Policy

Guideline

Coronial Process and the Coroners Act 2003

Policy developed by: Public Health and Clinical Systems
Approved at Portfolio Executive on: 21 June 2012
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Summary
This Guideline outlines the process for reporting SA Health related deaths being investigated by the State Coroner’s Office to the Chief Executive and the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse. It incorporates the reporting obligations of the SA Health Portfolio and the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse with regard to the Coroners Act 2003 and Coroners Regulations 2005.

Keywords
Guideline, Coroner, Reportable Death, Death, Investigation, Coroners Act 2003, SA Police

Policy history
Is this a new policy? N
Does this policy amend or update an existing policy? N
Does this policy replace an existing policy? Y
If so, which policies?
D0026 Protocol for Notifying Deaths to the State Coroner’s Office

Applies to
All Local Health Networks and SAAS

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

PDS reference
G0123

Version control and change history

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1 Purpose / Background

This Guideline outlines the process for reporting SA Health related deaths being investigated by the State Coroner's Office to the Chief Executive and the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse.

It incorporates the reporting obligations of SA Health and the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse with regard to the Coroners Act 2003 and Coroners Regulations 2005.

This Guideline is to be read / administered in conjunction with the Directive Coronial Process and the Coroners Act 2003.

2 Guideline Detail

2.1 Notified of Reportable Death

2.1.1 Insurance Services, Finance and Administration Division will be advised of a ‘reportable death’ and will notify the Safety and Quality Unit, Public Health and Clinical Systems Division.

2.1.2 The Safety and Quality Unit will disseminate the coronial notification spreadsheet to the designated Local Health Network (LHN) / SA Ambulance Service (SAAS) for quality improvement.

2.1.3 The Safety and Quality Clinical Review Meeting will discuss pertinent deaths, a desktop audit may be conducted on deaths of concern and / or further information may be sought from LHNs / SAAS as required.

2.2 Notified Coroner’s Inquest to Commence

2.2.1 When Insurance Services is notified that there will be coronial inquest, they will prepare a background report that will include likely issues for the State Coroner. The report will be provided to the Safety and Quality Unit.

2.3 Conclusion of Hearing / Inquest

2.3.1 Insurance Services will receive the summation from the SA Health appointed solicitor at the conclusion of some Coroner’s inquests and will provide these to the Safety and Quality Unit. (Note: if the case is of a sensitive nature, Insurance Services will provide the Media Unit, Operations Division with daily updates in regard to the inquest).

2.4 Notified Coroner’s Finding to be Released

2.4.1 Upon notification that the Coroner’s finding is to be released, Insurance Services will advise the Safety and Quality Unit.
2.5 Notified of Coroner's Findings and Recommendations following the conclusion of the inquest

2.5.1 Insurance Services are notified of the Coroner’s findings and recommendations, and will forward them to the Safety and Quality Unit.

2.5.2 The Safety and Quality Unit will forward the findings and recommendations to relevant LHN / SAAS and, where the death is related to mental health policy, a copy will be provided to the Office of the Chief Psychiatrist.

2.5.2 If no recommendations are directed to SA Health by the State Coroner, the Safety and Quality Unit will save an electronic copy, keep a hard copy and close the file.

2.5.3 If the State Coroner directs recommendations to SA Health, the Safety and Quality Unit will review the recommendations in conjunction with Clinical Advisors, as necessary, to determine the progress of the recommendations.

2.5.4 The Safety and Quality Unit may request consideration or implementation of recommendations from LHNs, SAAS, SA Health Department staff, or external organisations (e.g. Australian Medical Association, Australian Health Practitioners Regulation Agency) where recommendations are directed to SA Health and external organisations.

2.5.5 LHNs, SAAS, SA Health Department staff, and external organisations are to provide advice to the Safety and Quality Unit in relation to the actions that have been taken to ensure implementation of the recommendations.

2.6 If the case is a ‘Death in Custody’

2.6.1 Where the State Coroner has found that the case was a ‘death in custody’ under the Coroners Act 2003, the Safety and Quality Unit will liaise with the Cabinet Liaison Officer in the Chief Executive’s Office to have the item listed on the Cabinet Forward Agenda.

Note: Advice received from the State Coroner has indicated that where a patient is detained under the Mental Health Act 2009 and the detention order is revoked when it is obvious that the patient is dying, the death will still be considered a ‘death in custody’ under the Coroners Act 2003.

2.6.2 The Safety and Quality Unit will prepare a briefing to the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse attaching a Cabinet Pink Note, a copy of the Coroner's findings, a Report of Actions Taken by SA Health, and a draft letter to the State Coroner and submit them to the Executive Director, Public Health and Clinical Systems for approval.

2.6.3 Where the death is related to mental health policy, preparation of the documents referred to in 2.6.2 will be done in conjunction with the Office of the Chief Psychiatrist.

2.6.4 The correspondence must be provided to the Office of the Chief Executive within five months of the release of the Coroner’s findings, who will note that it is to be provided for Cabinet and forward to the Office of the Minister for Health and Ageing or Mental Health and Substance Abuse.

2.6.5 Upon receipt of the correspondence, the Office of the Minister for Health and Ageing will lodge the item with Cabinet, and ensure that the Report of Actions Taken is tabled in both Houses of Parliament (within 6 months and 8 sitting days after the release of the findings) and provided to the State Coroner. This is a legislative requirement under section 25(5) of the Coroners Act 2003.

2.6.6 The Safety and Quality Unit, Public Health and Clinical Systems Division include the actions taken by SA Health in the Annual Patient Safety Report.
2.7 If the case is not a ‘death in custody’

2.7.1 The Safety and Quality Unit will prepare a briefing and Report of Actions Taken by SA Health for the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse, along with a draft letter to the State Coroner. This is not a legislative requirement, but is done as a matter of best practice. It ensures that recommendations are considered and implemented where appropriate, and that a record is maintained.

2.7.2 Where the death is related to mental health policy, preparation of the documents referred to in 2.7.1 will be done in conjunction with the Office of the Chief Psychiatrist.

2.7.3 The correspondence should be provided to the Office of the Chief Executive within five months of the release of the Coroner’s findings, who will note it and forward to the Office of the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse.

2.7.4 The Office of the Minister for Health and Ageing or the Minister for Mental Health and Substance Abuse will provide the Report of Actions Taken to the State Coroner.

2.7.5 The Safety and Quality Unit will include the actions taken by SA Health in their Annual Patient Safety Report.

3 References

Coroners Act 2003 and Coroners Regulations 2005
### Flow chart for Coroners inquest procedures

- Death notified to Insurance Services Unit (ISU) by Local Health Network (LHN) / SA Ambulance Service (SAAS)
- ISU update Coronial notification spreadsheet
- Safety & Quality Unit (S&Q) access spreadsheet, add LHN / SAAS and whether incident is logged on Safety Learning System
- Spreadsheet disseminated to LHNs / SAAS
- Desktop review. Pertinent deaths discussed at Clinical Review Meeting
- Further information sought from LHNs / SAAS if required

- Receive email from ISU that inquest is about to commence

- Summation from solicitor received via ISU

- ISU notified inquest findings to be released
- ISU notify S&Q

- Findings received by ISU
- Findings provided by ISU to S&Q
- If no recommendations S&Q save an electronic copy / hard copy and close
- S&Q disseminate recommendations and (if required) review with clinical advisors
- S&Q request information about implementation of recommendations / actions taken from LHN / SAAS

#### Death in Custody
- S&Q prepare briefing to Minister attaching cabinet pink, report of actions taken and draft letter to State Coroner
- If death related to mental health, policy preparation of documents will be done in conjunction with the Office of the Chief Psychiatrist
- The correspondence must be provided to the CE’s office within 5 months of release of findings

#### Not Death in Custody
- S&Q prepare briefing to Minister attaching report of actions taken and draft letter to State Coroner
- If death related to mental health policy, preparation of documents will be done in conjunction with the Office of the Chief Psychiatrist
- The correspondence must be provided to the CE’s office within 5 months of release of findings

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**For more information**

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