Janice Chia

From: Attorney <Attorney@ministerial.qld.gov.au>
Sent: Wednesday, 11 September 2013 9:14 AM
To: Ministerial Correspondence Unit
Subject: FW: Coronial inquests for stillbirths
Attachments: MARECOPY_EXCHANGE_10092013-161304.pdf

Importance: Low

MCAR
Not sure if this is SPLES or Coroners
AG reply

Office of The Hon Jarrod Bleijie MP | Attorney-General and Minister for Justice
Email: attorney@ministerial.qld.gov.au | Phone: 07 3247 9068 | Fax: 07 3221 4352

From: Nicole Sweetman [mailto:NSweetman@mauriceblackburn.com.au]
Sent: Tuesday, 10 September 2013 4:24 PM
To: Attorney
Cc: Sarah Atkinson
Subject: Coronial inquests for stillbirths
Importance: Low

10 September 2013

Dear Mr Bleijie

Please find **attached** our letter to you dated 10 September 2013.

Kind regards,

Maurice Blackburn Lawyers Since 1919
"We fight for fair."

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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.

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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

SLY/3011962/BRS/6254637_1/Default

QUEENSLAND GOVERNMENT

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

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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

Attachment 3: Summary of reviews in Victoria, South Australia and Western Australia

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".

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

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.

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

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).

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.

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.

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)).

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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.

NP_R

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;

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- 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.

NP_R

Hon Lawrence Springborg MP
Minister for Health

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MI191128

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

QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

RECEIVED
9 AUG 2013
BY:

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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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

In reply please quote: 548628/1

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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.

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
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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

Queensland Government

Minister for Police and Community Safety

RECEIVED
29 JUL 2013
BY: .....

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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

SUBMISSIONS RECEIVED IN RESPONSE TO ISSUES PAPER—'Jurisdiction under the *Coroners Act 2003* to investigate stillbirths that occur during labour'

1. State Coroner, Mr Terry Ryan (8 August 2013)

2. The Honourable Lawrence Springborg MP, Minister for Health (13 August 2013)

3. The Honourable Jack Dempsey MP, Minister for Police and Community Safety (on behalf of the Queensland Police Service) (25 July 2013)

4. The Honourable Jack Dempsey MP, Minister for Police and Community Safety (on behalf of the Queensland Ambulance Service and Queensland Corrective Services) (22 July 2013)

5. The Honourable Campbell Newman MP, Premier of Queensland (21 August 2013)

QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

RECEIVED
9 AUG 2013
BY:.....

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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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.

[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

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

Queensland Government

In reply please quote: 548628/1

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Email attorney@ministerial.qld.gov.au

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

Hon Lawrence Springborg MP
Minister for Health

QUEENSLAND GOVERNMENT

MI191128

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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

Queensland Government

Minister for Police and Community Safety

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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

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

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)).

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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.

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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;

NP_R

- 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.

NP_R

Janice Chia

From: Attorney <Attorney@ministerial.qld.gov.au>
Sent: Monday, 15 September 2014 4:06 PM
To: ESB Allocations
Subject: FW: Coronial Inquests into stillbirths
Attachments: MARECOPY_LDAPMAIL_15092014-151135.pdf

MCAR
Normal – due 6/10
SPLS
AG reply

Thanks
Alayna

From: Nicole Sweetman [mailto:NSweetman@mauriceblackburn.com.au]
Sent: Monday, 15 September 2014 3:53 PM
To: Attorney
Subject: Coronial Inquests into stillbirths

15 September 2014

Dear Mr Bleijie

Please find **attached** copy of our letter to you dated 15 September 2014, the original of which is in this evening's post.

Kind regards,

Nicole Sweetman | Paralegal
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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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50 Ann Street Brisbane 4000
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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

Janice Chia

From: Thompson, Andrew (AGD) <Thompson.Andrew@agd.sa.gov.au>
Sent: Tuesday, 23 September 2014 9:32 AM
To: Heidi Carr
Subject: RE: Consideration of whether to amend Coroners Act 2003 to allow the coroner to investigate stillbirths

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Heidi

Yes I did. Sorry. I meant to email you. Apparently our AG has decided not to legislate. The relevant officer is Anna Markou. Her number is (08) 8207 2059. She can fill you in on the details if you give her a call.

Regards

Andrew

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Tuesday, 23 September 2014 8:56 AM
To: Thompson, Andrew (AGD)
Subject: RE: Consideration of whether to amend Coroners Act 2003 to allow the coroner to investigate stillbirths

Dear Andrew,

I just wanted to confirm that you received the below email, and whether yourself or another officer are able to provide an update on whether South Australia has implemented, or will be implementing, the South Australian Legislative Review Committee's recommendation to allow for a coronial inquest into stillbirths.

Please also advise whether I should redirect my request to another officer, if this would be more suitable.

Kind regards,

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

From: Heidi Carr
Sent: Tuesday, 16 September 2014 11:21 AM
To: 'thompson.andrew@agd.sa.gov.au'
Subject: Consideration of whether to amend Coroners Act 2003 to allow the coroner to investigate stillbirths

Dear Andrew,

I am the officer within the Strategic Policy and Legal Services division of the Department of Justice and Attorney-General (QLD) who is currently considering whether to amend the *Coroners Act 2003* (QLD) to give coroners the jurisdiction to investigate stillbirths.

I note that the South Australian Legislative Review Committee conducted an inquiry into current mechanisms for the investigation of stillbirths and whether and in what circumstances the Coroner should be given jurisdiction to

investigate. I also note recommendation 6 of that report recommends the Attorney-General take steps to amend section 21(1)(b) of the *Coroners Act 2003* (SA) to allow for a coronial inquest into stillbirths of an unexpected, unnatural, unusual, violent or unknown cause.

In light of this, I would to know whether yourself, or another officer, would be able to provide an update as to whether the SA AGD has commenced implementation of this recommendation so that I understand the current position in SA?

Kind regards,

Heidi Carr
Policy Advisor
Strategic Policy
Department of Justice and Attorney-General
Ph: 3239 6878

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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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

Janice Chia

From: Yolande Yorke
Sent: Wednesday, 5 November 2014 8:26 AM
To: Heidi Carr
Subject: Fwd: JAG-#2662382-v13-NP_Sch3(2)(1)(b)

Attachments: osc-guidelines-chapter3-3-investigations2012.pdf; ATT00001.htm

Sent from my iPhone

Begin forwarded message:

Yolande

It appears to accurately reflect the points we have made about the considerations relevant to the Government's determination of whether to give coroners jurisdiction to investigate intra partum deaths.

The only additional comment I would make is that the question as to whether death is reportable or not, and therefore has to be investigated, should not be contingent on a request being received from the child's parents.

No other category of deaths requires a family member to consent to the coroner's jurisdiction. For example, neonatal deaths can currently be investigated as health care related deaths as set out in the attached extract from the State Coroners Guidelines, without the need for parental consent. There are situations where parents may prefer not to proceed with a coronial investigation but there are competing public interests in examining the circumstances of the death. There are also likely to be cases where the parents of the child disagree between themselves about whether an investigation should take place. Parents whose own conduct may have influenced the outcomes of the delivery such as parents who refuse timely medical intervention are also unlikely to want to have a coronial investigation.

The guidelines will need to be amended if Government decides to amend the Act. However, the framework for the investigation of still-births should align with that in place for other deaths, including neonatal deaths.

The wishes of the family are a relevant consideration in determining the extent of the investigation (e.g. whether an autopsy should be performed) and in particular whether a matter will proceed to inquest.

In my view, should the Government wish to proceed with the extension of the jurisdiction it could be achieved by amending s96 of the Act to extend its application to a child who has reached 28 weeks or more gestation and who death occurred during confirmed labour. Based on Professor Humphrey's analysis this would potentially bring another 8-10 stillbirths within the scope of the Coroners Act.

NP_Sch3(2)(1)(b)

Regards

Terry Ryan
State Coroner
Ph: 38980360
Mob: NP_49-Sch4

From: Yolande Yorke
Sent: Monday, 3 November 2014 2:47 PM
To: Magistrate RyanT
Cc: Robert Walker
Subject: JAG-#2662382-v13

Hello Terry and Robert,

Please provide your comments at your earliest convenience.

Yolande Yorke
Director, Strategic Policy
Ph. 3239 7651

Janice Chia

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: Flagged

From: Robert Walker
Sent: Friday, 7 November 2014 10:03 AM
To: Yolande Yorke
Cc: Magistrate RyanT
Subject: RE: NP_Sch3(2)(1)(b)

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
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Email: imelda.bradley@justice.qld.gov.au

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NP_R

Janice Chia

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
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Fax +61 7 33646042
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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

Janice Chia

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 is as follows:

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.

NP_Sch3(2)(1)(b)

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