Purpose

To provide Primary Health Care remote staff with a guideline on the management and processes to follow when a death occurs in a remote health centre that is considered to be a reportable death under the NT Coroners Act.

Guideline

1. General Information

Note: this item refers to reportable deaths only. See Deaths - Overview for information on the routine processes around managing deaths that are not reportable.

Department of Health staff do not have any legal responsibility for:

- managing the body of the deceased person that is declared reportable
- managing grieving relatives in relation to a reportable death
- advising relatives on matters relating to an inquest and possible autopsy
- contacting senior next of kin in relation to the identity of the deceased
- any other matter relating to the timing, place and manner of death, or providing information to next of kin or relatives on when the body of the deceased will be available for burial.

Whilst it is correct that Departmental staff have no legal responsibility to manage the body of a deceased person, Police may request Primary Health Care (PHC) staff assistance with the short term storage of the body until retrieval can be organised. Any assistance to Police is therefore offered in good will, and where provided, this will often allow a gracious attitude to be shown to grieving families and the community. Where relevant, PHC staff are to inform family members that it is a Police request that the body is stored at the health centre.

Reportable deaths in the Northern Territory are within the jurisdiction of the Coroner. The functions of the Coroner are to; ensure that the coronial system in the Territory is administered and operates efficiently; oversee and co-ordinate coronial services in the Territory; and ensure that an inquest into a death is held where there is a duty to do so under the NT Coroners Act, or where it is desirable that an inquest be held.
Information in this document includes:
- Reporting a Reportable Death
- Notifying Next of Kin
- Life Extinct Form
- Managing a Body
- Transportation of Body
- Coroner's Power to Investigate
- Providing Statements to Police
- Providing Information / Advice to the Family of the Deceased
- Post-Mortem
- Cultural Issues
- Health Centre Opening Hours following a Death in the Community
- Health Record Documentation

2. Definitions

The following definitions are taken from the **NT Coroners Act**

**Reportable Death** Section 12 (1): a death where:

(i) the body of a deceased person is in the Territory; or
(ii) the death occurred in the Territory; or
(iii) the cause of the death occurred in the Territory.

being a death:

(i) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
(ii) that occurred during an anaesthetic; or
(iii) that occurred as a result of an anaesthetic and is not due to natural causes; or
(iv) of a person who, immediately before death, was a person held in care or custody; or
(v) that was caused or contributed to by injuries sustained while the person was held in custody; or
(vi) of a person whose identity is unknown; or
(vii) of a person who ordinarily resided in the Territory at the time of death that occurred at a place outside the Territory where the cause of death is not certified by a person who, under a law in force in the place, is a legally qualified Medical Practitioner

Additionally under Section 12 (3), a Medical Practitioner who is present at or after the death of a person, must report the death as soon as possible to a coroner if:

(a) the death is a reportable death; or
(b) the Medical Practitioner does not view the body of the deceased person; or
(c) the Medical Practitioner is unable to determine the cause of death.

**Senior Next of Kin** **Coroners Act** Definitions: in relation to the deceased person means:

(a) where a person was, immediately before death, married - the person's spouse ("spouse" includes a person's de facto partner), or
(b) where the person was not married or, if married, the spouse is not available – the person's son or daughter of over 18 years, or
(c) where a spouse, son or daughter is not available – the person's parent, or
(d) where a spouse, son, daughter or parent is not available – the person's brother or sister of or over 18 years, or
(e) where a person is an Aborigine – a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person, or

(f) where (a) and (e) do not apply or a person who would be the senior next of kin is not available – a person who immediately before the death of the deceased person had a relationship with the deceased person that, in the opinion of the coroner, is sufficient for the purpose of being the senior next of kin.

3. Responsibilities

3.1 Primary Health Care Staff

- Report all deaths to the relevant Medical Practitioner as soon as possible
- Complete a Life Extinct Form when appropriate
- Notify the Manager On-Call as soon as possible (not applicable if an expected death)
- In consultation with the relevant Manager, notify Legal Services Branch of any reportable death that occurs in relation to provision of health services
- Confirm with the Medical Practitioner that they will report the death to the Police

3.2 Medical Practitioner - RMP or Community-based General Practitioner (GP)

- Be familiar with the definition for a reportable death under the Act, including when a Medical Practitioner is present at or after the death of a person
- Notify the Police of a reportable death

3.3 Manager / Manager On-Call

- Ensure staff are aware of procedures for a reportable death as detailed in this document
- Support and monitor staff response or recovery and initiate and support interventions as required. Also see Critical Incident Follow-Up PHC Remote CAHS Guideline which provides guidelines for follow-up required following a critical incident / event.
- Consult with DoH Legal Services as appropriate and required

3.4 Police

- Removal of the body from the community
- Make request to PHC staff regarding the handling and storage of bodies until collection can be arranged, if assistance is required

3.5 Legal Services Branch

- Provide legal advice to PHC staff

4. Procedure

4.1 Reporting a Reportable Death

Primary Health Care expects the Medical Practitioner to advise Police of a reportable death, and as such it is not expected that Nurses or Aboriginal and Torres Strait islander Health practitioners (ATSIHPs) will have to do so. However, although it is usual for a Medical Practitioner to notify the Coroner of a reportable death, any person, including PHC employees, are legally required under the NT Coroners Act to report a death if they believe the Coroner may not have been informed. Failure to do so may attract a penalty. Therefore it is important for staff to confirm the Medical Practitioner will report the death to the Police.

Staff should also advise the Manager On-Call of any reportable deaths as soon as possible. Consideration should be given to whether an incident report should be completed. This is mandatory if the death has
occurred due to any relationship with the provision of health care; with particular need for attention to any incidents regarded as severe or sentinel events.

Also to be considered is the need to contact Legal Services for advice. Where staff have been involved in managing a reportable death (distinct from simply handling the temporary storage of the body) and there is likelihood of having to provide statements to police, staff should notify Legal Services and seek advice. Also see Section 4.7.

4.2 Notifying Next of Kin

It is the responsibility of the Coroner, or the Police on behalf of the Coroner, to notify the next of kin of the deceased person.

In the case of Aboriginal people the order of next of kin as per the above definition may not be appropriate. In some communities it is important to notify the right relative in the right order before the death becomes general knowledge. ATSIHPs or Community Leaders are able to assist Police in identifying the correct person to inform.

4.3 Life Extinct Form

When a reportable death occurs a Life Extinct Form must be completed by a health centre clinician. The Life Extinct Form provides a checklist for the clinical determination of death, details of the clinician determining death and related information. This form may be completed on the Electronic Health Record (EHR), however the completed form must be printed and signed by the clinician. A copy of the Life Extinct Form must:

- accompany the body
- be retained in the client’s EHR (ie signed form scanned into the client’s EHR)

4.4 Managing a Body

Whilst the management of a body, which is a reportable death, is wholly the responsibility of the Coroner (or the Police on behalf of the Coroner) health centre staff are to assist the Police in performing their duties. In the event of other options for storing a body not being available in the community, the usual assistance requested of health staff will be to store the body in the health centre until collection can be arranged at the earliest possible opportunity.

*Note: it is not reasonable to use the health centre as a first option for storage of bodies where this may affect the ability to continue delivery of health services. Hence the use of other options must be exhausted first.*

If an unexpected death occurs in the health centre or a body (due to an unexpected death) is brought to the health centre, staff should make arrangements with the Police regarding the care of the body. Ideally if mortuary facilities are available these should be used. If this is not an option the body should be placed on a trolley and stored in an air-conditioned room.

Police should provide instruction as to the correct procedure for managing the body, such as the use of body bags, etc. If there are any doubts as to correct procedure contact the Police for further instruction.

Where the deceased has received treatment in the health centre immediately prior to their death any medical equipment used during treatment attached to the body should not be removed eg ET Tubes, IV cannulas, defibrillation pads, etc. Equipment such as monitors or infusion pumps can be removed leaving attachments on the body in place. If a request is made by the family to remove items from the body, the Police are to be notified prior to any action.

Unexpected deaths occurring outside of the health centre, but within the community, may be more difficult to manage with grieving families wanting to keep the body with them. This will be a Police call, and generally it is agreed between Departments that PHC staff will assist in these circumstances as required (eg assisting with management of the body in the event that police are unable to attend, clinical management of grieving family, etc). PHC staff should take note of the scene and document observations in the medical record of the deceased person. Removal of the body should not occur without specific authorisation from the Police.
This is a very sensitive time for grieving relatives and staff are to exercise caution when removing a body. At no time are staff expected to place themselves in any danger. Police are to be notified should staff feel it would be unsafe to remove the body from a site outside of the health centre.

Cultural practices may need to be observed by the family. A common practice in Central Australia is to collect hair of the deceased. Permission should be sought from the Police before any procedure. The body should not be washed and clothing and jewellery should not be removed.

For infectious patients (eg Hepatitis B, HIV) wear mask, gown and gloves during preparation and place wrapped body in a body bag.

4.5 Transportation of Body

Transportation of bodies that are under the control of the Coroner are solely the responsibility of the Coroner. The Coroner’s staff will make all arrangements to collect the body from the community / health centre and return the body to the family once a certificate permitting disposal (burial) has been issued.

4.6 Coroner’s Power to Investigate

The Coroner has jurisdiction to investigate a death and therefore has the power to inspect a place, or anything at the place, related to the death, or take possession of anything that he/she believes is relevant to an investigation.

The Coroner or persons assisting the Coroner may access any material relevant to the enquiry by virtue of Section 19 of the Coroner’s Act. The Coroner may make a Request for Health Information & Records (section 4.2.3) via an appropriate written authorisation notice (Coroner’s Authority to a Member of the Police Service).

The Requests for Medical Records Flowchart outlines the PHC procedure for the release of health records and staff should refer to this flowchart and Request for Access to Medical Information & Records for guidance. Any requests for health records must be forwarded to PHC Clinical Governance generic e-mail account as detailed on the flowchart to facilitate preparation and provision of the information. A copy of the notice authorising such release must be retained in the client’s EHR (ie the authorisation notice scanned into the client’s EHR).

4.7 Providing Statements to Police

PHC staff are required to notify their Line Manager / Manager On-Call that a police statement has been requested and continue to communicate relevant developments related to the matter. In consultation with the relevant Manager, Legal Services Branch should be consulted prior to making any statement to the Police, when the death has occurred in relation to provision of health services. To contact Legal Services send an e-mail to DHFLegalServicesEnquiries@nt.gov.au or refer to the Legal Services intranet webpage (scroll down to contacts) for further details. Also see Police Statements for further information.

4.8 Providing Information / Advice to the Family of the Deceased

PHC staff are not authorised to provide any information regarding the Coroner’s actions in the event of a reportable death. Staff should refer the family to the Coroners Constable if they have any questions. Darwin: 08 8999 9777; Alice Springs: 08 8951 8888.

4.9 Post-Mortem

In a coronial case, the Coroner decides whether there should or should not be a post-mortem. The senior next of kin can request the Coroner to perform or not perform a post-mortem. Staff should refer the family to the Coroners Constable if they have any questions.
4.10 Cultural Issues

Different cultures have different ways of dealing with death, and there can be large variations even within cultures. Australian Indigenous cultures vary regionally and tribally, so there is no universal ‘ Aboriginal way’. 

It is common for relatives to be reluctant for the deceased to be autopsied or even examined post mortem; this may lead to antagonism and must be handled delicately. Staff safety is paramount in these circumstances, it may be better to distance yourself from the process and allow tensions to ease first.

It is common for relatives to express grief in public displays that may include cropping of hair, dressing in certain clothing and body painting. Some displays can be quite distressing to witness, such as self-mutilation (sorry cuts), throwing themselves to the ground repeatedly to cause injury, and intense wailing. Other displays such as destruction of objects may require the removal of vehicles to a safe distance.

Sensitivity needs to be exercised should relatives want to remain with the deceased; family may simply want time with the body before it is removed. Cultural practices may need to be observed also. If unsure about the appropriate action seek help from Aboriginal Health Workers or Community Leaders.

4.11 Health Centre Opening Hours following a Death in the Community

Health centres will ordinarily continue to operate normal opening hours of business following a death on the community or during the funeral unless cultural considerations suggest otherwise; for example the Shire / community may request that the health centre be ‘closed’ as a mark of respect for a deceased elder.

The decision to ‘close’ the health centre following a death on the community or during a funeral must only be made following consultation with the community and family members and District Manager. When this occurs, the health centre may be 'closed' to the general public but should remain open for 'emergencies only'.

Health Record Documentation

PHC staff are to record the facts of the death in the health record. Pertinent information that should also be included in the medical record is:

- a record of the clinical determination of death per checklist on the Life Extinct Form (available via the EHR)
- notification of the death to the relevant Medical Practitioner and relevant Manager (after hours contact the Manager On-Call)
- any subsequent discussions with the family, specifying which family members have been spoken to
- details regarding the deceased person’s valuables and property if relevant
- any extenuating circumstances that may have caused a delay in completing medical record documentation.

When a paper-based health record exists for the client, staff should remove the record from the paper-based collection, write ‘Deceased’ on the front cover and store appropriately. See Health Records - Management of Hard Copies and Archiving & Disposal of Records.

Additionally on the client’s EHR, the following is to be completed:

- **PCIS:** record deceased in the ‘Other Details’ tab in the ‘View Person/Client’ form and cancel medications, care plans, recalls and diary entries. See PCIS Quick Guide - Managing Deceased Client Files (intranet).
- **EACS:** select ‘Patient’ from the main tool bar, then select ‘Death’ from the dropdown box and insert client identifiers into the ‘search field’ to select the patient’s name. Complete the details required: date of death, cause of death and any contributing factors. Completing the ‘Death’ component will automatically cease all recalls, care plans, medicines, etc in EACS.
## Document Quality Assurance

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## Key Associated Documents

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<th>Forms</th>
<th>Life Extinct Form, also available via the Electronic Health Record</th>
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**Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents**

- Archiving and Disposal of Records
- Critical Incident Follow-Up PHC Remote CAHS Guideline
- Deaths - Overview
- Incident Reporting PHC Remote CAHS Guideline
- Management On-Call PHC Remote CAHS Guideline
- Police Statements
- Request for Access to Medical Information & Records
- Requests for Medical Records Flowchart
- NT Department of Health: intranet documents
- Health Incident Management Policy
- Health Incident Management Guideline
- RiskMan intranet site
- Primary Care information System website (intranet)
- PCIS Quick Guide - Managing Deceased Client Files
- East Arnhem Communicare System (Intranet)
- NT Coroners Act
- Practice Guidelines for Health Professional Dealing with the Death of a Northern Territory Aboriginal Person. 1996. Dr Tarun Weeramanthri.

## Evidence Table

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