

END OF LIFE - CORONERS CASES, DEATHS UNDER ANAESTHESIA AND THE CORONERS ACT (2009) D/2013/70768[V4]

Policy Owner : Deputy Director of Medical Services

No. of pages: 16

Policy Statement

To provide medical practitioners, nursing staff, managers and administrators with:

- Specific information about the Coroners Act (2009);
- Direction and guidance about reportable deaths to the NSW Coroner; and
- Direction and guidance about the Special Committee Investigating Deaths under Anaesthesia and reporting requirements if a patient dies under or within 24 hours of an anaesthetic.

Scope of Policy

This policy is aimed at all medical officers and nursing staff directly involved in the care of patients and at managerial, administrative and executive staff involved in ensuring the correct documentation and reporting of deaths to the Coroner and SCIDUA.

Definitions

Coroner

A person who investigates certain kinds of deaths in order to determine the identity of the deceased and the date, place, circumstances and medical cause of death.

SCIDUA

Special Committee Investigating Deaths Under Anaesthesia

Child Death Review Team

The Child Death review team is a team established by the Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW) whose functions include analysing data to identify trends relating to child death

SCIDUA Form

Report of Death associated with Anaesthesia/Sedation Form (previously Form B)

MOOH/ADON

Manager, Out-of-Hours/ After Hours Director of Nursing

NUM

Nursing Unit Manager

Roles and Responsibilities

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Hospital managers and medical staff must be aware of legislative requirements for the reporting of deaths to the Coroner and/or SCIDUA and other relevant review teams. Staff must be aware of the appropriate documentation required and provide the Coroner with original or copies of the medical records.

Hospital managers and medical staff must also be aware of the procedures involved in the notification of a death (not reportable to the Coroner) and the issuing of a Cremation Certificate.

The Mortality & Morbidity Sub-Committee is responsible for the screening of all deaths for compliance with notification regulations and will initiate follow-up in cases where it may have been missed.

The Director of Medical Services will be responsible for ensuring that notification does occur in these cases.

Background

A number of key changes have been enacted in the Coroners Act 2009 which is relevant to health care workers. These include changes to the categories of cases which must be reported to the Coroner and changes to coronial autopsy procedures.

Current versions of the Coroners Act 2009 and the Coroners Regulations 2010 are accessible at www.legislation.nsw.gov.au.

General Guidelines

1. Jurisdiction of the Coroner

The Coroner has the 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 a 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 or will not give) a certificate as to the cause of death

2. Circumstances in which a Medical Practitioner should NOT Issue a Certificate as to the Cause of Death

2.1 A medical practitioner must not issue a certificate as to the Cause of Death under the Births, Deaths and Marriages Registration Act 1995 if the death is a REPORTABLE death (s6 Coroners Act 2009) i.e.:

- The person died a violent or unnatural death
- The person died a sudden death, the cause of which is unknown,
- The person died under suspicious or unusual circumstances

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- The person died in circumstances where they had not been attended by a medical practitioner within 6 months prior to the patient's death,
- The person died in circumstances where the death was not a reasonably expected outcome of a health related procedure (see below)
- If the person died while in or temporarily absent from a declared mental health facility if the patient was a resident at the facility for the purpose of receiving care.

OR

- If the death is a death under s23 Coroners Act 2009 i.e.: a death in custody

OR

- If the death is a death under s24 Coroners Act i.e.:
 - 1) The death of a child who was:
 - a. A child in care
 - b. A child or the sibling of a child of whom a report was made under Part 2 of Chapter 3 of the Children and Young Persons (Care and Protection) Act 1998 within three (3) years preceding the death
 - c. A child whose death may be due to abuse or neglect or that occurs in suspicious circumstances
 - 2) The death of a disabled person:
 - a. A person who at the time of death was living in, or was temporarily absent from, residential care, or
 - b. A person who is in a target group within the meaning of the Disability Services Act 1993 who receives assistance (as prescribed by the regulations) from a service provider to allow the person to live in the community

2.2 Changes to categories of cases that were previously reportable to the Coroner (Coroners Act 1980):

- The Coroners Act 2009 does not specifically identify deaths occurring under or within 24 hours of administration of an anaesthetic as reportable to the Coroner. However From 1st September 2012, the [NSW Public Health Act 2010](#) requires **the health practitioner who is responsible for the administration** of the anaesthetic or sedative drug, where the patient died while under, or as a result of, or within 24 hours after the administration of an anaesthetic or sedative drug for a medical, surgical or dental operation or procedure, to report the death to the Director General via the SCIDUA
- The limitation whereby a death need only be reported if it occurred within a year

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and a day of an accident has been removed

- A death is not reportable if it follows an accident related to old age if the person is older than 72 years (65 years in previous legislation). This covers accidents that occur in a nursing home, hospital or at home. The medical practitioner **MUST STATE** on the certificate that it is given in pursuance of s38(2) of the *Coroners Act 2009*. If a relative objects to this the death becomes a reportable death

2.3 Definition of a Health-related Procedure and a 'reasonably expected outcome':

- **A health-related procedure** means a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug). Procedure is taken to mean health care provided to a patient. This does not include procedures of a kind prescribed by the regulations as being excluded procedures
- **What is meant by reasonably expected outcome**, The Coroners Act 2009 does not define '*reasonably expected outcome*'. Guidelines to assist a medical practitioner decide if a case should be reported to the Coroner appear below

○ **Guidelines to help determine if a case is reportable to the coroner:**

Consider:

- ❖ Did the health-related procedure cause the death (see below), and
- ❖ Was the death an unexpected outcome of this procedure? (See below)

IF THE ANSWER TO BOTH THE ABOVE IS YES, THE DEATH IS REPORTABLE

○ **In determining whether the health related procedure caused the death**

Consider:

- ❖ Was the health-related procedure necessary to improve the patient's medical condition, rather than an elective procedure, and
- ❖ With regards to the death would your peers consider the health-related procedures performed to be consistent with competent professional practice?

IF THE ANSWER TO BOTH THESE QUESTIONS IS YES, THEN *THE DEATH MAY NOT BE REPORTABLE*

○ **In determining whether the death was an unexpected outcome of a health related procedure**

Consider:

- ❖ Whether the patient's condition (including age and co-morbidities)

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was such that death was likely to occur had they not undergone the procedure;

- ❖ Was death recognised as being a significant risk of the procedure given the patient's medical condition, but potential benefits of the procedure were believed to outweigh the risks;
- ❖ With regards to the death would your peers consider the health-related procedure performed to be consistent with competent professional practice?

IF THE ANSWER TO ALL THESE QUESTIONS IS YES, THEN *THE DEATH MAY NOT BE REPORTABLE*

- 2.4 A flow chart and coronial checklist is attached for further direction as to whether a death is reportable or not (see Appendix 1)
- 2.5 If a medical practitioner is unsure as to whether a death is reportable he/she should contact the NSW State Coroner's Office on 02 8584 7777.

3. Obligation to report deaths or suspected deaths that are examinable by the Coroner

- 3.1 Under the Act, hospitals, medical practitioners or any other person, who has reasonable grounds to believe that a death or suspected death would be examined by the Coroner must report the death or suspected death to the police (who will then report it to the Coroner) as soon as possible (ss35 and 38 of the Act).
- 3.2 The Medical Officer or MOOH (ADON) involved in determining the death reportable (in consultation with patient's Admitting Medical Officer) should notify the police of the reportable death. (North Sydney precinct 02 9956 3199).
- 3.3 All Reports by medical personnel and hospitals must be on the prescribed form "**Report of Death to of a Patient to the Coroner**" (formally Form A, See appendix 2). This should be prepared in triplicate; the original and duplicate copy should go with police (a copy for the police and a copy for the police to give to the Coroner) the third copy must be retained in the medical record of the deceased patient.
- 3.4 This form is available with the Coronial checklist in the ADONs office and in ICU.

4. NSW Department of Health Requirement to Report Other Kinds of Deaths

4.1 Anaesthetic Deaths

From 1st September 2012, the [NSW Public Health Act 2010](#) requires **the health practitioner who is responsible for the administration** of the anaesthetic or sedative drug, where the patient died while under, or as a result of, or within 24 hours after the administration of an anaesthetic or sedative drug for a medical, surgical or dental operation or procedure, to report the death to the Director

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General via the SCIDUA.

- Health practitioners can notify the death by: Completing the State form [SMR010511: Report of Death Associated with Anaesthesia/Sedation form](#) and mailing it to:
Secretary, NSW Health
C/o Special Committee Investigating Deaths Under Anaesthesia
Clinical Excellence Commission
Locked Bag 8
Haymarket NSW 1240
- The completed form can also be scanned and emailed to: CEC-SCIDUA@health.nsw.gov.au
- This form is available in ICU, the ADONs office and the office of the NUM in theatres.
- All deaths at the Mater will be screened monthly by the Mortality and Morbidity Sub-Committee using the 'End of life Screening Tool'. Should a death meet the requirements for SCIDUA notification, the notes will be checked for a copy of the SCIDUA form.
- If the SCIDUA form is not present the matter will be referred back to the Head of Anaesthetics by the Director of Medical Services for follow up. The SCIDUA form should then be submitted to the Director-General by the medical officer responsible for the administration of the anaesthetic or sedative drug with a copy being sent to medical records. The Director of Medical Services should be informed that this has occurred.

Note that a death may require both notification to the Coroner and SCIDUA. The **form Report of a Death of a Patient to the Coroner** should be completed as above and the form **Report of a Death Associated with Anaesthesia/Sedation** should be completed and sent to SCIDUA

4.2 Certain other Deaths

NSW Department of Health has reporting requirements for other deaths that may not be covered by the Coroners Act such as reporting to:

- NSW Reportable Incident Review Committee
- NSW Maternal and Perinatal Committee
- Collaborating Hospitals Audit of Surgical Mortality (CHASM)
- Death of a child
 - employees must provide the Child Death Review Team with full and unrestricted access to records that are under their control
 - employees must provide the Ombudsman with full and unrestricted

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access to any records they may require in the execution of their duties

5. Death in the Operating Theatres

A copy of this policy and all flow charts can be found in the folder labelled "CORONERS PAPERWORK" in the Scrub/Scout NUMS OFFICE.

- 5.1 Where a patient has died in the operating theatres the ADON should be contacted and Appendix 1 should be used to determine if the case is reportable to the coroner
 - 5.1.1 If the flowchart in Appendix 1 (**Flowchart to determine whether a death is reportable to Coroner and/or SCIDUA**), determines the death is not reportable to the coroner then disregard this policy and refer to the policy **END OF LIFE CARE – DEATH OF A PATIENT D/2010/14935 [V5]**.
 - 5.1.2 If the flowchart in Appendix 1 (**Flow Chart to determine whether a death is reportable to Coroner and/or SCIDUA**) determines the death is reportable to the coroner than refer to Appendix 3 in this policy
- 5.2 The NUM and Theatre Staff must assist the ADON / VMO and Anaesthetist in completing the following documentation and a copy of each must be kept in the patients' medical record:
 - Death Register (ADON)
 - Coronial checklist (see Appendix 2)
 - Report of death of a patient to the Coroner (see 3.3)
 - Report of death associated with Anaesthesia/Sedation (see 4.1)
- 5.3 A debriefing session for the personnel involved in the case is to be organized as soon as possible.

6. Guidelines for Staff when Dealing with a Coroner's Case

6.1 General Considerations:

- Nothing should be done to the body after death
- All devices, cannulae tubes and drains must be left insitu
- All attached drip bags, bottles and lines must accompany the body
- All sharps or items of equipment left in-situ should be taped in such a way as to minimise risk of sharps injury or leakage
- The body must not be washed and should be placed only in a plastic body bag
- Limbs and jaws must not be tied and orifices must not be plugged

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- Any material aspirated from the stomach should be retained, placed in a screw top container, appropriately labelled and be forwarded with the body

6.2 Infectious Diseases:

- If the deceased may have been suffering one of the infectious diseases listed under List A or List B in section 3 of the Public Health (Disposal of Bodies) Regulation 2002, a label must be affixed to the body stating in indelible ink only either 'Infectious Disease List A-Handle with Care' or 'Infectious Disease List B-Handle with Care' The body should be placed in a plastic body bag. The body should 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

List A

- Creutzfeldt-Jakob Disease (CJD)
- Hepatitis C
- Human Immunodeficiency Infection (HIV)

List B

- Diphtheria
- Plague
- Respiratory Anthrax
- Small Pox
- Tuberculosis (TB)
- Any Viral Haemorrhagic Fever including (Lassa, Marburg, Ebola and Congo-Crimean Fevers).

The Public Health (Disposal of Bodies) Regulation 2012 Part 8 Division 3 Clause 53, updated the prescribed infectious diseases to include the following:

- Avian Influenza in Humans
- Middle East Respiratory Syndrome Coronavirus (MERS)
- Severe Acute Respiratory Syndrome (SARS)

6.3 Identification of the Body:

- Access to the body for identification purposes must be authorised and supervised by the police
- Two hospital identification bands are to be left on the wrist and ankle of the body

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- A patient identification label is to be adhered to the exterior of the body bag at the head
- Access to the body for any reason other than identification should be authorised by the Visiting Medical Officer, Nurse Manager or Manager, Out-of-Hours

6.4 Custody of the Body:

- The hospital is responsible for the safe custody of the body until a Coroner's order for burial has been issued or until the body is removed by the Police (when directed by the Coroner)
- The body must be kept in the same condition as when death occurred

6.5 Relatives:

- A senior Hospital Officer (Visiting Medical Officer, Nurse Manager or the Manager, Out-of-Hours) should contact relatives as soon as possible after a death has been determined as reportable to the Coroner. This officer should meet with relatives to explain to them the formalities required by the Coroners Act
- The Coronial Information and Support Program (CISP) at the office of the NSW State Coroner manage all objections to post-mortem throughout NSW. It has staff trained to deal with acutely bereaved families and can speak to the senior next-of-kin regarding objection to autopsy. Contact 02 8584 7777

6.6 Transfer of Medical Records to Forensic Pathologist for the Post Mortem:

Where a post mortem is to be conducted under direction of the Coroner a copy of the medical records must be provided:

- The release of records should be handled by the Medical Records staff and that the movement of medical records is recorded in a specific register. After hours this should be undertaken by the Nurse Manager or the Manager, Out-of-Hours
- Medical records sent with the deceased should be collated and packaged prior to dispatch. The records should be forwarded in a sealed envelope to the Coroner. If original records are sent a copy must be kept by the hospital
- A signed receipt should be obtained for all records from the Coroners Court
- Records should be forwarded within 24 hours of the death and should be transported by courier
- Hospitals may be asked to provide a discharge type summary by the Coroner (written request). It should outline treatment received by the deceased patient and must answer any questions the Coroner has raised in the request
- Staff must comply with a Coroner's request for information (documents) or

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anything relating to a coronial investigation

6.7 The hospital must not obstruct or hinder a person executing a coronial investigation scene order.

6.8 Persons involved in a coronial enquiry:

- A person who appears to give evidence or produce any document in coronial proceedings must not refuse to take the oath or affirmation, refuse to answer questions once the oath is taken or refuse to produce any requested document or thing
- A person involved in a coronial enquiry must not release any information about the process or the case being examined

6.9 Process involved in the notification and registration of a death reportable to the coroner

- The Visiting Medical Officer responsible for the deceased persons medical care immediately prior to death, or who examines the body after death, must, within 48 hours of the death:
 - Register the death and the cause of death by filling in a Death certificate. The original should accompany the body and the copy must stay in the patient's medical record
 - If the Medical Officer is not able to give a cause of death within that time they must notify that the death has occurred and indicate their intention to provide a cause of death
- A medical certificate must not be issued if the death has been reported to the Coroner
- A person must comply with any requests from the Registrar to provide information, or answer questions relevant to an inquiry on a registrable death. Failure to do so is an offence. (Births Deaths and Marriages Registration Act 1995 (NSW); Births, Deaths and Marriages Registration Regulation 2011 (NSW))

6.10 Process involved in the issuing of a cremation certificate:

- The Visiting Medical Officer that issues the Death Certificate should issue a Cremation certificate unless:
 - The death of the patient is examinable under the Coroner's Act
 - The proposed cremation is against the written wishes of the person
 - The medical officer has not examined the body
 - The medical officer is not satisfied that the identity of the body has been correctly disclosed on the Cremation certificate
- A medical officer that provides a Cremation certificate must include in the

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certificate any written direction left by the deceased person about any particular method of cremation that was or was not to be used

- The original Cremation certificate should be forwarded with the Death Certificate to the Deputy Director of Nursing or the Manager, Out-of-Hours for collection by the funeral directors
- Death Certificates and cremation certificates can be found in the Manager, Out-of-Hours office, the Intensive Care Unit and McAuley Ward.

Evaluation

Compliance with correct notification procedure will be monitored through the admitted patient death auditing processes.

National Safety & Quality Health Service (NSQHS) Standards

Standard 1 – Clinical Governance

References

NSW Health Policy Directive Coroners Cases and the Coroners Act 2009 (Document Number PD2010_054) Publication date 01-Sep-2010 revised 2015.

NSW Public Health Act 2010

Births Deaths and Marriages Registration Act 1995 (NSW)

Births, Deaths and Marriages Registration Regulation 2011 (NSW)

Public Health (Disposal of Bodies) Regulation 2002

Children and Young Persons (Care and Protection) Act 1998

Disability Services Act 1993

Revision History

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Date of Next Review: September 2023

Reviewed By: Deputy Director of Medical Services

Committee Approval (if applicable)

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Date:

Approved By: Deputy Director of Medical Services

Date: 26/09/2020

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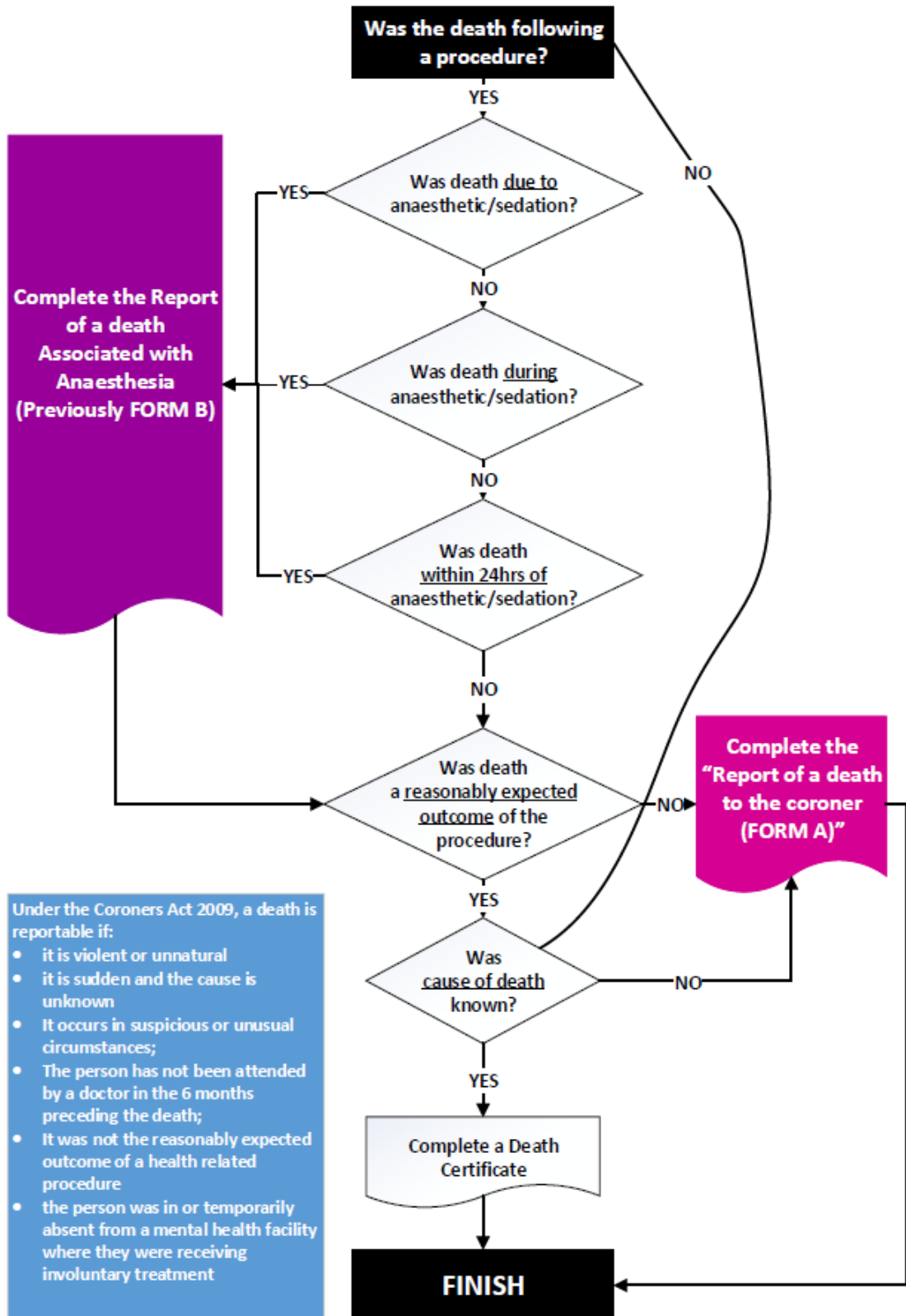
Appendix 1:

Flow Chart to determine whether a death is reportable to Coroner and/or SCIDUA

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Appendix 2:

Coronial Checklist- Example only. Please use hard copy available in Theatres, ICU or ADON's office.



SMR010513

NSW HEALTH	FAMILY NAME		MRN
	GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
Facility:	D.O.B. _____/_____/_____	M.O.	
ADDRESS			
CORONIAL CHECKLIST			
LOCATION			
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
<p>Deaths Reportable to the Coroner – check list</p> <p>This checklist is to be used to determine if a death should be reported to the coroner. It is to be completed by the officer determining extinction of life for all patients (PD 2005_488). The form is filed in the front of the medical record.</p> <p>This check list is to be used in conjunction with NSW Health Policy Directive "Coroners Cases and the Coroners Act" http://www.health.nsw.gov.au/policies/pd2010_054</p>			
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 the person HAD NOT been attended by a medical practitioner during the period of six months immediately before the person's death?			
5. 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 1 over page for further guidance)			
6. 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)			
7. Did the person die whilst in the custody of a police officer or in other lawful custody? (see point 2 over page for further guidance related to deaths in custody)			
8. Did the person die whilst escaping or attempting to escape from the custody of a police officer or other lawful custody?			
9. Did the person die as a result of, or in the course of police operations?			
10. Did the person die whilst temporarily absent from an institution or place where the person was an inmate?			
11. Was the person a child in care, or a child whose death is or may be due to abuse or neglect or that occurred in suspicious circumstances? (see point 3 over page for definitions and guidance related to death of a child)			
12. Was the person (child or adult) living in or temporarily absent from, residential care provided by a service provider and authorised or funded under the Disability Services Act 1993 or a residential centre for disabled persons? (see point 3 (e) over page for definitions and guidance)			
13. Was the person disabled within the meaning of the Disability Service Act 1993 and receiving from a service provider assistance to enable them to live independently in the community? (see over page point 3 (f) for definitions and guidance)			
<p>If answers to ALL of the questions are NO, the death is NOT required to be referred to the Coroner and a death certificate MAY be issued. Where doubt exists as to whether a death should be reported, telephone the Duty Pathologist (Glebe: Business Hours (02) 8584 7821, After Hours (02) 8584 7821. Northern Forensic Hub, Newcastle: Business Hours (02) 4922 3700, After Hours (02) 49290622) for clarification. The State Coroner's Court may also be contacted for advice on (02) 8584 7777.</p> <p>If the answer is YES to ANY question the death must be referred to the Coroner using SMR010.510 – Reporting of Death of a Patient to the Coroner and a death certificate MUST NOT be issued.</p> <p>The exception to this rule is that under S38 (2) of the Act, medical practitioners can issue a death certificate if they are of the opinion that the person:</p> <p>(a) was aged 72 years or older, and</p> <p>(b) died in circumstances other than in any of the circumstances referred to above, and</p> <p>(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)</p> <p>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.</p>			
Staff Name:	Signature:	Designation:	Date:

CORONIAL CHECKLIST

SMR010.513

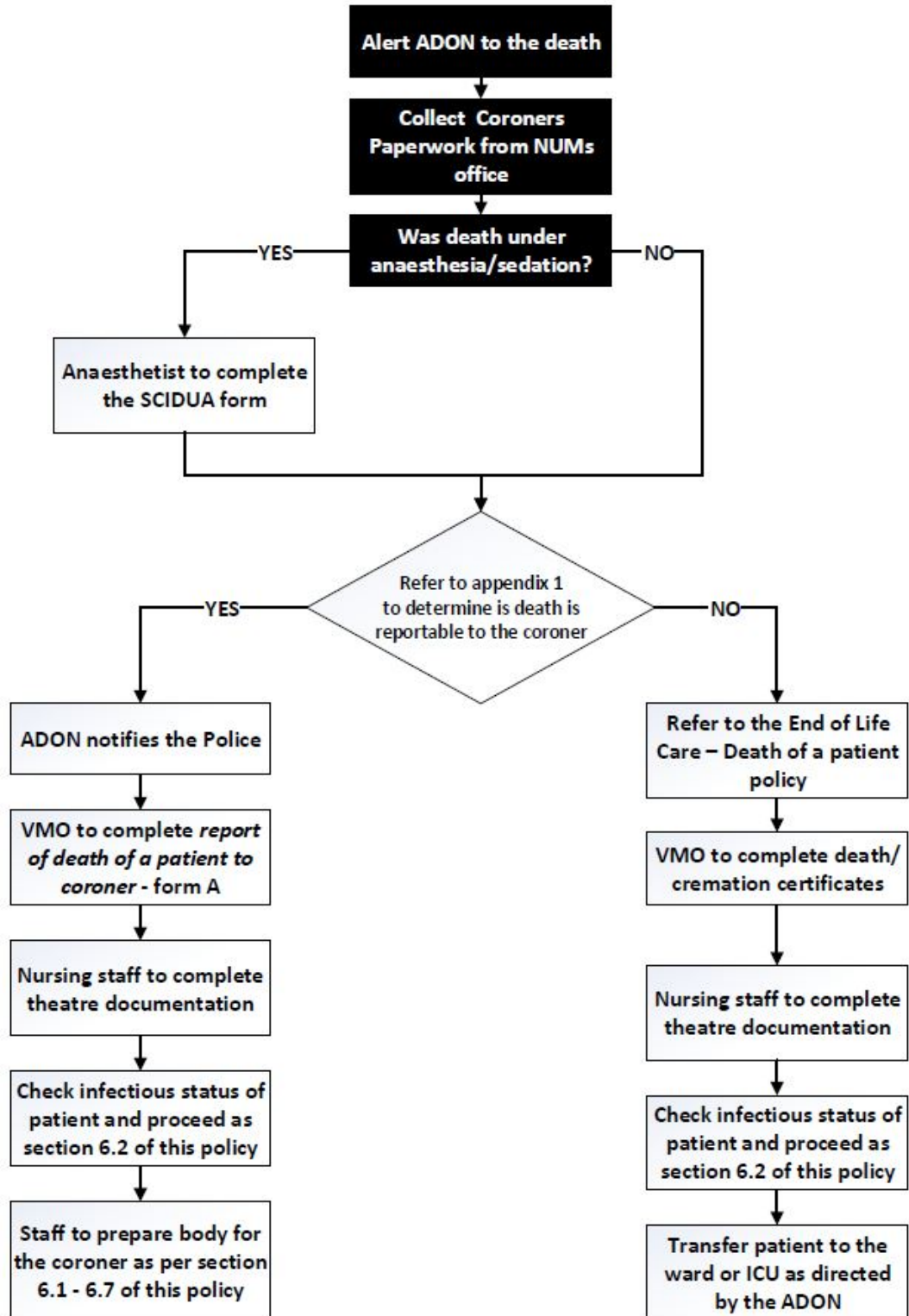
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Appendix 3 Death in the Operating Theatre



Coroners Act 2009 V1_07_2020


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Appendix 4:

Report of Death of a Patient to the Coroner. (Form A) Example only. Please use hard copy available in Theatres, ICU or ADON's office. One copy to be sent to Coroner, one retained by police, one kept in patient notes.

 SMR010510	NSW HEALTH	FAMILY NAME	MRN
	Facility:	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
	D.O.B. _____ / _____ / _____	M.O.	
	ADDRESS		
REPORT OF DEATH OF A PATIENT TO THE CORONER (FORM A)		LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE			
PATIENT'S DETAILS			
Patient's Surname: _____		Given Names: _____	
Sex: (please tick) Male <input type="checkbox"/> Female <input type="checkbox"/>		Age: _____ Marital Status: _____	
Address: _____			
NEXT OF KIN DETAILS			
Next of Kin: _____		Relationship: _____	
Address: _____			
Telephone contact details: W: _____		H: _____ M: _____	
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): _____			
Why has the case been referred to the Coroner?: _____			
Have any antemortem specimens been taken and/or stored that you are aware of? (If so, please provide detail.): _____			
Are there any specific issues which need addressing at autopsy?: _____			
List results of any discussion with Next of Kin (e.g. was the Next of Kin informed that this is a Coroner's case? Is the Next of Kin satisfied with the treatment? Does the Next of Kin object to an autopsy?): _____			
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 _____ 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 in circumstances outlined in PD2006_488 Death - Extinction of Life and the Certification - Assessment TO THE CORONER			



END OF LIFE - CORONERS CASES, DEATHS UNDER ANAESTHESIA AND THE CORONERS ACT (2009) [v4] D/2013/70768[V4]

Policy Owner : Deputy Director of Medical Services No. of pages: 13

Appendix 4:

Report of Death Associated with Anaesthesia or sedation. (Previously form B).

Example only. Please download form using link (4.1 above) or use hard copy available in Theatres, ICU or ADON's office. One copy to be sent to SCIDUA (as above) One copy to remain in patient notes

 SMR010511	 NSW Health	FAMILY NAME	MRN		
	Facility:	GIVEN NAME	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		
	REPORT OF DEATH ASSOCIATED WITH ANAESTHESIA/SEDATION (PREVIOUSLY FORM B)	D.O.B. ____/____/____	M.O.		
		ADDRESS			
LOCATION					
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE					
LOCATION OF DEATH (eg, OR, ICU, HDU etc)	DATE OF DEATH	TIME OF DEATH	WEIGHT		
Pre-operative diagnosis / condition					
ASA classification (please tick) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> E					
Operation(s) / procedure(s)					
Findings at operation/procedure					
Induction	DATE OF INDUCTION	TIME OF INDUCTION	TIME ANAESTHETIC CEASED		
Anaesthetic / Sedation (tick all relevant boxes) <input type="checkbox"/> GA <input type="checkbox"/> Regional <input type="checkbox"/> Local <input type="checkbox"/> Sedation					
List of all drugs given & doses (including premedication if any)					
Brief description of events					
Likely cause(s) of death					
Anaesthetist / Sedationist (Please print name, title and qualifications)					
1. _____					
2. _____					
Contact details of Medical Officer completing this report (for feedback)		PRIVATE MAILING ADDRESS	HOSPITAL ADDRESS		
Name of Medical Officer completing this report:		SIGNATURE	DATE		
Please send completed form to: Secretary NSW Health, o/o Special Committee Investigating Deaths Under Anaesthesia Clinical Excellence Commission, Locked Bag 8 HAYMARKET NSW 1240 SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA					