DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL BRIEF FOR DECISION

Date	12 June 2013
To	**Attorney-General and Minister for Justice**
From	Strategic Policy
Subject	Increased jurisdiction of *Coroners Act 2003* to investigate stillbirths
Requested by	Attorney-General's office
Decision required by	28 June 2013 - to enable consultation on draft options to commence

RECOMMENDATIONS

That you:

1. **note** that the *Coroners Act 2003* (the Act) currently prevents coroners from investigating stillbirths;

2. **sign** the attached consultation letters (**Attachment 1**) to the Premier, the State Coroner, the Minister for Health and the Minister for Police and Community Safety; and

3. **approve** enclosing the attached issues paper (**Attachment 2**) with the consultation letters.

BACKGROUND SUMMARY

4. On Sunday, 24 February 2013, you met with NP_49-Sch4 at the Fraser Coast Community Cabinet meeting.

5. [redacted] made submissions to you that Act should be amended to give coroners the discretion to investigate stillbirths where the death of a baby occurs during labour.

6. You instructed the Department of Justice and Attorney-General (DJAG) to investigate the legislative amendments suggested by [redacted] and report back on possible options for reform.

ISSUES

Current legislative context

7. Section 11 of the Act outlines the type of deaths that may be investigated under the Act. Section 11(2) provides that a coroner must investigate a death if the coroner both: (a) considers the death is a 'reportable death'; and (b) is not aware that any other coroner is investigating that death. The State Coroner may also direct a coroner to investigate the death if the State Coroner either: (a) considers the death is a 'reportable death'; or (b) has been directed by the Minister to have the death investigated, whether or not the death is reportable (section 11(4)).

8. A death is a 'reportable death' if certain circumstances set out in section 8 of the Act are met, and include violent or otherwise unnatural deaths, deaths in suspicious circumstances and health care related deaths. Section 10AA defines a person's death as a 'health care related death' if a person dies at any time after receiving health care that (a) either caused or is likely to have caused the death; or contributed to or is likely to have contributed to the death; and (b) immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person's death. 'Health care' is defined as (5)(a) any health procedure; or (b) any care, treatment, advice, service or goods provided for, or purportedly for, the benefit of human health.

9. Currently, section 12(2)(c) of the Act provides that a coroner must stop investigating a death if an autopsy of the body shows that the body is that of a stillborn child who was not born alive. The policy reason is that the death of a foetus occurs in utero, thus precluding the foetus from being born as a living person. In short, where there has been no independent life, there can be no death.

10. For the purposes of the Act, a 'stillborn child' is defined by reference to the definition in the *Births, Deaths and Marriages Registration Act 2003* (BDRM Act) to mean a child who has shown no sign of respiration or heartbeat, or other sign of life, after completely leaving the child's mother; and who has been gestated for 20 weeks or more; or weighs 400 grams or more.

11. Sections 6 and 26 of the BDRM Act provides that the birth and death of a stillborn child born after 30 April 1989 must be registered.

12. Under section 313 of the Queensland Criminal Code, it is an offence for a person, by an act or omission at child birth, to prevent the child from being born alive. Further, section 294 of the Criminal Code provides that when a child dies in consequence of an act or omission by a person before or during its birth, the person is deemed to have killed the child.

Current review mechanisms for stillborn deaths

13. Stillborn child deaths in Queensland public health facilities are audited by expert local perinatal mortality committees (local committees) with reference to the Department of Health (DOH) Queensland Maternity and Neonatal Clinical Guideline: 'Stillbirth care'. The Queensland guideline aligns with the Australia and New Zealand standards (the Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality).

14. Section 97 of the *Health and Hospitals Network Act 2011* (HHN Act) provides guiding principles for the conduct of a 'root cause analysis' (RCA) of such an incident. An RCA is a systematic process of analysis to identify the contributing factors and remedial measures that could be implemented to prevent a similar event occurring again (HHN Act, section 95(1)).

15. Under section 144 of the *Private Health Facilities Act 1999* private health facilities in Queensland must submit a report to the Chief Health Officer about any death (including a stillbirth) which was not the reasonably expected outcome of the health service provided. The purpose of these reports is to monitor the quality of health services provided. Under section 96 of the HHN Act, private health facilities may also undertake RCAs.

16. The Queensland Maternal and Perinatal Quality Council (the Council) is a quality assurance committee established under the HHN Act and oversees the local committees. The Council's role includes the collection and analysis of clinical information from public and private facilities regarding maternal and perinatal mortality and morbidity in Queensland. The Council uses this information to identify state-wide and facility-specific trends. Based on these trends and issues, the Council makes recommendations to the Minister for Health to enable both public and private health providers in Queensland to improve safety and quality in relation to the care provided to pregnant women and their unborn babies. This body is administered by DOH. The Council also has a significant prevention role and is tasked with proposing recommendations to effect system-wide reforms aimed at reducing perinatal and infant mortality rates. Unlike the State Coroner, the Council does not hold public hearings or present findings to the public. The current membership of the Council comprises of eminent doctors, nurse practitioners and midwifes in the areas of obstetrics, midwifery and genetics across Queensland. The full list of members is set out in **Attachment 3**.

17. Health service practitioners who have concerns about the performance of another practitioner may report concerns locally through health service facility processes. If they believe the matter presents a risk to the public, and they do not believe local measures are resolving the situation, they can report the matter directly to the relevant health professional registration board, for example, the Medical Board of Queensland.

18. Currently, consumers may complain to the Health and Quality Complaints Commission about services provided by health practitioners and about private and public hospitals, medical centres and other health service organisations.

19. On 4 June 2013, the Health Ombudsman Bill 2013 (the Bill) was introduced into the Legislative Assembly. The Bill repeals the existing *Health Quality and Complaints Commission Act 2006* and the *Health Practitioner (Disciplinary Proceedings) Act 1999*. The Bill will replace the Health Quality and Complaints Commission with the statutory position of Health Ombudsman supported by the Office of the Health Ombudsman.

20. The functions of the Health Ombudsman will include: to receive health service complaints and take relevant action to deal with them; to identify and deal with health service issues by undertaking investigations, inquiries and other relevant action; to identify and report on systemic issues in the way health services are provided including issues affecting the quality of health services; and oversee the national boards and national agency's performance of their functions relating to the health conduct and performance of registered health practitioners.

<u>The approach in other jurisdictions</u>

21. To date, no Australian State or Territory has legislated to allow coronial investigations into stillbirths. This position is the same in New Zealand and the United Kingdom.

22. Parliamentary committees in Victoria, South Australia and the Western Australian Law Reform Commission have recently considered the extension of the coronial jurisdiction to stillbirths. Both the Victorian and Western Australian reviews recommended against providing coroners with the jurisdiction to investigate stillbirths. However, the South Australian review supported legislative reforms that would allow coroners to hold inquests into stillbirths that were unexpected, unnatural, unusual, violent or from unknown causes. This recommendation is not limited to deaths occurring during labour, but would extend the coroners' jurisdiction to all stillbirths meeting the legislative definition and criteria.

23. In each province of Canada, dedicated maternal and perinatal death review committees sit within the Office of the Chief Coroner and investigate stillbirths. This initiative was a result of a 2004 Health Canada review into how stillbirths were investigated.

Options

24. Two options could be considered in Queensland:

- **Option 1** – Maintain the status quo, with stillbirths to continue to be investigated by expert local committees overseen by the Queensland Maternal and Perinatal Quality Council and other relevant health oversight and disciplinary bodies

or

- **Option 2** – Amend the *Coroners Act 2003* to allow coroners to investigate stillbirths that occur during labour.

Benefits of option 1

25. Consistent with the findings of the Victorian and Western Australian reviews, it would appear that the current review bodies are appropriately dealing with the systemic issues to be identified and addressed.

26. It would be a major departure from established law to make a foetus "a life in being" and include a foetal death within the class of reportable deaths.

27. Currently, there are highly trained and specialised experts in the field of perinatal death undertaking investigations and assessing systemic trends and issues. There is a risk that if this mechanism was removed, the Office of the State Coroner may not have the required experience and training to investigate stillbirths to the technical extent that the current process does.

28. It is imperative that an appropriate balance between the role of the coroner and current investigation mechanisms is found to ensure that the process is of the highest standard.

29. Any legislative reform in this area would also need to consider and address any potential duplication in the roles and functions of coroners, the Queensland Maternal and Perinatal Quality Council and the proposed Health Ombudsman in investigating and making relevant recommendations in relation to perinatal deaths.

Benefits of option 2

30. While there is an existing investigative and review structure in Queensland to investigate stillbirths, equally it could be argued that there is a public benefit in allowing a public inquest to be held into these deaths where the cause of death is related to the health care provided to the mother and/or occurred during labour.

31. Reforms would improve transparency and accountability for Queensland public and private health facilities, thus public confidence in health care could increase as a result of the independent role of the coroner.

32. Because the State Coroner facilitates public inquests and can publish findings and recommendations, there will be more information available for the public about stillbirths that are caused through the provision of health care during labour.

33. A more detailed explanation of what caused the stillbirth may reduce distress and provide families of the stillborn child with closure. Families may also gain some reassurance that systemic changes recommended by a coroner will be implemented.

34. As this is a highly sensitive and emotive issue and involves an assessment of the adequacy of existing stillbirth review processes, it is recommended that you invite feedback from relevant stakeholders before committing to legislative reform.

EMPLOYMENT IMPACT

35. Not applicable.

CONSULTATION WITH STAKEHOLDERS

Consultation with the State Coroner

36. Strategic Policy has undertaken preliminary consultations with the State Coroner, Mr Michael Barnes. Mr Barnes supports the coroners' jurisdiction being extended to include stillbirths that are an unexpected outcome of health care provided during labour. This would remove what he considers to be an illogical distinction between deaths that occur after labour (that can be investigated) and the deaths of babies that are stillborn occurring during labour (that cannot be investigated).

Consultation strategy

- **Stage one:** It is proposed that the Premier, the State Coroner, the Minister for Health and the Minister for Police and Community Safety, be formally consulted to identify potential issues, impediments to reform and financial implications.

- **Stage two:** After initial feedback is reviewed, it is proposed that other key stakeholders should be consulted, including the Treasurer and Minister for Trade; the Minister for Communities, Child Safety and Disability Services; the Minister for Science, Information Technology, Innovation and the Arts; the Australian Medical Association Queensland (AMAQ); the Queensland Nurses Union; the Medical Board of Australia; the Nursing and Midwifery Board of Australia; the Queensland Maternal & Perinatal Quality Council; the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG); the Royal College of Pathologists of Australasia; the Sands Australia National Council (miscarriage, stillbirth and newborn death support); and the Australian and New Zealand stillbirth alliance (ANZSA). DOH will also be asked to identify other appropriate government and non-government groups such as universities, research bodies, networks and private and public hospitals.

37. It is recommended that you sign the attached letters to Mr Michael Barnes, the State Coroner; the Honourable Campbell Newman MP, Premier of Queensland; the Honourable Lawrence Springborg MP, Minister for Health; and the Honourable Jack Dempsey MP, Minister for Police and Community Safety (**Attachment 1**) formally seeking feedback. A short issues paper has been drafted for your approval to be sent with the letters to assist with consultation (**Attachment 2**). Based on feedback from these stakeholders, a new issues paper will be developed for the second stage of consultation.

38. ANZSA has previously indicated that it does not support the investigation of stillbirths by coroners, and instead advocates that the investigation of stillbirths should be undertaken by expert perinatal care teams based in maternity units.[1]

FINANCIAL IMPLICATIONS

39. The Director of the Office of the State Coroner has advised Strategic Policy that expanding the coronial jurisdiction to investigate the death of stillborn babies would require significant additional resources.

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1 Charles, Dr A, 'Should the investigation of why my baby was stillborn be done by the coroner?' *ANZSA frequently asked questions*, <http://www.stillbirthalliance.org.au/doc/Coronial%20InvestigationFAQ%201210.pdf> accessed on 27 May 2013.

40. The extent of the resources required should the Act be amended will depend on the scope of powers provided under the Act to investigate stillbirths and whether all stillbirths that are not due to natural causes are to be investigated, or only those occurring during labour . In 2009, the most recently reported period for Queensland, 447 stillbirths were recorded.[2] Consultation with stakeholders will enable DJAG to identify how many stillbirths occur during labour and so will better inform the extent of the workload increase for the Office of the State Coroner should reform be approved.

POTENTIAL MEDIA

41. On 15 and 16 May 2013, media reported that a pregnant woman's baby was stillborn after she was repeatedly turned away from Rockhampton Hospital.

42. The Honourable Lawrence Springborg MP, Minister for Health, has initiated an independent investigation into the incident, to be led by former Australian Medical Association president Dr Andrew Pesce. An internal review by the hospital and health service responsible for the Rockhampton Hospital is also in progress.

43. On 17 May 2013, *The Courier-Mail* reported that you said you were considering amending the Act as per the proposals put forward by NP_49-Sch4 On the same day, *ABC News* reported that you said you would consider changing laws to allow the coroner to investigate stillbirths.

NOTED or APPROVED / NOT APPROVED
Attorney-General and Minister for Justice
Comments

Letters signed by AG. 19/6 BA

Jarrod Bleijie MP **Attorney-General and Minister for Justice**	**Chief of Staff and Principal Adviser**	**Policy Adviser**
/ /	/ /	/ /

Contact Officer:	Name: Amber Manwaring Position: Senior Legal Officer Phone: 353 90394 Date: 5 June 2013	Approved by Executive Director:	Name: Louise Shepherd Position: A/ Assistant Director-General Phone: 3898 0161 Date: 5 June 2013
Approved by:	Name: Natalie Parker Position: Acting Director Phone: 323 93536 Date: 5 June 2013	Endorsed: John Sosso Director-General	13/6/13

☐ Election Commitment ☐ CBRC / Cabinet related ☐ ECM related

[2] Queensland Maternal and Perinatal Quality Council, *2011 Queensland Maternal and Perinatal Quality Council, Review of Pregnancies, Births and Newborns in Queensland*, page 7, <http://www.health.qld.gov.au/chi/ais/docs/qmpqc-report-2011.pdf> accessed on 27 May 2013.

Queensland Government

The Hon Jarrod Bleijie MP
Attorney-General and Minister for Justice

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Email attorney@ministerial.qld.gov.au

In reply please quote: 548628/1

The Honourable Campbell Newman MP
Premier
Member for Ashgrove
PO Box 15185
CITY EAST QLD 4002

Dear Premier Campbell,

I believe there could be some merit in increasing the coronial jurisdiction under the *Coroners Act 2003* (the Act) to include investigations of stillbirths that occur during labour, to ensure there is a robust oversight system to assist in the prevention of these types of stillbirths.

I am currently considering options for reform. Enclosed is a short issues paper on the current legislative context, current review mechanisms, the approach in other jurisdictions and possible options in relation to this policy matter.

Your views are sought on this matter, including:

1. the merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour;
2. if you do agree with expanding the Act to include the investigation of stillbirths that occur during labour, any limits or other criteria that you think should be applied;
3. if you do not agree that the Act be expanded to include the investigation of stillbirths that occur during labour, whether and how existing review mechanisms could be improved; and
4. any funding implications that may result from expanding the jurisdiction.

I have also sent this paper to the Honourable Lawrence Springborg MP, Minister for Health, the Honourable Jack Dempsey MP, Minister for Police and Community Safety and Mr Michael Barnes, the State Coroner, to ascertain their views before consulting more broadly on this issue.

I would be grateful if you could provide any comments to Ms Amber Manwaring, Senior Legal Officer, Strategic Policy, Department of Justice and Attorney-General at amber.manwaring@justice.qld.gov.au or on 3239 0394 by 26 July 2013.

Yours sincerely

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

Enc.

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The Hon Jarrod Bleijie MP
Attorney-General and Minister for Justice

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Email attorney@ministerial.qld.gov.au

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Mr Michael Barnes
State Coroner
The Office of State Coroner
GPO Box 1649
BRISBANE QLD 4001

Dear Mr Barnes

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The Honourable Lawrence Springborg MP
Minister for Health
Member for Southern Downs
GPO Box 48
BRISBANE QLD 4001

Dear Minister Lawrence,

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The Honourable Jack Dempsey MP
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PO Box 15195
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Summary of issues: Jurisdiction under the *Coroners Act 2003* to investigate stillbirths that occur during labour

Current legislative context

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<u>The approach in other jurisdictions</u>

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2006 Victorian Parliament Law Reform Committee Inquiry into the Review of the Coroner's Act 1985 report

15. The committee noted the uncertainty and consequent distress around the wording of the *Coroners Act 1985* (Vic) and whether it conferred jurisdiction upon a coroner to investigate stillbirths.

16. The committee recommended that stillbirths continue to be investigated by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity (CCOPMM) and not the coroner, and that this be clarified in the *Coroners Act 1985* (Vic).

17. The committee considered that the CCOPMM's specialist medical skills are essential in investigating issues relating to the medical management of pregnancy and birth and that it is best placed to continue this investigative role.

18. The Victorian Government accepted this recommendation and progressed a change in the *Coroners Act 2008* (Vic). In the *Coroners Act 2008* (Vic), the definition of 'death' includes the note: "a still-birth within the meaning of the *Births, Deaths and Marriages Registration Act 1996* (Vic) is not a death". This amendment was to clarify that coroners do not have any jurisdiction to investigate a stillbirth.

2011 Parliament of South Australia Report of the Legislative Review Committee on its Inquiry into Stillbirths

19. The committee recommended the South Australian Attorney-General amend the *Coroners Act 2003* (SA) to allow for coronial inquests into stillbirths of unexpected, unnatural, unusual, violent or unknown causes.

20. The committee considered *Barrett v Coroner's Court of South Australia* (2010) where the court agreed that pulseless electrical activity detected in the unborn infant was a sign of life, even though the infant did not take a breath.

21. The committee considered the amendment would be useful to allow coronial inquest in this area that are in the public interest, including homebirths.

22. Currently, the *Coroners Act 2003* (SA) does not provide for coronial powers in relation to stillbirths. It is understood that the South Australian Attorney-General's Department is currently considering reforms as proposed by the committee.

2012 Law Reform Commission of Western Australia – Review of Coronial Practice in Western Australia Final Report Project No 100 January 2012

23. The commission recommended reforms to the *Coroners Act 1996* (WA) to provide that a stillbirth, as defined in section 4 of the *Births, Deaths and Marriages Registration Act 1998* (WA), is not a death for the purposes of the *Coroners Act 1996* (WA). This amendment was to clarify that coroners do not have any jurisdiction to investigate a stillbirth.

24. The commission noted that there was little benefit in the coroner assuming jurisdiction over stillbirths because of the existence of a dedicated statutory body, the Perinatal and Infant Mortality Committee, assigned with the function of investigating and researching perinatal deaths.

25. The commission also noted that the established Perinatal and Infant Mortality Committee has a significant prevention role and is tasked with proposing recommendations to affect systemwide reforms aimed at reducing perinatal and infant mortality rates. The Perinatal and Infant Mortality Committee therefore performs all relevant functions of a coroner except for holding public hearings.

Canada

26. In each province of Canada, dedicated maternal and perinatal death review committees sit within the Office of the Chief Coroner and investigate stillbirths. This initiative was a result of a 2004 Health Canada review into how stillbirths were investigated.

Maintain the status quo in Queensland - benefits

27. Currently expert local committees investigate stillbirths, overseen by the Queensland Maternal and Perinatal Quality Council, which has the power to make recommendations to the Minister for Health to reduce perinatal mortality rates as well as other relevant health provider oversight bodies.

28. Consistent with the findings of the Victorian and Western Australian reviews, it could be argued that these current responses are appropriate and already adequately allow for systemic issues to be identified and addressed.

29. It would be a major departure from established law to make a foetus "a life in being" and include a foetal death within the class of reportable deaths.

30. Currently there are highly trained and specialised experts in the field of perinatal death undertaking investigations and assessing systemic trends and issues. There is a risk that if this mechanism was removed, the Office of the State Coroner may not have the required experience and training to investigate stillbirths to the technical extent that the current process does.

31. It is imperative that an appropriate balance between the role of the coroner and current investigation mechanisms is found to ensure that the process is of the highest standard.

32. Any legislative reform in this area would also need to consider and address any potential duplication in the roles and functions of coroners, the Queensland Maternal and Perinatal Quality Council and the proposed Health Ombudsman in investigating and making relevant recommendations in relation to perinatal deaths.

Amend the Act to allow coroners to investigate stillbirths that occur during labour - benefits

33. While there is an existing investigative and review structure in Queensland to investigate stillbirths, equally it could be argued that there is a public benefit in allowing a public inquest to be held into these deaths where the cause of death is related to the health care provided to the mother and/or occurred during labour.

34. Reforms would improve transparency and accountability for Queensland public and private health facilities, thus public confidence in health care could increase as a result of the independent role of the coroner.

35. Because the State Coroner facilitates public inquests and can publish findings and recommendations, there will be more information available for the public about stillbirths that are caused through the provision of health care during labour.

36. A more detailed explanation of what caused the stillbirth may reduce distress and provide families of the stillborn child with closure. Families may also gain some reassurance that systemic changes recommended by coroners will be made to reduce stillbirths.

Your views are sought on this matter, including:

- the merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour;
- if you do agree with expanding the Act to include the investigation of stillbirths that occur during labour, any limits or other criteria that you think should be applied, for example should a coronial investigation during labour that results in a still birth only occur if the foetus has reached a certain gestational period;

- if you do not agree that the Act be expanded to include the investigation of stillbirths that occur during labour, whether and how existing review mechanisms could be improved, for example providing a specific legislative base for the Council and specific investigatory powers binding both the public and private system, including homebirths; and
- any funding implications that may result from expanding the jurisdiction.

Attachment 2: Queensland Maternal and Perinatal Quality Council membership

Professor Michael Humphrey **(Chair)**	Clinical Advisor, Office of Rural and Remote Health Senior Medical Coordinator (Obstetrics), Retrieval Services Queensland
Associate Professor Leonie Callaway	Head, University of Qld, Royal Brisbane Clinical School, Herston
Ms Cheryl Clayton	Director of Clinical Services, Mater Private Hospital Redland
Professor Paul Colditz *(Chair of Congenital Anomalies Sub-Committee)*	Director, Perinatal Research Centre, The University of Queensland
Ms Helen Coxhead	Midwifery Unit Manager, The Townsville Hospital
Associate Professor Vicki Flenady	Director, Translating Research into Practice, Mater Medical Research Institute
Ms Rebecca Jenkinson	Consumer Representative
Associate Professor Rebecca Kimble *(Chair of Perinatal Mortality Sub-Committee)*	Clinical Director, Obstetric Services, Royal Brisbane and Women's Hospital
Dr David Knight	Director, Neonatology, Mater Mother's Hospital
Ms Jonelle Mayers	Neonatal Nurse Practitioner, The Townsville Hospital
Dr Julie McGaughran	Director, Genetic Health Qld
Dr Ian Mottarelly	Senior Medical Officer, Gympie Hospital
Dr Diane Payton	Pathologist, Pathology Qld
Dr Peter Schmidt	Senior Medical Officer, Paediatrics, The Gold Coast Hospital
Dr Renuka Sekar	Consultant, Obstetrics & Gynaecological Services, Royal Brisbane & Women's Hospital
Dr Mary Sidebotham	Senior Lecturer, School of Nursing & Midwifery, Griffith University
Dr Nikki Whelan *(Chair of Maternal Mortality Sub-Committee)*	Obstetrician and Gynaecologist (Private Practice), Brisbane

DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL

Fraser Coast Community Cabinet

Sunday, 24 February 2013

Extension of Coronial jurisdiction to include stillbirth in limited circumstances

Attendee:

Background:

- NP_49-Sch4 is seeking amendment to the *Coroners Act 2003* (the Act) to grant the State Coroner the discretion to investigate stillbirths where the death of a baby occurs during labour.
- believes the amendment is in the public interest and in line with similar reforms undertaken in other states. advises that it is likely that the reform will result in fewer than 20 additional coronial investigations each year in Queensland.
- It appears is meeting with the Attorney-General in a personal capacity. However, works for

Issues:

Current legislative and policy environment

- Currently, section12(2)(c) of the Act provides that a coroner must stop investigating a death if an autopsy of the body shows that the body is that of a stillborn child who was not born alive. The policy reason for this provision is that a coroner may only investigate deaths and a stillborn baby was not born alive and so did not technically die.
- For the purposes of the Act, a "stillborn child" is defined by the *Births, Deaths and Marriages Registration Act 2003* to mean a child who has shown no sign of respiration or heartbeat, or other sign of life, after completely leaving the child's mother; and who has been gestated for 20 weeks or more; or weighs 400g or more.
- Stillborn baby deaths are audited by local perinatal mortality committees using the Queensland Health *Queensland Maternity and Neonatal Clinical Guideline: Stillbirth care* which aligns with the Australia and New Zealand standards (the *Perinatal Society of Australia and New Zealand Clinical Practice Guideline for Perinatal Mortality*).
- The Queensland Maternal and Perinatal Quality Council (the Council) oversees these local committees and identifies state-wide and facility-specific trends regarding maternal and perinatal mortality and morbidity in Queensland; and makes recommendations to the Minister for Health to enable health providers in Queensland to improve safety and quality in relation to pregnant women and their unborn babies. This body is administered by Queensland Health.
- Further, the Council has a significant prevention role and is tasked with proposing recommendations to effect systemwide reforms aimed at reducing perinatal and infant mortality rates.
- Strategic Policy is of the view that any legislative reform in this area would need to ensure there is no duplication between the role of the coroner and the role of the council in investigating and researching perinatal deaths.
- No other State or Territory has legislated to allow coronial investigations into stillbirths.
- The Queensland Criminal Code creates criminal offences for killing an unborn child, where a person prevents a child from being born alive, by an act or omission (section 313); and for death by acts done at childbirth, if the child dies as a result of any act or omission of the person, before or during the birth of the child (section 294).

2011 Parliament of South Australia Report of the Legislative Review Committee on its Inquiry into Stillbirths (SA Legislative Review Committee report)

- As part of her request to meet with the Attorney-General, [redacted] **attached** the SA Legislative Review Committee (committee) report to her meeting request form.
- The committee recommended the South Australian Attorney-General amend the *Coroners Act 2003* (SA) to allow for coronial inquests into stillbirths of unexpected, unnatural, unusual, violent or unknown causes.
- The committee considered *Barrett v Coroner's Court of South Australia* (2010) where the court agreed that pulseless electrical activity detected in the unborn infant was a sign of life, even though the infant did not take a breath.
- The committee considered the amendment would be useful to allow coronial inquest in this area that are in the public interest, including homebirths.
- Currently, the *Coroners Act 2003* (SA) does not provide for coronial powers in relation to stillbirths. Strategic Policy has contacted the South Australian Attorney-General's Department which has advised they are currently considering reforms as proposed by the committee.

Consultation with the State Coroner

- The State Coroner, Mr Michael Barnes, is of the view the jurisdiction should be extended to include stillbirths that are an unexpected outcome of health care provided during labour. He is of the view it is illogical to distinguish whether the baby was still born during or died after labour.
- Mr Barnes agrees with the recommendation of the South Australia Legislative Review Committee to amend the legislation to allow the investigation of stillbirths.
- Mr Barnes also noted that the proposed amendment would close a gap where stillbirths caused by the violent act of another towards a pregnant woman are currently unable to be investigated by a coroner.
- The Director of the Office of the State Coroner has advised Strategic Policy that expanding the coronial jurisdiction to investigating the deaths of still born babies would require significant additional resources. Data from 2011 suggests up to 75% per cent of the 400 still births reported that year could be included in the extended jurisdiction, which equates to the majority of a full time coroner's workload.

Response:

- The Attorney-General will consider the proposed amendments.
- The proposed amendments will require extensive consultation with the State Coroner, Queensland Health, medical professionals and the community.

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Endorsed by Director-General /02/13