REFERRAL TO THE CORONER IN MATERNITY SERVICES BUSINESS RULE

SESLHDBR/007

Name	Referral to the Coroner in Maternity Services		
What it is	A guideline for referral to the coroner in maternity services		
Risk Rating	Low	**Review Date**	August 2023
What it is not	It is not a policy or procedure for all coroners cases		
Who it applies to	Maternity Services, SESLHD		
What to do	**BEST PRACTICE PRINCIPLES** Reportable deaths to the coroner which are relevant to maternity services are: • Violent or unnatural deaths • Suspicious or unusual circumstances • The woman (i.e. mother of the baby) had not attended a medical practitioner over the preceding 6 months (i.e. no antenatal care) • The maternal or neonatal death was associated with a health care procedure where death was not a reasonably expected outcome or complication, i.e. the procedure caused the death and death was not the expected outcome. If, however, the procedure was necessary to improve the patient's medical condition (rather than an elective procedure), in particular if death was likely to occur if they did not undergo the procedure, and peers would consider the procedure to be consistent with competent professional practice, then the death is NOT reportable Reporting a maternal or neonatal death to the coroner must be in conjunction with the senior medical officer in obstetrics (maternal death) or paediatrics (neonatal death). Refer to NSW Heath PD2010_054 Coroners Cases and the Coroners Act, 2009 for management of the body after death in reportable cases, and the mechanics of arranging a coronial post-mortem. Although stillbirths are very rarely coroner's cases, there may be circumstances which arise where a stillbirth may have resulted from a criminal action (such as violence to the mother). In these cases, autopsy should be recommended to the mother, and the autopsy should be performed by an experienced and specialised perinatal pathologist. Where there is uncertainty as to whether a maternal or perinatal death is reportable, advice can be sought from the Women's and Children's Stream Director and/or or the Medical Director of the maternity service at the facility. **POTENTIAL RISKS** • Inappropriate/unnecessary referral to the coroner • Undue distress to the family		

	DOCUMENTATION • Neonatal Care Plan • e Maternity • Clinical notes • Complete iPM **EDUCATIONAL NOTES** • It is extremely rare that a neonatal death will be referred to the coroner. • Stillbirths are not coroner's cases, the baby must take an independent breath before a referral is made to the coroner. In the absence of an independent breath, life is deemed not to have occurred, and referral to the coroner is not necessary. • Maternal and or neonatal deaths which occur as a recognised complication of pregnancy and birth and when management seemed appropriate are not coroners cases, e.g. death from prematurity, fetal anomalies, cord prolapse, placenta praevia etc. • Complications of birth resulting in death, such as a subgaleal haematoma from an instrumental birth, severe hypoxia due to cord prolapse, shoulder dystocia etc are not generally reportable to the coroner if death was likely to occur if they did not undergo the procedure, and management appeared appropriate. • The factors to consider in each particular case will be different and medical officers must use professional judgement to determine whether the death is reportable. • If a medical officer is uncertain, then they should contact the NSW State Coroner's Office, or the local Police after business hours. • An expert autopsy can be still obtained from a perinatal pathologist at NSW Pathology/SEALS if the case is not reportable to the coroner.
When to use it	When there is a fetal or maternal death and consideration is given regarding referral to the coroner.
Why the rule is necessary	To ensure appropriate referral to the coroner and avoid inappropriate referrals.
Who is responsible	Senior Medical Officers Midwifery Managers
Ministry of Health / SESLHD reference	NSW Heath PD2010_054 Coroners Cases and the Coroners Act, 2009

Revision and Approval History

Date	Revision Number	Contact Officer (Position)	Reason for Revision
September 2012	1	CMC Maternity - Clinical Risk Management	SESIAHS Business rule due for review
September 2012	1	Approved A/Executive Director Women and Babies Clinical Stream	
August 2018	2	CMC W&CC Stream	SESLHD Business Rule