STANDARDS

1. The Bay of Plenty District Health Board (BOPDHB) Form FM.D1.4 Hospital Record of Death (HROD) must be completed immediately if possible, but no later than within 3 hours after death so that family/whānau can make arrangements in a timely manner.
   1.1 The entire HROD form must be completed after every death.
   1.2 The HROD Form and the issues it covers are to be completed by a registered medical practitioner employed by, or contracted to, BOPDHB. This individual must be a member of the team that treated the patient or the doctor on duty after hours.
   1.3 The HROD form can be filled in by the House Surgeon who must refer to seniors if the need for Coronial involvement is identified. If you answer yes or unsure to any of questions in the Circumstances of Death section then the death must be reported to, or discussed with, the National Duty Coroner. If the Coroner needs to be notified refer to policy 6.6.1 protocol 2 Death of a Patient – Coroner Notification and Investigation.
   1.4 Coroner or Police contact, where necessary, is made in most cases by the Registrar / MOSS or Consultant and not by the House Surgeon.
   1.5 Every HROD form will be emailed to the Medical Director with the original to be printed and placed in the patient’s health record. The Form FM.D1.5 Death of a Patient - Checklist must also be completed by the Doctor and Clinical Unit Administrator (CUA) and filed in the patient’s health record.
   1.6 Where the patient has been in the hospital only a short time, or is dead on arrival at the hospital, it may be appropriate to contact the GP for the patient’s medical history etc.
   1.7 The GP will be notified via completion of the Discharge Summary by the Doctor. The completed HROD will be emailed to the GP by the ward CUA. The Police will contact the GP on behalf of the Coroner in relevant cases.
   1.8 If cremation is indicated, the Cremation form (Form B) must be completed by the clinician who last saw the patient alive.

ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.6.1 Death of a Patient
- Bay of Plenty District Health Board Form FM.D1.4 Death – Hospital Record of Death Form
- Bay of Plenty District Health Board HROD Guide
- Bay of Plenty District Health Board Form FM.D1.5 Death of Patient – Checklist
- Bay of Plenty District Health Board Form FM.D1.6 Death of a Patient – Body Release
- Bay of Plenty District Health Board policy 6.6.1 protocol 2 Death of a Patient – Coroner Notification and Investigation
- Bay of Plenty District Health Board policy 6.6.1 protocol 7 Death of a Patient - Care of the Deceased
- Bay of Plenty District Health Board policy 6.6.1 protocol 11 Death of a Patient - Perinatal / Paediatric Post Mortem Transfer to Auckland, Wellington
- Bay of Plenty District Health Board policy 6.6.1 protocol 13 Death of a Patient - Blessings
- Bay of Plenty District Health Board policy 6.3.9 Body Parts and Tissues
- Bay of Plenty District Health Board policy 1.1.1 Informed Consent
- Bay of Plenty District Health Board policy 1.4.4 Māori Cultural Safety
- Bay of Plenty District Health Board policy 2.1.4 Incident Management
- Bay of Plenty District Health Board policy 2.5.1 Health Information Privacy
The entire HROD form must be completed after every death.

The HROD form and the issues it covers are to be completed by a registered medical practitioner employed by or contracted to BOPDHB. This individual must be a member of the team that treated the patient (or the doctor on duty after hours).

The HROD form should normally be completed immediately but must be completed within three (3) hours of death. This enables decisions to be communicated to family / whanau within that timeframe.

Coroner or Police contact, where necessary, is made in most cases by Registrar / MOSS or Consultant and not by House Surgeon.

A copy of every HROD form will be automatically emailed to the Medical Director (“Coronial” or “Non-Coronial”). Original HROD is to be printed and placed in patient’s health record.

The following deaths must be reported immediately for the following circumstances of death categories on the HROD form:
- Without known cause / self-inflicted / unnatural / violent / patient admitted due to injury
- Death occurred during, or appears to be the result of, a medical procedure AND was medically unexpected
- Death occurred while person affected by anaesthetic AND was medically unexpected
- Death occurred while person affected by anaesthetic AND was medically unexpected
- Death occurred while person affected by anaesthetic AND was medically unexpected
- Death occurred while person affected by anaesthetic AND was medically unexpected
- Death occurred in official custody or care (including being subject to Mental Health legislation)
- Doctor has not given a MCCD (Certificate as defined in section 21(1) Burial and Cremation Act 1964)
- A person is expressing concern as to cause of death or hospital treatment of the deceased

The following deaths should be reported immediately for the following circumstances of death categories on the HROD form:
- Any death which could be the result of actions or inaction’s of any person (i.e. medical treatment or lack of it) - any significant adverse event.
- Any other case that the Consultant has some concern about

Referral to the Coroner is:
- Not automatic if death occurs within a certain time period after a procedure e.g. 24 - 48 hours
- If a reasonable clinical assessment by a Registrar or Specialist well acquainted with the case finds no causative relationship between any procedure and death
- Any other case that the Consultant has some concern about

Coroner Referral?

MUST

SHOULD

NO

The Police act for the coroner and should be contacted directly for cases that must be reported.

The following deaths should be discussed with the Coroner or Police in order to determine if a post mortem and/or coroners inquest is required:
- Any death which could be the result of actions or inaction’s of any person (i.e. medical treatment or lack of it) - any significant adverse event.
- Any other case that the Consultant has some concern about

Referral to the Coroner is:
- Not automatic if death occurs within a certain time period after a procedure e.g. 24 - 48 hours
- If a reasonable clinical assessment by a Registrar or Specialist well acquainted with the case finds no causative relationship between any procedure and death
- A patient over 70 years where death was due to injury arising principally from age-related infirmity and, death is not otherwise suspicious, violent or unnatural and there is no requirement for a Coroners Act inquest i.e. suicide or death of an institutionalised patient.