Robert Walker

From: Heidi Carr
Sent: Wednesday, 10 December 2014 3:39 PM
To: Robert Walker
Subject: QMPQC view - gestational period at which stillbirths warrant clinical review

Hi Robert,

I just wanted to let you know that Professor Humphrey has provided me with the following information with respect to my query. Thank you very much for your efforts in trying to locate OSC's notes.

Kind regards,
Heidi

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

From: QMPQC [mailto:QMPQC@health.qld.gov.au]
Sent: Wednesday, 10 December 2014 2:54 PM
To: Heidi Carr
Subject: FW: Statistics with respect to intrapartum stillbirths

Hello Heidi – please see the response below from Prof Michael Humphrey.

Kind regards

Andrea

Dear Heidi

The Queensland Maternal and Perinatal Quality Council discussed your question at its 9 December 2014 meeting.

The Council believes that the most appropriate form of review for stillbirths is multi-disciplinary clinical review, with special attention being paid to normally formed mature babies who died during labour/birth. It is the Council's view that this latter group (babies of 37 weeks gestation or more [and that could reasonably be extended back to 28 weeks or more] without congenital malformation should die quite infrequently in the labour/birth process, and should be examined by a Root Cause Analysis or some other formal form of process review.

If the Coronial Law is to be changed to encompass stillbirths the Council would suggest that it would be quite inappropriate to examine all of the 450-500 stillbirths per year in Queensland. It is reasonable to say that most unexpected stillbirths are in the group of babies of 37 weeks gestation or more without congenital malformation that die during the birth process

Cheers
Michael Humphrey

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Tuesday, 25 November 2014 11:24 AM
To: QMPQC
Subject: RE: Statistics with respect to intrapartum stillbirths

Thank you Andrea.

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

From: QMPQC [mailto:QMPQC@health.qld.gov.au]
Sent: Tuesday, 25 November 2014 11:16 AM
To: Heidi Carr
Subject: RE: Statistics with respect to intrapartum stillbirths

Hey Heidi – thanks for your email. I have just forwarded it on to Prof Humphrey for his consideration and response. Stay tuned.

Regards

Andrea
Andrea Chitakis
Secretariat
Qld Maternal and Perinatal Quality Council
Clinical Access and Redesign Unit | Health Systems Innovation Branch | Health Services and Clinical Innovation Division
Department of Health | Queensland Government
Level 2, 15 Butterfield Street Bldg, HERSTON QLD 4029
t. 07 33289364
e. QMPQC@health.qld.gov.au | www.health.qld.gov.au
<image001.gif> <image002.gif> <image003.gif>
<image004.jpg>

From: Heidi Carr [mailto:Heidi.Carr@justice.qld.gov.au]
Sent: Tuesday, 25 November 2014 11:14 AM
To: QMPQC
Subject: RE: Statistics with respect to intrapartum stillbirths

Hi Andrea,

I hope you are well.

As you may recall, I have been considering possible amendments to the *Coroners Act 2003* regarding the investigation of stillbirths. In correspondence from the Office of the State Coroner a reference is made to advice from Professor Humphrey that in his view 'only those intrapartum stillbirths where the foetus has reached 28 weeks or more gestation warrant independent review'. I have been asked to ascertain the rationale for Professor Humphrey's view. Are you able to facilitate this?

Thanks very much,
Heidi

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

Robert Walker

From: Heidi Carr
Sent: Tuesday, 9 December 2014 10:56 AM
To: Robert Walker
Subject: RE: NP_Sch3(2)(1)(b)

Thanks Robert – much appreciated.

Heidi

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

From: Robert Walker
Sent: Tuesday, 9 December 2014 10:53 AM
To: Heidi Carr
Subject: RE:

Hi Heidi,

We're looking for any notes that might exist of the meeting Professor Humphrey refers to. The Deputy State Coroner and Ainslie recall the meeting, although recollections of the detail have faded with time. I'll get back to you as soon as I have news of any notes.

Regards,

Robert

From: Heidi Carr
Sent: Tuesday, 9 December 2014 10:37 AM
To: Robert Walker
Subject: RE:

Hi Robert,

I'm just following-up on how you are progressing with the below query.

Kind regards,
Heidi

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

From: Robert Walker
Sent: Tuesday, 25 November 2014 1:21 PM

To: Heidi Carr
Subject: RE: NP_Sch3(2)(1)(b)

Hi Heidi,

I'm looking into it and will get back to you as soon as I can. Terry and Ainslie are both away from the office for a couple of days, so I won't be able to get back to you immediately.

Regards,

Robert

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

From: Heidi Carr
Sent: Tuesday, 25 November 2014 12:37 PM
To: Robert Walker
Subject:

Hi Robert,

I am attempting to ascertain the rationale for Professor Michael Humphrey's view that 'only those intrapartum stillbirths where the foetus has reached 28 weeks or more gestation warrant independent review' and Professor Humphrey cannot recall having provided this information - at least not formally. Professor Humphrey recalls a meeting around 18 months ago, but is unsure whether he provided this view at that time.

Are you able to advise when/where Professor Humphrey expressed this view to the Office of the State Coroner (OSC) and perhaps the OSC's understanding of the basis for this view.

Kind regards,
Heidi

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

Robert Walker

From: Robert Walker
Sent: Friday, 5 December 2014 3:37 PM
To: Ron McDonald
Subject: FW: 20141205_Media_Response_OSC_stillbirth
Attachments: 20141205_Media_Response_OSC_stillbirth.doc

Hi Ron,

Terry has drafted the attached and would like it to go out.

Regards,

Robert

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

From: Magistrate RyanT
Sent: Friday, 5 December 2014 3:34 PM
To: Robert Walker
Subject: 20141205_Media_Response_OSC_stillbirth

Robert

As discussed,

Terry

Draft media response **Doc ref:**

Inquiry received:	5 December 2014
Journalist:	Kay Dibben
Organisation:	Sunday Mail
Deadline:	5pm, 3 December
Subject:	Opinion on stillbirths
Inquiry:	I am a journalist for The Courier-Mail Newspaper researching an article on a proposal to extend the jurisdiction of the State Coroner to enable reportable deaths that involve stillborn babies to be subject to an inquest. This proposal is currently being considered by the Queensland Attorney-General, who says he will seek the views of the state's coroners. The Courier-Mail has been looking at this issue and has conducted interviews with those advocating for this change, along with legal and medical experts. I was hoping to talk to you about this issue over the phone if possible, after which you could decide whether you wish to provide comment for the story. While I would prefer to speak to you about this, if this is not possible, my specific questions that will be sent to all of the state's coroners are: 1. Would you support a change to legislation to allow the option of an inquest into stillbirths (perinatal deaths where the baby is born without sign of life) in circumstances that would ordinarily be classified as a reportable death and why/why not? 2. What is your view of calls to expand the jurisdiction of coroner's to enable a potential inquest into a stillbirth? 3. Have you provided feedback to the Attorney-General's office on this issue as yet, and if so, what was the nature of this feedback?
Category:	4

The following can be attributed to a spokesperson for the Office of the State Coroner:

"The State Coroner has provided feedback to the Attorney-General as requested.

The response outlined a range of issues associated with extending the jurisdiction of coroners, including the potential difficulty in defining what constitutes a still birth and the need for coroners to have access to suitable specialist expertise in this field.

The response acknowledged that it was a matter for the Government to decide whether the Coroners Act should be changed to enable of coroners to investigate these deaths.

If the Act is changed coroners will investigate stillbirths in the same way that other reportable deaths are investigated."

Ends

Robert Walker

From: Ron McDonald
Sent: Friday, 5 December 2014 3:07 PM
To: Robert Walker
Subject: Coroner response to Kay Dibben
Attachments: 20141205_Media_Response_OSC_stillbirth.doc

Hi Robert

As discussed, here is the proposed response.

Regards

Ron

Ron McDonald
Principal Media Officer
Communication Services Branch
Department of Justice and Attorney-General Level 15, State Law Building, 50 Ann St Brisbane
3247 4436

Draft media response **Doc ref:**

Inquiry received:	5 December 2014
Journalist:	Kay Dibben
Organisation:	Sunday Mail
Deadline:	5pm, 3 December
Subject:	Opinion on stillbirths
Inquiry:	I am a journalist for The Courier-Mail Newspaper researching an article on a proposal to extend the jurisdiction of the State Coroner to enable reportable deaths that involve stillborn babies to be subject to an inquest. This proposal is currently being considered by the Queensland Attorney-General, who says he will seek the views of the state's coroners. The Courier-Mail has been looking at this issue and has conducted interviews with those advocating for this change, along with legal and medical experts. I was hoping to talk to you about this issue over the phone if possible, after which you could decide whether you wish to provide comment for the story. While I would prefer to speak to you about this, if this is not possible, my specific questions that will be sent to all of the state's coroners are: 1. Would you support a change to legislation to allow the option of an inquest into stillbirths (perinatal deaths where the baby is born without sign of life) in circumstances that would ordinarily be classified as a reportable death and why/why not? 2. What is your view of calls to expand the jurisdiction of coroner's to enable a potential inquest into a stillbirth? 3. Have you provided feedback to the Attorney-General's office on this issue as yet, and if so, what was the nature of this feedback?
Category:	4

The following can be attributed to a spokesperson for the Office of the State Coroner:

"The State Coroner has provided feedback to the Attorney-General as requested.

"It would be inappropriate for this office to discuss the content while the matter is being considered by the Attorney-General."

Ends

Robert Walker

From: Ainslie Kirkegaard
Sent: Friday, 12 September 2014 9:49 AM
To: Magistrate RyanT; Robert Walker
Subject: RE: Stillbirths

I suggest John as he has accrued a lot of neonatal death inquest experience in recent years, so is well across the issues.

Ainslie Kirkegaard
Registrar
Office of the State Coroner (Qld)
Department of Justice and Attorney-General
Ph: 310 99698
Fax: 3239 0176

-----Original Message-----
From: Magistrate RyanT
Sent: Thursday, 11 September 2014 5:45 PM
To: Ainslie Kirkegaard; Robert Walker
Subject: RE: Stillbirths

It looks like there are new policy officers working on it so it may be useful to meet - I expect the outcome will be politically driven.

I am in Maryborough until Wednesday. John or Chris should be involved as they deal with these types of matters a lot more than I do.

-----Original Message-----
From: Ainslie Kirkegaard
Sent: Thursday, 11 September 2014 3:17 PM
To: Robert Walker; Magistrate RyanT
Subject: RE: Stillbirths

Happy to be guided by you Terry - I feel we have already said all there is to say about our position several times now.

Ainslie Kirkegaard
Registrar
Office of the State Coroner (Qld)
Department of Justice and Attorney-General
Ph: 310 99698
Fax: 3239 0176

-----Original Message-----
From: Robert Walker
Sent: Thursday, 11 September 2014 3:10 PM

To: Magistrate RyanT; Ainslie Kirkegaard
Subject: RE: Stillbirths

Hi Terry and Ainslie,

NP_Sch3(2)(1)(b) SPLES like to meet with us next week to go over our position. Heidi, Yolanda Yorke and possibly Jenny Lang will attend.

Would you both like to come along and should anyone else from OSC be there?

Regards,

Robert

-----Original Message-----
From: Magistrate RyanT
Sent: Thursday, 11 September 2014 2:53 PM
To: Robert Walker; Ainslie Kirkegaard
Subject: RE: Stillbirths

Thanks - we should at least be given an opportunity to provide input on the budgetary impact for OSC.

-----Original Message-----
From: Robert Walker
Sent: Thursday, 11 September 2014 2:43 PM
To: Magistrate RyanT; Ainslie Kirkegaard
Subject: Stillbirths

Hi Terry and Ainslie,

I drew Heidi's attention to the detailed letter to the AG of 13 August 2013 setting out the collective views of the coroners that jurisdiction not be expanded in this area and asked her to take account of those views in formulating the policy paper. Heidi was grateful for this being drawn to her attention.

Heidi said she'd find out and get back to me.

Regards,

Robert

Robert Walker

From: Magistrate RyanT
Sent: Wednesday, 12 November 2014 4:35 PM
To: Magistrate Lock; Robert Walker
Cc: Ainslie Kirkegaard
Subject: RE:

Thanks

NP_Sch3(2)(1)(b)

Terry

Sent from my Windows Phone

From: Magistrate Lock
Sent: 12/11/2014 17:23
To: Robert Walker; Magistrate RyanT
Cc: Ainslie Kirkegaard
Subject: RE:

Ainslie and I have looked at this and we were of the same mind and are in agreement. I think there is a fundamental misunderstanding about our jurisdiction.

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.

So 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.

NP_Sch3(2)(1)(b)

Regards

John Lock
Deputy State Coroner
GPO Box 1649 Brisbane Q. 4001
Tel: 07 30064504 (61504 speed dial)
Mob: 0429990767
Fax:07 31099659

From: Robert Walker
Sent: Wednesday, 12 November 2014 11:44 AM
To: Magistrate Lock
Subject: FW:

Hi John,

Terry asked me to get your views on the below

Regards,

Robert

From: Magistrate RyanT
Sent: Wednesday, 12 November 2014 10:17 AM
To: Robert Walker
Subject: FW:

Robert

Would you pls run this past John Lock.

Thanks

Terry

Sent from my Windows Phone

From: Yolande Yorke
Sent: 12/11/2014 10:25
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

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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However, my colleagues and I anticipate the proposal would generate a higher number of 'apparent intrapartum stillbirths' as experience with the current category of health care related deaths has shown an increasing tendency by the health sector to report out of an abundance of caution where it is not immediately clear whether the death in fact meets the reporting criteria. Clinicians should never be discouraged from seeking advice about their coronial reporting obligations. However, we envisage additional reporting of intrapartum stillbirths due to the inevitable 'grey area' issues about whether labour had commenced and accuracy of the 'ageing' of the foetus. These are not issues that can be resolved without a full investigation informed by obstetric expertise.

While an additional 10 or more investigations per annum may seem inconsequential when compared to the total number of deaths reported to coroners each year (4992 deaths were reported State wide in 2012-2013), it is important to understand the extent of investigation required for these clinically complex cases.

Apparently intrapartum stillbirths will generally require a full internal autopsy with brain and/or other organ retention and examination of the placenta in order to investigate the cause, as is required for sudden unexplained death in infancy cases. These investigations will involve extensive investigations (toxicology, microbiology, radiology, neuropathology, vitreous chemistry and metabolic screening) and due to increasing pressure on limited neuropathology expertise available to the coronial system, would take at least 12 months or more before the pathologist could provide a final autopsy report.

The coroner's investigation would need to be informed by statements from members of the obstetric team about the mother's antenatal care and the management of her labour and delivery, the outcomes of any root cause analysis or other clinical incident review undertaken in respect of the events leading to the stillbirth and the outcomes of any related investigation undertaken by another health regulatory agency (for example, the proposed Health Ombudsman or AHPRA).

As the coroner does not have access to the obstetric expertise necessary to properly examine these cases, the coroner would need to engage an independent specialist to review the investigation material and provide an opinion about whether the stillbirth could have been prevented. This may in turn lead to other interested parties engaging their own experts to respond to any criticisms made by the coroner's expert. This information gathering process would then inform the coroner's decision as to whether it is in the public interest for an inquest to be held.

Every apparently reportable intrapartum stillbirth would generate additional cost to the coronial system comprising:

- police attendance at the birthplace, generally with Scenes of Crime and Criminal Investigation Branch involvement to rule out suspicious circumstances. Attending police take witness statements, seize

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

Not every intrapartum death reported to a coroner will proceed to coronial autopsy. This is because, consistent with current coronial case law, unless there are suspicious circumstances, a coroner will generally not override a family's strong objections to autopsy, particularly when the family is content to accept a 'cause of death undetermined'. In practice, this would mean the coroner's investigation of an intrapartum stillbirth may well be no better informed than the current perinatal mortality committee reviews.

We respectfully question the issues paper's assumption that "a more detailed explanation of what caused the stillbirth may reduce distress and provide families of the stillborn child with closure". In our collective experience, and having regard to feedback from the coronial counsellors, the 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 the shock and disbelief of the death, when their ability to retain and process complex information may be severely compromised.

The length of these complex investigations (often up to 24 months or more) can also exacerbate a grieving family's distress, though there are equally many families who are grateful for some, even if not all answers to how the death may have occurred.

Access to specialist obstetric expertise

Coroners currently have access to clinical advice from the forensic medicine officers employed by the Queensland Health Clinical Forensic Medicine Unit. These are general practitioners with specialist forensic medicine qualifications. They do not have the necessary expertise to critique complex obstetric cases. Consequently, coroners engage independent obstetricians, neonatologists and paediatricians to review complex obstetric and neonatal deaths. This external expertise would be required to inform any coronial investigation of an intrapartum stillbirth.

For this reason, we feel a coronial investigation would unnecessarily duplicate the work of a body such as the QMPQC, which comprises an appropriately mixed skill-base to independently examine these complex cases.

Issues of timeliness and duplication of existing specialist review processes

Given the complexity of stillbirth cases, my colleagues and I feel a coronial investigation would largely duplicate and/or rely on the outcomes of existing clinical review processes (root cause analysis, HEAPS analysis, QMPQC) and independent health regulatory investigation processes (proposed Health Ombudsman and AHPRA).

In our experience, independent specialist clinical review can be progressed much more swiftly than a coronial investigation and is well-placed to identify systemic issues. We suggest it would be appropriate to consider amending

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

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.

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.

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.

Jason Schubert

From: Ainslie Kirkegaard
Sent: Tuesday, 9 July 2013 12:50 PM
To: Terry Ryan
Cc: Brigita White
Subject: AG request for State Coroner response to proposal to expand stillbirth jurisdiction

Attachments: 20130709120906825.pdf; Stillbirths info as requested

Hi Terry.

As flagged last Friday, Michael received the attached letter from the AG seeking a State Coroner response to the proposals outlined in the issues paper. Michael did not have an opportunity to respond and nor has there been any consultation/discussion about the issue with the other coroners to date. The response date is 26 July.

20130709120906825.pdf (463 KB)...

About a month ago, Michael Brigita and I met with QH DDG Michael Cleary and other QH personnel including an obstetrician (Dr Kimble) who sits on the Qld Maternal and Perinatal Quality Council (QMPQC). QH had sought the meeting in anticipation of the Health Minister and AG seeking advice about possible options to respond to the representations of NP_49-Sch4 and the QH response to the recent stillbirth incident at Rockhampton Hospital. It was a fairly loose discussion of possible options and impacts, with the outcome being commitment to develop an issues paper. We opted out of this process considering SP was more appropriately placed in that process.

The limitations of the coroner's current stillbirth jurisdiction are explained in State Coroner Guideline 3.3.1 (Stillbirths)

Very briefly, the range of issues we need to consider include:

- the fundamental shift in recognising a child not born alive as a 'death'
- what some perceive as the artificiality of coroners being able to investigate the death of a baby they manage to resuscitate after intrapartum difficulties and not the stillbirth of those who cannot be resuscitated even though the same difficulties occurred during labour and delivery
- potential volume of reportable stillbirths - I've attached emails explaining to Michael the numbers that may become reportable depending on the scope of the stillbirth expansion - this data comes from the QMPQC via the Chair,

Stillbirths info as requested

Michael Humphrey (they are confidential at this stage).
- access to specialist paediatric forensic pathologist expertise - two of our Brisbane pathologists (Nathan Milne and Rebecca Williams) are developing their paediatric expertise, but the real specialist FP expertise in this field lies in Diane Paton and her colleagues at the RBWH and their counterparts at the Mater
- Dr Kimble made the point that in up to 20% or more cases (Brigita, correct me if I'm wrong), even after autopsy, the cause of the stillbirth is not determined
- coroners' willingness to override family objections to autopsy - the current rate of consented stillbirth autopsies suggests we can expect many families to object to autopsy in these cases - the authorities are clear that in the absence of suspicious circumstances or any forensic need, then coroners should not override family objections, so there is an issue about how far the coronial process can take these matters in these circumstances
- access to appropriate clinical expertise - CFMU simply do not have the specialist clinical expertise to review these matters for us - to investigate them properly, we would need to engage independent experts either from Queensland or interstate. Michael Humphrey and his colleagues have previously offered their expertise on a case by case basis, but this is an added expense for us.

NP_Sch3(2)(1)(b)

- unnecessary duplication of internal clinical incident review processes (HEAPS analysis and RCA) and the work of the QMPQC - I tend to agree with the Victorian and WA review outcomes in this regard.
- unnecessary duplication of the health investigation jurisdiction of HQCC/AHPRA/the proposed Health Ombudsman

I suggest you distribute the issues paper to the coroners for their comments, with or without any suggestions to them about the issues they might to consider when responding. You could also put it on the agenda for our next monthly coroners meeting.

It's also important to seek some formal feedback from QHFSS via Charles and CFMU via Dr Adam Griffin.

I'm happy to draft a response for you in due course if that would help.

AK

Ainslie Kirkegaard
Registrar
Office of the State Coroner
Department of Justice and Attorney-General
Ph: 310 99698
Fax: 3239 0176

Jason Schubert

From: Ainslie Kirkegaard
Sent: Monday, 20 May 2013 3:26 PM
To: Michael Barnes
Subject: Stillbirths info as requested
Sensitivity: Confidential
Attachments: Stillbirth data; Inquiry into Stillbirths[1].pdf

Here you go.

The SA Parliamentary Inquiry recommendation was to amend their Coroners Act to allow investigation of "*stillbirths of unexpected, unnatural, unusual, violent or unknown cause*" - a nice concrete concept...

From: Ainslie Kirkegaard
Sent: Friday, 8 March 2013 2:23 PM
To: Michael Barnes
Subject: RE: Extended Coronial jurisdiction
Sensitivity: Confidential

NP_49-Sch4

The data came from a confidential draft of the 2013 QMPQC report - it is <u>all</u> stillbirths per annum, irrespective of cause - antepartum or peripartum - my initial email attached.

The stillbirth data does not drill down to the gestational age of the foetus but it does categorise by cause eg only 1.5% were known hypoxic peripartum deaths (n= 19 over 2009-2011) but I would need some expert guidance from Prof Humphrey about the extent to which the other listed causes might coincide with gestational cut off of 37 weeks. You would have to expect there would be some within the categories of perinatal infection, hypertension, maternal conditions, specific perinatal conditions etc.

From: Michael Barnes
Sent: Friday, March 08, 2013 12:14 PM
To: Ainslie Kirkegaard
Subject: FW: Extended Coronial jurisdiction
Sensitivity: Confidential

did I ask you to explain how we arrived at our estimate of the numbers? if not, can you tell me anyway?

m

Michael Barnes
State Coroner
Queensland
GPO Box 1649, Brisbane, Q. 4001
07 38980360
0418 721 930

NP_73(2)

Sent: Monday, 4 March 2013 10:10 PM
To: Michael Barnes
Subject: RE: Extended Coronial jurisdiction
Sensitivity: Confidential

NP_73(2)

NP_R

NP_73(2)

****

Please think about the environment before you print this message.

****

3 3 14

Stillbirths

Discretion to investigate stillbirths

Gestation period?

In Labor? Why? alot happen before.

May not address the catalyst case in question

Policy & resourcing implications.

* about 300 per annum.
150 already investigated

With stringent criteria.
eg. concerned with labor & delivery.
or
Certain # of weeks gestation.
30 weeks??

Resources required before discretion imposed.

20% - 40% remain unexplained.

Are we designing system for a very small cohort - handful of controversial cases

Could Coroner oversee present system or
Is ~~does~~ Health Ombudsman better situated

$4,000 costs passed onto parents.

SP-7 Tack further to Prof Humphreys.

Health Minister - "No significant benefits"
- suggests QPMOC ~~public~~ findings!

* Coronial system would not publish either (except inquests) Could not even de-identify - too small a pool

Natalie will brief Premiers Dept.

Jason Schubert

From: Ainslie Kirkegaard
Sent: Thursday, 21 February 2013 12:22 PM
To: Brigita White
Cc: Michael Barnes
Subject: Stillbirth data

Hi Brigita.

Prof Humphrey has very kindly given me the following (surprisingly high) stillbirth data from the yet-to-be-completed QMPQC report for 2009-2011:

- Total no. stillbirths per annum in Qld - 400 in 2011 (down from 447 in 2009 and 413 in 2010)
- principal causes of stillbirths were unexplained antepartum death (30.6%) and congenital abnormality (25%)
- other causes quantified include perinantal infection (2.9%), hypertension (2.8%), antepartum haemorrhage (6%), maternal conditions (1.7%), specific perinatal conditions (8.3%), hypoxic peripartum deaths (1.5%), fetal growth restriction (4.8%), spontaneous pre-term (13.9%) and no obstetric antecedent (2.6%)
- there continue to be low autopsy rates for stillbirths (36.9% in 2011)

One has to question how easy it would be in practice to single out those stillbirths that fall neatly within the SA Inquiry recommendation of "*stillbirths of unexpected, unnatural, unusual, violent or unknown cause*" for coronial investigation - in my view, issues like access to and quality of antenatal and obstetric care could easily feature in the management of pregnancies which fail because of most of the causes identified above.

Let me know if you need anything further.
AK

Ainslie Kirkegaard
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