

Our Ref: CE-2023-6401 Your Ref: 1868/2020

MINUTES forming ENCLOSURE to

To THE CHIEF EXECUTIVE OFFICER
Barossa Hills Fleurieu Local Health Network
Central Adelaide Local Health Network
Eyre and Far North Local Health Network
Flinders and Upper North Local Health Network
Limestone Coast Local Health Network
Northern Adelaide Local Health Network
Riverland Mallee Coorong Local Health Network
Southern Adelaide Local Health Network
Women's and Children's Health Network
Yorke and Northern Local Health Network

CORONIAL REVIEW OF DEATH OF A BABY BORN AT 25 WEEKS GESTATION

The State Coroner's office provided me with a copy of the attached correspondence, dated 27 March 2023, addressed to the Royal Australian College of General Practitioners and the Chief Executive Officer of Central Adelaide Local Health Network, regarding a review into the death of a premature baby.

It is noted that the post-mortem report indicates the cause of death cannot be attributed to the attempted termination and the Coroner has determined not to hold an inquest into the death of this baby.

A request is made within the letter that a reminder be issued to general practitioners that "if they are advised that a patient has not followed up with the Pregnancy Advisory Centre (in relation to completing termination), then they should take action to confirm via consultation with the patient whether the pregnancy has been terminated or is continuing."

To support a state-wide approach to shared learning from coronial investigations, I am writing to request that all SA Health Networks communicate this request as a reminder to relevant staff and general practitioners within your network and ensure this practice is reflected in relevant procedural documents.

Thank you for your assistance with this matter.

DR ROBYN LAWRENCE

Chief Executive

25 / 05 / 2023

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Att: Correspondence from the South Australian Coroner's Court

CC: Samantha Farrugia, Director, Safety and Quality