STANDARDS TO BE MET

1. Reporting to Coroner

1.1 The following must be reported to the Coroner by the Registrar / MOSS / Consultant via the Hospital Record of Death (HROD) form. (note these relate to the issues identified in the five (5) Circumstances of Death categories on the HROD form):

a) Death without known cause / self-inflicted / unnatural / violent / patient admitted due to injury
b) Death occurred during, or appears to be the result of, a medical procedure AND was medically unexpected
c) Death occurred while person affected by anaesthetic AND was medically unexpected
d) Death of woman occurred while she was giving birth, or appears result of her being pregnant or giving birth
e) Death occurred in official custody or care (including being subject to Mental Health legislation)
f) Doctor has not given a MCCD (Certificate as defined in section 21(1) Burial and Cremation Act 1964)
g) A person is expressing concern as to cause of death or hospital treatment of the deceased

1.2 If the Coroner accepts jurisdiction then the case will be investigated by the Police on his behalf.

1.3 If the Coroner needs to contact the notifying medical practitioner for any clarification they will use the cellphone number provided on the HROD form.

1.4 Family / whanau are to be notified as soon as possible that the Coroner has accepted jurisdiction and must be fully informed of the process.

2. Care of deceased / tupapaku if Coroner takes jurisdiction

2.1 The body is **not** to be released until the Police or Coroner has given permission.
2.2 Remove tubes and lines only with the consent of the Senior Registrar or Consultant
2.3 If there is any question that the position of a line or tube may have contributed to the death then that line / tube **must** be left in situ.
2.4 Any lines / tubes removed from the deceased / tupapaku are to be retained and sent with the deceased to the mortuary.
2.5 Other cares should be as per the policy 6.6.1 protocol 7 Death of a Patient - Care Following Death.

3. Coroner's Investigation (will be undertaken by the Police)

3.1 The Police will notify those BOPDHB managers that a Coroner's Inquest is to take place
3.2 The Manager Quality & Patient Safety (or Duty Manager out of hours) will be informed and advise the relevant staff line managers
3.3 Once a Manager is informed of this decision they will notify relevant staff
3.4 Relevant BOPDHB staff will have a preliminary meeting to clarify roles and evidence, prior to the inquest (including DHB legal representative if appropriate).
3.5 BOPDHB staff will co-operate fully with the investigation.

3.6 The Police may need to take a statement from the staff member which will form part of the Coroner's Inquest. Staff may have a support person / legal representative present during the taking of this statement.
3.7 Staff may be requested to attend the Coroner's Inquest. Any staff member called may apply to give sworn written evidence rather than appear in person. The individual must make this request in writing to the Coroner. (The Quality & Patient Safety Manager or GM Governance & Quality can assist the individual with this if requested).
3.8 Staff are entitled to have legal representation at the Inquest (contact GM Governance & Quality to arrange this).
3.9 Staff are entitled to have paid time off to attend a Coroner's Inquest and any direct costs incurred whilst they are attending the Inquest will be reimbursed.
3.10 After the Coroner's Inquest staff must be debriefed and receive ongoing support if required. Support is available through the manager or directly with EAP services.
3.11 The Coroners recommendations are to be communicated to all relevant staff
3.12 The GM Governance & Quality / Quality & Patient Safety Manager will ensure the recommendations are sent to relevant line managers to implement.

4. Documentation to be Provided to Coroner

The Coroner should be provided with a copy of the patient record (NB copy only – originals are not to leave the organisation).

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.6.1 Death of a Patient
- Bay of Plenty District Health Board policy 6.6.1 protocol 1 Death of a Patient - Record of Death
- Bay of Plenty District Health Board policy 6.6.1 protocol 7 Death of a Patient - Care of the Deceased
- Bay of Plenty District Health Board policy 6.6.1 protocol 11 Death of a Patient - Perinatal / Paediatric Post Mortem Transfer to Auckland, Wellington
- Bay of Plenty District Health Board policy 6.6.1 protocol 13 Death of a Patient - Blessings
- Bay of Plenty District Health Board policy 6.3.9 Body Parts and Tissues
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 1.4.4 Māori Cultural Safety
- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
- Bay of Plenty District Health Board Form FM.D1.4 Death - Record of Death Form
- Bay of Plenty District Health Board Hospital Support Services protocol HSS.O1.1 Body Storage Facility (Tauranga Hospital)