

CIRCULAR

File No	02/2185
Circular No	2002/52
Issued	7 May 2002
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HOSPITAL PROTOCOL FOR UNEXPECTED INFANT DEATH

Enclosed is a revised Hospital Protocol for Unexpected Infant Death. Previous Circular No 97/88 (issued 11 September 1997) is now superseded.

This Circular outlines procedures to be followed in the case of an unexpected infant death. This revised Protocol broadens the application of this protocol to all unexpected infant deaths in hospital, including those infants brought to an Emergency Department and unexpected infant deaths during a hospital admission.

It also strengthens liaison and consultation procedures between the Hospital, the Institutes of Forensic Pathology and the Coroner's Office. A key issue in ensuring good interface between the medical and legal systems in the case of an unexpected infant death is effective liaison and consultation between the responsible hospital clinician and the forensic pathologist. In order to exclude the possibility of metabolic disease this Circular makes provision for the timely collection of samples, such as blood and liver biopsy, following discussion with and the concurrence of the Duty Forensic Pathologist. Hospitals should ensure that local protocols regarding the collection of samples for metabolic assessment are consistent with this Circular.

This Circular should be read in conjunction with Circular No 99/57 Coroners' Cases and Amendments to Coroners Act 1980 which outlines jurisdiction of the Coroner, obligation to report death and guidelines for nursing staff and medical officers on Coroners' cases dying in hospital.

This Circular is referred to all Area Health Services for implementation by all hospitals. Local policies and protocols should be updated to reflect this revised Circular. Staff working in Hospitals, Child and Family Health Services, Community Health and the NSW Ambulance Service should be familiar with this Circular.

Robert McGregor
Acting Director-General

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In accordance with the provisions incorporated in the Accounts and Audit Determination, the Board of Directors, Chief Executive Officers and their equivalents, within a public health organisation, shall be held responsible for ensuring the observance of Departmental policy (including circulars and procedure manuals) as issued by the Minister and the Director-General of the Department of Health.

NSW HEALTH
HOSPITAL PROTOCOL FOR THE
UNEXPECTED DEATH OF AN INFANT
(Revised April 2002)

INTRODUCTION

This protocol is to be observed in all cases of unexpected infant deaths in hospital. It is to be observed when there is an unexpected infant death during an admission to hospital and following an unexpected death of an infant where the infant is brought into an Emergency Department.

The death may be due to Sudden Infant Death Syndrome (SIDS) which should be considered when a baby who is either well or has had only a trivial illness dies suddenly and unexpectedly. As SIDS is a post mortem diagnosis, the term 'unexplained death of an infant' should be used until SIDS is the confirmed cause of death following post mortem examination. Successful diagnosis of the cause of unexpected infant death is dependent on the post mortem being carried out as soon as practicable after the death of the infant.

The unexpected death of an infant is a tragedy for the parents, happening without warning. The immediate care provided for parents by staff in all hospitals may make a great difference to the resolution of grief by the particular family. This requires that the staff concerned have appropriate knowledge, skills and sensitivity.

Sudden Infant Death Syndrome (SIDS)

If it seems that it is most likely the baby has died of SIDS, then the parents should be given a few simple facts about this cause of death. This should include that the SIDS could not have been predicted. It is the most common cause of death in babies under one year. Fewer than 50 babies die of SIDS in NSW annually.

The parents will be in shock. Their behaviour may be atypical. There is no "correct" or "appropriate" response to such an overwhelming shock. If they so desire the family should be given the opportunity to say goodbye to their baby, and to hold the baby for a time in the presence of a health professional. It is important that they are given support during this time. This process cannot be hurried but it should be acknowledged that an urgent post mortem is required.

PROTOCOL

- 1) **Following an unexpected death of an infant where the infant is brought into an Emergency Department**
 - a) All babies suspected of dying of SIDS and brought to the hospital should be taken into the Emergency Department. The Emergency Department can then serve as a "safe place" where parents and other relatives are able to talk with health professionals.

- b) The Director or Supervisor of the Emergency Department should nominate a **key person** to coordinate the care of the parents. This could be the senior nurse on duty, the duty social worker or the paediatrician on call, depending on the circumstances.
- c) If the baby is deemed dead on arrival, the parents should be informed of this as soon as possible by the Emergency Department doctor or nominated key person.
- d) After telling the parents their baby has died a brief medical history should be taken by the doctor. This history should include such matters as perinatal problems, immediate or continuing health problems and family history.
- e) The nominated **key person** should ensure that the police have been promptly informed of the death of the infant so that an early post mortem can be conducted.

2) **Following a sudden infant death during a hospital admission**

- a) The Admitting or Senior Medical Officer who had cared for the infant should nominate a **key person** to coordinate the care of the parents. This could be the nurse unit manager, the ward social worker or other appropriate person depending on the circumstances and/or who has been involved with the family during the admission. The parents should be informed of the death of the infant as soon as possible.
 - b) The nominated **key person** should ensure that the police have been promptly informed of the death of the infant so that an early post mortem can be conducted.
 - c) *The Guidelines for Nursing Staff and Medical Officers on Coroners' Cases Dying in Hospital* as detailed in section (4) of Circular No 99/57 *Coroner's Cases and Amendments to the Coroner's Act 1980* should be followed by nursing staff and medical officers following a sudden infant death during a hospital admission.
- 3)** The names of all health professionals (General Practitioner, Child and Family Health Nurse, Paediatrician, Obstetrician or Postnatal Clinic Nurse etc) involved in the baby's care should be sought so that they can be informed (with permission) and become involved in the parents' care. The baby's Personal Health Record, if available, may give details of health professionals involved in the baby's care. The parents should be offered the support services of SIDSnew south wales (see page 5).
- 4)** **Once the child is declared deceased the police officer, as the representative of the Coroner, is responsible for the care of the body**, the investigation of the death, and timely removal of the infant for examination by a forensic pathologist.

- 5) Because the cause of death can be difficult to establish, it is very important that the post mortem examination be done by a pathologist with extensive experience in infant post mortems at a centre with appropriate facilities for special tests. The **NSW State Coroner has therefore directed that all post mortems following unexpected deaths of infants be done in Sydney, either at the Central Sydney Laboratory Service, Department of Forensic Medicine at Glebe, or the Department of Forensic Medicine in the Institute of Clinical Pathology and Medical Research, Westmead or in Newcastle at the Department of Forensic Medicine, Royal Newcastle Hospital by Dr TJ Lyons.** Based on the post mortem results, the NSW Health Department monitors the occurrence of SIDS, looking for trends which might provide information that will help in the prevention of this tragic condition.
- 6) As soon as death is established, the responsible hospital clinician is to contact the Duty Forensic Pathologist:
 - Central Sydney Laboratory Service, Department of Forensic Medicine at Glebe - (02) 8584 7800;
 - Department of Forensic Medicine, Westmead Hospital - (02) 9845 7592;
 - Dr TJ Lyons, Department of Forensic Medicine, Royal Newcastle Hospital - (02) 4923 6846 or mobile 0417 268 422 (24 hours).
- 7) **No further examination of the child should be undertaken without prior discussion with and permission of the Duty Forensic Pathologist.** Effective liaison and consultation between the responsible hospital clinician and the forensic pathologist is required to ensure good interface between the medical and legal systems in the case of an unexpected infant death.
- 8) In order to exclude the possibility of metabolic disease the responsible hospital clinician should arrange for timely collection of samples, such as blood and liver biopsy, following discussion with and the concurrence of the Duty Forensic Pathologist. Protocols should be established which would meet the requirements associated with both forensic examination and obtaining tissue for metabolic studies. A sample protocol from the Children's Hospital at Westmead on which protocols for local facilities can be developed is attached at Appendix A *Protocol for Sampling of Tissue on Possible Metabolic Cases.*
- 9) The amount of handling of the body should be minimised. However, the parents may feel the need to hold the baby after the diagnosis of death has been made and should be given the opportunity to do so in the presence of a health professional.
- 10) Ink prints of the baby's feet or hands should not be made until after the post mortem examination. At the parents' request, ink prints can be taken at each of the forensic facilities by the grief counsellors or by the SIDSnew south wales representative.
- 11) Parents should be informed that unexpected infant deaths have to be reported to the Coroner and that the Coroner orders a post mortem examination. It is acknowledged that some parents may have reservations about a post mortem examination because of cultural, religious or other reasons. It should be

explained that a post mortem will ensure that the cause of death was thoroughly investigated and no illness was missed. If parents have continuing concern regarding the post mortem process they can discuss this with the counsellors at the Central Sydney Laboratory Service, Department of Forensic Medicine at Glebe telephone (02) 8584 7800 or the counsellors at the Department of Forensic Medicine, Westmead Hospital (02) 9845 6001 or 9845 7247. *The Coroner's Court* brochure provides information on the coronial system, why the Coroner has become involved and the processes which may be necessary to determine the cause of death. *The Coroner's Court* brochure is reproduced and attached at Appendix B.

- 12) There will be no charge to the parents for transporting the infant to Glebe, Westmead or Newcastle or returning the infant to the home locality. Every effort will be made to ensure that post mortems are done as quickly as possible.
- 13) Post mortem reports are available to parents from the Coroner's offices in Sydney, or the clerk of the local court in country areas. The initial report can be obtained by telephone and should be available within 48 hours but a request for the final report has to be made in writing. There is no charge to parents for the report. Because these tests are complex processes the final report may take three to four months to produce.
- 14) Formal identification by the police is necessary in all coronial cases. In view of the circumstances surrounding an unexpected infant death, positive identification may be obtained in a number of ways. The parents may be asked to do this. The police or anyone who knew the baby's identification in life, or to whom the baby's body has already been identified, can assist in this formality. **Formal identification is best done before leaving the Hospital Ward or Emergency Department.**
- 15) If there is a surviving twin, management and advice should be obtained from a paediatrician.
- 16) Practical help should be offered to the parents such as arranging transport home, making sure they are calm enough to drive if they brought their baby in the family car, care of the other children, discussing funeral arrangements, contacting any relatives (with permission), and helping the mother if she had been breastfeeding. The **key person** should inform the hospital or community social worker of the case so that ongoing support can be arranged.
- 17) It is often difficult for Hospital staff to know how to help someone in this tragic situation. Just being with the parents, allowing them to talk or even sitting in silence with them can be very helpful. Staff should not be afraid to show their emotions, as parents will find it reassuring to know that others sympathise with them.

SUPPORT AVAILABLE TO THE FAMILY

1. The family General Practitioner
2. The Paediatrician (if one has been involved)
3. The Community Health and/or the Community Mental Health Team
4. The Forensic Pathologist
5. SIDSnew south wales
 SIDSnew south wales is a self help organisation that supports all who experience the sudden and unexpected death of a young child, as well as undertaking community education, research and fundraising activities. Professional counsellors and trained volunteers are available to provide phone support and information to parents and families following the death of a child. Home visits can be arranged when the family is ready. SIDSnew provides information booklets to both parents and health professionals.
 SIDSnew can be contacted on (02) 9681 4500 or 1800 651 186 (for country and after hours support). SIDS Hunter is available for families in the Hunter region and can be contacted on (02) 4969 3171.
6. The Counsellors at the Central Sydney Laboratory Service, Department of Forensic Medicine at Glebe (02) 8584 7800 or the Department of Forensic Medicine, Westmead (02) 9845 6001 or 9845 7247 are available to help parents, relatives and professional staff to obtain information where possible. A pamphlet regarding post mortems is available from both places.

PAEDIATRIC HOSPITALS

Contacts for further information on SIDS at NSW Paediatric Hospitals are listed below.

HOSPITAL	TELEPHONE	CONTACT PERSON
The Children's Hospital at Westmead	(02) 9845 0000 (24 Hours)	<ul style="list-style-type: none"> ▪ Dr Karen Waters ▪ Dr Chris Seton ▪ Social Worker on call
Sydney Children's Hospital Randwick	(02) 9382 1111 (24 Hours)	<ul style="list-style-type: none"> ▪ Dr Arthur Teng or Emergency Department Director on Duty ▪ Paediatric Social Worker
John Hunter Children's Hospital Newcastle	(02) 4921 3676 or (02) 4921 3000 (24 hours) (02) 4921 3000 (24 Hours)	<ul style="list-style-type: none"> ▪ Dr Bruce Whitehead ▪ Dr Jodi Hilton ▪ Paediatric Social Worker

APPENDIX A

PROTOCOL FOR SAMPLING OF TISSUE ON POSSIBLE METABOLIC CASES

Cases:

If the patient is to be a Coroner's case then the biopsy process, tissue taken, condition of the body and internal organs must be carefully documented so as to assist the forensic pathologist to establish a cause of death.

1. The body should be looked at carefully and any marks, incisions, puncture sites or haematomas near the sites of sampling should be noted.
2. For maximum information the following biopsies and body samples need to be taken.
 - (a) Suprapubic bladder tap for urine: this should be done with a 19-gauge needle attached to a 10-20ml syringe. The bladder should be palpated and the needle inserted centrally above the pubic bone. Note any pathology in the region and note colour of urine and amount of urine and number puncture marks you make and position.
Freeze urine obtained.
 - (b) CSF should be obtained via a lumbar puncture. It should be done using the regular method however, marks on the back should be noted and colour/type CSF and amount CSF and note where and number of puncture sites you make.
 - (c) Muscle, skin and liver biopsies can all be done via the same abdominal right upper quadrant incision.
 - i. Again note any marks on the skin in this region and note state of subcutaneous tissue - haemorrhage, pus etc. Wipe area with an alcohol swab. Make procedure sterile until skin biopsy is taken.
 - ii. Make a 2-4cm incision below the right lower costal margin approximately 3-4cm lateral to centre where rectus abdominus muscle is. Palpate for liver and try to make incision superior to the edge.
 - iii. Take a thin ellipse of skin from the edge of the incision under sterile conditions. Place in cytogenetics fluid (Hanks). If this is not available, then sterile normal saline or Stuart's viral transport medium can be used. Place in normal fridge.
Do NOT freeze
 - iv. Note state muscle and take a rectangular biopsy approximately 10x20mm if possible - stay anterior to the peritoneum.

- I. Wrap half muscle in foil. Place in a suitable sealed container and freeze at -70°C and maintain at that temperature or place on dry ice.
Do NOT allow to thaw.
 - II. If available, place half of remainder in formalin and freeze other half on a chuck with fibres orientated transversely. The most important step is the freezing at -70°C .
- v. Cut through peritoneum and expose liver.
- Note any free fluid in abdomen - amount, colour, blood etc.
 - Note appearance of liver - colour, presence contusions, haemorrhage and texture.

Take a wedge of liver 10x10mm. Wrap majority in foil, place in a suitable container and freeze at -70°C or on dry ice.

Do NOT allow to thaw.

(d) If able, blood should be placed on the Guthrie card. This may be available from the liver biopsy. If possible this should be taken prior to death.

APPENDIX B

THE CORONER'S COURT

About this brochure

The Coroner recognises that dealings with the coronial system usually occur at a time of great sorrow and distress. Uncertainty about court procedures and concerns about what will happen add to the anxiety.

This brochure will provide you with information about the coronial system, why the Coroner has become involved and the processes which may be necessary to determine the cause of death.

At the end of this brochure you will find contact numbers and addresses if you need support or more information.

Table of Contents

The Coronial System	3
The State Coroner	3
The Role of the Coroner	3
Counselling Services	3
The Coronial Process	
When must a death be reported to the Coroner?	4
What is an inquest?	4
When is an inquest held?	5
Can I request an inquest?	5
Will I be required as a witness at the inquest?	5
Will I receive notice of the inquest?	6
Must I be represented by a solicitor at the inquest?	6
What if I am not satisfied with some part of the coronial process?	6
The Post Mortem	
What is a post mortem (autopsy) examination?	7
When is a post mortem necessary?	7
What does a post mortem involve?	7
Getting tissues and organs returned	7
Can I stop a post mortem?	8
For more information about post mortems	8
Can I see the body?	8
Am I entitled to a copy of the post mortem report?	8
When can funeral arrangements be made?	9
Can I have the body transported overseas?	9
How do I obtain a copy of a death certificate?	9
Addresses and contact numbers	10
Interpreter Assistance	10

THE CORONIAL SYSTEM

The State Coroner

The State Coroner oversees and co-ordinates coronial services in NSW.

The State Coroner's role is to ensure that:

All deaths, suspected deaths, fires and explosions which come under the Coroner's jurisdiction are properly investigated and concluded; and where the law requires an inquest to be held, or in cases where the Coroner believes an inquest is necessary, a full inquest is undertaken.

The State Coroner is assisted by the Senior and the Deputy State Coroners.

The Role of the Coroner

Coroners are situated around New South Wales in Local Courts. They inquire into the circumstances surrounding deaths that are reported to them. As part of this inquiry, the Coroner will:

- Determine the identity of the deceased person;
- Inquire into the time, place, cause and manner of death;
- Refer the matter to the Director of Public Prosecutions if the inquest reveals that a known person has committed a serious criminal offence in connection with the death;
- Protect lives and well being by bringing to the notice of relevant authorities any practices, policies or laws which could be changed to prevent similar deaths in the future; and
- Expose other matters of public importance.

Deaths occurring within NSW are reportable to the Coroner. Deaths which occur on journeys to or from NSW are also reportable if the deceased person is normally a resident of NSW.

The Coroner also has jurisdiction to inquire into fires and explosions where property has been destroyed or damaged or where people have been injured.

Counselling Services

Qualified grief counsellors are employed on a full time basis at the NSW Institute of Forensic Medicine at Glebe and at the Department of Forensic Medicine, Westmead.

These counsellors are available to assist relatives and friends of the deceased person. They provide the bereaved with information, support and counselling.

If you live outside Sydney you may be able to obtain counselling services through your local Community Health Services. You can obtain information about the services available in your local area from the Office of the Coroner to whom the death has been reported.

If no counsellor is available at your local Community Health Centre or other organisation in your area, counsellors from Glebe and Westmead Institutes of Forensic Medicine may be able to assist you. Contact numbers are available at the back of this brochure.

When must a death be reported to a Coroner?

A death **must** be reported to a Coroner where:

- ❑ A person has died a violent or unnatural death;
- ❑ A person has died suddenly and the cause is unknown;
- ❑ A medical practitioner has not issued a certificate stating the cause of death;
- ❑ The deceased person was not attended by a medical practitioner within three months before death;
- ❑ A person has died within 24 hours of, or as a result of, the administration of an anaesthetic (not including a local anaesthetic used for resuscitation);
- ❑ A person has died within one year and one day of any accident to which the cause of death may be attributable;
- ❑ A person has died while in, or temporarily absent from, certain establishments that have been providing them with care, treatment and assistance, such as a hospital, residential centre, welfare facility or residential child care centre; or
- ❑ A person has died while in police custody or while they were in, or temporarily absent from, a prison or a detention centre. The State Coroner or Deputy State Coroners must conduct an inquest where there is a death in custody or during a Policy Operation.

If you are unsure why a death has been reported, you can ask the Coroner.

What is an inquest?

An inquest is a court hearing where the Coroner considers information to help determine the manner and cause of death. At this hearing, the Coroner may call witnesses to give evidence of their knowledge of the circumstances of the death.

Inquests are generally open to the public, so you may attend and listen to the proceedings. In certain circumstances, however, the Coroner has the power to exclude individuals, or the public generally, from attending the proceedings. The Coroner can also prohibit the publication of evidence.

When is an inquest held?

Not all deaths reported to the Coroner will result in an inquest. If the Coroner is able to consider all available evidence, such as the statements of witnesses and medical reports, and is satisfied that there are no outstanding matters to be determined, the Coroner can decide an inquest is not necessary.

However, a Coroner, **must** conduct an inquest where:

- ❑ The deceased person has not been identified;
- ❑ The cause of death has not been determined;
- ❑ The person died as a result of a homicide;
- ❑ The person died as the result of the administration of an anaesthetic;
- ❑ The person died within 24 hours of the administration of an anaesthetic and a relative or interested person has made a request within 28 days of the death that an inquest be held;
- ❑ The Attorney General orders that an inquest be held; or
- ❑ The State Coroner directs that an inquest be held.

If the person died while in custody, while escaping or while attempting to escape from custody, an inquest must be held by the State Coroner or one of the Deputy State Coroners.

Can I request an inquest?

A relative or person whom the Coroner determines has a sufficient interest in a death, fire or explosion can request an inquest.

The request must be made in writing to the Coroner and state the reasons for the request.

The Coroner will consider those reasons when deciding whether or not to hold an inquest. If the Coroner decides not to hold an inquest, the next of kin will be notified.

You can ask the Coroner to provide you in writing with the reasons why an inquest will not be held.

Will I be required as a witness at the inquest?

It may be necessary for you or another member of your family to make a statement to police about your knowledge of the circumstances of the death.

A police officer will usually make an appointment with you to take that statement.

If an inquest is set for hearing, the Coroner will read your statement and determine whether it is necessary for you to attend to give further evidence at the hearing.

You will be notified by the Coroner if you are required to give evidence.

Will I receive notice of the inquest?

If an inquest is to be held, the Coroner will advise the next of kin about the time and place of the hearing.

Any person who has given notice in writing of their intention to seek leave to appear or be represented at an inquest will also be notified of these details.

After the inquest is completed, a copy of the Coroner's findings will be sent to the next of kin.

Must I be represented by a solicitor at the inquest?

No. Any person who, in the opinion of the Coroner, has a sufficient interest in any aspect of the inquest may apply to the Coroner for permission to appear in person, or to be legally represented at the inquest.

This person, or his or her legal representative, may examine and cross examine any witnesses on matters relevant to the inquest.

What if I am not satisfied with some part of the coronial process?

If you are not satisfied with part of the investigation, the inquest or inquiry or any other matter, you should raise your concerns with the Coroner.

It is part of the Coroner's role to ensure that all relevant aspects of a matter are investigated and he or she will listen to any concerns that you may have.

If you feel your concerns have still not been addressed, you should contact the State Coroner.

THE POST MORTEM

NOTE: *Some people may find this section upsetting. If you DO NOT wish to know more about post mortems, please go straight to page 12.*

What is a post mortem (autopsy) examination?

A post mortem examination or autopsy is an external and internal examination of the body by a doctor who has special training and experience in this field.

When is a post mortem necessary?

A post mortem examination is ordered by a Coroner to ensure that he or she is able to deliver a balanced and accurate finding as to the cause of death.

What does a post mortem involve?

During a post mortem, all parts of the body undergo a detailed inspection to determine the presence, nature and extent of any disease or damage. This inspection requires all organs to be removed from the body and examined.

In some cases, the Coroner may retain organs for a more thorough examination by chemical or other means to detect finer details of disease or damage. This is especially true of parts of the nervous system, such as the brain.

In some cases, organs may have to be retained for several months. Small parts of organs are usually retained forever to ensure that any questions which may arise months, or years after the death, can be answered by further examination, perhaps by new techniques which were not available at the time of the inquest.

Getting tissues and organs returned

Retained tissue and organs, including the brain, can be returned when the final post mortem report is completed. This is generally around twelve weeks after the actual post mortem.

Your Funeral Director can usually arrange for collection of these tissues and organs and cremation or burial in the same grave site.

If you would like the tissue and organs returned for later burial or cremation, you should speak to your Funeral Director at the time of making funeral arrangements. You also need to make a written application to the Coroner for return of any tissue or organs retained as soon as you have made this decision.

If no request is made within twelve months from the date of post mortem, retained tissue and organs are disposed of by the NSW Institute of Forensic Medicine.

Can I stop a post mortem examination?

The **senior next of kin** has a legal right to lodge an objection to a post mortem examination.

The Coroner should be advised immediately of any objection so that the post mortem can be delayed whilst the objection is being considered. The objection should be in writing and should set out the reasons why you are objecting to the post mortem examination.

If the Coroner determines that the examination should take place, a notice will be sent informing you that you have 48 hours to make an application to the Supreme Court to seek an order preventing the post mortem examination. You will most likely need legal assistance to make an application to the Supreme Court.

Should you decide not to proceed to the Supreme Court, you should inform the Coroner's office immediately so that the post mortem examination can be undertaken and there will be no undue delay in releasing the body for burial.

For more information on post mortems

If you want further advice regarding post mortems or retained organs or tissue, you should contact a grief counsellor at the NSW Institute of Forensic Medicine or the Coroner's Office at which the death has been reported.

Can I see the body?

The police may ask a family member or friend of the deceased to view the body so that there is no mistake about identification.

General viewing of the body by family and friends should be organised through your funeral director **after** the post mortem.

In special circumstances, viewing may be arranged before the post mortem process.

Usually there is no impediment to viewing the body of a person after they have had an autopsy, but where an infectious disease is present, health regulations may not permit this.

At the NSW Institute of Forensic Medicine, Glebe, and the Department of Forensic Medicine, Westmead you should contact the Grief Counsellors for more information.

At other centres you should contact the Coroner's Office handling the matter.

Am I entitled to a copy of the post mortem report?

Yes. A copy of the post mortem report can be sent to you. You will need to request a copy of the report in writing from the Office of the Coroner, giving the name and details of the deceased. You must also state your relationship to the deceased.

Copies of medical reports are available to the next of kin of the deceased person or to any other person who, in the opinion of the Coroner, has sufficient interest in the cause of death.

If you do not understand the report it is suggested you discuss the report with the deceased person's doctor or doctor of your choice.

When can funeral arrangements be made?

Even though a post mortem is to be conducted, you can still proceed with funeral arrangements.

A funeral director normally acts on behalf of the family and will find out when the body is likely to be released. They will collect the body and obtain the necessary orders for burial or cremation.

The body cannot be released until the initial post mortem is completed. In some situations, delays may occur because:

- ❑ Further medical tests are required;
- ❑ The body needs to be transported to the Sydney metropolitan area for specialist post mortem; or
- ❑ Problems arise in confirming identify.

Can I have the body transported overseas?

If the body needs to be transported to another country, you should arrange with a Funeral Director to prepare the body and the necessary documentation.

How do I obtain a copy of the death certificate?

All deaths are registered with the Principal Registrar at the Registry of Births, Deaths and Marriages. Your Funeral Director will forward the relevant documents to enable a death to be registered.

The Coroner will advise the Principal Registrar the cause of death.

You must apply to the Principal Registrar at the Sydney office for a copy of the death certificate.

If the death occurred in a rural location, your Local Court is an agency for this registry and can give you information about obtaining a certificate. A fee is charged for a copy of the death certificate.

In certain circumstances, it is not possible for the Coroner to advise the Principal Registrar of the cause of death at the time the death is registered. If this is the case, a death certificate can still be obtained but the cause of death will not be shown.

You will be advised when the Principal Registrar has been told the cause of death and when the inquest has been finalised.

Addresses and contact numbers

Registry of Births, Deaths and Marriages

191 Thomas Street, Haymarket 2000
Phone 1300 655 236

Coroner's Court

- ❑ **State Coroner's Court, Glebe**
44-46 Parramatta Road, Glebe 2037
Phone (02) 8584-7777
- ❑ **Westmead Coroner's Court**
Institute Road, Westmead 2145
Phone (02) 9633 8000

Forensic Medicine Institutes

- ❑ **NSW Institute of Forensic Medicine**
50 Parramatta Road, Glebe 2037
Phone (02) 8584 7800
- ❑ **Department of Forensic Medicine**
Level 1, 1 CPMR
Westmead Hospital,
Westmead 2145
Phone (02) 9845 7592

Counselling Services

- ❑ Glebe (02) 8584 7800
- ❑ Westmead (02) 9845 6001
- ❑ Community Health Centres are listed in the Yellow Pages, telephone book under 'c'.
- ❑ Contact the Coroner at your nearest Local Court to find out about Counselling Services in your local area.

Interpreter Assistance

This brochure is about the Coroner's Court. If you need interpreter assistance, ask an officer at the Local Court about the Translating and Interpreting Service or phone 13 14 50.