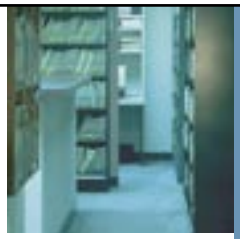

Should I report the death to the Coroner?

Sara Bird, MBBS, MFM (clin), FRACGP, is Medicolegal Adviser, MDA National. sbird@mdanational.com.au

Case histories are based on actual medical negligence claims, however certain facts have been omitted or changed by the author to ensure the anonymity of the parties involved.

The aim of this article is to outline the circumstances in which a general practitioner should report a patient's death to the Coroner.

Case history

The 48 year old patient attended his general practitioner after suffering a knee injury while playing soccer. The GP made a provisional diagnosis of a ruptured anterior cruciate ligament and organised prompt referral to an orthopaedic surgeon. The patient subsequently underwent an arthroscopy and ligament repair. Postoperatively the patient experienced increasing leg swelling and pain. The surgeon ordered a duplex venous ultrasound to exclude a deep venous thrombosis (DVT). The ultrasound was reported as normal and the patient was advised to rest and elevate the leg. About 1 month after surgery, the patient experienced an episode of acute shortness of breath while at home. He borrowed his wife's Ventolin puffer and went to lie down. Some hours later, his wife found him dead on the bathroom floor.

Medicolegal issues

The patient's general practitioner was contacted by a resident medical officer (RMO) at the local hospital and informed of the circumstances of the patient's death. The RMO was seeking information about the patient's past medical history and clarification as to whether the GP could complete a death certificate. The GP felt that the most likely cause of death was pulmonary embolism (PE). However, he did not feel 'comfortably satisfied' that this was the probable cause of death. In any event, the GP believed that even if he was confident that the death was the result of PE, the death should be reported to the Coroner because it was related to the knee injury. The GP advised the RMO that he was unable to complete a death certificate and the Coroner's office was notified of the patient's death by the RMO. A subsequent autopsy confirmed a finding of a DVT and saddle PE.

Discussion and risk management strategies

Completing a death certificate and reporting a death to the Coroner are mutually exclusive exercises. A lack of training about legal obligations regarding reportable deaths and infrequency in certifying deaths can cause anxiety and uncertainty about when to complete a death certificate and when to report a death to the Coroner. Recent reports have suggested that there may be 'under-reporting' of deaths to the Coroner.[1,2]

The Coroner is mainly concerned with investigating deaths which occur in a number of unexplained circumstances. 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.

The legislative provisions for death certification and reporting to the Coroner vary from state to state and are summarised in *Table 1*. If a GP is not 'comfortably satisfied' as to the probable cause of death, or any of the other circumstances listed in *Table 1* are present, a death certificate cannot be written and the death should be reported to the office of the Coroner or local police. If a GP is unsure about their obligations in a certain situation, the GP can seek advice from the office of the Coroner.

Conflict of interest: none.

References

1. Walker B. Final Report of the Special Commission of Inquiry into Camden and Campbelltown Hospitals. July 2004.
2. Victorian Parliament Law Reform Committee. Coroners Act 1985 Discussion Paper. April 2005.

AFP

Correspondence
Email: afp@racgp.org.au

Table 1. When should I report to the Coroner?

	NSW Coroners Act 1980	VIC Coroners Act 1985	QLD Coroners Act 2003	SA Coroners Act 2003	WA Coroners Act 1996	TAS Coroners Act 1995	NT Coroners Act	ACT Coroners Act 1997
Cause of death								
Unknown	✓	✓	✓	✓	✓	✓	✓	✓
Unexpected		✓	✓ Not reasonably expected to be the outcome of a health procedure	✓	✓	✓ Child less than 1 year	✓	
Unnatural or violent	✓	✓	✓	✓	✓	✓	✓	✓ Killed or drowned
Suspicious or unusual	✓		✓	✓				✓
Nature of death								
Identity unknown		✓	✓		✓	✓	✓	
Directly/ indirectly from an accident or injury	✓ Within 1 year and a day of the accident	✓	✓ Unnatural or violent	✓ Unnatural or violent	✓	✓	✓	✓ Directly attributable to the accident
Not attended by practitioner in 3 months before death	✓							✓
Under, or as a result of anaesthetic	✓	✓	✓ If not expected to be the outcome of a health procedure	✓	✓	✓ Not due to natural causes	✓	✓
Within 24 hours of anaesthetic	✓			✓ Within 24 hours of surgical procedure or invasive medical or diagnostic procedure				✓ Within 72 hours of medical, surgical, dental, or invasive medical or diagnostic procedure
Within 24 hours of discharge from hospital (inpatient, emergency treatment)			✓					
In police custody/ other lawful custody	✓	✓	✓	✓	✓	✓	✓	✓
Held in care	✓	✓	✓	✓	✓	✓	✓	✓
Occurred outside the state		✓ Ordinarily resided in Vic and cause of death is not certified by authorised person	✓ Body in Qld at time of death, ordinarily lived in Qld, caused by event in Qld, on a journey to or from Qld		✓ Where cause of death is not certified by authorised person	✓ While travelling to or from Tas, ordinarily resided in Tas and death not certified	✓ Ordinarily resided in NT and death not certified	
On aircraft (during flight) Vessel (during voyage)				✓				