Emilio Fernandez

From: Fiona Hawthorne [Fiona.Hawthorne@health.qld.gov.au]
Sent: Thursday, 18 December 2014 2:05 PM
To: Heidi Carr
Subject: FW: CLEARED RESPONSE:
Attachments: NP_Sch3(2)(1)(b)

Here is the email showing it has been cleared. Thanks, F

From: Alexa van Straaten
Sent: Thursday, 18 December 2014 2:04 PM
To: Fiona Hawthorne
Subject: FW:

FYI
Kind Regards
Alexa

From: Kirstine Sketcher-Baker
Sent: Thursday, 18 December 2014 2:01 PM
To: Elizabeth Robertson; Alexa van Straaten
Subject: FW:

From: HSCI_Corro
Sent: Thursday, 18 December 2014 1:51 PM
To: HSIB
Cc: Kirstine Sketcher-Baker
Subject:

Hi Jo

The attached response has been cleared by Dr Kingswell, A/DDGHSCI.

Many thanks
Vanessa

Vanessa Walsh
Senior Briefings Officer
Office of the Chief Operations Officer, Department of Health and
Deputy Director-General, Health Service and Clinical Innovation Division
Queensland Government
Level 16 Queensland Health Building
147 – 163 Charlotte Street
Brisbane QLD 4001
t. 07 3008 7381 ext. 18381
e. HSCI_Corro@health.qld.gov.au | www.health.qld.gov.au

From: HSIB
Sent: Thursday, 18 December 2014 9:39 AM
To: HSCI_Corro
Cc: DDGHSCI

Subject:
Importance: High

Hi Emma

As per below request sent directly to Kirstine Sketcher-Baker yesterday, please see below her comments and attached draft response

This has been cleared by Jan Phillips, 18 December 2014.

Kind regards,

Jo Golinski
Correspondence Officer
Health Systems Innovation Branch

Health Service and Clinical Innovation Division | Department of Health
Level 2, 15 Butterfield Street, Herston
P: 3328 9112
E: HSIB@health.qld.gov.au| www.health.qld.gov.au

Always download and use a Corporate template http://qheps.health.qld.gov.au/corro-templates/

From: Kirstine Sketcher-Baker
Sent: Wednesday, 17 December 2014 5:37 PM
To: PSU; HSIB
Subject:
Importance: High

Hi

Apologies this one is overdue!

NP_Sch3(2)(1)(b)

Thanks
ksb

From: HSCI_Corro
Sent: Monday, 15 December 2014 12:50 PM
To: Kirstine Sketcher-Baker

Cc: DDGHSCI
Subject:
Importance: High

Hi Kirstine

Please see attached documents which Dr Cleary has requested this be forwarded to you as per the following comments:
Could we please ask Kristine Sketcher-Baker to review this for me and provide a draft response that includes a summary of existing review mechanism.

Please submit to HSCI Corro by midday Wednesday, 17 December 2014.

Our deadline to DJAG is close of business Thursday.

Many thanks,
Emma

Emma Lawson
Senior Briefings Officer
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Deputy Director-General, Health Service and Clinical Innovation Division
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From: Yolande Yorke [mailto:Yolande.Yorke@justice.qld.gov.au]
Sent: Tuesday, 9 December 2014 4:23 PM
To: DDGHSCI
Cc: Jennifer Lang; Heidi Carr
Subject:

Hello Michael,

NP_Sch3(2)(1)(b)

Y
Yolande Yorke

Director, Strategic Policy
Ph 3239 6571

Emilio Fernandez

From: Yolande Yorke
Sent: Monday, 10 November 2014 2:21 PM
To: Heidi Carr; Margaret Forrest
Subject: FW:
Follow Up Flag: Follow up
Flag Status: Red

From: Robert Walker
Sent: Friday, 7 November 2014 10:03 AM
To: Yolande Yorke
Cc: Magistrate RyanT
Subject: RE:

Hi Yolande,

In addition to the information contained in the State Coroner's letter of 8 August 2013, including the quantified autopsy costs set out therein ($7,500 per case), the following information also relates to cost.

First of all, based on our estimate that just over 16% of stillbirths would be reported under the *Coroners Act* (arrived at by comparison of perinatal deaths reported) and using the figure of 451 stillbirths, we estimate 74 stillbirths would be reported to coroners per year.

Conveyancing costs vary from centre to centre, from a low of $1000 on average per conveyance for centres such as Cairns and Nambour, up to $6000 and $6500 for Torres Strait Islands and Mt Isa respectively.

Expert reports are charged at $250 per hour for an average of 8 hours, at a total average cost per report of $2000.

As to the increased workload for Coroners and investigative resources, the Deputy State Coroner, makes the following observations:

I have conducted a number of investigations of similar deaths. I can say they are some of the most complex and certainly time consuming cases. They invariably involve multiple considerations and often multiple disciplines. Each case involves consideration initially, and if issues noted, further investigation of antenatal care at GP, Obstetrician and hospital levels, midwifery care, residents/consultants at the time of birth, reviews of CTG, paediatric, neonatologists, resuscitation adequacy etc. as birthing is very much a team effort. After issues are noted we may then have to look to a number of expert disciplines for further reports. I cannot emphasise the issue of the relative lack of specialist paediatric pathologists who would need to conduct autopsies and the delays we have invariably experienced in receiving autopsy reports. 12/18 months would be usual.
Once all this is collated we would likely need to engage external counsel, although internal lawyers would have been involved. If the matter proceeds to inquest we are 2 years down the track. The inquests are in themselves some of the most complex we conduct. Because doctors reputations are often on the line, they can also be the most adversarial. Multiple counsel are usual to represent family, hospitals and staff but often nurses and doctors are separately represented.

Please advise if you require further detail.

Regards,

Robert

Robert Walker
Director
Office of the State Coroner
Phone (07) 324 74590
Mobile 0477 746 826

NP_Sch3(2)(1)(b)

Imelda Bradley
A/Assistant Director-General
Strategic Policy and Legal Services
Department of Justice and Attorney-General
Phone: 07 3239 3299
Fax: 07 3239 3046
Email: imelda.bradley@justice.qld.gov.au

State Coroner's Guidelines 2012

Chapter 3

Investigations

3.3 Reporting of particular deaths

Chapter 3

Reporting deaths

3.3 Reporting of particular deaths

3.3.1 Stillbirths

The coroner's power to investigate a stillbirth[1] is extremely limited. This guideline clarifies the circumstances in which this power is invoked.

Scope of coroner's jurisdiction

The Coroners Act prevents a coroner from investigating how a child came to be stillborn. The coroner can only order an autopsy to determine whether a baby was born alive.[2] If the autopsy confirms the child was stillborn, the coroner's investigation must stop.[3]

Reportability

A child who shows no sign of respiration or heartbeat or other sign of independent life at birth is stillborn[4].

A confirmed stillbirth is not reportable to the coroner. Clinicians should consult the *Queensland Maternity and Neonatal Clinical Guideline: Stillbirth care* about the non-coronial reporting requirements for these babies.[5]

A possible stillbirth is reportable if:

- the body is that of an abandoned newborn whose birth was unwitnessed by clinicians
- there is clinical disagreement or doubt about whether the child was born alive.

In these cases, the presumed 'death' is reportable so an autopsy can be performed to determine whether the child was born alive.

Recent judicial authority has confirmed pulseless electrical activity, even in the absence of respiration, is a sufficient sign of independent life.[6] Clinicians should consult the *State Coroner's Guidelines: Reporting Neonatal Deaths* when determining whether the subsequent death of a child born with limited signs of life is reportable.

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[1] Still born child is defined in the *Coroners Act 2003* by reference to the term in the *Births Deaths and Marriages Registration Act 2003*
[2] Coroners Act s19(2)
[3] Coroners Act s12(2)(c)
[4] *Births Deaths and Marriages Registration Act 2003*, Schedule 2
[5] http://www.health.qld.gov.au/qcg/documents/g_still5-0.pdf
[6] *Barrett v Coroners Court of South Australia* [2010] SASCFC 70

Autopsy outcomes

If the autopsy confirms the child was stillborn, the coroner is limited to ordering release of the child's body for burial and in suspicious cases, provide a copy of the autopsy report to investigating police. The coroner can not investigate how the child came to be stillborn.

3.3.2 Neonatal deaths - when and how they should be reported

Introduction

Neonatal deaths raise a number of unique challenges for coroners, namely:-

- Which should be reported?
- How should they be reported?
- Assisting grieving parents without compromising the investigation
- Informing the autopsy process in these cases.

Reportability:

While there are certain circumstances in which a neonatal death clearly is or is not reportable under the *Coroners Act 2003*, many neonates die in circumstances where the decision is not so clear cut.

Deaths not reportable to the coroner

- preterm babies born at less than 26 weeks gestation, where the death results from immaturity per se or from a recognised and appropriately treated complication of immaturity e.g. intraventricular haemorrhage, sepsis, hyaline membrane disease/respiratory distress syndrome

- babies who die as a result of severe congenital abnormality, either diagnosed antenatally with a palliative care plan in place or diagnosed postnatally and intensive care is redirected to palliation after diagnosis.

These guidelines recognise the babies born in these circumstances will generally not survive irrespective of the quality of medical care available to them. They also acknowledge the involvement of parents and caregivers in clinical decision making about the appropriateness of withholding or discontinuing active treatment. It is appropriate for a cause of death to be certified without reference to the coroner for these babies unless the parents are expressing concern about the quality of the health care or the decision making process.

Deaths reportable to the coroner via the police

Hospital staff should contact police to report:-

- a death of a baby born alive either as the result of trauma to the baby or to the mother or the foetus *in utero* e.g. assault, motor vehicle accident, fall, electrocution, drug overdose

- babies who die in suspicious circumstances e.g. smothering, suspected tampering with life support equipment or medication dosage.

These deaths should be reported to police as suspicious or violent and unnatural deaths. There is no need to contact the coroner at the time of reporting unless the police or treating team wish to clarify what action the coroner wants taken.

Deaths reportable directly to the coroner via the Form 1A process

A death should be reported to the coroner using a Form 1A if:-

- the treating team considers the death is due to potentially preventable conditions or complications arising antenatally, during the birth process or during treatment after birth (e.g. lack of timely resuscitation or subsequent neonatal care);

- a parent or caregiver expresses concerns about the mother's antenatal management, management of the labour and delivery and/or neonatal management of the child; or

- the treating clinician is not sure whether or not the death is reportable.

The Coroners Act definition of *health care related death* encompasses two broad scenarios relating to (a) the provision of health care or (b) the failure to provide health care.

Provision of health care - the Act makes reportable a death where the provision of health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would not have expected the death to occur as a result of the health care provided to the person.

Failure to provide health care - the Act also makes reportable a death where failure to provide health care caused or contributed to the death, in circumstances where an independent appropriately qualified person would have expected health care, or a particular type of health care, to be provided to the person.

It can be difficult to determine whether a particular neonatal death comes within this definition. This is because of variables peculiar to obstetric and neonatal management including the complexity of decision making about appropriate antenatal, obstetric and neonatal interventions; diversity of opinion about whether intervention would have enhanced the child's survival prospects and limitations on the extent of a reporting paediatrician's knowledge of the circumstances in which the child was born. For example, a treating neonatologist may be given very little, if any, information about the mother's antenatal management or the delivery of a baby retrieved from another hospital and consequently may have difficulty assessing whether the baby suffered hypoxic-ischaemic encephalopathy (HIE) because of potentially preventable events arising before or during labour and delivery.

Appendix A contains a scenario based reporting aid to guide clinicians and coroners in 'grey area' cases where clinical intervention or the failure to intervene or a decision to withhold or discontinue active treatment may be considered to have caused or contributed to the baby's death. Clinicians are strongly encouraged to discuss these and like cases with the coroner in the first instance.

The determination of whether a neonatal death is reportable may require input from members of the antenatal management and birthing team, as well as the treating paediatric intensive care team responsible for the baby's neonatal care. The Form 1A process can be used to inform this information gathering exercise. The coroner's determination may need to be informed by independent clinical opinion.

In cases where the coroner requires a Form 1A, it should be accompanied by medical records for both mother and child, with as much information as is known by the reporting clinician about the child's birth e.g. where, when and how it occurred and the lead clinician from the birthing team. The Form 1A should also report the parent or caregiver's concerns, if any, and their attitudes towards a coronial autopsy/investigation, if known.

The coroner must consider this information and make his or her determination promptly so that, if necessary, early consideration can be given to autopsy issues and an appropriate autopsy order can be issued as soon as possible.

Scene preservation

Unless the operation or positioning of medical equipment **may** have contributed to the child's death, items such as nasogastric or endotracheal tubes can be removed and lines attached to catheters or syringe drivers can be disconnected.

The sites of any injuries caused by therapy or resuscitation efforts should be marked on the child's body and noted in the chart. For more detail on what material should be preserved see Scene preservation guidelines at http://www.courts.qld.gov.au/Coroners_Court/OSC-ScenePreservation.pdf

Parents and caregivers should then be given unrestricted access to the body of their baby, unless they are implicated in the circumstances of the death e.g. tampering with life support equipment, smothering etc.

The coroner's decision

The coroner will consult with such experts as considered necessary and advise the hospital and the family as soon as possible of whether a coronial autopsy and investigation will occur. In the meantime, after the family have had an opportunity to be with their baby, the body can be held in the hospital mortuary.

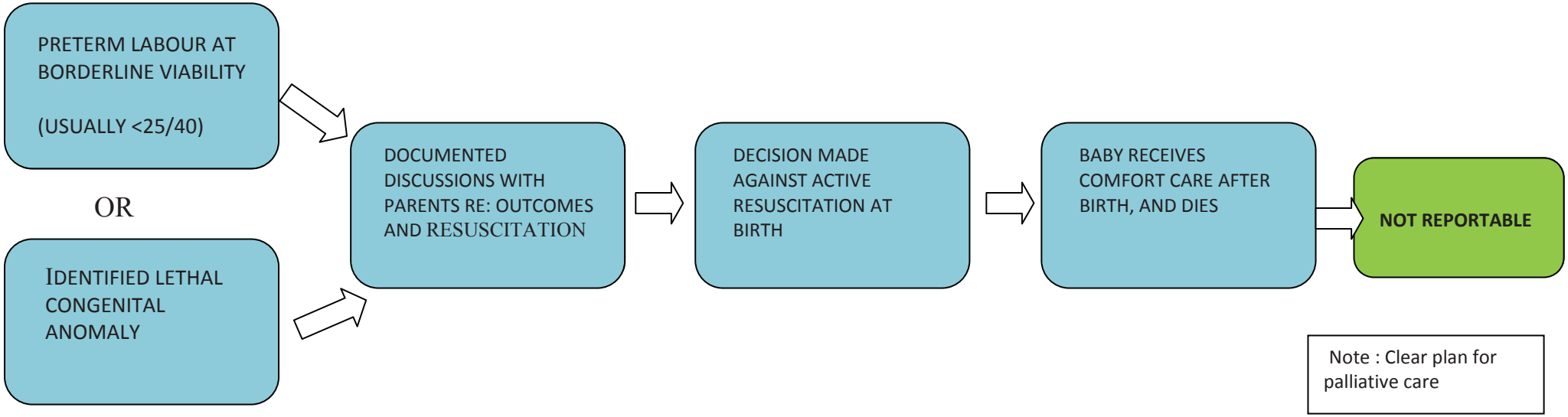
Opportunities for clinical input to the autopsy process

Given the specialist nature of infant autopsies, the forensic pathologist undertaking the autopsy is encouraged to seek collateral information from treating clinicians. The pathologist is responsible for seeking the coroner's approval for this information exchange to occur and documenting it appropriately.

The forensic pathologist may also seek input from independent clinical sources such as an experienced paediatric anatomical pathologist or members of a non-treating hospital's perinatal mortality group.

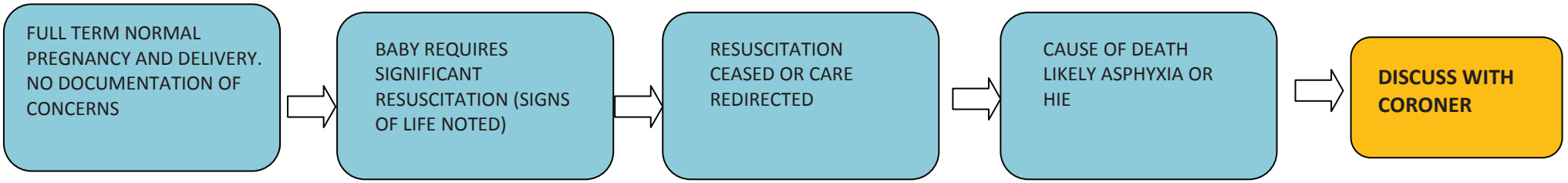
REPORTING GUIDE FOR NEONATAL DEATHS

SCENARIO 1 – PLANNED NON-INITIATION OF RESUSCITATION



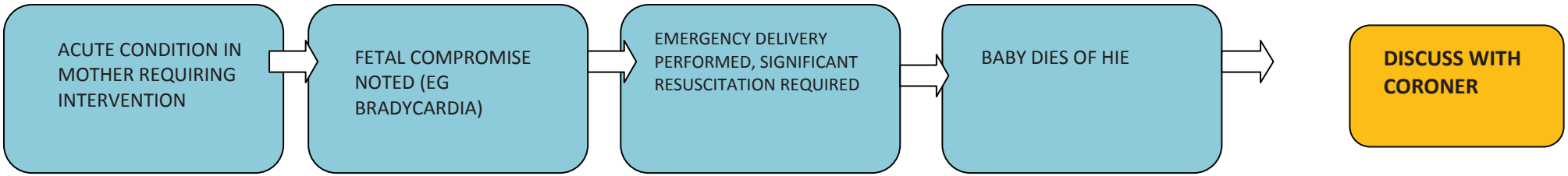
Note : Clear plan for palliative care

SCENARIO 2 – RESUSCITATED STILLBIRTH AFTER APPARENTLY NORMAL LABOUR



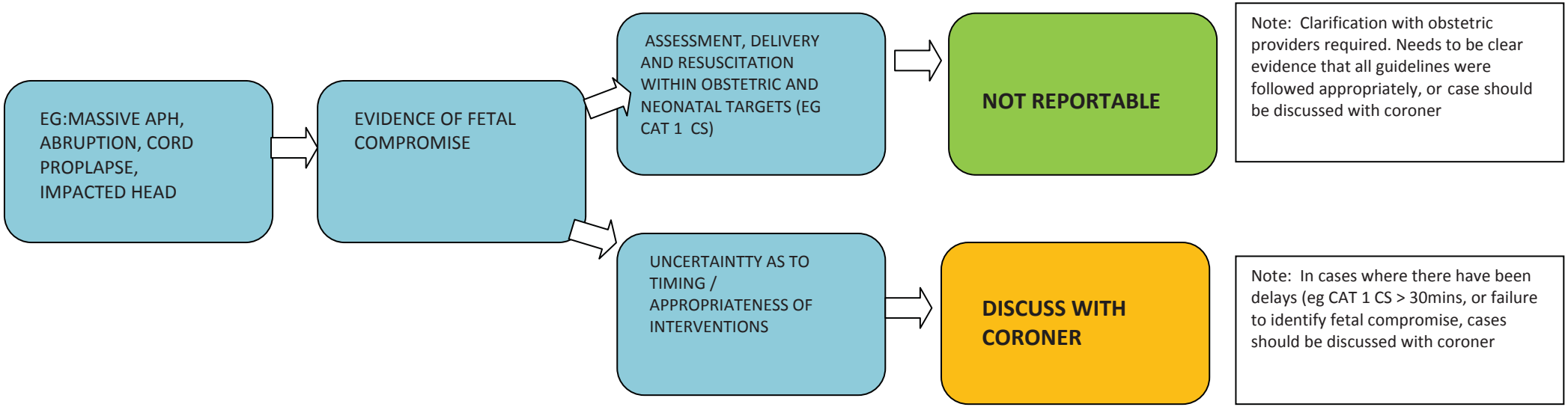
Note: needs to be discussed, neonatal care providers should not be assessing adequacy of antenatal / peripartum management

SCENARIO 3 – ACUTE MATERNAL CONDITION IN PREGNANCY



Note: Examples of maternal conditions include : MVA, seizure, (eclamptic or otherwise) DKA, overdose, trauma.
Should be discussed as care provision (or access to) may have impacted on neonatal outcome

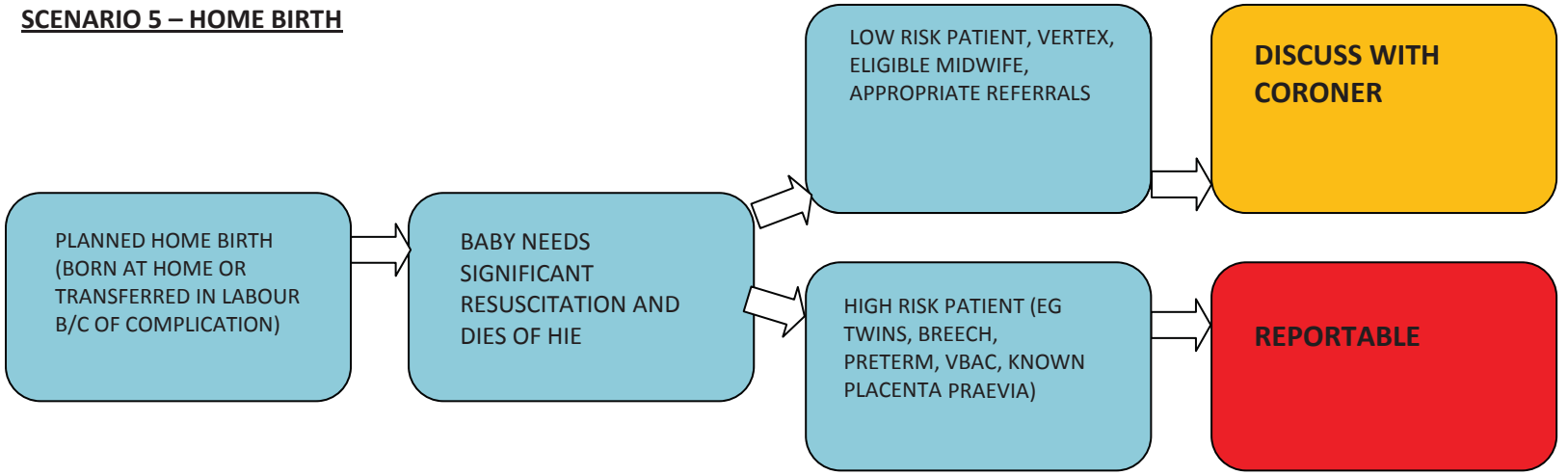
SCENARIO 4 – ACUTE COMPLICATION OF FULL TERM DELIVERY (baby resuscitated but subsequently dies)



Note: Clarification with obstetric providers required. Needs to be clear evidence that all guidelines were followed appropriately, or case should be discussed with coroner

Note: In cases where there have been delays (eg CAT 1 CS > 30mins, or failure to identify fetal compromise, cases should be discussed with coroner

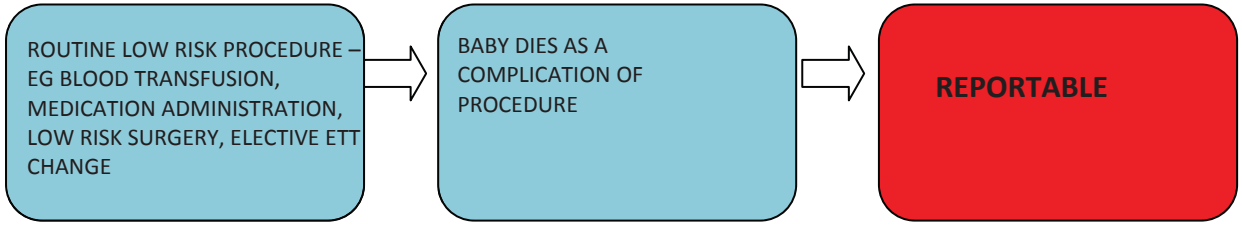
SCENARIO 5 – HOME BIRTH



Note: Care should be taken to ensure documentation is appropriate. Neonatal providers should not make decisions regarding appropriateness of home midwifery care

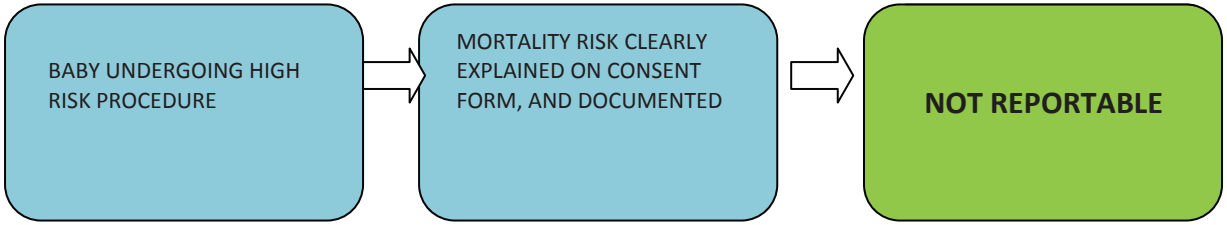
Note: Planning birth outside of accepted care guidelines makes death reportable

SCENARIO 6 – COMPLICATION OF ROUTINE NEONATAL TREATMENT



Note: Low risk surgery eg: hernia repair, ROP laser surgery in stable baby

SCENARIO 7 – HIGH RISK NEONATAL TREATMENT



Note: high risk procedure eg: NEC surgery, CDH repair, exchange transfusion in significantly unwell baby, PDA ligation in extremely preterm unwell infant
However, if known family concerns, discuss with coroner

Community Cabinet AG meeting request - increase jurisdiction of *Coroners Act 2003* re stillbirths

Proposal	Issues/ problems	Analysis	Options for reform	Support/ Not support
That the jurisdiction of the Coroners Act is extended to grant the State Coroner discretion to investigate stillbirths where the death occurs during labour	Raised by NP_49-Sch4 What are reasons for these issues? Amendment is in the public interest and in line with similar reforms being undertaken in other states. It is likely that the reform will result in fewer than 20 additional coronial investigations each year in Queensland	Current Qld legislative environment: ***Coroners Act 2003*** **12 Deaths not to be investigated or further investigated** (2) A coroner must stop investigating a death if— (c) an autopsy of the body, ordered by the coroner, shows that the body is that of a stillborn child. **19 Order for autopsy** (2) As part of the investigation of a death or to find out whether a body is that of a stillborn child, a coroner— (a) if burial of the body has not happened—must order a doctor to perform an autopsy; or (b) Otherwise—may order a doctor to perform an autopsy. (3) The autopsy may consist of— (a) for a body that has been cremated—an examination of the cremated remains of the body; or (b) for a body that has not been cremated— (i) an external examination of the body; or (ii) an external and partial internal examination of the body; or (iii) an external and full internal examination of the body. (5) Before ordering an internal examination of the body, the coroner must, whenever practicable, consider at least the following— (a) that in some cases a deceased person's family may be distressed by the making of this type of order, for example, because of cultural traditions or spiritual beliefs; (b) any concerns raised by a family member, or another person with a sufficient interest, in relation to the type of examination to be conducted during the autopsy. (6) If, after considering any concern mentioned in subsection (5)(b), the coroner decides it is still necessary to order the internal examination, the coroner must give a copy of the order to the person who raised the concern. **96 Application of Act to stillborn child**	1. retain the status quo Why? - Not on legislative reform agenda. - Current system works well because local committees are experts at investigation.	<Support/ Not support>

		Only sections 12(2)(c), 19, 25(1) to (3), 26(2)(c) and 95 of this Act apply to a stillborn child. **25 Autopsy reports** (doctor must provide report as soon as practicable) **26 Control of body** (Coroner stops having control of body when stops investigating death under 12(2)(c)) **95 Authorising burial of body etc.** **Section 10AA** – how can the definition of health care related death work? Refers to a person. Section 8(b), (c) and (d) of the Act could provide a framework for this to occur by extending a 'reportable death' to include stillbirths. The definition of 'health related death' in section 10AA of the Act would also need to be amended as this specifically refers to the death of 'a person'. 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*** 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. ***Ex notes: Coroners Bill 2002*** *Clause 12* (c) (Like the common law and the *Coroners Act 1958* it is the bill's intention that the coroner must not investigate the circumstances of a stillborn child. This is reinforced by clause 95 of the bill. However, like section 18 of the *Coroners Act 1958*, the coroner can, under the bill, order an autopsy to determine whether the body is that of a stillborn child. Clause 19 (1)(b) specifically allows for this.) *Clause 19* Order for autopsy: Provides that a coroner must order a doctor to perform an autopsy as part of the investigation of a person's death or to find out whether the body is that of a stillborn child.(Like the common law and the Coroners Act 1958 it is the bill's intention that the coroner must not investigate the circumstances of a stillborn child. This is reflected in clause 95 of the bill. However like section 18 of the Coroners Act 1958, the coroner can, under this clause, order an autopsy to find out whether the body is that of a stillborn child. This is to deal with situations such as where what appears to be an abandoned stillborn child has been discovered. The coroner can order the autopsy to confirm whether or not it is a stillborn child.) *Clause 95* Application of Act to stillborn child: This clause makes it clear that the Act, like the common law and the *Coroners Act 1958*, does not apply to a stillborn child (which is defined in the dictionary to mean a child not born alive as defined in the *Registration of Births, Deaths and Marriages Act 1962*). The exceptions to this are that the coroner can order an autopsy to find out whether the body is that of a stillborn child (clause 19(1)(b)). The other clauses mentioned in the provision are the consequence of the coroner making the order for autopsy to find out whether the body is that of a stillborn child ie		

		• the coroner has to stop investigating if the autopsy establishes that the body is that of a stillborn child(clause 12(2)(c); and • the coroner has to order the release of the body if the autopsy establishes that the body is that of a stillborn child (clause 26(2)(c)) **<u>State Coroners Guidelines:</u>** Chapter 3 Investigations: Page 1-2 *Scope of coroner's jurisdiction* The Coroners Act prevents a coroner from investigating how a child came to be stillborn. The coroner can only order an autopsy to determine whether a baby was born alive. If the autopsy confirms the child was stillborn, the coroner's investigation must stop. *Reportability* A child who shows no sign of respiration or heartbeat or other sign of independent life at birth is stillborn. A confirmed stillbirth is not reportable to the coroner. Clinicians should consult the *Queensland Maternity and Neonatal Clinical Guideline: Stillbirth care* about the non-coronial reporting requirements for these babies. A possible stillbirth is reportable if: - the body is that of an abandoned newborn whose birth was unwitnessed by clinicians; - there is clinical disagreement or doubt about whether the child was born alive. In these cases, the presumed 'death' is reportable so an autopsy can be performed to determine whether the child was born alive. Recent judicial authority has confirmed pulseless electrical activity, even in the absence of respiration, is a sufficient sign of independent life. Clinicians should consult the *State Coroner's Guidelines: Reporting Neonatal Deaths* when determining whether the subsequent death of a child born with limited signs of life is reportable. *Autopsy outcomes* If the autopsy confirms the child was stillborn, the coroner is limited to ordering release of the child's body for burial and in suspicious cases, provide a copy of the autopsy report to investigating police. The coroner can not investigate how the child came to be stillborn. **Office of the State Coroner, director Brigita White advises:** The State Coroner is of the view the jurisdiction should be extended to include stillbirths that are an unexpected outcome of health care provided during labour. He says it is illogical to focus on whether or not the baby was stillborn and not on the adequacy of health care and whether the death was unexpected.		

		He agrees with the recommendation of the SA legislative review committee to amend the legislation to allow the investigation of unexpected, unusual, violent etc. stillbirths and notes that this would also capture stillbirths caused by the violent act of another towards a pregnant woman - these deaths are currently unable to be investigated by a coroner. Queensland Health Queensland Maternity and Neonatal Clinical Guideline: Stillbirth care: http://www.health.qld.gov.au/qcg/documents/g_still5-0.pdf **Queensland Maternal and Perinatal Quality Council** investigates If there was medical intervention: **Complaints to Queensland Health:** http://www.health.qld.gov.au/psq/hemt/feedback/complaints.asp If that avenue is exhausted, can complain to **Health Quality and Complaints Commission**: http://www.hqcc.qld.gov.au/Complaints/Pages/What-you-can-complain-about.aspx including: 1. Hospital, health institution or nursing home services. 2. Medical, dental, pharmaceutical, paramedical, mental health, community health, environmental health, specialised health or allied services. If no medical intervention (eg homebirths): Is there any jurisdiction under the Criminal Code? Criminal negligence? – check and then ask Louise S. The NSW government decided to codify this ruling rather than create a child destruction offence. This was achieved through an addition to the definition of 'grievous bodily harm' in the NSW *Crimes Act*. 'Grievous bodily harm' now includes destruction of the fetus of a pregnant woman, other than in the course of a medical procedure, whether or not the woman suffers any other harm. <u>Is reform needed?</u> How often do stillbirths (including during homebirths etc) happen in Qld? Queensland Maternal and Perinatal Quality Council Report 2011, page 7: In 2009, the most recently reported period for Queensland, there were 447 stillbirths, a rate of 7.2 per 1,000. Cross jurisdictional analysis: Important to note that the SA *Coroners Act 2003* is silent as to how stillbirths are to be interpreted. **Report of the Legislative Review Committee on its Inquiry into Stillbirths**, November 2011 Page 67:		

		"Recommendation 6: That the Attorney-General take steps to amend section 21(1)(b) of the *Coroner's Act 2003* to allow for a coronial inquest into still births of unexpected, unnatural, unusual, violent or unknown cause." Whether the infant is a person for the purpose of law is determined by the common law 'born alive rule'. To satisfy the rule, an infant needs to have completely left the mother's body and exhibit some sign of life either at or after birth. Rule considered in June 2010 by Supreme Court of SA: *Barrett v Coroner's Court of South Australia*. The court agreed that pulseless electrical activity detected in the infant was a sign of life and enough to satisfy the born alive rule, even though the infant did not take a breath. The committee considered the amendment would be useful in describing the type of still birth which would benefit from a coronial inquest and that the Coroner would have the discretion to inquest only those matters that are of a public interest, including homebirths. Contact SA SCLJ officer - Strategic Policy has contacted the South Australian Attorney-General's Department which has advised they are currently considering reforms as proposed by the committee. **2012 WA Law Reform Commission paper – Review of Coronial Practice in Western Australia Final Report Project No 100 January 2012** Recommended reforms to the WA *Coroners Act 1996* to stipulate that a stillbirth, as defined in s 4 of the WA *Births, Deaths and Marriages Registration Act 1998*, is not a death for the purposes of the Act. ie – similar wording to the Qld Coroners Act. Page 28: "In coming to its conclusion, the Commission noted that there was little utility in the coroner assuming jurisdiction over stillbirths in Western Australia 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.12 The Commission highlighted that this body (comprised of a panel of experts) performs a specialist medical investigation into each stillborn death – including 'homebirth' deaths where no medical practitioner or midwife was present – to establish circumstances and cause of death, possible preventable factors and other issues of public health significance. In addition, the Perinatal and Infant Mortality Committee has a significant prevention role and is tasked with proposing recommendations to effect systemwide reforms aimed at reducing perinatal and infant mortality rates. The Committee therefore performs all relevant functions of a coroner except for the holding of public hearings."		

		2006 Victorian Parliament Law Reform Committee Inquiry into the Review of the *Coroner's Act 1985* report (Victorian Law Reform Committee report) 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. 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). 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. 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". **Next steps:** How do maternal death investigations intersect with the coroner? Further research into how the other jurisdictions examined the matter Main difference in the two models is a lack of public hearings? Compellability?		

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: NP_49-Sch4

Background:

- 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, Ms Lang **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.

Contact Name Amber Manwaring
Position Senior Legal Officer
Telephone *(work)* 3227 7605

Approval Officer Jenny Lang
Position Assistant Director-General
Telephone *(work)* 3898 0161 (81361)
(after hours) NP_49-Sch4

Endorsed by Director-General /02/13

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.

42.

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

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	_____ / /

☐ 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.

In reply please quote: 548628/1

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

Dear Mr Barnes

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 Campbell Newman MP, Premier, the Honourable Lawrence Springborg MP, Minister for Health and the Honourable Jack Dempsey MP, Minister for Police and Community Safety, 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.

Prepared by:	Amber Manwaring, Senior Legal Officer, SPLES
Telephone Number:	07 3239 0394
Submitted through:	Louise Shephard
Date:	4 June 2013
Document Name:	2172934

In reply please quote: 548628/1

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

Dear Premier

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.

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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

Prepared by:	Amber Manwaring, Senior Legal Officer, SPLES
Telephone Number:	07 3239 0394
Submitted through:	Louise Shephard
Date:	4 June 2013
Document Name:	2172934

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

Enc.

In reply please quote: 548628/1

The Honourable Jack Dempsey MP
Minister for Police and Community Safety
Member for Bundaberg
PO Box 15195
CITY EAST QLD 4002

Dear Minister

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.

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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.

Prepared by:	Amber Manwaring, Senior Legal Officer, SPLES
Telephone Number:	07 3239 0394
Submitted through:	Louise Shephard
Date:	4 June 2013
Document Name:	2172934

In reply please quote: 548628/1

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

Dear Minister

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.

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I have also sent this paper to the Honourable Campbell Newman MP, Premier, 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

Prepared by:	Amber Manwaring, Senior Legal Officer, SPLES
Telephone Number:	07 3239 0394
Submitted through:	Louise Shephard
Date:	4 June 2013
Document Name:	2172934

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

Enc.

Summary of issues: Jurisdiction under the *Coroners Act 2003* to investigate stillbirths that occur during labour

Current legislative context

1. The *Coroners Act 2003* (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 (s 11(4)).

2. 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.

3. 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.

4. 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.

5. Sections 6 and 26 of the BDRM Act provide that the birth and death of a stillborn child must be registered.

6. 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

7. 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).

8. 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)).

NP_R

9. 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.

10. 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.

11. 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.

12. 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. It should be noted that on 4 June 2013, the Health Ombudsman Bill 2013 was introduced into the Legislative Assembly. If passed, 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; with resulting changes to the review and monitoring of health care complaints.

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

13. 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.

14. 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.

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.

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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.

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
__ / __ / 2013

☐ URGENT ☑ NORMAL

ACTION BY

- ☑ JUSTICE SERVICES
- ☐ OFFICE OF FAIR AND SAFE WORK
- ☐ FAIR TRADING, LIQUOR & GAMING
- ☐ YOUTH JUSTICE
- ☑ SPLES
- ☐ CORPORATE SERVICES
- ☐ ESB
- ☐ _____

Date of Entry: 30 / 07 / 2013

Signature:

AG Ref:

Dept Ref: 553410/1

Other Ref:

ACTION OFFICER
(DLO IN AG'S OFFICE)

SE AB

ACTION REQUESTED

- ☐ BRIEFING NOTE
- ☐ MINISTER REPLY
  Response to: ☐ MP ☐ Constituent
- ☐ CHIEF OF STAFF REPLY
- ☐ DEPARTMENT TO RESPOND DIRECT
- ☐ NO RESPONSE REQUIRED
- ☑ FOR INFORMATION ONLY
- ☐ NOTE AND FILE IN ESB
- ☐ REFER TO _____
- ☐ _____

Chief of Staff / Adviser Comments:

Maggie: Feedback for SPLES to inform updated brief.

Signature: MF Date: 1/8/13

Other Comments:

SPLES FYI

2.8.13

Signature: Date:

NP_R

Queensland Government

Minister for Police and Community Safety

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PO Box 15195 City East
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Email: police@ministerial.qld.gov.au or communitysafety@ministerial.qld.gov.au

ABN 65 415 158

Ref: 11481 P25 BJ

25 JUL 2013

The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

Thank you for your letter of 20 June 2013 regarding the proposed expansion of the *Coroners Act 2003* (the Act) to include investigations of stillbirths that occur during labour.

I acknowledge that expanding the Act may increase the transparency of these matters by allowing public access to information. It may also potentially reduce distress and provide closure for families who experience an event of stillbirth and may increase public confidence in health care.

Notwithstanding this new level transparency, the Queensland Police Service (QPS) is concerned the proposed changes may result in an additional workload for frontline officers should the Coroner request assistance to investigate stillbirths that occur during labour. A change may also require additional specialist training for frontline officers who may be requested to assist the Coroner's office.

Thank you for providing an advance copy of the issues paper. Should your officers wish to further discuss the proposal, the QPS contact is Ms Shellee Wakefield, Senior Policy Officer, Strategy and Business Review Command, who is available on telephone 3234 2115.

I trust this information is of assistance.

Yours sincerely

Jack Dempsey MP
Minister for Police and Community Safety

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
__/__/ 2013

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ACTION REQUESTED

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  Response to: ☐ MP ☐ Constituent
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- ☐ DEPARTMENT TO RESPOND DIRECT
- ☑ NO RESPONSE REQUIRED
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- ☐ NOTE AND FILE IN ESB
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Date of Entry: 29/07/2013

Signature:

AG Ref:

Dept Ref: 548628/1

Other Ref:

ACTION OFFICER
(DLO IN AG'S OFFICE)

SE AB

Chief of Staff / Adviser Comments:

Maggie → SPLES for the purpose of rebriefing on this issue.

Signature: MF Date: 6/8/13

Other Comments:

SPLES FYI (note comments from AG's office)
AO 7.8.13

Signature: Date:

NP_R

Queensland Government

Minister for Police and Community Safety

RECEIVED
26 JUL 2013
BY:.....

File No: CSD/01491
Ref No: 05194-2013
Your Ref: 548628/1

22 JUL 2013

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The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
GPO Box 149
BRISBANE QLD 4001

Dear Attorney

Thank you for your correspondence received on 21 June 2013, regarding increasing the coronial jurisdiction under the *Coroners Act 2003* (the Act) to include investigations of stillbirths that occur during labour.

I want to thank you for your interest in ensuring a robust oversight system exists in assisting to prevent these types of deaths.

Fortunately, stillbirths within correctional facilities or whilst a patient is in the care of the Queensland Ambulance Service (QAS) are extremely rare, with no instances recorded within the last 12 months. It is unlikely that the inclusion of stillbirths as reportable deaths would have a significant impact on the Department of Community Safety (DCS).

It is noted however that Queensland Corrective Services and the QAS currently apply existing procedures and protocols with respect to managing a reportable death. Should the definition of a reportable death expand to include stillbirths occurring during labour, consideration would need to be given to amending current procedures and the provision of training and awareness with regard to its implementation.

Additionally, QAS has expressed some concern regarding the proposed definition of a reportable stillbirth, particularly in regards to the capacity of paramedics to make determinations in the pre-hospital environment regarding gestational period and the point at which death has occurred. Appropriate implementation of procedures relating to reportable deaths will be dependent on such determinations.

The DCS welcomes an opportunity to participate in future consultative processes.

Should you require further assistance, please contact Mr David Crossen, Chief of Staff, on telephone number (07) 3239 0199.

Yours sincerely

Jack Dempsey MP
Minister for Police and Community Safety

Increased jurisdiction of Coroners Act 2003 to investigate stillbirths: stakeholder feedback

Stakeholder	Merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour	Agreed with expanding the Act to include the investigation of stillbirths that occur during labour?	If agree, any limits or other criteria that should be applied.	Issues identified with proposal	Whether and how existing review mechanisms could be improved	Funding implications that may result from expanding the jurisdiction
State Coroner	N/A	**No** – more appropriately and more efficiently investigated by an independent specialist perinatal death review committee such as the QMPQC, than the coroner.	Clinically understood concept of intrapartum stillbirth: a foetus of 28 weeks or more gestation	***Expected number of reportable stillbirths under the proposal*** Advice from Professor Michael Humphrey: 2009-11 data - number of intrapartum stillbirths reportable under proposal: 10 intrapartum stillbirths per annum. Estimate reflects the number that would 'fit' within the clinically understood concept of intrapartum stillbirth. Anticipate proposal would generate a higher number of apparent intrapartum stillbirths due to increasing tendency by health sector to report out of an abundance of caution when it is not immediately clear whether the death meets the reporting requirements. 20-40% of stillbirths per annum remain unexplained, despite consented hospital autopsy and clinical investigation. ***Complexity of investigations and required coronial expertise*** Investigations will involve extensive investigations (toxicology, microbiology, radiology, neuropathology, vitreous chemistry and metabolic screening – would take at least 12 months before a pathologist could provide a final autopsy report. ***Access to specialist advice and expertise*** Coroner does not have access to *obstetric expertise* necessary to properly examine these cases. Would need to engage independent specialist to review investigation material and provide an opinion about whether stillbirth could have been prevented. Currently, only have access to clinical advice from the forensic medical officers employed by Qld Health Clinical Forensic Medical Unit. These are GPs with specialist forensic medicine qualifications; do not have necessary expertise to critique complex obstetric cases. As a result, coroners engage independent obstetricians, neonatologists and paediatricians to review complex obstetric and neonatal deaths. *Perinatal pathologists*: only three perinatal pathologists in Qld with specialist expertise in stillbirth autopsies. All based in Brisbane.	Consider amending the root cause analysis legislation to mandate this process for all intrapartum stillbirths that occur in hospitals. **(CF Minister for Health)**	***Costs to the coronial system*** *Police attendance*: Scenes of Crime and Criminal Investigation Branch generally involved to rule out suspicious circumstances. Attending police take witness statements, seize medical records, arrange govt undertaker and prepare initial report for coroner. **(CF Police Minister response)** *Conveyance by govt undertaker*: coronial autopsies only performed in Brisbane, Nambour, Gold Coast, Rockhampton, Townsville and Cairns. Regional or rural stillbirths may need to be conveyed from the child's birthplace for autopsy. Not all forensic pathologists who perform coronial autopsies are credentialed to perform infant autopsies. *Autopsy costs*: Forensic pathology, toxicology, neuropathy, mortuary, and coronial counsellor costs. **(CF Minister for Health)** Dept of Health estimate for full internal autopsy with histology and toxicology approx $7,500. *Investigation costs*: includes independent specialist clinical experts, cost of coroner and registry involvement. OSC advises that an additional part time coroner or registrar and additional AO3 registry staff would be required. Very difficult to quantify the cost per investigation. Examples of

Stakeholder	Merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour	Agreed with expanding the Act to include the investigation of stillbirths that occur during labour?	If agree, any limits or other criteria that should be applied.	Issues identified with proposal	Whether and how existing review mechanisms could be improved	Funding implications that may result from expanding the jurisdiction
				Managing family objections to autopsy Coroners expect objections to coronial autopsy due to anecdotal evidence about current low rates of consent to hospital autopsies for stillbirths. Not every intrapartum death reported to coroner will proceed to coronial autopsy – consistent with current coronial case law, unless there are suspicious circumstances (OSC advises: eg violence/assault leading to stillbirth or allegation of medical negligence) coroner will not override family's strong objections to autopsy. Rejects the assumption that "a more detailed explanation of what caused the stillbirth may reduce distress and provide families with closure" – based on coronial experience and feedback from coronial counsellors, coronial process can be extremely distressing for families of deceased babies and children, particularly when they are forced to consider their views about invasive autopsy and possible organ retention while still in the grip of shock and disbelief at the death. **(CF DJAG issues paper)** ***Timeliness*** Length and complexity of investigations (up to 24 months) can exacerbate grieving family's distress, though there are equally as many families that are grateful for some (if not all) answers as to how the death may have occurred. Independent specialist clinical review (e.g. by RCA or QMPQC) can be progressed much more swiftly than coronial investigation and well placed to identify systemic issues. **(CF Minister for Health)** ***Duplication of existing mechanisms*** Despite the coroners having restricted access to the required expertise, QMPQC comprise an appropriately mixed skill-base to independently examine these complex matters. Given the complexity of stillbirth cases, State Coroner and coroners believe coronial investigation would largely duplicate and/or rely on the outcomes of existing clinical review processes (root cause analysis (RCA), HEAPS analysis, QMPQC) and independent health regulatory investigation processes (e.g. proposed Health Ombudsman and AHPRA). **(CF Minister for Health)**		costs include $1,000 per expert report, approx. $30,000 for an inquest. **(CF [redacted] 'negligible additional expenditure')**

Stakeholder	Merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour	Agreed with expanding the Act to include the investigation of stillbirths that occur during labour?	If agree, any limits or other criteria that should be applied.	Issues identified with proposal	Whether and how existing review mechanisms could be improved	Funding implications that may result from expanding the jurisdiction
Minister for Health	N/A	**No** – does not consider there would be any significant additional benefits to expanding the jurisdiction of the Coroners Act.	N/A	Pleased to support a review of existing mechanisms to identify opportunities for improvement. Currently several robust internal and external mechanisms in place. **(CF State Coroner)**	Additional direction/ guidance to hospitals in reviewing stillbirths, inc. whether or not RCAs should be mandated for intrapartum stillbirths. **(CF State Coroner)** Reviewing role, functions and reporting of the QMPQC, inc. whether or not hospitals should be required to specifically respond to QMPQC recommendations and including those responses in QMPQC public reports.	Expansion of coronial jurisdiction would have resource implications for the health system due to the need for expert clinicians, perinatal pathologists, morgue staff and coronial counselling staff to support additional coronial investigations. **(CF State Coroner)**
Premier of Queensland	N/A	N/A	N/A	NP_Sch3(2)(1)(b)	N/A	N/A
Minister for Police and Community Safety	N/A	N/A	N/A	***Skill of paramedics:*** Queensland Ambulance Service concerned about capacity of paramedics to make determinations in a pre-hospital environment re gestational period and the point at which the death occurred.	N/A	Additional workload and possibly additional specialist training for frontline police officers **(CF State Coroner response)**

Stakeholder	Merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour	Agreed with expanding the Act to include the investigation of stillbirths that occur during labour?	If agree, any limits or other criteria that should be applied.	Issues identified with proposal	Whether and how existing review mechanisms could be improved	Funding implications that may result from expanding the jurisdiction

NP_73(2)

Stakeholder	Merits of expanding the jurisdiction of the Act to include the investigation of stillbirths that occur during labour	Agreed with expanding the Act to include the investigation of stillbirths that occur during labour?	If agree, any limits or other criteria that should be applied.	Issues identified with proposal	Whether and how existing review mechanisms could be improved	Funding implications that may result from expanding the jurisdiction

NP_73(2)

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
16 / 9 / 2013

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ACTION BY

- ☐ JUSTICE SERVICES
- ☐ OFFICE OF FAIR AND SAFE WORK
- ☐ FAIR TRADING, LIQUOR & GAMING
- ☐ YOUTH JUSTICE
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ACTION REQUESTED

- ☑ BRIEFING NOTE
- ☐ MINISTER REPLY
  Response to: ☐ MP ☐ Constituent
- ☐ CHIEF OF STAFF REPLY
- ☐ DEPARTMENT TO RESPOND DIRECT
- ☐ NO RESPONSE REQUIRED
- ☐ FOR INFORMATION ONLY
- ☐ NOTE AND FILE IN ESB
- ☐ REFER TO _____
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Date of Entry: 23 / 08 / 2013
Signature:
AG Ref:
Dept Ref: 5486628/1
Other Ref:
ACTION OFFICER **(DLO IN AG'S OFFICE)** SE AB

NP_Sch3(2)(1)(b)

Other Comments:
Signature: _____ Date: _____

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
__/__/ 2013

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- ☑ FOR INFORMATION ONLY
- ☐ NOTE AND FILE IN ESB
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Date of Entry:	13 / 3 / 2013
Signature:	
AG Ref:	
Dept Ref:	5486028/1
Other Ref:	

ACTION OFFICER
(DLO IN AG'S OFFICE)

SE AB

Chief of Staff / Adviser Comments:
Maggie - SPLES to action info to updated brief.
Signature: _____ Date: 13/3/13

Other Comments:
SEE ATTACHED LETTER TO CORONER - 2211968.
Signature: _____ Date: _____

NP_R

QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

Your reference: 548628/1
Our reference: TR:JS

8 August 2013

The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General,

I refer to your letter to my predecessor, Michael Barnes, inviting his views about a proposal to expand the coroner's jurisdiction to include the investigation of stillbirths that occur during labour ('intrapartum stillbirths').

My coronial colleagues and I have carefully considered the Department's issues paper and the proposal's implications for the coronial system. We acknowledge the considerable distress to families and health professionals involved in intrapartum stillbirths and the importance of independent review of these particular perinatal deaths. However, our consensus view is they are more appropriately and more efficiently investigated by an independent specialist perinatal death review committee such as the Queensland Maternal and Perinatal Quality Council (QMPQC), than the coroner.

We readily acknowledge the artificiality of the current situation whereby the coroner has jurisdiction to investigate the death of a baby resuscitated after a complicated birth but not those babies who are delivered stillborn after the same intrapartum difficulties. However, given our experience investigating the former category of deaths, we do not believe the coronial system is appropriately placed to investigate the clinical complexities of intrapartum stillbirths or to provide timely outcomes for families experiencing this particular form of bereavement. The reasons for this are multifactorial.

Number of intrapartum stillbirths reportable under proposal and implications for the coronial system

Advice from Professor Michael Humphrey, QMPQC Chairperson indicates that of the 1954 stillbirths over 2009-2011, 179 occurred during labour and of these, 147 were foetuses of less 28 weeks gestation. We agree with Professor Humphrey's view that only those intrapartum stillbirths where the foetus has reached 28 weeks or more gestation warrant independent review. Having regard to the 2009-2011 data, this equates to around 10 intrapartum stillbirths per annum.

This estimate reflects the number that 'fit' within the clinically understood concept of intrapartum stillbirth of a foetus of 28 or more weeks' gestation.

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State.Coroner@justice.qld.gov.au

medical records, arrange the government undertaker and prepare an initial report for the coroner.

- conveyance by the government undertaker of the body from birthplace to a coronial mortuary – as coronial autopsies are only performed in Brisbane, Gold Coast, Nambour, Rockhampton, Townsville and Cairns, a regional or rural stillbirth may need to be conveyed sometimes several 1000km from the child's birthplace for autopsy. Further, not all forensic pathologists who perform coronial autopsies are credentialed to perform infant autopsies. For example, any stillbirths occurring in South West Queensland would need to be transported to Brisbane for autopsy because the Toowoomba pathologists are not appropriately credentialed for these cases.

- autopsy costs including forensic pathology, toxicology and neuropathology, mortuary and coronial counsellor costs -- Queensland Health's current estimate for a full internal autopsy with histology and toxicology is approximately $7,500.

- investigation costs, including costs associated with independent specialist clinical experts and the cost of coroner and registry involvement.

These costs will place additional pressure on the coronial system which is experiencing ever-increasing demand.[1]

Access to perinatal pathologist expertise

There are only three perinatal pathologists in Queensland with specialist experience in stillbirth autopsies – Drs Diane Paton and Gayle Phillips at the Royal Brisbane & Women's Hospital and Dr Rohan Lourie at the Mater Mothers Hospital.

While several of the younger Queensland Health Forensic and Scientific Services pathologists are developing infant autopsy expertise, the group of pathologists who perform coronial autopsies do not possess the specialist perinatal expertise of their non-coronial colleagues. If the proposal were to be adopted, consideration would need to be given to how the coronial system could be equipped with the necessary perinatal pathology expertise.

We are also mindful of Professor Humphrey's advice that 20-40% of stillbirths per annum remain unexplained despite consented hospital autopsy and clinical investigation.

Managing family objections to autopsy

Anecdotal evidence about the current low rates of consent to hospital autopsies for stillbirths suggests coroners could expect many families to object to coronial autopsy.

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[1] Between 2007-2008 and 2011-2012, there has been a 26.9% increase in the number of deaths reported to Queensland coroners

the root cause analysis legislation to mandate this process for all intrapartum stillbirths that occur in hospitals.

We consider the independence and transparency of the coronial process can equally be achieved by the QPMQC, in conjunction with the proposed Health Ombudsman. We note the *Public Health Act 2005* currently empowers the health chief executive to require designated persons to provide information about perinatal deaths (including stillbirths) to inform the perinatal death collection. This information is then used by the QPMQC to inform its perinatal death reviews. Further, the root cause analysis legislation could be amended to mandate the provision of root cause analyses of intrapartum stillbirths to QPMPC as a matter of course. Although the QPMQC can not conduct public inquiries, it can refer systemic issues to the Health Minister who can then direct the proposed Health Ombudsman to conduct an inquiry into the matter.

For these reasons, it is our collective view that the Coroners Act should not be amended to expand the coroner's stillbirth jurisdiction to include the investigation of intrapartum stillbirths. We acknowledge this position does not resolve the current anomalous situation whereby coroners have jurisdiction to investigate those neonatal deaths resulting from intrapartum complications, and suggest the Government may also wish to consider divesting coroners of this investigative responsibility.

Thank you for the opportunity to comment on the proposal. I am available to discuss the issue further if you wish.

Yours sincerely,

Terry Ryan
State Coroner

Queensland Government

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

Level 18 State Law Building
50 Ann Street Brisbane 4000
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Queensland 4001 Australia
Telephone +61 7 3247 9068
Facsimile +61 7 3221 4352
Email attorney@ministerial.qld.gov.au

In reply please quote: 548628/1

COPY

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

Dear Mr Barnes

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 Campbell Newman MP, Premier, the Honourable Lawrence Springborg MP, Minister for Health and the Honourable Jack Dempsey MP, Minister for Police and Community Safety, 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.

NP_R

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
__ / __ / 2013

☐ URGENT ☐ NORMAL

ACTION BY

- ☐ JUSTICE SERVICES
- ☐ OFFICE OF FAIR AND SAFE WORK
- ☐ FAIR TRADING, LIQUOR & GAMING
- ☐ YOUTH JUSTICE
- ☑ SPLES
- ☐ CORPORATE SERVICES
- ☐ ESB
- ☐ _____

ACTION REQUESTED

- ☐ BRIEFING NOTE
- ☐ MINISTER REPLY
  Response to: ☐ MP ☐ Constituent
- ☐ CHIEF OF STAFF REPLY
- ☐ DEPARTMENT TO RESPOND DIRECT
- ☑ NO RESPONSE REQUIRED
- ☑ FOR INFORMATION ONLY
- ☐ NOTE AND FILE IN ESB
- ☐ REFER TO _____
- ☐ _____

Date of Entry: 19/08 / 2013

Signature:

AG Ref:

Dept Ref: 548628/1

Other Ref:

ACTION OFFICER
(DLO IN AG'S OFFICE)

SE AB

Chief of Staff / Adviser Comments:
Maggie: Please action to brief me still briefing.
Signature: _____ Date: 23/8/13

Other Comments:
Signature: _____ Date: _____

NP_R

QUEENSLAND GOVERNMENT

Hon Lawrence Springborg MP
Minister for Health

MI191128

Level 19
147-163 Charlotte Street Brisbane 4000
GPO Box 48 Brisbane
Queensland 4001 Australia
Telephone +61 7 3234 1191
Facsimile +61 7 3229 4731
Email health@ministerial.qld.gov.au

The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
Member for Kawana
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General Jarrod

13 AUG 2013

Thank you for your letter dated 20 June 2013, in relation to options for reform of the coronial jurisdiction for the investigation of stillbirths. I apologise for the delay in responding.

I have carefully considered this very difficult issue and sought advice from the Department of Health. While I acknowledge the importance of finding and providing as much information as possible to parents following a stillbirth and identifying any systemic learnings that may prevent future stillbirths, on balance, I do not consider that there would be any significant additional benefits to expanding the jurisdiction of the *Coroners Act 2003,* as there are currently several robust internal and external review mechanisms in place as identified in the issues paper.

However, I would be very pleased to support a review of existing mechanisms to identify opportunities for improvement. The Department of Health has identified the following preliminary options that might be considered within the health system:

- additional direction or guidance to hospitals in reviewing stillbirths, including whether or not Root Cause Analysis should be mandated for intrapartum stillbirths
- reviewing the role, functions and reporting of the Queensland Maternal and Perinatal Quality Council (QMPQC), including whether or not hospitals should be required to specifically respond to QMPMC recommendations and including those responses in QMPQC public reports.

In terms of potential funding implications to consider, any expansion of the coronial jurisdiction to include the investigation of stillbirths would certainly have resource implications for the health system due to the need for expert clinicians, perinatal pathologists, morgue staff and coronial counselling staff to support additional coronial investigations.

Thank you for the opportunity to provide my views on this matter. I look forward to hearing the outcome of your review.

Yours sincerely

LAWRENCE SPRINGBORG MP
Minister for Health

Ministerial Correspondence Action Request
Attorney-General and Minister for Justice

Due Date REQUIRED:
10 / 10 / 2013

☐ URGENT ☐ NORMAL

ACTION BY

- [x] JUSTICE SERVICES
- [ ] OFFICE OF FAIR AND SAFE WORK
- [ ] FAIR TRADING, LIQUOR & GAMING
- [ ] YOUTH JUSTICE
- [x] SPLES
- [ ] CORPORATE SERVICES
- [ ] ESB
- [ ] _____

ACTION REQUESTED

- [ ] BRIEFING NOTE
- [x] MINISTER REPLY
  Response to: ☐ MP ☒ Constituent
- [ ] CHIEF OF STAFF REPLY
- [ ] DEPARTMENT TO RESPOND DIRECT
- [ ] NO RESPONSE REQUIRED
- [ ] FOR INFORMATION ONLY
- [ ] NOTE AND FILE IN ESB
- [ ] REFER TO _____
- [ ] _____

Date of Entry: 17 / 9 / 2013

Signature:

AG Ref:

Dept Ref: 554383/1

Other Ref:

ACTION OFFICER
(DLO IN AG'S OFFICE)

SE AB

Chief of Staff / Adviser Comments:
Signature: _____ Date: _____

Other Comments:
Signature: _____ Date: _____

QUEENSLAND GOVERNMENT

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

In reply please quote: 554324/1 2331723
Your reference: SLA/njs

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Facsimile +61 7 3221 4352
Email attorney@ministerial.qld.gov.au

Ms Sarah Atkinson
Principal
Maurice Blackburn Lawyers
PO Box 6381
MAROOCHYDORE BC QLD 4558

Dear Ms Atkinson

Thank you for your letter dated 10 September 2013 regarding the jurisdiction of the *Coroners Act 2003* to investigate stillbirths. I apologise for the delay in responding.

I also thank you for taking the time to write to me again about this issue and for the clear concern that you have shown to improve the current system for the investigation of deaths of stillborn babies to better meet the needs of Queensland families.

Given the complexity of the issues raised, it is important to ensure that the potential merits and impacts of such a proposal are thoroughly examined. This includes a full assessment of the adequacy of existing mechanisms to investigate and review stillbirths within the Queensland health system and how these might operate in conjunction with an expanded jurisdiction of coroners to investigate unexpected intrapartum deaths. There may also be alternative options that should be considered.

I have directed the Department of Justice and Attorney-General to conduct a comprehensive review of these matters taking into account your views and to report back to me as soon as possible.

Thank you again for bringing this matter to my attention and your kind offer of assistance. I will continue to keep you informed of my decisions based on the results of this investigation.

Yours sincerely

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

NP_R

Increased jurisdiction of *Coroners Act 2003* to investigate stillbirths – chronology and notes

Background

24 February 2013, AG met with NP_49-Sch4 at the Fraser Coast Community Cabinet meeting who suggested that the Act should be amended to give coroners the discretion to investigate stillbirths where the death of a baby occurs during labour.

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

AG 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.

20 June 2013, AG wrote to the following stakeholders seeking their views as to whether the coronial jurisdiction under the Act should be extended:

- Mr Michael Barnes, the then State Coroner;
- Honourable Campbell Newman MP, Premier;
- Honourable Lawrence Springborg MP, Minister for Health; and
- Honourable Jack Dempsey MP, Minister for Police, Fire and Emergency Services,

Results of consultation:

- Premier did not support expansion.
- Current State Coroner, Magistrate Terry Ryan did not support expansion, noted significant additional costs to coronial system.
- Minister for Police, Fire and Emergency Services raised concerns about additional workload and additional specialist training required for frontline police officers.
- Minister for Health recommended consideration should instead be given to improving the current review framework.

Premier raised the following concerns:

NP_Sch3(2)(1)(b) [redacted]

18 November 2013, DJAG briefed AG:

[redacted]

17 December 2013, AG did not approve the recommendation in the 18 November brief and provided the following response:
"I believe that if a parent requests it, it should occur".

NP_Sch3(2)(1)(b)

Issues

Current legislative environment:

No other Australian state or territory has legislated to allow coronial investigations into stillbirths, although a 2011 report of the South Australian Parliamentary Legislative Review Committee recommended that the *Coroners Act 2003* (SA) be amended to allow for coronial inquests into stillbirths of unexpected, unnatural, unusual, violent or unknown causes. The committee's recommendation is yet to be acted upon.

Duplication with current mechanisms for investigation

Current Queensland Health investigation processes (see summary of issues document #2457655)
NB – there may have been changes to processes since independent investigation commissioned by QH into circumstances surrounding Rockhampton stillbirth.

Financial implications

State Coroner noted the likely significant additional costs to the coronial system of expanding the current jurisdiction including:

- investigation costs, such as independent specialist clinical experts, the cost of the coroner and registry involvement;

- autopsy costs, such as forensic pathology, toxicology, neuropathy, mortuary, and coronial counsellor costs at a cost for a full internal autopsy with histology and toxicology estimated by the Department of Health at approximately $7,500;

- conveyance by the government undertaker, because coronial autopsies can only be performed in Brisbane, Nambour, Gold Coast, Rockhampton, Townsville and Cairns, regional or rural stillbirths may need to be conveyed thousands of kilometres from the child's birthplace for autopsy. This is further exacerbated by the fact that not all forensic pathologists who perform coronial autopsies are credentialed to perform infant autopsies; and

- increased costs for police due to the need to rule out suspicious circumstances, take witness statements, seize medical records, arrange for the government undertaker, and prepare the initial report for the coroner.

Premier's advice and questions
See document #2333411

Agenda

Coronial jurisdiction to investigate stillbirths

Date	Monday 3 March 2014
Time	4:30 – 5:30 pm
Location	Level 18 conference room, State Law Building

- **Welcome/ introductions**
- **Background**
- **Proposal**
- **Issues**
    - **Premier's advice and questions**
    - **Duplication with current mechanisms for investigation?**
    - **Financial implications?**
    - **Non-legislative reforms?**
- NP_Sch3(2)(1)(b)
- **Close**

Summary of issues: Jurisdiction under the *Coroners Act 2003* to investigate stillbirths that occur during labour

Current legislative context

1. The *Coroners Act 2003* (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 (s 11(4)).

2. 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.

3. 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.

4. 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.

5. Sections 6 and 26 of the BDRM Act provide that the birth and death of a stillborn child must be registered.

6. 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

7. 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).

8. 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)).

NP_R

9. 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.

10. 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.

11. 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.

12. 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. It should be noted that on 4 June 2013, the Health Ombudsman Bill 2013 was introduced into the Legislative Assembly. If passed, 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; with resulting changes to the review and monitoring of health care complaints.

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

13. 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.

14. 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.

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.

Meeting notes

Coronial jurisdiction to investigate stillbirths

Date	Monday 3 March 2014
Time	4:30 – 5:30 pm
Location	Level 18 conference room, State Law Building
Attendees	**DJAG:** Natalie Parker, Amber Manwaring, Victoria Moore **Office of the State Coroner (OSC):** Jason Shubert, Ainslie Kirkegaard **State Coroner:** Magistrate Terry Ryan (State Coroner), Magistrate Christine Clements (Brisbane Coroner) **Queensland Health (QH):** Dr Jeanette Young (Chief Health Officer), Michael Cleary, Kirstine Sketcher-Baker, Peter Fredericksen, Dr Charles Naylor.

NP_Sch3(2)(1)(b)

- **Other points**
    - **Duplication with current mechanisms for investigation?**
        - QH indicated that since NP_49-Sch4 stillbirth, an external review into root cause analyses (RCA) had resulted in recommendations had been implemented for hospitals to standardise RCAs. QH advised that only a handful of RCAs would be completed for stillbirths each year.

- All parties questioned the value of investigation in addition to RCA and other internal QH investigation.

o **Financial implications**

- State Coroner: specialist expertise in the area not currently available. Autopsy alone would cost $4000 per stillbirth.
- State Coroner: re benefit of proposal: in current coronial investigations of newborn baby deaths, roughly 20% do not reveal the cause of the death – it is anticipated that this rate would be higher in stillbirths.

- **Action:**

NP_Sch3(2)(1)(b)

Queensland Government

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

In reply please quote: 554324/1; 2664631

Your reference: SLA/njs

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50 Ann Street Brisbane 4000
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29 OCT 2014

Ms Sarah Atkinson
Principal
Maurice Blackburn Lawyers
PO Box 6381
MAROOCHYDORE BC QLD 4558

Dear Ms Atkinson

Thank you for your letter dated 15 September 2014 regarding expanding the jurisdiction of the *Coroners Act 2003* (the Act) to investigate stillbirths. I apologise for the delay in responding.

I can confirm that I am currently considering a proposal for the Coroner to investigate stillbirths. As you can appreciate this is a complex matter and I will need to consider the views of my Cabinet colleagues and statutory officers, including the State Coroner.

Thank you again for your interest in this matter and your offer of further assistance.

Yours sincerely

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

Version 3.3 last updated: 12/09/11

Parent information sheet

Explaining hospital autopsy examinations for stillborn babies

This information sheet is about hospital autopsy examinations in Queensland. It does not cover information about Coroner's autopsies. It includes graphic information that is best discussed with your health care provider.

As the authors of this parent information sheet, the Queensland Centre for Mothers & Babies and the Stillbirth and Neonatal Death Support (SANDS) organisation extend our sympathy to you after the death of your baby.

IMPORTANT: The information contained in this information sheet is general information only. It is not intended to be treated by you as professional advice for a particular factual situation and is no substitute for seeking professional advice from your health care provider. In all procedures your health care provider will explain what will happen, the risks and benefits and will ask for your informed consent. If you choose not to have an intervention, your decision will be respected.

What is a hospital autopsy?

A hospital autopsy is a detailed physical and surgical examination of your baby's body to understand more about the cause of death. A hospital autopsy can also find abnormalities which may not be obvious.

Why give consent to a hospital autopsy for your baby?

The most important reason for a hospital autopsy after stillbirth is to help understand the reasons why the death occurred. Hospital autopsies may provide:

- information about internal problems which led to the death of your baby but which are not obvious from external examination of your baby's body
- information that may be relevant for any future pregnancies
- information that may be important for your future healthcare
- medical knowledge that could help other families in similar situations

Who does the autopsy?

A pathologist usually does the autopsy. A pathologist is a doctor who studies and diagnoses diseases by examining organs, tissues and body fluids.

Do I have to give consent?

Unless the autopsy has been ordered by the Coroner (in rare circumstances), it is your choice whether your baby has an autopsy or not. Before the autopsy is done, your health care provider must have your informed consent. Being informed about the procedure involves:

- knowing all your options
- having the opportunity to ask questions and have your questions answered
- understanding the reasons for the autopsy
- knowing what will be done during the autopsy in as much detail as you want and/or need
- having time to talk to others about your decision
- knowing how your baby will look after the procedure

Where will the autopsy occur?

Only certain hospitals in Queensland have the facilities for autopsies. Your baby may be transferred to a different hospital for the autopsy. You may like to ask your health care provider where the autopsy will be done and how long your baby will be at that hospital. After the autopsy, your baby will be transferred back to the original hospital.

How long can I have to decide about an autopsy for my baby?

There is no specific timeframe for making this decision. The pathologist can get better information if the autopsy is done as soon as possible after your baby's death.

What happens during an autopsy?

The procedures carried out during an autopsy will depend on the age of your baby, your medical and pregnancy history, and the circumstances of your baby's death. Procedures may be limited to the outside of the body (an 'external examination') or may also include the inside of the body (an

Queensland Centre for Mothers & Babies
www.qcmb.org.au

SANDS Queensland
Miscarriage, Stillbirth and Newborn Death Support
www.sandsqld.com/

Queensland Government
www.health.qld.gov.au/qcg

'internal examination' of organs, tissues and body fluids). Autopsies can also be referred to as limited or full autopsies.

What is a limited autopsy?

A limited autopsy is when only some areas or organs of the baby's body are examined - for example, the chest area only. This can be external only or internal as well. A limited autopsy does not provide as much information as a full autopsy as it is focused only on a selected area.

What is a full autopsy?

A full autopsy involves a full external and internal examination. A full autopsy provides more information about the whole body.

What procedures are involved in an external examination?

The pathologist may do some or all of these tests:

- surface swabs of the baby's ear, throat and skin
- blood samples of the umbilical cord
- examination of the placenta and umbilical cord
- blood tests
- X-Rays and MRI scans
- external photographs
- skin samples for chromosome testing

What procedures are involved in an internal examination?

An autopsy is similar to a surgical operation.

An internal examination involves a cut in the baby's body. The pathologist will close this using either sutures (a stitch used by doctors) or surgical glue.

The cut is usually made from the lowest part of the neck to the pubic bone. There may also be a cut on the back of the baby's head if the brain is to be examined. The cut is made so that when sutured, the baby's clothing will cover it.

During an internal examination organs are examined and replaced after small tissue samples are taken.

These tissue samples are small, up to two centimetres across and three millimetres in thickness, and are used for examining the cells under a microscope.

Sometimes the pathologists will ask parents if they can remove larger portions or whole organs from their baby's body for examination. Larger portions or whole organs will only be removed if you give consent.

In some cases, the pathologist can do a needle biopsy to take samples from inside the body without making a cut.

Who decides what type of autopsy is done?

Your health care provider may recommend a certain type of autopsy and will speak with you about this. The kind of information you may get from an internal, external, limited or full autopsy will be discussed with you. If you have concerns about the autopsy relating to your religious beliefs, your health care provider can speak with you about how these can be respected.

How long will the samples be stored?

The tissue samples and organs taken in the autopsy will be stored according to legal requirements. This is usually between 20 and 30 years. These tissue samples are small, up to two centimeters across and three millimeters in thickness.

How long will the autopsy take?

The autopsy of your baby's body will usually be done in a day. However depending on the type of autopsy, it can take up to three weeks to complete all the tests. Your baby's body will be returned as soon as it is complete.

Am I able to travel with my baby if the autopsy is at another hospital?

Parents are not usually able to travel with their baby when their baby is being transferred to a different hospital. You can make private arrangements to travel to the hospital if you wish. Talk with your health care provider about the travel arrangements.

What costs are involved in a hospital autopsy?

Costs depend on individual circumstances. Your health care provider and hospital will be able to tell you. The costs of transfer to another hospital will normally be covered by QLD Health. You can also confirm this with your funeral director.

What can I expect after the autopsy?

After the autopsy, you will be able to see and hold your baby if you wish. You should let your health care provider know before the autopsy that you might wish to see and hold your baby again.

Your funeral director can assist you and arrange for you to spend time with your baby if you wish.

After the autopsy, there will usually be some changes to your baby's appearance. These changes will depend on what procedures were performed in the autopsy and the length of time since the death of your baby.

If your baby had an internal examination, you will notice stitches from the lower part of your baby's neck to their pubic bone and across the back of your baby's head if the brain was examined.

Depending on what examinations have occurred and whether organs have been removed (with your prior consent), you may also notice a change in the balance (weight) of your baby's head and body.

When will I know the results of the autopsy of my baby?

The results will usually be available within about three months. Sometimes it may take longer for all necessary laboratory tests to be completed. Results will be sent to your doctor and/or your obstetrician. You can then make an appointment with your doctor or obstetrician to discuss these results and any issues that arise.

Autopsies can't always provide all the answers. However autopsies do provide important information that can help to reduce the number of 'unexplained' stillbirths.

Comfort, support & information

Your friends, family, doctor and hospital staff can offer you comfort, support and information at this time. Other services include:

SANDS provides support to parents and families who experience miscarriage, stillbirth and neonatal and infant death. For more information or support, please contact the SANDS Queensland office: 07 3254 3422 or 13 000 SANDS (13 000 72637), admin@sandsqld.com or via our website www.sandsqld.com

At SANDS there are people who understand what it's like because they too have been through this experience. People have many different needs at this time and SANDS is here to offer support and information 24 hours a day for anyone affected by the death of a baby.

SANDS offers empathy and understanding and the opportunity to talk, listen and share experiences in a safe, non-judgmental and caring environment.

We offer a wide range of support services including:

- **Phone Support** – bereaved parents, family members, health professionals and members of the wider community can talk in confidence to an experienced parent support worker. Phone 13 000 SANDS (13 000 72637).
- **Email Support** – sometimes it can be easier to communicate by email than by phone. By emailing the SANDS office, we will put you in touch with a parent supporter who is able to offer support via email. Our office email is admin@sandsqld.com
- **Support Groups** – run by and for bereaved parents at a local level in many parts of Queensland. All support group meetings and contact details are listed on our website www.sandsqld.com
- **Information Resources** – we have a large range of resources including books, leaflets, videos and DVDs as well as a library service. These resources cover many of the emotional and practical issues faced by parents and families following pregnancy loss.
- **SANDS Newsletter** – our monthly newsletter provides information and support and provides a link with other parents. Many find it especially helpful to read about the experiences of other bereaved parents and to know they are not alone.

Teddy Love Club 1800 824 240 The Teddy Love Club is a support program for bereaved families who have experienced loss through miscarriage, stillbirth, and termination of pregnancy for foetal abnormality or neonatal death. www.teddyloveclub.org.au

Small Miracles Foundation 1300 266 643 The Small Miracles Foundation provides Australia wide, free grief counselling services to families who have lost a baby. www.smfoundation.org.au

Heartfelt 1800 583 768 or Qld Representative Andrea Sproxton: 0423 132 601 A volunteer organization of professional photographers who provide photographic memories to families. All services are provided free of charge. www.heartfelt.org.au

SIDS and KIDS 1300 308 307 (24 hour) Bereavement support and counselling to families who have experienced stillbirth or the sudden and unexpected death of a child, regardless of the cause. www.sidsandkids.org

Centrelink (Family Assistance Office) 13 61 50 Centrelink provides financial assistance including maternity allowances and bereavement payments. www.centrelink.gov.au

If you have comments about the content of this parent information sheet email info@qcmb.org.au

Emilio Fernandez

From: Lowe.RogerA@police.qld.gov.au
Sent: Tuesday, 11 November 2014 10:41 AM
To: Yolande Yorke; Lingwood.MarkS@police.qld.gov.au
Cc: Heidi Carr
Subject: RE: Coroners and Stillbirths

Yolande

Thank you for your email. Mark and I have given considerations to the estimation of the QPS resources in reporting a still birth to the Coroner.

Background

Generally where a still birth may occur the cause of event is likely to be unexplained. Where a health condition may be known to be likely cause of the still birth, I anticipate these type of still births will not be reportable similar to the current process for a child death, where a Doctor may issue a cause of death certificate for apparent natural causes deaths.

The responsibility of a first response officer is to ascertain whether a doctor will issue a certificate, and where such a certificate is not forthcoming, prepare a report to the Coroner. Police report a death to the Coroner by way of a Form 1. A coroner may then issue directions to the Queensland Police Service to investigate the death.

Under section 794 of the Police Powers and Responsibilities Act 200, it is the duty of police to help Coroners in the performance of a function, including the investigation of deaths.

Initial reporting.

Where a still birth may occur in the community or at a hospital where the cause of the still birth is unexplained, it is anticipated police will be called to report the matter to the coroner, consistent with the current process for an unexplained child death.

Front line police will attend the event and gather sufficient information to prepare a Form 1 for the Coroner. This will involve interviewing the parents and any other witnesses at the scene, conversations which are normally recorded. This report is completed through the QPS QPRIME system and electronically submitted to the QPS Coronial Support Units. The form is then reviewed and electronically transferred to the relevant Coroner and Qld Health.

I estimate this process would take four hours for a front line police team (Usually two police = 8 hrs).

The officers may be assisted by a District Duty Officer who are on road supervisors who attend events to assist crews. DDOs would generally attend most deaths.

Forensic Police

Front line police for an unexplained child death will generally call forensic officers to attend to take photographs and conduct a forensic examination where appropriate. This preserves any evidence for the Coroner should pathology or investigations indicate any abuse or neglect. Officers are required under policy to make enquiries to establish whether the family (or child) are known to the Department of Communities, Child Safety and Disability Services.

I estimate this may take a minimum of 2 hours for the forensic examinations and subsequent recording of the QPS forensic register.

Specialist investigators

Under the QPS Operational Procedures Manual (Deaths of Children), all child reportable deaths are to be investigated by an officer of at least the rank of Detective Sergeant or a senior experienced investigator. Routinely officers from the Child Protection Investigation Unit are called to the scene to conduct specialist inquiries and examine the scene. The attendance and observations of the investigators is included in the initial report to the Coroner. Officers then assess the risk to any children remaining the care of the parents and will consult with the Regional Crime Coordinator.

I estimate a child protection investigation unit team (two officers) initial investigations would take a minimum of 4 hours but may be significantly greater should the matter require statements or further reporting. Full coronial investigations into a child death take approximately 6 months.

Conveyance.

Following the forensic and specialist investigator investigations at a scene, the front line officers will arrange for the attendance of the government contacted undertaker to collect the body. Officers remain at the scene until the attendance of the undertaker. In the Brisbane metropolitan area, bodies are received at the Qld Health Forensic and Scientific Services facility by Coronial Support Police.

In regional and remote areas, the attendance of a government undertaker can take a considerable time.

CSU review.

The Coronial Support Unit review of the Form 1, briefing to coroner and distribution would take an estimated one hour

Autopsy.

Where a Coroner may order an autopsy for an unexplained child death, generally Child Protection Unit investigators and forensic police attend the autopsy. This may take up to 8 hours each.

Regards

Roger

Roger Lowe
Acting Superintendent
Forensic Services Group
Operations Support Command, Queensland Police Service

Phone +61 7 33646564
Mobile NP_49-Sch4
Fax +61 7 33646042
Email Lowe.RogerA@police.qld.gov.au
Address Level 4 200 Roma Street, Brisbane, Queensland 4000, Australia
Postal GPO Box 1440, Brisbane, Queensland 4001, Australia

From: Yolande Yorke [mailto:Yolande.Yorke@justice.qld.gov.au]

Sent: Monday, 10 November 2014 5:05 PM
To: Lingwood.MarkS[OSC]; Lowe.RogerA[OSC]
Cc: Heidi Carr
Subject: Coroners and Stillbirths

Gentlemen,

NP_Sch3(2)(1)(b) I realise without time and any sophisticated modelling all I will receive is guestimates. You mentioned 3 levels of police resources in responding to an incident. How many hours in prep work is there before you refer a matter to the Coroner?

I think we really need to spell out all of the support work that goes into a matter before it gets to the Coroner.

I would appreciate it if you could provide me with something at your earliest.

Thanks

Emilio Fernandez

From: Robert Walker
Sent: Thursday, 13 November 2014 8:59 AM
To: Yolande Yorke
Cc: Magistrate RyanT; Magistrate Lock; Ainslie Kirkegaard; Heidi Carr
Subject: RE:

Hi Yolande,

After consideration by Terry, John and Ainslie, the OSC position NP_Sch3(2)(1)(b)

At the moment we investigate deaths of babies born where there may be an issue about the management of labour and/or delivery in late term babies, and where the baby survives for a few seconds or hours. We agreed in our submission there was a somewhat artificial distinction to exclude a case where the baby dies in utero in such a situation.

We do not investigate cases where babies die from natural causes (usually diagnosed during pregnancy and not unexpected) shortly after birth, for instance. Certificates issue for those cases. Potentially there will be clinical reviews and sometimes in-house hospital autopsies for those cases. Similarly, stillbirths in such situations should not fall within our jurisdiction.

We of course can commence an investigation to get to that point, ie it is natural causes and not health care related, as we do every day with other deaths via the form1a process.

Still births that are unexpected, unnatural or violent have the potential to cover the abortion scenario, as well as MVA, assaults, overdose by mother etc, all of which are potentially covered by the criminal law.

In addition where the stillbirth is due to an unknown but apparent natural cause, the appropriate investigation should be a clinical one, and if the parents consent a hospital autopsy could be performed, as can and does happen now. We should not be expanding our jurisdiction to include areas where there is already capacity.

Regards,

Robert

Robert Walker

Director
Office of the State Coroner
Phone (07) 324 74590
Mobile 0477 746 826

From: Yolande Yorke
Sent: Wednesday, 12 November 2014 9:26 AM
To: Magistrate RyanT; Robert Walker
Cc: Heidi Carr
Subject:

HI Terry/Robert,

NP_Sch3(2)(1)(b)

The AG has not seen these yet. I would appreciate your thoughts.

Y

CHIEF OF STAFF

Ref: 2118974

REQUEST FOR FURTHER ACTION
COMMUNITY CABINET MEETING FRASER COAST– 24 & 25 FEBRUARY 13

Date of Meeting: Sunday, 24 February 2013	Venue: Brolga Theatre, Foyer 5 Walker Street, Maryborough

Meeting with: Attorney-General / Chief of Staff / Director-General / Policy Advisor (Please circle)

FORMAL MEETING DETAILS

NP_Sch3(2)(1)(b)

ISSUES DISCUSSED

ISSUES:

t [redacted]

OUTCOMES/ACTIONS:

Some suggested removal prohibition & leave to coroner's discretion.

- AG will look at

DIVISION TO ACTION

☐ Director-General	☐ Justice Services
☐ Office of Fair and Safe Work Queensland	☐ Strategic Policy, Legal and Executive Services
☐ Youth Justice	☐ Office of Liquor, Gaming and Fair Trading
☐ Corporate Services	☐ Director of Public Prosecutions
☐ Crown Solicitor	☐ Legal Aid Queensland
☐ Public Trust Office	☐ Anti-Discrimination Commission
☐ Legal Services Commission	☐ Crime and Misconduct Commission
☐ Ombudsman	☐ Electoral Commission

ACTION REQUIRED

☐ Acknowledgement letter	☐ Response for Attorney-General's signature
☐ Other:	☐ Ministerial Briefing Note

Additional Information:

Maurice Blackburn
Lawyers
Since 1919

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Our Ref: SLA/njs
Your Ref:
Direct Tel: 07 5430 8718
Direct Fax: 07 5443 6711

15 September 2014

The Attorney-General
Mr Jarrod Bleijie MP
GPO Box 149
BRISBANE QLD 4001

By post and by email: attorney@ministerial.qld.gov.au

Dear Mr Bleijie,

I am writing in response to your undated letter (copy **enclosed**) concerning whether there should be changes to the law regarding the ability of the Coroner to investigate stillbirths, in appropriate circumstances.

We believe that there is a valid need for the laws to be reviewed, particularly given that we receive many new enquiries from distraught parents who have lost babies through medical care that could be regarded as being negligent.

I should be grateful if you would please provide me regarding the progress of your Department's review of these issues, the likely timescale for completion of that review and whether there will be opportunity for us to have further input.

Please let me know whether I can be of further assistance in your ongoing investigations.

Yours faithfully

Sarah Atkinson (Enquiries: Sherryl Godley - 07 5430 8718)
Principal
MAURICE BLACKBURN

Encl

SLY/3011962/BRS/8134360_1/Default

QUEENSLAND GOVERNMENT

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

In reply please quote: 554324/1 2331723
Your reference: SLA/njs

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Ms Sarah Atkinson
Principal
Maurice Blackburn Lawyers
PO Box 6381
MAROOCHYDORE BC QLD 4558

Dear Ms Atkinson

Thank you for your letter dated 10 September 2013 regarding the jurisdiction of the *Coroners Act 2003* to investigate stillbirths. I apologise for the delay in responding.

I also thank you for taking the time to write to me again about this issue and for the clear concern that you have shown to improve the current system for the investigation of deaths of stillborn babies to better meet the needs of Queensland families.

Given the complexity of the issues raised, it is important to ensure that the potential merits and impacts of such a proposal are thoroughly examined. This includes a full assessment of the adequacy of existing mechanisms to investigate and review stillbirths within the Queensland health system and how these might operate in conjunction with an expanded jurisdiction of coroners to investigate unexpected intrapartum deaths. There may also be alternative options that should be considered.

I have directed the Department of Justice and Attorney-General to conduct a comprehensive review of these matters taking into account your views and to report back to me as soon as possible.

Thank you again for bringing this matter to my attention and your kind offer of assistance. I will continue to keep you informed of my decisions based on the results of this investigation.

Yours sincerely

JARROD BLEIJIE MP
Attorney-General and Minister for Justice

Our Ref: SLA/njs
Your Ref:
Direct Tel: 07 5430 8712
Direct Fax: 07 5443 6711

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10 September 2013

The Attorney-General
Mr Jarrod Bleijie
GPO Box 149
BRISBANE QLD 4001

By post and e-mail: attorney@ministerial.qld.gov.au

Dear Mr Bleijie,

I refer to my letter to you dated 17 May 2013 and to your response dated 2 July 2013.

It is great news for Queensland families that you are considering whether there should be changes to the law regarding the ability of the Coroner to investigate stillbirths in appropriate circumstances.

I am writing to enquire how your investigations are proceeding and whether I can be of any assistance to you.

I have also been following the very sad story of Emma Green from Rockhampton. You may be aware that Emma delivered a stillborn baby in Rockhampton in May of this year and that questions have been raised about the standard of care that Emma received from the Rockhampton Base Hospital and whether the death of her baby, Waylan, could have been prevented. Dr Andrew Pesce was appointed by Queensland Health to investigate the situation and his seven recommendations were tabled in Parliament on 6 September 2013.

I raise this case as an example of a real situation to demonstrate the need for a Coroner to be able to investigate this type of death. The first comment I would make is that it is unusual in the situation of a stillbirth for an investigation of this type to be ordered and for the results to be tabled in Parliament. So most families in the situation of Emma Green do not even have the benefit of an investigation of this type.

However, I also question whether investigation by a Queensland doctor is appropriate and can be viewed as a reliable and independent way to investigate. It is also not a substitute for the family having their "day in court" which, whilst distressing and difficult, can also be cathartic for many families. I make these observations from my experience of dealing with many families who have lost babies to try to help demonstrate the need for stillbirths to be included in the category of deaths that may be investigated by the Coroner.

SLY/3011962/BRS/6254637_1/Default

Please let me know if I can be of any further assistance and I thank you once again for considering this issue.

Yours faithfully

Sarah Atkinson (Enquiries: Nicole Sweetman - 07 5430 8707)
Principal
MAURICE BLACKBURN

Our Ref: SLY/3004661
Your Ref:
Direct Tel: 07 5430 8707
Direct Fax: 07 3236 1966

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17 May 2013

The Attorney- General
Mr Jarrod Bleijie
GPO Box 149
BRISBANE QLD 4001

By post and e-mail: attorney@ministerial.qld.gov.au

Dear Mr Bleijie,

We commend you on your recent consideration of changes to the *Coroners Act 2003 (Qld)* with respect to the powers of coroner's in cases of stillbirth.

We are a firm who, among other areas, acts for Plaintiffs in medical negligence cases. As part of our medical negligence practice we are often consulted on issues relating to stillbirths.

The current Queensland *Coroners Act 2003* ("the Act") requires a coroner to investigate a death if that death is classified a 'reportable death' under the Act. Section 8 defines a 'reportable death' with s.8(3)(d) including a death that is a 'health care related death'.

Section 10AA states that a death is reportable under the 'health care related death' category if:

1. The health care caused or contributed to the death, or, a failure to provide health care caused or contributed to the death; and
2. The death was an unexpected outcome of the health care being provided.

However stillbirths are specifically excluded from the ambit of a Coroner's investigations by s.12(2)(c) which provides that a coroner *must* stop investigating a death if 'an autopsy of the body, ordered by the coroner, shows that the body is that of a stillborn child'.

A stillborn child is defined as one who:

1. Has shown no sign of respiration or heartbeat, or other sign of life, after completely leaving the mother's body; and
2. Is more than 20 weeks gestation or weighs more than 400 grams.

There are more than 2000 cases of stillborn children in Australia each year and the loss of a baby in these circumstances is tragic. While we recognise that some cases of stillbirth are unavoidable we also recognise that in some cases poor health care may have contributed to the death.

It appears to us to be a clear anomaly to exclude stillbirths from coronial investigations. In our experience coroners inquests in health care related deaths ensure that thorough and independent investigations of unexpected deaths occur in a public forum. We know that coroners' findings often drive changes in health care policies, procedures and standards. They lift levels of public safety and can prevent similar deaths in the future.

For these reasons we believe it is important that a change in the law occurs to allow coroners to investigate and, where appropriate, hold inquests into stillbirths that may have been contributed to by poor health care.

Yours faithfully

Sarah Atkinson (Enquiries: Nicole Sweetman - 07 5430 8707)
Senior Associate
MAURICE BLACKBURN

Emilio Fernandez

From: Jennifer Lang
Sent: Wednesday, 24 December 2014 11:42 AM
To: Julie Rylko
Cc: Heidi Carr
Subject: NP_Sch3(2)(1)(b)

Hi

Not sure if Yolande advised Fern who to circulate this to when it was sent up – can you check and if not, give her advice.

thanks

Jenny Lang
Assistant Director-General
Strategic Policy and Legal Services
Department of Justice and Attorney-General Ph 3898 0161 (81361)