



## Guidelines for reporting deaths to the Coroner

This guideline addresses some commonly asked questions, but it does not cover all possible categories of reportable deaths.

### General principles:

- The **age** of the deceased is irrelevant in determining whether a death is reportable.
- Duration or **time of onset** is sometimes relevant:
  - Some remote injuries included on the death certificate may not be reportable, such as a remote history of a fracture (e.g. fractured neck of femur 10 years ago - see breaks and fractures below)
  - However, a car crash 40 years ago may still have contributed to the death and is therefore reportable (e.g. car crash -> head injury -> aspiration pneumonia -> death).
  - The most common relevant conditions where time of onset can cause problems are:
    - Acquired brain injury
    - Traumatic cervical cord injury.
    - Subdural haematoma
    - Fractured neck of femur
- A recent or prior fall does not make a death reportable. There needs to have been some significant injury caused by the fall and that injury must have directly or indirectly caused or contributed to the death.
- **Illicit substance use is likely to be considered not reportable** if it has not directly caused the death. For example, Pneumonia in a smoker or marijuana use.
- **Part II of a death certificate** is often erroneously used to record comorbidities that did not directly cause the death. In filling out a 'death certificate', considering the inclusion of a potentially reportable cause of death in **either part I or part II** of the certificate is sufficient reason to instead report the death to the Coroner
- **"Unknown"** is not an acceptable cause of death. If a doctor does not know the cause of death the death must be referred to the coroner.
- **The strength or certainty of a cause of death.** A doctor may arrive at a cause of death in a number of ways. The provision of a cause of death on a 'death certificate' does not necessarily mean that the doctor had comprehensively investigated the patient's medical status and that the test results provided an unequivocal evidence base for the cause of death statement they provided. It may be that the doctor has a reasonable belief as to the cause of death on clinical and circumstantial grounds, or that some test results suggested a diagnosis but that not all the confirmatory tests could be conducted prior to the death. In this situation if the death is from natural causes and there are no other reportable factors the doctor can complete the cause of death statement on the 'death certificate' on the basis of a reasonable clinical belief as to the cause of death and the death does not need to be reported on the basis that the cause is 'unknown'.
- **Organ failures as a Cause of Death.** Organ failures are not a 'Cause of Death'. Indeed, the instructions on 'death certificate' forms make it clear that terms such as 'Heart Failure' or 'Respiratory Failure' cannot be given as 'Causes of Death'. What is required is the underlying disease process that led to the organ failure. (e.g. No one dies **OF** heart failure, they may die **IN** heart failure or **WITH** heart failure, but that heart failure is due to a specific individual or mixed set of diseases or pathological processes. – ischaemic heart disease,

Hypertensive heart disease, cardiac amyloid, dilated cardiomyopathy, etc. What must be recorded is the underlying disease itself not the symptoms it led to).

## Natural deaths – not reportable

The following conditions are considered natural causes and are usually **not** reportable:

- **Old age / extreme age / natural causes are clumsy causes of death.** Doctors are encouraged to attempt to define the main underlying ‘cause’ or ‘causes of death’, but we recognise that this can be difficult particularly where patients have multiple disease states all of which are contributing to the death to varying degrees. Use of these generic terms should be avoided but may be acceptable in certain situations.
- **Septicemia and toxemia** related to a natural infective disease process is not reportable unless the infection is an unexpected consequence of a medical procedure.
- **Dementia** is usually a degenerative and terminal natural disease. As such it is an acceptable ‘cause of death’ on its own without recourse to including the terminal consequences of the disease. Recording the type of dementia would be preferable if it is known. (N.B. if the patient is an involuntary patient in a nursing home and as such in state care the death, even from completely natural causes, is reportable to the Coroner as the patient is ‘in care’.)
- **Starvation / dehydration / poor oral** intake if part of a natural disease process such as dementia or cachexia due to poor oral intake in a setting of disseminated malignancy, is not reportable. However, care should be taken in formulating the ‘Cause of Death’ and using the substantial underlying disease entity is preferable to recording the multiple symptoms of the disease.
- **Falls with no injury are not reportable.** If the deceased has had a fall (at any time) but no injury occurred that caused or contributed to death then the death is **not** reportable. In this situation there is no need for a doctor to include the ‘fall’ on death certificate if it has not contributed directly or indirectly to the death as it is not a ‘cause’ but rather a description of some of the background circumstances of the patient’s life. Including the ‘fall’ as part of the cause of death in any either part I or part II of the certificate will result in the Registrar of Births Deaths and Marriages reporting the death to the Coroner and this may create difficulties and delays for the family.

## Injury deaths - reportable

Deaths following an injury are reportable if the injury has caused or contributed to the death.

- **Breaks and fractures** that are injury related and also directly caused or contributed to a death are reportable to the Coroner. These deaths are reportable regardless of the age of the patient. Even if the likelihood of a fracture occurring as a result of the injury was increased because of a natural disease process such as osteopenia or related bony pathology, the death is still reportable.

*There are a number of exceptions that largely relate to the fracture not being part of an external injury. (e.g. Pathological fractures caused solely due to metastatic disease or spontaneous crush fractures of vertebrae in the setting of osteopenia etc.)*

- **Subdural haematomas** that are injury related and caused or contributed to death are reportable. This includes traumatic acute subdural haemorrhage, acute or chronic subdural haemorrhage and the pathological sequelae of chronic subdural haemorrhage due to repeated head trauma.

*Exception to the reporting of subdural haemorrhage include non-traumatic haematomas, for example, “spontaneous subdural” and “non-traumatic subdural although these are comparatively rare.”*

- **Intracerebral haemorrhages** that caused or contributed to death and that are the result of a head injury or an unexpected consequence of a medical procedure are reportable.

*Exceptions to the reporting of deaths from intracerebral haemorrhage would include haemorrhage occurring as a result of natural disease processes such as hypertension, spontaneous rupture of cerebral artery aneurysm/arteriovenous malformation, amyloid angiopathy etc. or 'non-traumatic intracerebral haemorrhage' or 'spontaneous subarachnoid haemorrhage' that was not trauma related.*

- **Acquired brain injuries** that caused or contributed to death and are head injury related, or the result of other non-natural processes such as hypoxic/ischaemic brain injury directly or indirectly related to drug usage or overdose, are reportable independent of the time interval between the original injury and the subsequent death.
- **Spinal cord injury / Paralysis / Quadriplegia / Paraplegia** that are injury related and caused or contributed to death are reportable independent of the time interval between injury and death.

**Remember deaths following an injury are not reportable if the injury has NOT caused or contributed to the death.**

## Deaths where a medical procedure has been performed

**Deaths where a medical procedure has been performed are reportable** if they occurred during or following a medical procedure and the treating practitioner would not have reasonably expected the death.

*For example:*

- 1a) Uncontrolled haemorrhage 1b) Cholecystectomy or  
1a) Cardiac arrest during bladder cystoscopy*

**Deaths where a medical procedure has been performed may not be reportable if:**

- A procedure has occurred as part of treatment and there is no unexpected complication of the procedure. For example:
  - Cancer of the larynx where a tracheostomy tube was replaced before death without complication
  - Sepsis from an infected PEG tube.
- A procedure was undertaken and the deceased had an underlying condition from which they died, and the procedure was an attempt to remedy the condition. For example:
  - Ruptured abdominal aortic aneurysm with attempted repair that they did not survive.
  - If the deceased had an elective procedure and their pre-existing co-morbidities caused death and there were no complications of the surgical procedure.
  - Pneumonia in a person with severe COPD following total hip replacement.
  - If the death is due to a known complication of the procedure and there were no problems with the procedure
  - Stroke following aortic valve replacement

## Unnatural or unexpected deaths

The following are some examples of reportable deaths that are unnatural or unexpected.

- **Intravenous drug use** should be reported if it has caused death, for example, a heroin overdose
- **Choking** on a food bolus
- **Burns** should be reported if directly or indirectly a factor in the cause of death
- **Anaphylaxis** should be reported
- **Hyperthermia** should be reported
- **Hypothermia** should be reported.