

Coronial Reports and Death Certification



Contents

Coronial Reports and Death Certification	1
What is the Role of the Coroner?	2
When Should I Report a Death to the Coroner?	3
Case History 1	4
Preparing Reports to the Coroner	5
When Should I Report to the Coroner? - Table 1	6-7
Case History 2	8-9
Death Certification	10-11
Case History 3	12
Conclusion	13
More Information	14

Coronial Reports and Death Certification

From time to time, JMOs will need to consider whether they are required to refer the death of a patient to the Coroner or whether a death certificate can be completed. JMOs may also be asked to prepare statements for the Coroner and, on occasion, be required to attend a Coronial Inquest (or hearing) as a witness. The aim of this booklet is:

- to outline the circumstances in which a patient's death should be reported to the Coroner
- to provide guidance on the preparation of:
 - a report to the Coroner
 - a death certificate.

What is the Role of the Coroner?

The primary role of the Coroner is to determine:

- the identity of the person who died;
- the date and place of death; and
- the manner and cause of death.

Historically, the Coroner's role was to take charge of investigations into sudden and violent deaths, and to collect "chance" revenues which fell to the Crown as a result of these deaths. Today, the Coroner is mainly concerned with investigating deaths that occur in a number of unexplained circumstances.

In addition, in some states the Coroner is involved in the investigation of the causes of fires and disasters. The office of the Coroner has an educative role. Coronial Inquests and recommendations may receive widespread media publicity and so the office may be used as a means of preventing other similar deaths in the future.

When Should I Report a Death to the Coroner?

Each state and territory has separate legislative provisions for the certification of deaths and the notification of deaths to the Coroner. These legislative provisions are summarised in Table 1 (When Should I Report to the Coroner?). If a JMO is not able to form an opinion as to the probable cause of death, or any of the circumstances listed in Table 1 are present, a death certificate cannot be written and the death should be reported to the Coroner.

It should be noted that completing a death certificate and reporting a death to the Coroner are mutually exclusive exercises. JMOs should seek advice from the office of the Coroner or MDA National if they are uncertain of their obligations in a particular situation [see Case History 1].

Is this a Case for the Coroner?

Case History 1

A 55-year-old man was brought to the Emergency Department (ED) by the police. Some hours earlier, he had been arrested and charged with a number of serious offences. However, soon after his arrest, the patient complained of the onset of severe chest pain and nausea, prompting the police to bring him to the ED. On arrival, the patient was found to be hypotensive and tachycardic. His ECG revealed ST elevation consistent with anterior myocardial infarction. The ED registrar proceeded to insert an intravenous line and take blood. However, the patient developed runs of ventricular tachycardia which soon progressed to ventricular fibrillation. Despite intensive medical intervention, the patient went into asystole and was unable to be resuscitated.

The cause of the patient's death was clear - acute myocardial infarction and cardiac arrhythmia - but the registrar was not sure in the circumstances whether she was able to complete a death certificate. The registrar contacted MDA National for advice. She was informed that because the patient was still technically in police custody at the time of his death, the case should be reported directly to the office of the Coroner.

Preparing Reports to the Coroner

How do I know if I am required to prepare a report to the Coroner?

What should I do if I am asked to prepare a report?

A request for you to prepare a report or statement to the Coroner will usually be received from medical administration, the hospital's solicitors or directly from the police assisting the Coroner. The request may be either verbal or in writing.

If you are asked to prepare a report or statement to the Coroner, you should:

- immediately seek advice and assistance from MDA National. Although the majority of coronial matters are quite straightforward from a JMO's point of view, from time to time these cases may proceed to a Coronial Inquest (a court hearing). In this situation, you may need to obtain legal representation in order to best protect your interests at the inquest. MDA National can provide you with advice about how best to proceed in a particular situation; and
- ask your hospital to review your report or statement before you submit it to the Coroner.

Reports or statements to the Coroner should include the following information:

- full name and date of birth of the patient

- full name and qualifications of the JMO
- the position in which the JMO was working at the time of the event(s)
- a detailed and chronological summary of the JMO's direct involvement in the medical care of the patient, including relevant dates and times.

You may be asked to answer a series of questions by the Coroner. If you are able to answer these questions, you should do so succinctly. You are not obliged to answer all of the questions (it's not like doing an exam!). If you are unable to answer the questions, you should say so [see Case History 2].

The report or statement should always be prepared with reference to the medical records. It should be noted that a report or statement to the Coroner is not the same as preparing a medical report for another doctor or a discharge summary. As a general rule, JMOs should only include information about their first hand knowledge of the patient's medical care. If other practitioners were involved in the patient's care, these practitioners should be identified. The Coroner can then determine whether it is necessary to obtain statements from any of these practitioners. In this way, the Coroner can piece together the "jigsaw" of reports to provide a complete picture of the patient's recent illness and/or the events leading to their death.

When Should I Report to the Coroner? - Table 1

	NSW	VIC	QLD
	Coroners Act 2009	Coroners Act 2008	Coroners Act 2003
CAUSE OF DEATH			
Unknown	✓	✓	✓
Unexpected	Following healthcare procedure ✓	Following healthcare procedure ✓	Following healthcare procedure ✓
Unnatural or violent	✓	✓	✓
Suspicious or unusual	✓		✓
NATURE OF DEATH			
Identity unknown		✓	✓
Resulted directly or indirectly from an accident or injury	Unnatural or violent ** ✓	✓	Unnatural or violent ✓
Not attended by medical practitioner	Within 6 months prior to death ✓		
During, or as a result of an anaesthetic, or a surgical procedure, or invasive medical or diagnostic procedure	if not reasonably expected outcome ✓	if not reasonably expected outcome ✓	if not reasonably expected outcome NB Includes failure to provide healthcare ✓
Not a reasonably expected outcome of a health care procedure and healthcare caused/ contributed to death and the death was not expected by an independent person	✓	✓	✓
Within 24 hours of discharge from a hospital as an inpatient or having sought emergency treatment at a hospital			
In police custody/other lawful custody	✓	✓	✓
Held in care, e.g. mental health facility, residential service including children	✓	✓	✓

NB: "health-related procedure" means a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug), but does not include any procedure of a kind prescribed by the regulations as being an excluded procedure.

SA	WA	TAS	NT	ACT
Coroners Act 2003	Coroners Act 1996	Coroners Act 1995	Coroners Act 1993	Coroners Act 1997
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓ Killed or drowned
✓				✓
	✓	✓	✓	
✓ Unnatural or violent	✓	✓	✓	✓ Directly attributable to the accident
				✓ Within 6 months prior to death
✓ Within 24 hours of the procedure, including administration of an anaesthetic	✓ During an anaesthetic; or as a result of an anaesthetic, and is not due to natural causes	✓ During anaesthesia or sedation; or as a result of anaesthesia or sedation and is not due to natural causes	✓ During an anaesthetic; or as a result of an anaesthetic, and is not due to natural causes	✓ During or within 72 hours of procedure
✓				
✓	✓	✓	✓	✓
✓	✓	✓	✓	✓

** In NSW, a death is not reportable if it follows an accident attributable to old age, if the person is 72 years old or older and the accident was not caused by an act or omission by any other person. This provision does not exclude a medical practitioner from making a report when they would otherwise be required to (e.g. if the death was suspicious or unusual). The provision covers accidents that occur in a nursing home, hospital or at home. The medical practitioner must state on the certificate that it is given in pursuance of section 38(2) of a Coroners Act 2009. If a relative of the deceased person objects to a medical practitioner issuing a death certificate any circumstances, the death must be reported.

The Coroner Calls Case History 2

The JMO was working in the emergency department (ED) when an eight-month-old baby was brought in by ambulance. The baby had reportedly been found unconscious and cyanosed in her cot by her mother. The JMO participated in the attempted resuscitation of the baby, along with a number of other senior staff in the ED. The resuscitation was unsuccessful and the patient's death was reported to the coroner.

Two years later the JMO received a letter from the police acting on behalf of the office of the Coroner requesting a report in relation to his management of the baby. The request stated that an autopsy had been performed but the direct cause of the baby's death could not be established. The letter noted that the Coroner was currently investigating the matter and required a report which addressed the following issues:

1. Your current qualifications.
2. Times and dates of your contact with the patient. Please expand on the medical records and include any further observations you made, your diagnosis and any treatment you provided.
3. In your opinion or experience, what do you think caused the patient's death?
4. Did you have any conversations with either or both of the patient's parents? If so, recount the conversation(s) and time/date it occurred.

A copy of the medical records was enclosed with the letter to the JMO.

This was the first time that the JMO had been asked to prepare a report to the Coroner. He did not know how to proceed and contacted MDA National for advice. In particular, the JMO was not sure whether he should answer all of the questions posed by the police in their letter. He was also concerned that he had not made an entry in the medical records and he could not recall the specific details of the events because they had occurred more than two years ago.

The JMO told the Medico-legal Adviser at MDA National that in view of his junior status he had minimal involvement in the resuscitation attempt. The nursing records noted that he had attempted to obtain IV access but this had been unsuccessful.

With the assistance of the Medico-legal Adviser, the JMO provided the following report to the police:

1. My full name is Dr John Doe. I am a qualified medical practitioner. I obtained my medical degree, MBBS from the University of Western Australia in 2012. At the time of my involvement in the patient's care, I was working as a second year Resident Medical Officer (RMO) in the emergency department at the district hospital.
2. I am unable to expand on the information in the medical records because with the passage of time I do not have a specific recollection of my involvement in the patient's care. On review of the medical records, it appears that my role in this patient's care was limited to an unsuccessful attempt at intravenous cannulation.
3. Based upon my experience as a RMO, the answer to this question is beyond my expertise. A Paediatrician may be able to provide further clinical advice.
4. I do not have any specific recollection of having a conversation with the patient's parents.

After review by the Director of Medical Services at the district hospital, the JMO sent the report to the police. He did not hear anything further about the matter.

Tips on preparing a report or statement to the Coroner

- Always seek advice from MDA National before providing a report to the Coroner.
- A report to the Coroner should outline your first hand knowledge and direct involvement in the patient's care. You should not prepare a complete summary of the patient's care.
- At the beginning of your report, it is useful to outline your qualifications and the position you were working in at the time of the incident/event(s).
- Always review and use the medical records to prepare your report. Do not rely solely on your memory.

Death Certification

How do I complete a death certificate?

The general format of the standard Medical Certificate of Cause of Death is shown below. JMOs should print clearly in block letters and avoid abbreviations on death certificates. The information recorded on the death certificate should be your best medical opinion as to the sequence of events leading to the patient's death.¹

Part I, Line (a) – Disease or condition directly leading to death

Enter on Part I Line (a) the direct cause of death; that is, the disease or complication which led directly to death. There must always be an entry on Part I Line (a) and this condition may be the

only condition reported in Part I of the certificate. If conditions such as cardiac arrest or respiratory failure are entered on Part I Line (a), always enter the underlying cause(s) on Part I Lines (b), (c), etc. to indicate the sequence of events leading to the death.

Part I, Lines (b), (c) and (d) – Antecedent causes

A condition should be regarded as being antecedent not only in an aetiological or pathological sense, but also where it is believed that this condition prepared the way for the direct cause of damage of tissues or impairment of function, even after a long interval.

INTERNATIONAL FORM OF MEDICAL CERTIFICATE OF CAUSE OF DEATH		Approximate interval between onset and death
CAUSE OF DEATH		
I <i>Disease or condition directly leading to death*</i>	(a)..... due to (or as a consequence of)	
<i>Antecedent causes</i> Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)..... due to (or as a consequence of)	
	(c)..... due to (or as a consequence of)	
	(d).....	
II <i>Other significant conditions contributing to the death, but not related to the disease or condition causing it</i>		
*This means the disease, injury or complication which caused death NOT ONLY, for example, the mode of dying, such as "heart failure, asthenia" etc.		

Part II - Other significant conditions

After completing Part I, the JMO should consider whether there were any other significant conditions which, though not included in the sequence in Part I, contributed to the fatal outcome. If so, these should be entered in Part II.

For example:

Part I

(a) Renal failure 1 year

(b) Nephritic syndrome 3 years

(c) Diabetes mellitus 20 years

Part II

Ischaemic Right foot 3 months

Duration between onset and death

Where the time or date of onset is not known, the best estimate should be made. The unit of time should be entered in each case. In a correctly completed certificate, the duration entered for Part I Line (a) will never exceed the duration entered for the condition(s) on Part I Line (b), (c) or (d); nor will the duration for Part I Line (b) exceed that for Part I Line (c) or (d).

The Australian Bureau of Statistics (ABS) has published a booklet which provides detailed guidance on completing Medical Certificates of Cause of Death.¹ In addition, you can refer to the *Handbook for Doctors on Cause-of-Death Certification* published by the University of Queensland.²

Why is it important to complete death certification accurately?

Accurate death certification is important to family members. It allows them to understand what caused the death and to be aware of conditions that may occur in other family members, now and in the future. The information is also coded by the Australian Bureau of Statistics for use by the public health sector and medical researchers for evaluating and developing measures to improve the health of Australians generally [see Case History 3].

Common Problems in Death Certification

- Listing the mode of death (e.g. cardiac arrest) rather than a pathological condition (e.g. myocardial infarction), as cause of death
- Failure to list conditions in a logical causative sequence
- Problems in determining whether a condition caused or contributed to their death
- Inclusion of conditions unrelated to the death (e.g. "glass eye" listed in part II). Death certificates should not include all comorbidities, just the causative disease.³
- If including dementia on the certificate, failure to state the interval between the onset of dementia and death (if known).

Reference

1. Information Paper – Cause of Death Certification, Australia. Australian Bureau of Statistics, 2008. Available at: abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1205.0.55.0012008?OpenDocument
2. Practical Guide - Handbook for Doctors on Cause-of-Death Certification. University of Queensland, 2012. Available at: uq.edu.au/hishub/handbook
3. Neate SL, Bugeja LC, Jelinek GA et al. Non-reporting of Reportable Deaths to the Coroner: When in Doubt, Report. *Med J Aust* 2013; 199: 402-405.

Death Certification Drama

Case History 3

The JMO was working on night shift when he was called to certify the death of a patient and complete the Medical Certificate of Cause of Death. The patient had been receiving palliative care for metastatic breast cancer. The death was expected and was not reportable to the Coroner. The JMO had never completed a death certificate before. He was in a hurry and was uncertain what to include under the various headings on the certificate. In his haste, he simply recorded “metastatic cancer two years” under the heading “Disease or condition directly leading to the death”. He did not make any notation under the other headings “Antecedent causes” and “Other significant conditions”.

Several days later, the JMO received an angry phone call from the patient’s husband. The husband had received a copy of his wife’s death certificate. He was extremely upset that the certificate was not accurate. The husband told the JMO that his wife had been diagnosed with breast cancer two years earlier and she had developed liver metastases six months prior to her death. She also had diabetes mellitus which had not been recorded on the certificate. To make matters worse, the patient’s name had been spelled incorrectly.

Conclusion

MDA National deals with numerous requests each year from JMOs seeking advice and assistance in relation to the preparation of reports to the Coroner. JMOs are encouraged to always seek advice from MDA National before responding to a request for a report to the Coroner, no matter how routine the request may appear. We are available to advise you at each stage of the process, from the preparation of the report through to legal representation at a Coronial Inquest, if this is necessary.



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more

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