases, a senior medical practitioner or hospital administrator must first obtain the written consent of the deceased person's Senior Next of Kin and then obtain the approval of the Coroner (see NSW Health Policy Directive *Anatomical Examinations and Anatomy Licensing* (PD2023_044) for related information).

7. Coronial Post-Mortems

7.1. Coronial Post-Mortem examinations

When a death is reported to the Coroner, post-mortem examinations can only be performed at the direction of the Coroner by specialist forensic pathologists at one of 3 dedicated NSW Health Pathology Forensic Medicine facilities in Sydney, Newcastle and Wollongong.

7.2. Senior next of kin

The senior next of kin (**SNOK**) is a family member who is recognised by the Coroner as the main point of contact and main decision-maker when family decisions need to be made. The SNOK is supported in the coronial process by the Forensic Medicine Social Work team.

The SNOK will be notified about:

- any proposed post-mortem examinations
- updates on the progress of the investigation
- any medical reports provided to the Coroner

- any Medical Certificate of Cause of Death (MCCD) or Coroner's Certificates issued.

The functions of the SNOK for coronial cases is different to the functions of the Senior Available Next of Kin for the purposes of organ and tissue donation (see NSW Health Policy Directive *Organ and Tissue Donation, Use and Retention* [PD2024_022]).

As defined in section 6A of the *Coroners Act 2009* (NSW) [the Act], the SNOK of a deceased person is:

(a) the deceased's spouse (includes de facto partner), or

(b) if the deceased person did not have a spouse or a spouse is not available, any of the deceased's adult children, or

(c) if the deceased person did not have a spouse or child or a spouse or child is not available, either of the deceased's parents, or

(d) if the deceased person did not have a spouse, child or living parent or none are available, the deceased's person's adult brothers or sisters, or

(e) if the deceased person did not have a spouse, child, brother or sister or none are available, the executor named in the deceased's will, or the deceased's personal legal representative immediately prior to death.

A Coroner may treat a person who was the deceased's legal personal representative immediately before the deceased's death as the deceased's SNOK for the purposes of the Act if the Coroner is satisfied that the person who is available to act as SNOK is unable to do so.

A SNOK may delegate their authority in writing to another person, who may then assume the functions of the SNOK. It is essential that this delegation is made with the consent of the SNOK and that they understand what granting such an authority to another person will mean.

In some cultures and communities, such as Aboriginal families, it is usual for responsibilities relating to death to be undertaken by someone other than the person who would be legally defined as the SNOK under the Act. See section 8.4 in this Policy Directive in relation to family support and kinship structures for Aboriginal families.

In the event that the culture of the deceased's person requires that burial take place within 24 hours of death, the Coroner will try to avoid unnecessary delay, if possible, consistent with the requirements of the Act.

7.3. Power to dispense with a post-mortem

The Coroner has powers to dispense with a post-mortem if the cause and manner of death can be established by a less invasive procedure in accordance with respect for the dignity of the deceased person under section 88 of the Act. For example, after obtaining advice from Police and medical practitioners, the Coroner may be satisfied that the person died from natural causes.

7.4. Dignity of deceased person to be respected

Under the terms of the Act the dignity of the deceased person is to be respected.

Forensic pathologists undertaking post-mortems are to endeavour to use the least invasive procedures that are appropriate in the circumstances. Examples of procedures that are less invasive than a full post-mortem examination of the remains of a deceased person include (but are not limited to) the following:

- an external examination of the remains
- a radiological examination of the remains
- blood and tissue sampling
- a partial post-mortem examination.

7.5. Transfer of health records to forensic medicine for post-mortem

Where a post-mortem is to be conducted under the direction of the Coroner, the forensic pathologist or medical practitioner conducting the post-mortem examination must have access to a full copy of the health records.

The hospital/health service is responsible for providing a copy of the health records and should provide access without delay. It is not necessary for the Coroner to issue an Order for Production. Some hospitals and health services have specific arrangements with a NSW Health Pathology forensic pathologist for the provision of records.

The current means by which forensic pathologists obtain health records depends upon their access arrangements to the electronic health record (eMR) at the relevant local health district (LHD).

Whatever the process of providing the forensic pathologists with the records, there should be a local procedure for documenting the records provided.

8. Information for Relatives of a Deceased Person Whose Death has been Reported to the Coroner

This section provides information that should be given to the relatives of a deceased person, irrespective of whether that person was a public or private patient, whose death has been reported to the Coroner.

8.1. The right to object to the exercise of post-mortem investigative function

The senior next of kin (**SNOK**) (as defined at section 7.2 of this Policy Directive) of a deceased person whose death has been reported to a Coroner may object in writing to the conduct of a post-mortem investigation including the retention of whole organs during the conduct of such investigations.

If the Coroner decides that a post-mortem examination is necessary or desirable, the Coroner must notify the SNOK in writing of this decision. The senior next of kin may apply to the Supreme Court within 48 hours of receiving the notice for an order that the post-mortem examination not be conducted or a whole organ not be retained.

8.2. Coronial Information and Support Program (CISP) – Objectives and other support

The Coronial Information and Support Program (**CISP**) at the Office of the State Coroner provides information and support to families. CISP staff provide support to families in the following matters:

- When a Coronial direction for a post-mortem examination is received and the SNOK objects to the examination.
- In natural deaths where a Coroner's Certificate is recommended.
- During the conduct of an inquest, or facilitating requests to view sensitive or traumatic material.
- In cases where specialist testing is requested by the forensic pathologist and approved by the Coroner.

Further information on CISP is available on the Coroners Court website Guidance and information. The CISP staff can be contacted on Tel. 02 8584 7777.

Whilst CISP may provide guidance about how to access coronial file materials, access to the post-mortem report and other case file information is a matter for the Coroner to decide.

The Coroners Court website also contains information, support and guidance for families and friends about the coronial process and post-mortem examinations.

8.3. Grief Counselling

NSW Health Pathology's Forensic Medicine Social Work (FMSW) teams provide the lead support service for families when a death is referred to the Coroner. A Forensic Medicine Social Worker will:

- contact the family when the death is referred or body is admitted to a Forensic Medicine facility.
- explain the coronial process and examination types.
- convey the family's views and any concerns regarding the examination to the medical team and the Coroner.
- provide information and support about Coronial directions in relation to both natural and unnatural deaths.
- support the family to undertake visual identifications under the direction of NSW Police.
- facilitate viewings of the body where possible for family members.

- deliver the Interim Cause of Death findings and discharge process to a funeral director.
- provide counselling referrals and bereavement support information.
- ensure continuation of support when the post-mortem report is pending finalisation.

The service is available during business hours and an after-hours service is available at weekends for urgent cases. The service can be contacted as follows:

- Sydney on (02) 9563 9000.
- An after-hours service is available for urgent cases via the John Hunter Hospital switchboard (02) 4921 3000.
- Via the on call social worker at Wollongong (02) 4925 4501.

Further information is available on the NSW Health Pathology, Forensic Medicine website.

8.4. Support for family of deceased Aboriginal or Torres Strait Islander peoples

Local health districts/specialty networks have Aboriginal Health Units that can provide cultural support for Aboriginal families either with Aboriginal staff or to enable access to hospital staff such as, but not limited to, Aboriginal Health Workers, Aboriginal Hospital Liaison Officers and social workers.

If the deceased is an Aboriginal child, parents or adult siblings of the child may not necessarily be the SNOK of the child. The need for consent may extend beyond the immediate family group and may include aunts, uncles and grandparents.

The NSW State Coroner has issued a First Nations Protocol in which it acknowledges that it is important to recognise that Aboriginal Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which binds Aboriginal Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process. So far as possible and as appropriate in the particular case, arrangements should be made to accommodate the deceased's extended family and community in the Coronial process.

There may be an option for the SNOK to delegate their authority in writing to another person, who may then assume the functions of senior next of kin. It is essential that this delegation is made with the consent of the SNOK and that they understand what granting such an authority to another person will mean.

Aboriginal Coronial Information and Support Program (**CISP**) officers are available to provide culturally safe and appropriate support to Aboriginal families. For example, they work with families to identify cultural considerations relevant to investigations and inquest, and they share information and provide regular updates according to the First Nations Protocol. Further information on CISP is available on the Coroners Court website Guidance and information. The CISP staff can be contacted on Tel. 02 8584 7777.

9. Coronial Investigations

9.1. Power to obtain documents and things for purposes of coronial investigation

For the purposes of assisting a Coroner in their investigation, section 53 of the *Coroners Act 2009* (NSW) [the Act] gives the coroner the power to direct a person to produce a document or other thing (Notice to Produce). The power to give direction includes:

- power to direct that a document be produced relating to the medical care or treatment of a person.
- the power to direct a person to provide any tissue in the person's possession or under the person's control that was taken from the deceased before his or her death.

The production of an electronic copy of a document is taken to be sufficient compliance with the direction unless the direction expressly requires the production of the original document.

9.2. Cross border coronial assistance

Under the section 102 of the Act the State Coroner may request in writing that the person holding a corresponding office in another State or Territory provide assistance in relation to a matter that is the subject of an investigation. Likewise, the State Coroner, at the written request of a person holding a corresponding office in another State or Territory, provide assistance in relation to that person or a Coroner of that State or Territory in connection with the exercise of power under the law of that State or Territory.

In practice this section allows the NSW State Coroner to request assistance from a public health organisation (such as a local health district). This could be a request for clinical records or statements from staff in relation to an inquest that is being held in another State, at the request of a Coroner from another State.

10. Coroners Recommendations

The role of the State Coroner in NSW is to ensure all deaths, suspected deaths, fires and explosions, which come under the Coroner's jurisdiction are properly investigated and concluded.

Where an inquest or inquiry is held, the *Coroners Act 2009* (NSW) [the Act] allows NSW Coroners to make any recommendation that they consider necessary or desirable in relation to a death, suspected death, fire or explosion.

When a Coroner addresses a recommendation to the Minister for Health, the NSW Ministry of Health (the Ministry), a local health district or specialty network, the Ministry's System Management Branch (SMB), Patient Safety First Unit (Coronials) is responsible for ensuring a response is provided to the Coroner.

SMB liaise with relevant areas within the NSW Health system, particularly those areas responsible for implementing recommendations, to prepare the response.

The Ministry's SMB is also responsible for reporting to the (Department of Communities and Justice) as referred in the Premier's Memorandum *M2009-12 Responding to Coronial Recommendations*, which requires a response within 6 months on whether recommendation/s have been implemented and outlining any action taken and, where it is not proposed that a recommendation be implemented, reasons given.

The Ministry's Patient Safety First Unit (Coronials) in the SMB can be contacted via email MOH-Coronials@health.nsw.gov.au.

11. Requirement to report certain deaths to NSW Ministry of Health and Clinical Excellence Commission

In addition to any reporting obligations to the Coroner, there is a requirement to report certain kinds of deaths to the NSW Ministry of Health via its Mortality Review (Authorised Committees).

These include anaesthetic and sedation related deaths, perinatal deaths, maternal deaths and surgical deaths as outlined below. Staff should be familiar with any relevant policy directives and their responsibility to report to these committees.

See the Clinical Excellence Commission's (CEC) Review Incidents webpage for relevant notification processes.

11.1. Anaesthetic and sedation deaths

Section 84 of the *Public Health Act 2010* (NSW) requires that the Secretary, Ministry of Health, must be notified of deaths which occur where a patient dies 'while under, or as result of, or within 24 hours after, the administration of an anaesthetic or sedative drug administered in the course of a medical, surgical or dental operation or procedure or other health operation or procedure (other than a local anaesthetic or sedative drug administered solely for the purpose of facilitating a procedure for resuscitation from apparent or impending death)'. This is regardless of whether the death is reportable to the Coroner. The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA), is appointed by the Secretary, Ministry of Health to review such deaths.

The health practitioner responsible for administration of the anaesthetic or sedative drug must report the death to the SCIDUA, using the *Report of Death Associated with Anaesthesia/Sedation* (SCIDUA Notification Form).

The completed Notification Forms should be mailed or emailed to:

C/O Special Committee Investigating Deaths Under Anaesthesia

Clinical Excellence Commission

Locked Bag 2030

St Leonards NSW 1590

Email: CEC-SCIDUA@health.nsw.gov.au

For further information, please refer to the CEC's SCIDUA website.

11.2. Certain other deaths reportable to NSW Ministry of Health

In addition to SCIDUA deaths, other deaths that may not necessarily be reported to the Coroner are required to be reported to the NSW Ministry of Health via its Mortality Review (Authorised Committees). These include:

Perinatal deaths

Perinatal deaths comprise stillbirths and neonatal deaths and must be reported to the NSW Perinatal Mortality Review Committee (PMRC). The NSW Health Policy Directive *Investigation, Review and Reporting of Perinatal Deaths* (PD2022_026) sets out the reporting requirements.

Maternal Deaths

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

A late maternal death is a death occurring from 43-days up to and including 365-days post-partum. All such deaths must be reported to the CEC's Maternal and Perinatal Review Committee (MPMRC) in addition to other existing reporting obligations. The NSW Health Policy Directive *Reporting of Maternal Deaths to the NSW Clinical Excellence Commission* (PD2021_006) sets out the reporting requirements and procedures.

Surgical deaths

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Committee audits surgical death. Information on reporting and assessing surgical deaths is available on the CEC's website for Surgical Mortality Audit.

Serious clinical adverse events

The NSW Clinical Risk Action Group (CRAG) Committee is responsible for the assessment and oversight of management of serious clinical adverse events reported to the NSW Ministry of Health via Reportable Incident Briefs (RIB), which are prepared specifically for the Committee. See the CEC's Incident management policy resources for further information.

12. Appendices

1. Report of Death of a Patient to the Coroner (SMR01510)
2. Coronial Checklist (SMR010513)

12.1. Report of Death of a Patient to the Coroner (SMR01510)

NSW Health

Facility:

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010510

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

PATIENT'S DETAILS

Patient's Family Name: _____ Given Names: _____

Sex: (please tick) ☐ Male ☐ Female Age: _____ Marital Status: _____

Address: _____

SENIOR NEXT OF KIN

Senior Next of Kin: _____ Relationship: _____

Address: _____

Telephone contact details: Work: _____ Home: _____ Mobile: _____

SYNOPSIS OF CLINICAL NOTES

Date admitted: _____/_____/ 20_____ Time of admittance (24 hour clock) _____: _____

Date of death: _____/_____/ 20_____ Time of death (24 hour clock) _____: _____

History (Including relevant past history): _____

Examination on admission (Including evidence of any injuries, consumption of drugs or other relevant clinical findings): _____

_____

Treatment and subsequent progress: _____

Opinions as to cause of death (Include whether you believe the cause of death is a result of natural causes or other factors): _____

_____

Describe why the case has been referred to the Coroner? (What Coronial Flag in the checklist does it meet?): _____

_____

Is the death a sudden unexpected death in infancy (SUDI)? ☐ Yes ☐ No

If yes, has a SUDI medical history been taken and provided to Forensic Medicine?: _____

Have any antemortem specimens been taken and/or stored that you are aware of? (If so, please provide details and retain specimens):

_____

List any specific issues which need addressing at post-mortem: _____

List results of any discussion with Senior Next of Kin: (e.g. was the Senior Next of Kin informed this is a Coroner's Case, satisfied with treatment and/or do they object to a post-mortem?): _____

_____

Are the results of any potentially relevant tests awaited? If yes, please specify: _____

_____

Additional comments: _____

_____

_____

_____

I (print name) _____ a registered Medical Practitioner or a registered Nurse/Midwife* in the state of New South Wales hereby certify that at _____: _____ time (24 hour clock) on _____/_____/ 20_____ date (day, month and year), I examined the body of the above named patient and pronounced life extinct.

Your relationship to the deceased (e.g. treating practitioner or Nurse Unit Manager of ward): _____

CONTACT DETAILS OF CLINICIAN COMPLETING FORM (Please print)

Work Address: _____

Work telephone number: _____ Mobile telephone number: _____ Pager number: _____

Signature: _____ Qualifications: _____ Date: _____/_____/ 20_____

NH606160 141124

*Only to be completed by an RN/RM in circumstances outlined in PD2023_014 Verification of Death and Medical Certificate of Cause of Death TO THE CORONER

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010.510

NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010510

Holes Punched as per AS2828.1: 2019 BINDING MARGIN - NO WRITING

PATIENT'S DETAILS

Patient's Family Name: _____ Given Names: _____

Sex: (please tick) ☐ Male ☐ Female Age: _____ Marital Status: _____

Address: _____

SENIOR NEXT OF KIN

Senior Next of Kin: _____ Relationship: _____

Address: _____

Telephone contact details: Work: _____ Home: _____ Mobile: _____

SYNOPSIS OF CLINICAL NOTES

Date admitted: _____/_____/ 20_____ Time of admittance (24 hour clock) _____: _____

Date of death: _____/_____/ 20_____ Time of death (24 hour clock) _____: _____

History (Including relevant past history): _____

Examination on admission (Including evidence of any injuries, consumption of drugs or other relevant clinical findings): _____

Treatment and subsequent progress: _____

Opinions as to cause of death (Include whether you believe the cause of death is a result of natural causes or other factors): _____

Describe why the case has been referred to the Coroner? (What Coronial Flag in the checklist does it meet?): _____

Is the death a sudden unexpected death in infancy (SUDI)? ☐ Yes ☐ No

If yes, has a SUDI medical history been taken and provided to Forensic Medicine?: _____

Have any antemortem specimens been taken and/or stored that you are aware of? (If so, please provide details and retain specimens):

List any specific issues which need addressing at post-mortem: _____

List results of any discussion with Senior Next of Kin: (e.g. was the Senior Next of Kin informed this is a Coroner's Case, satisfied with treatment and/or do they object to a post-mortem?): _____

Are the results of any potentially relevant tests awaited? If yes, please specify: _____

Additional comments: _____

I (print name) _____ a registered Medical Practitioner or a registered Nurse/Midwife* in the state of New South Wales hereby certify that at _____: _____ time (24 hour clock) on _____/_____/ 20_____ date (day, month and year), I examined the body of the above named patient and pronounced life extinct.

Your relationship to the deceased (e.g. treating practitioner or Nurse Unit Manager of ward): _____

CONTACT DETAILS OF CLINICIAN COMPLETING FORM (Please print)

Work Address: _____

Work telephone number: _____ Mobile telephone number: _____ Pager number: _____

Signature: _____ Qualifications: _____ Date: _____/_____/ 20_____

*Only to be completed by an RN/RM in circumstances outlined in PD2023_014 Verification of Death and Medical Certificate of Cause of Death

TO THE POLICE

NH606180 141124

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010.510

NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010510

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

PATIENT'S DETAILS

Patient's Family Name: _____ Given Names: _____

Sex: (please tick) ☐ Male ☐ Female Age: _____ Marital Status: _____

Address: _____

SENIOR NEXT OF KIN

Senior Next of Kin: _____ Relationship: _____

Address: _____

Telephone contact details: Work: _____ Home: _____ Mobile: _____

SYNOPSIS OF CLINICAL NOTES

Date admitted: _____/_____/ 20_____ Time of admittance (24 hour clock) _____: _____

Date of death: _____/_____/ 20_____ Time of death (24 hour clock) _____: _____

History (Including relevant past history): _____

Examination on admission (Including evidence of any injuries, consumption of drugs or other relevant clinical findings): _____

_____

Treatment and subsequent progress: _____

Opinions as to cause of death (Include whether you believe the cause of death is a result of natural causes or other factors): _____

_____

Describe why the case has been referred to the Coroner? (What Coronial Flag in the checklist does it meet?): _____

_____

Is the death a sudden unexpected death in infancy (SUDI)? ☐ Yes ☐ No

If yes, has a SUDI medical history been taken and provided to Forensic Medicine?: _____

Have any antemortem specimens been taken and/or stored that you are aware of? (If so, please provide details and retain specimens):

_____

List any specific issues which need addressing at post-mortem: _____

List results of any discussion with Senior Next of Kin: (e.g. was the Senior Next of Kin informed this is a Coroner's Case, satisfied with treatment and/or do they object to a post-mortem?): _____

_____

Are the results of any potentially relevant tests awaited? If yes, please specify: _____

_____

Additional comments: _____

_____

_____

_____

I (print name) _____ a registered Medical Practitioner or a registered Nurse/Midwife* in the state of New South Wales hereby certify that at _____: _____ time (24 hour clock) on _____/_____/ 20_____ date (day, month and year), I examined the body of the above named patient and pronounced life extinct.

Your relationship to the deceased (e.g. treating practitioner or Nurse Unit Manager of ward): _____

CONTACT DETAILS OF CLINICIAN COMPLETING FORM (Please print)

Work Address: _____

Work telephone number: _____ Mobile telephone number: _____ Pager number: _____

Signature: _____ Qualifications: _____ Date: _____/_____/ 20_____

*Only to be completed by an RN/RM in circumstances outlined in PD2023_014 Verification of Death and Medical Certificate of Cause of Death

MEDICAL RECORDS

NH606180 141124

REPORT OF DEATH OF A PATIENT TO THE CORONER

SMR010.510

12.2. Coronial Checklist (SMR01513)

NSW Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CORONIAL CHECKLIST

SMR010513

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

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 should be completed by a registered nurse or registered midwife, qualified paramedic or medical officer prior to verification of death.
It must be reviewed or completed by a medical officer prior to completion of the Medical Certificate of Cause of Death.
This check list is to be used in conjunction with NSW Health Policy Directive 'Coroners Cases and the Coroners Act' PD2024_036

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 death **WAS NOT** the reasonably expected outcome of a health related procedure carried out in relation to that person? *(see point 2 over page for further guidance)*		
5. 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)		
6. Did the person die whilst in the custody of a police officer or in other lawful custody? *(see point 3 over page for further guidance related to deaths in custody)*		
7. Did the person die whilst escaping or attempting to escape from the custody of a police officer or other lawful custody?		
8. Did the person die as a result of, or in the course of police operations?		
9. Did the person die whilst temporarily absent from an institution or place where the person was an inmate?		
10. Was the person a child in care?		
11. Was the person a child in respect of whom a report was made under Part 2 of Chapter 3 of the **Children and Young Persons (Care and Protection) Act 1998** within the period of three years immediately preceding the child's death?		
12. Was the person a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the **Children and Young Persons (Care and Protection) Act 1998** within the period of three years immediately preceding the child's death?		
13. Was the person a child whose death is, or may be due to abuse or neglect or that occurs in suspicious circumstances?		
14. Was the person (child or adult) living in or temporarily absent from, specialist disability accommodation under the direction, management or control of an NDIS provider or in an assisted boarding house? *(see point 4 (e) over page for definitions and guidance)*		

If answers to ALL of the questions are NO, the death is NOT required to be referred to the Coroner and a Medical Certificate of Cause of Death MAY be issued. Where doubt exists as to whether a death should be reported, telephone the Duty Pathologist - Forensic Medicine: Sydney (02) 9563 9000. **If the answer is YES to ANY question, the death must be referred to the Coroner using *SMR010.510 – Report of Death of a Patient to the Coroner* and a Medical Certificate of Cause of Death MUST NOT be issued.**

The exception to this rule is that under S38 (2) of the Act, medical practitioners can issue a certificate as to the cause of death 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: ___/___/____

NO WRITING

Page 1 of 2

CORONIAL CHECKLIST

SMR010.513

NH606536 061124

NSW Health	FAMILY NAME	MRN
	GIVEN NAME	☐ MALE ☐ FEMALE
Facility:	D.O.B. _____ / _____ / _____	M.O.
	ADDRESS	
CORONIAL CHECKLIST		
	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

The following are extracts from the NSW Health Policy Directive 'Coroners Cases and the Coroners Act 2009' (PD2024_036)

1. **Voluntary Assisted Dying (VAD):**

Where a person has died from the administration of a VAD substance in accordance with the VAD Act, the person's death is not a reportable death unless the death falls under a Coronial Flag on page 1.

2. **NSW Health Guidelines Regarding Whether a Death is a Reasonably Expected Outcome of a Health Related Procedure**

The NSW Coroner's Act does not define the term '*reasonably expected outcome*', this is a matter for medical practitioners to decide based upon the facts of the case. '*Health related procedure*' is defined in the Act. Guidelines to assist the medical practitioner determine whether or not the death should be reported to the coroner are below:

(i). Is the death a reportable death? Consider:
- did the health related procedure cause the death?
- was the death an unexpected outcome?

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

(ii). Did the health related 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.

(iii). 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, but 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.

The factors to consider in each particular case will be different and doctors should use their professional judgement to determine whether the death is reportable. After the Coroners Checklist has been completed, if the medical practitioner remains uncertain about whether the death is reportable then s/he should contact the Duty Pathologist - Forensic Medicine: (02) 9563 9000.

Health related procedure: Health related procedure means a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug).

3. **Deaths in Custody**

A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died (or that there is reasonable cause to suspect that the person has died):
(a) while in the custody of a police officer or in other lawful custody, or
(b) while escaping, or attempting to escape, from the custody of a police officer or other lawful custody, or
(c) as a result of, or in the course of, police operations, or
(d) while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
(i) a detention centre within the meaning of the *Children (Detention Centres) Act 1987*,
(ii) a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*,
(iii) a lock-up, or
(e) while proceeding to an institution or place referred to in paragraph (d), for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

4. **Death of a Child and/or a Disabled Person/person with a disability**

A senior coroner has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person was (or that there is reasonable cause to suspect that the person was):
(a) a child in care, or
(b) a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death, or
(c) a child who is a sibling of a child in respect of whom a report was made under Part 2 of Chapter 3 of the *Children and Young Persons Care and Protection) Act 1998* within the period of 3 years immediately preceding the child's death, or
(d) a child whose death is, or may be due to abuse or neglect or that occurs in suspicious circumstances, or
(e) a person (whether or not a child) who, at the time of the person's death, was living in, or was temporarily absent from, specialist disability accommodation under the direction, management or control of an NDIS provider or an assisted boarding house.

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NO WRITING