MEDICAL SERVICES
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BallaratHealthServices
Putting your health first

Your reference: COR 2018 000437

2 January 2019

Ms Mikaela MEGGETTO
Coroner's Registrar
Coroner's Court of Victoria
65 Kavanagh Street
Southbank, VIC, 3006

Dear Ms Meggetto,

Re: The late Ms Winifred MORFFEW UR: 271368
DOB: 05/12/1928 DOD: 07/01/2018

Thank you for your letter dated 20 November 2018, and addressed the Ballarat Health Services' Chief Executive Officer Mr Dale Fraser, requesting a written response to a recommendation made by Coroner Audrey Jamieson. I am responding on behalf of Mr Fraser.

This recommendation followed Coroner Jamieson's finding without inquest into the death of Ms Morffew's. The recommendation is:

*"With the aim of promoting public health and safety, **I recommend** that Ballarat Health Services implement training to educate their clinicians on their obligations to report deaths to the Coroners Court of Victoria".*

I can advise the Court that the Coroner's recommendation has been implemented at Ballarat Health Services.

Prior to receiving this recommendation, Ballarat Health Services already has in place a number of educational strategies and safe-guards ensuring obligations around reportable deaths are met:

1. Education sessions for interns early in the clinical year covering all aspects of death certification and Coronial reporting, including provision of written guidelines and Coroners' Court of Victoria flowchart "Determining whether a death is reportable or reviewable";
2. Comprehensive Governance Documentation regarding Coronial reporting obligations and procedure available on the Ballarat Health Services' intranet;

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3. Straight forward links on the Ballarat Health Services' intranet to electronic death certification and Coronial Deposition submission sites;
4. Real time review of all electronically submitted death certificates and Coronial depositions by the Deputy Chief Medical Officer, to enable errors or potentially Coronial reportable deaths to be flagged and actioned in a timely manner;
5. Review of all acute hospital inpatient deaths by senior clinicians at a monthly Mortality Review Committee meeting.

In addition to these already implemented safeguards, I can advise that Ballarat Health Services is shortly embarking on a Clinical Documentation Improvement Initiative, which will review all aspects of documentation by doctors, including death certificate and Coronial reporting.

With respect to the failure to report Ms Morffew's accident related death to the Coroner, can I respectfully suggest the following points for consideration by Coroner Jamieson:

1. Ms Morffew was discharged from Ballarat Health Services on 20 December 2017, to Ballan Hospital for on-going comfort care. This transfer enabled Ms Morffew to be closer to her family. Ballarat Health Services was not involved in Ms Morffew's care following discharge.
2. Discharge summaries provided to Ms Morffew's general practitioner in Ballan, Dr Rakhi Basu, clearly identify Ms Morffew's admission to Ballarat Health Services being related to injuries she sustained in a motor vehicle accident on 28 November 2017.
3. Ballan Hospital is a separate and independent health service to Ballarat Health Services over which Ballarat Health Services has no authority.
4. The practitioners caring for patients at Ballan Hospital act in a private capacity and are not in any way employed or managed by Ballarat Health Services
5. Ms Morffew died on 7 January 2018, eighteen days after her discharge from Ballarat Health Services, and her death certificate was completed by general practitioner Dr Rakhi Basu, who is neither affiliated with nor accountable to Ballarat Health Services. Ballarat Health Services did not know Ms Morffew had died until notified by you. Further, other than being informed by Dr Basu, had she wished to, Ballarat Health Services had no legal way of knowing of Ms Morffew's progress at Ballan Health Service, given it is a breach of privacy legislation for clinicians to access a patient's medical record once they have left the care of that clinician

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Ballarat Health Services thanks Coroner Jamieson for her thorough review of Ms Morffew's death, and for this opportunity to scrutinise and review our own processes around the very important topic of reportable deaths in Victoria. On-going, every effort will be made by Ballarat Health Services to ensure that obligations relating to reportable deaths at the Health Service are met.

Should you require any further information regarding the care of the late Ms Morffew at Ballarat Health Services please do not hesitate to contact this office.

Yours sincerely

DR LINDA DANVERS
MBBS, FRACGP, DipRACOG, MPH, AFRACMA
Deputy Chief Medical Officer

Ballarat Health Services first

NON CLINICAL PROTOCOL

Coronial Reporting & Reports
SCOPE (Area): All Areas
SCOPE (Staff): All Staff

Printed versions of this document SHOULD NOT be considered up to date / current

Rationale

The Coroner reviews and investigates unexpected or accidental deaths with the purpose of establishing the identity of the deceased and cause of death. The investigation may involve a review of the person's medical history and circumstances of the the death, an inspection/autopsy and pathology and/or radiology tests, specialist reports from experts and external investigators, witness statements and other relevant supporting documents and information.

A Coroner may also hold an inquest, which is mandatory for deaths in custody or suspected homicides, or at his/her discretion if there are issues of interest to the public.

The Coroner also has the authority to refer an individual to the Director of Public Prosecutions if an indictable offence is believed to have been committed.

Once the investigation or inquest is concluded, the facts and any recommendations are documented in a report that details the Coroner's findings, which is a public record.

Coroner's also have a separate jurisdiction to investigate fire.

Ballarat Health Services is obligated under the Coroner's Act 2008 (Vic) and under its Code of Conduct to ensure that the proper processes are followed when a "reportable" or "reviewable" death occurs, and to provide assistance to Coronial investigations in a timely and open manner.

Expected Objectives / Outcome

Undertake the effective and accurate notification of "reportable" and "reviewable" deaths and provision of responses to Coronial inquiries.

Definitions

Section 4 of the Coroner's Act 2008 (Vic) defines a **reportable death** as a death:

- Where the body is in Victoria; or
- That occurred in Victoria; or
- The cause of which occurred in Victoria; or
- Of a person who ordinarily resided in Victoria at the time of death

In addition the death must also be one where:

- The death was unexpected;
- The death was violent or unnatural;
- The death resulted, directly or indirectly, from an accident or injury (even if there is a prolonged interval between the incident and death);
- The death occurs during a medical procedure or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death;
- A Medical Certificate of Cause of Death has not been signed and is not likely to be signed;
- The identity of the person is unknown;
- The death occurred in custody or care (as defined in the Coroner's Act 2008);
- The patient was a patient within the meaning of the Mental Health Act 1986; or
- The death is otherwise specified in section 4 of the Coroner's Act 2008

A **reviewable death** is a death of a second or subsequent child of a parent. The coroner has the same investigative powers in relation to a reviewable death as in relation to a reportable death.

Issues To Consider

For all patient deaths that meet the criteria for "reportable" and "reviewable" deaths.

Detailed Steps, Procedures and Actions

1. At the time of a patient death, the treating practitioner must determine whether the death meets the criteria for being a "reportable" or "reviewable" death. All deaths that meet the criteria must be reported to the Coroner's office. If the treating practitioner is uncertain whether the death should be reported to the Coroner, assistance may be obtained from Medical Administration or the Coroner's Office. The Coronial Admissions and Enquiries office (Melbourne) may be contacted on 1300 309 519 (available 24 hours).

2. For deaths that meet the criteria for "reportable" or "reviewable" deaths, a Death Certificate is **NOT** to be completed. Instead a **Coronial eDeposition (electronic deposition)** is to be completed, as soon as possible. This eDeposition may be completed by any medical member of the treating unit.

3. The medical practitioner reporting the death and responsible for completing the eDeposition, must phone the Coronial Admissions and Enquiries office on 1300 309 519. This Office will provide the medical practitioner with a court reference number and a unique URL link. The medical practitioner will follow the URL link and when they enter the court reference number a Medical Deposition form will be available for completion. The medical practitioner must complete the eDeposition on-line, and press submit. The medical practitioner may print a copy of the Deposition. However a copy of the Deposition will be automatically forwarded to Ballarat Health Services if the medical practitioner selects BHS as the Health Service where death occurred.

4. The medical practitioner may also need to notify:

- The Ballarat Police on (03) 5336 6000 (if directed by the Coronial admissions and enquiries office to do so), who will attend the hospital to identify the deceased and may interview the medical practitioner;
- The Office of the Chief Psychiatrist for all deaths occurring in patients of Ballarat Health Services Psychiatric Services;
- The Next of Kin where applicable.

5. Appropriate notation must be made in the deceased patient's medical record regarding any contact with the Coroner's Office and any subsequent outcomes, including whether the Coroner's office has accepted the referral or not, and that a **Coronial eDeposition** has been completed.

6. The medical record of the deceased is to remain with the deceased, and is then to be forwarded to Medical Administration.

As most Coronial inspections and post mortems are now being performed in the Ballarat Health Services' mortuary, it is unusual for a deceased person to be transferred to the Melbourne Coronial facility urgently. In most cases the medical record should be sent to Medical Administration. From

there urgent BOSSnet scanning will be arranged, and the visiting Forensic Pathologist will be able to access all records on BOSSnet.

However very occasionally the police will insist on a copy of the medical record to accompany the deceased to Melbourne. If this occurs, the medical record must be copied before sending the original to the Coroner. If the Coroner (or Coroner's representative eg Police) insists that the medical record accompany the body, the Patient Flow Co-ordinator (PFC) must arrange urgent photocopying of the record. This may be done by the PFC or by clerical resources available after hours (ED Reception, Night Ward Clerk or Switchboard).

Under no circumstances must the original medical record leave BHS without a copy being taken.

7. The deceased should not have any personal or medical items removed until after review by Coronial investigators. Under the Coroner's Act it is an offence for a person to hinder or obstruct a Coroner or a person acting under a Coroner's authority in exercising powers under the Act. The family of the deceased may touch the body and remove jewellery (if requested) after permission has been sought from the State Coroner. Please contact 1300 309 519 if advice is needed.

8. Coronial post mortems or inspections may be undertaken at BHS and an arrangement is in place with the Melbourne Coronial service for this to occur. Even though a case has been referred to and accepted by the Coroner, the guardian, family or next-of-kin may object to a Coroner's post mortem being performed.

9. Further liaison with the Coroner's office will be undertaken by Medical Administration staff. This will include liaison with clinicians and/or their line managers regarding the Medical Deposition and any other statements or reports required for the Coroner. When a staff member of BHS is asked to provide a statement or report for the Coroner, this must be undertaken in consultation with their line manager, Executive Director and Medical Administration. All requests for statements or medical records must be in writing.

No statement or report is to be released without approval from Medical Administration or the appropriate Executive Director.

10. Guidelines re the preparation of a statement for the Coroner can be found at <http://www.coronerscourt.vic.gov.au/resources/ab66d7a2-d756-47c4-9d06a1d076ad5f82/a+guideline+for+writing+a+statement+when+requested+by+a+coroner+v2.pdf>

(link also available in the references)

11. If the treating doctor wishes the case to be referred to the Coroner and the case has not been accepted by the Coroner's Office, then further advice should be sought from Medical Administration.

12. Reportable or reviewable deaths may be referred to the Governance and Risk Management Unit to determine if there are issues of clinical risk that warrant internal review via clinical investigation, Root Cause Analysis (RCA) or other process. Additionally, any death that is also a Sentinel Event is to be reported to the Department of Health and an RCA undertaken.

13. Clinical staff involved in the management of a patient whose death has been reported to the Coroner may be required to participate in an internal review of the patient's management for quality purposes, if requested.

14. Medical Administration will co-ordinate feedback and dissemination of Coronial findings, both general and specific to BHS, and recommendations to the Mortality Review Committee, and to relevant staff within BHS. Any Coronial recommendations that are considered to be appropriate for adoption by BHS shall be referred to the appropriate governing committee for action.

USEFUL CONTACTS:

Coroner's Office: Coronial Admissions and Enquiries office (24/7 service): 1300 309 519
State Coroner's Office, 57-83 Kavanagh Street, Southbank, VIC, 3006
Telephone: 1300 309 519

Ballarat Coroner's Office:
Telephone: 03 5336 6200 (weekdays 9.00 - 5.00)

Chief Psychiatrist: 50 Lonsdale Street, GPO Box 4057, Melbourne, VIC, 3001
Telephone: 1300 650 172 (weekdays 9.00 - 5.00)

Ballarat Police Station: Telephone: 03 5336 6000 (24/7)

Victorian Institute of
Forensic Medicine: www.vifm.org

Related Documents

SOP0001 - Principles Of Clinical Care

References

- Australian Bureau of Statistics (2008). Information paper: cause of death certification.
- Guidelines for statement preparation
- Information for Health Professionals - Coroner's Court of Victoria

Appendix

- Reportable deaths flowchart

Reg Authority: Corporate Governance Committee	**Date Effective:** 24-05-2016
Review Responsibility: Deputy Director of Medical Services	**Date for Review:** 24-05-2019

Coronial Reporting & Reports - *NCP0089* - Version: 3 - (Generated On: 18-12-2018 10:32)

Coroners Court of Victoria

All reasonable care has been taken in summarising these sections of the Act. No guarantee is made as to the accuracy of these relevant sections. When referring to the *Coroners Act 2008* users should consult the official copy of the Act. To purchase the Act contact Information Victoria on 1300 366 356

Determining Whether a Death is Reportable or Reviewable

When to prepare a death certificate

Where the death is not reportable to the coroner, the registered medical practitioner should prepare one of the following forms to provide to the *Registrar of Births, Deaths and Marriages*:

- **Medical Certificate of Cause of Death** *(MCCD 28+)* – of a person aged 28 days or over
- **Medical Certificate of Cause of Perinatal Death** *(MCCD Perinatal)* – used in relation to a death of a child aged less than 28 days or a still-birth

Who is authorised to complete the certificate?

A medical practitioner who was responsible for a person's medical care immediately before the death or who examines the body of a deceased person after death. The form must be submitted to the Registry of Births, Deaths & Marriages within 48 hours of the death.

***Please note**: It is an offence to complete a medical certificate if the death should be reported to the coroner. (12 Penalty Units*)*

When to report to the coroner

If the death is a reportable or a reviewable death, a medical practitioner or any person must report the death to the coroner.

Obligation to report reportable & reviewable deaths

- A registered medical practitioner who is present at or after the death of a person must report the death without delay to a coroner if the death is a reportable death. *(20 Penalty Units*)*
- A registered medical practitioner who is present at or after the death of a child (being the death of a second or subsequent child of a parent) must report the death without delay to the State Coroner if the death is a reviewable death. *(20 Penalty Units*)*
- If there are two or more medical practitioners present at or after a death and one of them reports the death, the other practitioners need not report the death.
- Any person who has reasonable grounds to believe that a reportable or reviewable death has not been reported must report it without delay. *(20 Penalty Units*)*

*One Penalty Unit = $122.14 (as of 1/7/2011)

What is a reportable death?

A death is 'reportable' if the death is connected with Victoria and comes within one of the following categories.

Categories of reportable deaths

(Please refer to section 4 of the *Coroners Act 2008* – for a complete listing)

Where the deceased was:

- **held in care** e.g. in the care of Dept. of Health / DHS
- **held in custody or in the process of being detained**
- **admitted or committed to an assessment centre for treatment**
- **or the person was a mental health patient** in an 'approved mental health service within the meaning of the *Mental Health Act 1986*'

Where the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury.

Where the person's identity was unknown.

Where the death occurs during a medical procedure[1], or following a medical procedure which is causally linked to the death (Criteria One) AND a medical practitioner would not immediately before the procedure was undertaken, have reasonably expected the death (Criteria Two).

[1] **Medical procedure** means a procedure performed by or under the general supervision of a medical practitioner and includes imaging, internal examination and surgical procedure.

In determining whether the death meets **Criteria One**, the medical practitioner should consider the following questions:

- Would the person have died at about the same time if the medical procedure was not undertaken?
- Was the medical procedure necessary for the person's recovery?

If 'no' to any of the above (and the death meets criteria two) - the death is reportable.

In determining whether the death meets **Criteria Two**, the medical practitioner should consider the following question:

- Before the medical procedure was performed, was the person's condition such that death was foreseen as more likely than not to occur?

If 'no' to the above question (and the death meets criteria one) - the death is reportable.

Includes:

- All homicides, suicides and accidental deaths, e.g. workplace and road accidents, falls and fractures.

Deaths are reportable under this category even if there is a prolonged interval between the incident and death.

Excludes:

- 'Natural' death, for example: carcinoma of the lung resulting from tobacco abuse; cirrhosis of the liver as a result of alcohol abuse; etc.
- Septicaemia and toxaemia unless caused by an unnatural event, i.e. an injury or trauma.

What is a reviewable death?

A death is 'reviewable' if it is the death of a second or subsequent child of a parent.

A death will not be considered 'reviewable' if:

- the death occurs in a hospital and
- the child was born at a hospital and has always been an 'in patient' of a hospital and
- the death is not a reportable death

*An '**in-patient**' of a hospital includes a child whose only period spent outside a hospital was during a transfer from one hospital to another.*

Notifying 'reportable' or 'reviewable' deaths to the Coroners Court of Victoria

After ascertaining that a death is reportable or reviewable, a medical practitioner (or other person) should report the death to the court by telephone (1300 309 519). Court staff will then request written confirmation of that report from the medical practitioner in a medical deposition form.

Assistance to the Coroner in an investigation

A person who reported a reportable death or a reviewable death and the medical practitioner (who was responsible for a person's medical care immediately before that person's death, or was present at or after the person's death) – must give any information or assistance that the Coroner requests for the purposes of the investigation. *(20 penalty units)*

Are still-births considered to be a reportable or reviewable death?

- A coroner does not have jurisdiction to investigate a still-birth.
- A *still-born child* means a child 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, with a body mass of at least 400 grams at birth, which exhibits no sign of respiration or heartbeat, or other sign of life, after birth.

To report a death or for further advice (24 hrs / 7 days a week), call 1300 309 519 and ask for the 'Initial Investigations Office'