Directive: compliance is mandatory

Coronial Process and the Coroners Act 2003 Policy Directive

Policy developed by: Public Health and Clinical Systems
Approved at Portfolio Executive on: 21 June 2012
Next review due: 31 December 2018

Summary
The purpose of the Coronial Process and the Coroners Act 2003 Policy Directive is to provide SA Health with a better understanding of the Coroners Act 2003 and give clear direction and guidance regarding employee obligations in accordance with the Coroners Act 2003 and this policy directive.

Keywords
Coroner, Coronial process, reportable death, investigation, Coroners Act, Coronial process and the Coroners Act

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? Y
Does this policy replace an existing policy? N
If so, which policies?

Applies to
All Local Health Networks and SAAS

Staff impact
All Staff, Management, Admin, Students; Volunteers

PDS reference
D0274

Version control and change history

<table>
<thead>
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<th>Version</th>
<th>Date from</th>
<th>Date to</th>
<th>Amendment</th>
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<td>1.0</td>
<td>01/06/2005</td>
<td>06/07/2012</td>
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<tr>
<td>2.0</td>
<td>06/07/2012</td>
<td>20/07/2012</td>
<td>Updated directive to provide clarity regarding roles and responsibilities of Coroners and health staff relating to reportable deaths</td>
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<tr>
<td>3.0</td>
<td>20/07/2012</td>
<td>18/10/2012</td>
<td>Update 4.1.1 and Appendix A</td>
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<td>4.0</td>
<td>19/10/2012</td>
<td>08/03/2013</td>
<td>Update to reflect the restructures within the portfolio and are not material in nature.</td>
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<td>5.0</td>
<td>08/03/2013</td>
<td>06/08/2013</td>
<td>Update 4.2.1 and 4.2.2 to align with the protocol between the Department and SA Police regarding requests for patient records.</td>
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<td>6.0</td>
<td>07/08/2013</td>
<td>Current</td>
<td>4.1.13 – documentation and process notification changes now via Safety Learning System.</td>
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Coronial Process and the Coroners Act 2003
Policy Directive
1 Purpose/Background

The purpose of this Directive is to provide SA Health with a better understanding of the Coroners Act 2003 and give clear direction and guidance regarding staff obligations in accordance with the Coroners Act 2003 and this policy directive.

2 Scope

This Policy Directive applies across the SA Health portfolio.

3 Directive Principles

With the implementation of this Directive, SA Health will ensure:

> that all reportable deaths are reported to the Coroner or SA Police (for SAAS staff at the time of attendance to a deceased person). Deaths in custody must be reported to the Coroner;
> that all staff (except SAAS who report in a different manner) are aware of the requirements of reporting a death to the Coroner and the penalties that may apply for non compliance;
> that all SAAS staff are aware of the requirements of reporting a death to SA Police immediately (who will report the death to the Coroner) and the penalties that may apply for non compliance;
> that all staff will assist in the coronial process where required;
> that all staff have a clear understanding of their obligations and rights in regards to the coronial enquiries; and
> that relatives / next of kin of the deceased are informed of the requirement to report to the Coroner and the processes that are involved per the coroners website.

4 Directive Detail

4.1 DEATH

Reportable Deaths

4.1.1 Health services, SA Ambulance Services (SAAS) and other organisations providing a health service on behalf of SA Health (e.g. RDNS) must have processes in place to ensure that the Coroner or SA Police are immediately notified of any death that is, or may be, a reportable death. SAAS officers are required to contact SA Police through the SAAS State Duty Manager in the first instance.

4.1.1 The Coroner's office phone will be diverted to the Adelaide Police Station for reports made after hours.

4.1.2 SAAS officers are required to request police attendance at a suspected reportable death scene. A brief statement will be taken at the scene. A more comprehensive statement will be followed up at a later date.

4.1.3 The person notifying the Coroner or Police Officer must:

(a) give the Coroner or Police Officer any information that the person has in relation to the death.

(b) where the person is a medical practitioner who was responsible for the medical care of the deceased person prior to death, or who examined the body of the person after death, he or she must give their opinion as to the cause of death.
In making a determination as to whether a death is a reportable death consider the following;

(a) the original admission diagnosis or provisional diagnosis, which may fall within the Coroner's jurisdiction;

(b) treatment whilst in hospital; at the scene (SAAS officers) or in transition between hospitals (SAAS officers/MedSTAR medical practitioners); and

(c) the medical cause of death (medical officers only).

4.1.4 The Coroner or Police Officer may ask for a Medical Deposition from the notifying medical practitioner/SAAS officers/MedStar medical practitioner. The deposition may include date of admission, admission diagnosis, retrieval provisional diagnosis, any procedures or tests undertaken, relevant medical history, progress and suggested cause of death. For SAAS officers, the deposition may include medical history ascertained from others at the scene, status of patient on arrival at the scene, procedures/interventions undertaken and declaration of life extinct details.

For further guidance refer to protocol Police requests for Information and Witness Statements in the Public Health System in South Australia 2011.

4.1.5 To gain additional information relating to the notified death, the Coroner or Police Officer can:

(b) enter the health site at any time and by force (if necessary) and inspect and remove anything in or on site;

(c) take photographs, films and audio, video or other recordings;

(d) examine, copy or take extracts from any medical records or relevant documents.

**Body of the Deceased**

4.1.6 The body of the person whose death is reportable is under the exclusive control of the Coroner until the Coroner issues an authorisation for the disposal of human remains in respect of the body.

4.1.7 Following a reportable death, the medical practitioner must not:

4.1.7.1 perform or authorise a post mortem examination to determine the cause of death unless directed by the Coroner or the Coroner’s Court and / or;

4.1.7.2 notify the Registrar of Births, Deaths and Marriages.

4.1.8 With the exception of a death in custody or a suspicious death, the body of the deceased may be moved providing all equipment such as intravenous therapy, tubes and drains are left in situ. SAAS officers may remove intubation tubes etc, as movement of the body in an uncontrolled setting has a high incidence of dislodgement.

4.1.9 Where the death is unexpected, unnatural or suspicious in nature the surrounding area must not be disturbed or cleared.

4.1.10 In accordance with the Transplantation and Anatomy Act 1983, the Designated Officer at the health site is to be contacted to initiate discussions regarding organ donation. Organ donation can occur only once the Coroner has given permission for the body to be released.

**Internal Notification**

4.1.11 If a medical practitioner is uncertain of the nature of the death, or identifies an issue that has the potential to be litigious, and/or believes a criminal act may have occurred, he/she is to notify the relevant Chief Executive Officer, Executive Officer, Director of Nursing and Midwifery or Medical Director (or delegate).

4.1.12 If a SAAS officer is uncertain of the nature of the death, or identifies an issue that has the potential to be litigious, and/or believes that a criminal act may have occurred, he/she is to notify the State Duty Manager immediately for escalation pathway culminating in CEO notification.
4.1.13 Potential Coronial matters are made via the Safety Learning System (SLS) Notifications module. A mandatory confirmatory email is sent from the individual Coronial notification to Insurance Service Unit and the Safety and Quality Unit at time of entering the notification. Notifications are to be made within 24 hours of a death being notified to the Coroner's office. (Health sites should have local process that define who is responsible for this e.g. clinical risk management)

4.1.14 Where the death is a Safety Assessment Code 1 (SAC1) or Sentinel Event, it should also be reported through the Safety Learning System.

**Notification of Relatives:**

4.1.15 Relatives of the deceased person should be advised by the medical practitioner or SAAS officer of the health site's requirements to report the death to the Coroner's Office or SAPOL as soon as possible. This should occur wherever possible by personal contact with the relatives.

4.1.16 In the event of a Coronial Investigation, the site CEO (or delegate) and / or Consumer Advisor (where available) or the Department for Health and Ageing Insurance Services Unit can provide advice to the deceased relatives on the course of the investigation and / or inquest.

4.2 **INQUEST – Investigations**

4.2.1 All health site personnel are to ensure the medical/clinical records of the deceased are up to date including all pathology reports, x-rays and electronic health records and are available for further discussion or review by the Coroner. Medical records *should not* be sent to the Coroner unless requested and are to be supplied only if the investigator produces the Coroner's Direction (or, in the case of a police officer not in uniform, his or her warrant card).

4.2.2 Health site personnel must photocopy the records of a deceased person before releasing the original to the Coroner. The protocol that the Department has with SA Police states that:

> Where a patient/client’s medical records are required for a Coroner's investigation, the health site is to ensure that it has a copy of the records prior to delivering to SAPOL the original records. If a copy of the medical records cannot be readily obtained (e.g. the request for medical records occurs outside normal business hours), efforts should be made to negotiate a time to enable the health site to copy the records. In the event of a dispute the State Duty Police Officer is to be contacted (ph 0417 800 902).

4.2.3 On occasion, the Coroner (or delegate) may request a witness statement by staff to determine what had transpired leading up to the death of a patient.

Upon receipt of the request from the Coroner or Investigator for information, the Chief Executive Officer (or delegate) of the health service or SA Ambulance Service will appoint an appropriate employee to facilitate the request in a timely manner.

**NOTE:** The Chief Executive, Department for Health and Ageing has provided written authorisation to disclose information to the Coroner during the investigation stage (Refer to Appendix A).

4.3 **CORONER’S FINDINGS AND RECOMMENDATIONS**

4.3.1 The role of the Coroner is to ensure all deaths, suspected deaths, fires or accidents that cause injury to person or property, which come under the Coroner's jurisdiction are properly investigated and concluded.

4.3.2 The Coroner's Court must, as soon as practicable, after completion of the inquest or (where no inquest was required); following conclusion of autopsy and investigation, give its findings in writing, setting out as far as has been ascertained, the cause and circumstances of the event that was subject to the inquest.
4.3.3 The Coroner’s Court may add to its findings any recommendation that might, in the opinion of the Coroner, prevent, or reduce the likelihood of, a recurrence of an event similar to that in the inquest. Findings from inquests are available on the Coroners Court website: http://www.courts.sa.gov.au/courts/coroner/index.html

4.3.4 When the Coroner addresses a recommendation to the Minister for Health and Ageing or Minister for Mental Health and Substance Abuse, the Department for Health and Ageing through the Public Health and Clinical Systems Division is responsible for ensuring a response is provided to the Coroner.

4.3.5 The Public Health and Clinical Systems Division will liaise with relevant areas within the SA Health portfolio, particularly those responsible for implementing the recommendations in order to prepare the response.

5 Responsibility

5.1 Chief Executive - SA Health is responsible for:

5.1.1 Ensuring reporting of all reportable deaths occur in relation to this Directive

5.1.2 Ensuring SA Health Portfolio staff are aware of the reporting requirements under the Coroners Act 2003

5.1.3 Receiving briefings and final report of actions taken for authorisation.

5.2 Minister for Health and Ageing / Minister for Mental Health and Substance Abuse is responsible for:

5.2.1 Receiving briefings once notification has been received that the inquest is to commence and once findings are to be released (if an update is required)

5.2.2 Receiving final report of actions taken for authorisation - to be provided to the Coroner (and Cabinet and both Houses of Parliament if a ‘death in custody’) within timeframes stipulated under the Coroners Act 2003.

5.3 Manager, Insurance Services – Finance and Administration is responsible for:

5.3.1 Notifying the Safety and Quality Unit, Public Health and Clinical Systems

1.3.1.1 that a ‘reportable death’ has been notified

1.3.1.2 that an inquest is to be held

1.3.1.3 that inquest findings are to be released (and provide a copy of findings and recommendations)

5.3.2 Providing the Safety and Quality Unit with relevant documents including background report, Coronial findings and summation from SA Health appointed solicitor

5.3.3 Providing Media Unit, Operational Division with daily updates if case is of a sensitive nature.

5.4 Executive Director - Public Health and Clinical Systems through the Director, Safety and Quality is responsible for:

5.4.1 Establishing, maintaining and reviewing the SA Health Coroners Reporting System and associated processes

5.4.2 Providing advice to SA Health in response to specific queries about the Directive and legislative requirements
5.4.3 Providing advice to the Chief Executive and the Minister for Health and Ageing or Minister for Mental Health and Substance Abuse on issues of public concern / media or public attention as a result of a Coroner’s inquest.

5.4.4 Providing advice and/or support information requirements of Insurance Services Unit.

5.4.5 Providing briefings and reports to the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse.

5.4.6 Liaising with the Cabinet Liaison Officer, Office of the Chief Executive and others as appropriate.

5.5 Clinical Risk Analyst – Safety and Quality Unit is responsible for:

5.5.1 Notifying appropriate people that an inquest is to be undertaken and providing them with any relevant information.

5.5.2 Requesting information as appropriate from Local Health Networks, SAAS and the Department.

5.5.3 Preparing and processing briefings and other relevant documents via the Director, Safety and Quality, Executive Director, Public Health and Clinical Systems to the Office of the Chief Executive.

5.5.4 Considering recommendations, make determination regarding how to progress them (in conjunction with Clinical Advisors where necessary), and preparing letters to Local Health Networks, SAAS and external groups and emails, where appropriate.

5.6 Clinical Advisors: Chief Medical Officer, Chief Pharmacist, Chief Nurse, Chief Psychiatrist, Chief Allied Health are responsible for:

5.6.1 Providing advice to the Safety and Quality Unit regarding how to progress recommendations when requested.

5.7 Chief Executive Officers Local Health Networks, SA Ambulance Service and other health organisations procured to deliver health services on behalf of SA Health are responsible for ensuring:

5.7.1 Adherence to the Directive and appropriate reporting.

5.7.2 Internal processes are in place to investigate ‘reportable deaths’ and identify and address opportunities to improve care and service delivery that may have contributed to the cause or circumstances of the death.

5.7.3 Appropriate support and resources are provided to all staff.

5.7.4 Staff are made aware of their obligation to report deaths in accordance with this Directive and the relevant legislation.

5.7.5 That the response to coronial inquest findings address all recommendations, including all actions undertaken and proposed actions to be taken with timeframes for implementation.

5.8 Nominated health site delegate is responsible for:

5.8.1 Ensuring staff are educated on their reporting obligations in accordance with the Coroners Act 2003.

5.8.2 Responding to requests from the Safety and Quality Unit, Public Health and Clinical Systems for information relevant to a Coroner’s inquest.
5.9 Office of the Chief Psychiatrist is responsible for:

5.9.1 Contributing to briefings and content for final reports as required.

5.10 Cabinet Liaison Officer – Office of the Chief Executive is responsible for:

5.10.1 Receiving a copy of the findings and liaising with Director, Safety and Quality regarding Cabinet Forecast and Cabinet Pink.

5.11 Communications Unit – Office of the Chief Executive is responsible for:

5.11.1 Receiving a copy of the most recent briefing prior to the inquest findings being released.

5.12 Advisor – Office of the Minister for Health and Ageing / Minister for Mental Health and Substance Abuse is responsible for:

5.12.1 Liaising with Director, Safety and Quality regarding the requirements for providing reports to the Coroner, Cabinet and Parliament.

5.13 All SA Health employees or persons who provide health services on behalf of SA Health are required to adhere to the principles and process of this Directive.

6 Definitions

In the context of this document and the accompanying guideline:

‘Coroner’ means –

(a) The State Coroner; or
(b) A Deputy State Coroner; or
(c) Any other coroner appointed under Part 2 of the Coroners Act 2003.

‘Death in Custody’ means the death of a person where there is reason to believe that the death occurred, or the cause of death, or a possible cause of death, arose, or may have arisen, while the person—

(a) was being detained in any place within the State under any Act or law, including any Act or law providing for home detention (and, for the purposes of this paragraph, a detainee who is absent from the place of his or her detention but is in the custody of an escort will be regarded as being in detention, but not otherwise); or

(b) was in the process of being apprehended or was being held—
   (i) at any place (whether within or outside the State)—by a person authorised to do so under any Act or law of the State; or
   (ii) at any place within the State—by a person authorised to do so under the law of any other jurisdiction; or

(c) was evading apprehension by a person referred to in paragraph(b); or

(d) was escaping or attempting to escape from any place or person referred to in paragraph(a) or (b).

(Section 3, Coroners Act 2003)
'Delegate' for the purpose of this policy means the person identified by the health site and notified to the Coroner as being the person to deal with requests for information from the Coroner/SA Police during business hours e.g. clinical risk manager or police liaison officer.

'Designated officer' means, in relation to a hospital, a person appointed under section 6 of the Transplantation and Anatomy Act 1983 to be a designated officer for that hospital.

'Investigator' under section 9 of the Coroners Act 2003 means –

(a) A police officer; or
(b) A person appointed under the Coroners Act 2003 to be an investigator.

'Medical Practitioner' means a person registered under the Health Practitioner Regulation National Law (South Australia) Act 2010 to practice in the medical profession (other than a student) (section 26, Health Practitioner Regulation National Law (South Australia) Act 2010). (Refer to appendix B for detail of the professions registered in accordance with the Health Practitioner Regulation National Law (SA) Act 2010.

'Reportable death' means the State death of a person -

(a) by unexpected, unnatural, unusual, violent or unknown cause; or
(b) on an aircraft during a flight, or on a vessel during a voyage; or
(c) in custody; or
(d) that occurs during or as a result, or within 24 hours, of—
   (i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure**; or
   (ii) the administration of an anaesthetic for the purposes of carrying out such a procedure,
   not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply;
(e) that occurs at a place other than a hospital but within 24 hours of—
   (i) the person having been discharged from a hospital after being an inpatient of the hospital; or
   (ii) the person having sought emergency treatment at a hospital; or
(f) where the person was, at the time of death—
   (i) a protected person under the Aged and Infirm Persons’ Property Act 1940 or the Guardianship and Administration Act 1993; or
   (ii) in the custody or under the guardianship of the Minister under the Children’s Protection Act 1993; or
   (iii) a patient in an approved treatment centre under the Mental Health Act 1993; or
   (iv) a resident of a licensed supported residential facility under the Supported Residential Facilities Act 1992; or
   (v) accommodated in a hospital or other treatment facility for the purposes of being treated for drug addiction; or
(g) that occurs in the course or as a result, or within 24 hours, of the person receiving medical treatment to which consent has been given under Part 5 of the Guardianship and Administration Act 1993; or
(h) where no certificate as to the cause of death has been given to the Registrar of Births, Deaths and Marriages; or
that occurs in circumstances prescribed by the regulations;  

(Section 3, Coroners Act 2003)

**Specified procedures excluded from definition of reportable death**  
(Section 4, Coroners Regulations 2005):
The following procedures are specified and thereby excluded:

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

NOTE: Medical practitioners should be aware that in line with the Coroner's advice, haemodialysis is considered to be an invasive medical procedure and therefore if a death occurs during haemodialysis or within 24 hours of the procedure, it is considered a 'reportable death' under the Coroners Act 2003.

'SA Ambulance Service (SAAS) Officer' means any operational practising ambulance officer, paramedic, intensive care paramedic or extended care paramedic.

'State Coroner' means the person holding or acting in the office of State Coroner under Part 2 of the Coroners Act 2003 (Section 3, Coroners Act 2003).

'State death' means the death of a person –

(a) that occurred in the State; or
(b) where the place of death is unknown but it is reasonably possible that the death occurred in the State; or
(c) where the body of the person is in the State; or
(d) a cause of which occurred, or possibly occurred, in the State; or
(e) where, at the time of death, the person was ordinarily a resident in the State; or
(f) in the case of a death on an aircraft or vessel – where flight or voyage was to a place of disembarkation in the State.

7 Evaluation

7.1 When a person has become aware of a reportable death, the death is reported to the Coroner immediately.
8 Risks

8.1 If ‘reportable deaths’ are not reported in a timely manner the body may be cremated and the opportunity for autopsy may be lost.

8.2 If processes are not followed in line with the Coroners Act 2003 a maximum penalty of up to $10,000 or imprisonment for up to 2 years may apply for the failure to notify a death, section 28(1). A penalty of $5000 may apply for a failure to provide an opinion as to the cause of death, section 28(2)(b). A penalty of $1 250 may apply if a death certificate is provided to the Registrar of Births, Deaths and Marriages if the death is a Coronial death, section 36(2)(b) of the Births, Deaths and Marriages Registration Act 1996.

9 Associated Directives or Guidelines

> SA Health Incident Management Policy Directive (D0165)
> SA Health Incident Management Guideline Incorporating Open Disclosure Response (G0075)
> SA Health Police investigations into unnatural or suspicious deaths and injuries and/or major criminal activities in public health care facilities (D00027)
> SA Health Protocol for Police Requests for Information and witness Statements in the Public Health System in South Australia (September 2009)

10 References

> Coroners Act 2003 and Regulations 2005
> Health Care Act 2008
> Mental Health Act 2009
> Health Practitioner Regulation National Law (South Australia Act) 2010
> Transplantation and Anatomy Act 1983
> Children’s Protection Act 1993 – Child Death and Serious Injury Review Committee
Appendix A – Authorisation to disclose information to the South Australian Coroner during inquest – investigation stage

HEALTH CARE ACT 2008, SECTION 93
MENTAL HEALTH ACT 2009, SECTION 106

Authorisation to disclose information to the South Australian Coroner
during the investigation stage

I, MR DAVID SWAN, hereby authorise pursuant to section 93 of the Health Care Act 2008 and section 106 of the Mental Health Act 2009, persons employed or working at incorporated hospitals or the SA Ambulance Service Inc (SAAS) and staff working within the Department of Health, to make disclosures of personal information relating to a person obtained while so engaged to the following:
1. The South Australian Coroner (as defined in the Coroners Act 2003);
2. A South Australian Police Officer investigating a death of behalf of the South Australian Coroner;
3. Any other Investigator appointed pursuant to the Coroners Act 2003 investigating a death on behalf of the South Australian Coroner.

This authorisation operates from the date of signing of this instrument and has effect until varied or revoked.

The Chief Executive of the Department of Health may vary or revoke this authorisation at any time.

[Signature]

Mr David Swan
Chief Executive
Department of Health

Dated \[5/5/11\]
Appendix B Definition of ‘Medical Practitioner’ means a person registered under the Health Practitioner Regulation National Law (South Australia) Act 2010

(as outlined in the below Table - taken from Schedule, Divisions)

39—References to members of professions

(1) Unless the contrary intention appears or the context requires a different interpretation, a reference within an Act or another instrument within the ambit of column 1 of the following table will have effect as if it were the corresponding reference in column 2 of the table.

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
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<tbody>
<tr>
<td>chiropractor</td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the chiropractic profession (other than as a student)</td>
</tr>
<tr>
<td>dental practitioner</td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the dental profession (including, if appropriate, a dental therapist, dental hygienist, dental prosthodontist or oral health therapist but not including a student)</td>
</tr>
<tr>
<td>dentist</td>
<td>a person registered under the Health Practitioner Regulation National Law— (a) to practise in the dental profession as a dentist (other than as a student); and (b) in the dentists division of that profession</td>
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<tr>
<td>enrolled nurse</td>
<td>a person registered under the Health Practitioner Regulation National Law— (a) to practise in the nursing and midwifery profession as a nurse (other than as a student); and (b) in the enrolled nurses division of that profession</td>
</tr>
<tr>
<td>legally qualified medical practitioner</td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student)</td>
</tr>
<tr>
<td>medical practitioner</td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the medical profession (other than as a student)</td>
</tr>
<tr>
<td>midwife</td>
<td>a person registered under the Health Practitioner Regulation National Law— (a) to practise in the nursing and midwifery profession as a midwife (other than as a student); and (b) in the register of midwives kept for that profession</td>
</tr>
<tr>
<td>nurse</td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the nursing and midwifery profession as a nurse (other than as a student)</td>
</tr>
<tr>
<td><strong>optometrist</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the optometry profession (other than as a student)</td>
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<td><strong>osteopath</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the osteopathy profession (other than as a student)</td>
</tr>
<tr>
<td><strong>pharmacist</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the pharmacy profession (other than as a student)</td>
</tr>
<tr>
<td><strong>physiotherapist</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the physiotherapy profession (other than as a student)</td>
</tr>
<tr>
<td><strong>podiatrist</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the podiatry profession (other than as a student)</td>
</tr>
<tr>
<td><strong>psychologist</strong></td>
<td>a person registered under the Health Practitioner Regulation National Law to practise in the psychology profession (other than as a student)</td>
</tr>
</tbody>
</table>
| **registered nurse**| a person registered under the Health Practitioner Regulation National Law—

(a) to practise in the nursing and midwifery profession as a nurse (other than as a student); and

(b) in the registered nurses division of that profession |

(2) Unless the contrary intention appears or the context requires a different interpretation, a reference in an Act or another instrument to a registered health practitioner will have effect as if it were a reference to a health practitioner registered in the relevant health profession under the *Health Practitioner Regulation National Law.*