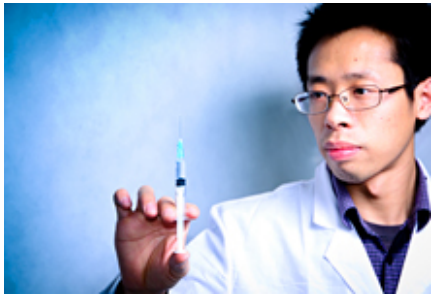
# For healthcare professionals

The procedures below are designed to assist health professionals comply with their obligations under the *Coroners Act 2009*. It should be read in conjunction with NSW Health Policy Directive 2010_54.



## 1. Which deaths must be reported to a Coroner?

If a death is "reportable" or "examinable" under the *Coroners Act 2009,* it is an offence to knowingly not report it to police or a coroner - section 35. With a limited exception outlined below in section 2, a cause of death certificate cannot be issued in relation to these deaths - section 38.

A death is **reportable** under section 6 if:

- it is violent or unnatural - see section 2 for clarification;
- it is sudden and the cause is unknown - see section 3 for clarification;
- It occurs in suspicious or unusual circumstances;
- The person has not been attended by a doctor in the 6 months preceding the death;
- It was not the reasonably expected outcome of a health related procedure - see section 4 for clarification; or
- the person was in or temporarily absent from a mental health facility where they were receiving involuntary treatment.

A death is **examinable** under section 23 and section 24 of the Coroners Act, and even those caused by identified natural disease must be reported to a Coroner if:

- The person was in custody of police or other lawful custody or was attempting to escape when the death occurs;
- it occurs as a result of or in the course of a police operation;
- the deceased person is an inmate of a child detention centre or a correctional centre, even if at the time of death he/she was temporarily absent from the centre when the death occurs;
- The deceased person is a child:

    in care;

    in respect of whom a report of risk of significant harm has been made to within the preceding 3 years or the sibling of such child;

    whose death may be due to neglect;

- The deceased person was living in residential care provided or funded under the Disability Services Act or an assisted boarding house;
- The deceased person has a disability within the meaning of the Disability Services Act and receives from a government funded service provider assistances to live independently in the community.

**Neonates**

A still birth is not a death. Accordingly, it need not be reported to a coroner unless you are unsure whether the baby took a breath after it was expelled from its mother. If a baby dies at birth due to prematurity or congenital abnormality the death is not reportable.

However, if it is likely the death was due to sub-optimal management of the birth it is reportable. Further, even if the death was due to a natural condition such as prematurity, it may still be reportable if it is caught by s24 (described above).

## 2. Geriatric deaths may not need to be reported

A death due to traumatic injury is reportable even if the injury is suffered months or even years before the death and the proximate cause is a naturally occurring condition. For example, a death due to sepsis may be reportable if recurring urinary tract infections are due to paraplegia flowing from a motor vehicle crash.

However, even though a person has died from the direct or indirect effects of trauma a cause of death certificate may be issued under s38(2) if:

- The person was 72 years of age or older;
- He/she died after sustaining an accidental injury that was attributable to the deceased's age and was not caused by the act or omission of another person; and
- No relative of the deceased objects to the certificate being issued.

For example, an 82 yr old woman with diagnosed Parkinson's disease has a witnessed fall at home and fractures her right neck of femur. She is admitted to hospital and the fracture is pinned. The procedure is completed without mishap and she appears to be recovering well but on day three post-surgery she complains of severe chest pain on inspiration and is found to have diminishing oxygen saturations. There is a strong clinical suspicion that she may have had a pulmonary thromboembolism, but she dies before this can be confirmed with special investigations.

Although the death may be indirectly due to traumatic injury, with the family's consent a cause of death certificate can be issued:

1a) pulmonary thrombo embolism

b) neck of femur fracture

2. Parkinson's disease.

A similar medical picture would have a different coronial outcome if the fall occurred in hospital after the patient's falls management plan had been drawn up but it was not followed. In that case, it is arguable that the death was contributed to by the omission of ensuring the patient did not move about unaided and the authority to issue the certificate under s38(2) would not exist and the death would need to

be reported to police and the coroner.

## 3. Natural cause deaths should not usually be reported

Coroners focus on unnatural, violent and suspicious deaths. Natural cause deaths need only be reported if the ***probable*** cause is unable to be identified as a result of reviewing the medical history of the deceased and considering the signs and symptoms that immediately preceded the death.

It is not necessary that a doctor considering issuing a cause of death certificate has a complete understanding of the mechanism by which the condition progressed to be fatal. The question is whether the likely proximate cause of death can be identified.

It is not necessary for the issuing doctor to have treated the deceased provided he or she examines the body and provided the deceased has seen some doctor in the 6 months preceding the death.

The doctor who was responsible for the deceased's medical care immediately prior to the death *must* issue a cause of death certificate if he or she can identify a natural disease or condition that more likely than not caused the death.

## 4. Which health care related deaths need be reported?

Section 6(1)(e) provides that a death is reportable if it was *"not the reasonably expected outcome of a health related procedure".*

**What is a health-related procedure under the Coroners Act?**

The definition of health-related procedure is very wide - section 6(3). It includes medical, surgical, dental or other health-related procedure. This includes the administration of anaesthetics, sedatives and other drugs.

**When is a death "not a reasonably expected outcome"?**

The application of the definition of reportable death following a health-related procedure can be problematic because it requires post facto reconstruction of what was known and what should have been anticipated before the health procedure that preceded the death was undertaken. Because it is a threshold question for determining whether a death should be investigated precision is not possible or necessary. Guidance can be provided by consideration of two related but separate questions:

**1. Was the death an outcome of the procedure?**

When considering whether the procedure caused or contributed to the death ask would it have occurred anyway, at about the same time, as a result of the patient's condition? If the answer is "yes" the death is not reportable. It is also relevant to ask whether the procedure was performed to the expected professional standard? If the answer to that question is "no", further consideration should be given to

whether the adverse outcome was caused or contributed to by that sub-standard treatment.

For example, if a patient presents with acute abdominal pain and an exploratory laparotomy discovers inoperable necrotic bowel from which the patient dies days after the procedure, it is reasonable to conclude the death was not the outcome of the procedure but the condition and the death is therefore not reportable.

**2. Was the death reasonably expected?**

**Before the procedure was commenced**, was it recognised that because of the patient's condition it was more likely than not that the procedure would not preserve the patient's life but his/her outlook was so bleak that despite being informed of that risk the patient (or their statutory substituted decision maker) and the treating team elected to continue with it?

When considering the expected outcome it is appropriate to have regard to the clinically accepted range of risk associated with the procedure and the circumstances in which the health care was provided.

It is also relevant to ask whether the procedure was performed to the expected professional standard because a negative answer might lead to a conclusion that the procedure contributed to the death that might not have occurred had a better standard of health care been provide it which case the death is reportable.

For example, in the case outlined above, because of the relatively young age of the patient and his otherwise good health it is decided to attempt to resection the bowel and anastomose the remaining intestine. It is explained to the patient's next of kin that the patient's chances of surviving the procedure are not good but that without it he will certainly die. The tissue is found to be very friable; 6 hours post-surgery, a leak is detected and the patient is taken back to theatre but sepsis has already set in and the patient dies the following night. It would be reasonable to conclude that the procedure has contributed to the death but that outcome was not unexpected. The death is not reportable. Conversely, if the surgeon failed to investigate the leak despite the indications that it was occurring it is could more cogently be argued that the death was preventable and that it should therefore be reported.

## 5. Seek advice

If there is uncertainly as to whether a patient's death should be reported to a coroner advice can be sought from the duty forensic pathologist by calling **(02)8584-7800**. Generally, advice should be sought during business hours. If a health procedure related death occurs outside of business hours and it is uncertain whether it needs to be reported, after family have been afforded an opportunity to view the body, it can be moved to the hospital mortuary, pending the obtaining of advice.

## 6. How to document a coronial death

On occasions the events preceding a hospital death will be hectic and while a scribe should always been appointed if possible, it is unreasonable to expect all involved in the efforts to preserve life to make contemporaneous notes. There is nothing untoward about making notes after the event, as long as it is clear that is what has been done. Because a patient has died it is likely that the notes might be more extensive than when nothing untoward has occurred and it is also appropriate. The notes should include a description of the signs and symptoms and the treatment/therapy provided.

Once the death has been reported to police they will attend and complete the report to the coroner – From P79A.

A senior member of the treating team should complete a Form A and if the death is associated with anaesthetic the form formerly known as a Form B should also be completed.

Ideally, a copy of the records of the last admission should accompany the body to the forensic pathology mortuary. In any event a copy must be provided within 24 hours.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Department of Forensic Medicine

NSW Police

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For healthcare professionals

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Help for family and friends of missing persons

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