Neil MacLean

District Court Judge

Auckland

Better Certification of Death - Concurrent Workshop Repeated

Sunday, 23 June 2013	Start 8:30am	Duration: 55mins	Warhol
	Start 9:35am	Duration: 55mins	Warhol

CORONIAL SERVICES
OF NEW ZEALAND
Purongo O te Ao Kakarauri

Better Certification of Death

Chief Coroner of New Zealand, Judge MacLean

NZMA General Practice Conference and Medical Exhibition
Rotorua, June 2013

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The Coroners Act 2006

- Came into force 1 July 2007
- Establishes a dedicated, professional, full-time Coronial system
- Recognises and prescribes the rights of families and other interested parties
- Acknowledges the spiritual and cultural needs of the family

Role of the Coroner

- Specialist Judge
- Legal responsibility to investigate certain deaths
- Decides cause and circumstances of sudden, unexplained deaths and deaths in special circumstances
- Makes recommendations to prevent deaths in similar circumstances

The Coroner's Functions

- To receive reports of deaths (and to decide whether or not to accept jurisdiction)
- To decide whether or not a post mortem should be authorised, and the extent of such post mortem
- To release the body
- To decide whether to open an Inquiry which may proceed to a formal court proceeding (Inquest)
- To make recommendations/comments to reduce the chances of deaths occurring in similar circumstances
- To notify family of significant matters (e.g. objection rights to PM, retention of body samples)

Deaths in NZ

- Keep it in perspective
- In 80% of deaths in NZ a doctor is able to sign a medical certificate as to cause of death
- Only 20% of deaths are reported to a Coroner and of these approximately half have an inquiry opened

Coroners and Doctors

- If death must be reported or where doctor unsure of whether to certify a death – doctor will often call Coroner
- If reporting not mandatory, conversation enables Dr and Coroner to discuss
- Coroner will note details of any conversation
- If agreed that Dr will certify – copy of MCCD will be faxed or scanned to NIIO

Coroners and Doctors

- Important to have an open and trusting relationship
- Common goal - preventing loss of life
- Coroner seeks to identify practices that have cost human life
- **Not** seeking to hold medical practitioners responsible for deaths

Purpose of Death Certification

- COD certificate an important legal document
- A record of deaths is kept on the NZ Births, Deaths and Marriages (BDM) Register
- BDM supplies cause of death into to NZHIS of MOH
- NZHIS assigns underlying cause in accordance with WHO classification and produces and publishes cause of death statistics
- Stats are used to monitor causes of death for research and for policy development

The Decision to Certify

- Required standard - being satisfied as to the probable cause of death
- Do not have to be absolutely certain – just your best medical opinion which is reasonable and justifiable
- There are no time frames to be followed (eg. one month since last seen)
- Can seek advice – from senior doctor/colleague, discuss with Coroner

Deaths that Must be Reported

- Mandatory reporting provisions in Coroners Act 2006 (section 13)

- Deaths that must be reported:
  - Without known cause, suicide, unnatural or violent
  - Where doctor cannot sign death certificate
  - Medical, surgical, dental, or similar, anaesthetic, medicine, or maternal (pregnancy, childbirth, post-partum)
  - Official custody or care

Accidental Deaths in the Elderly

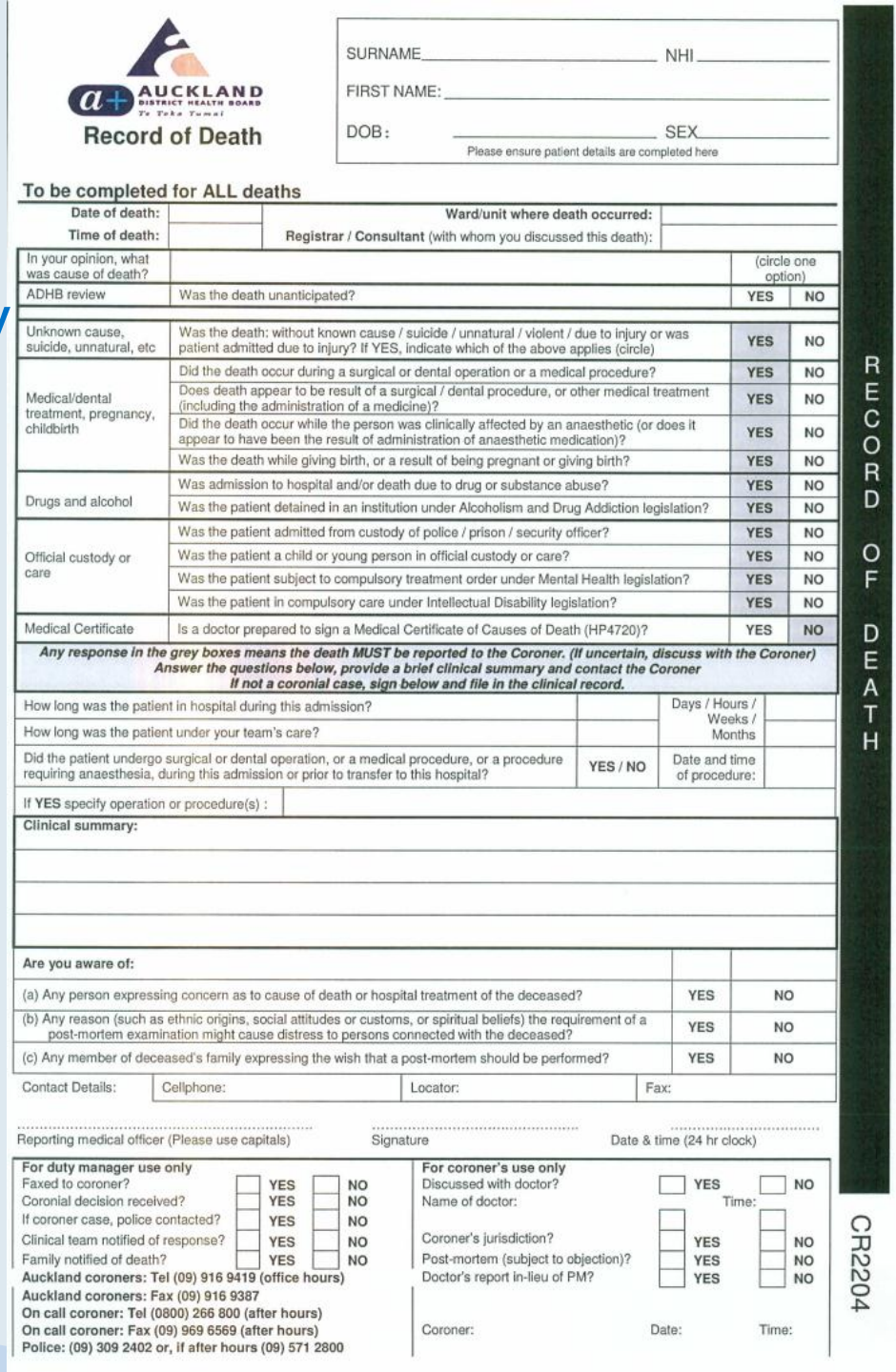
- Deaths which result directly or indirectly from an accident or injury are reportable under the Coroners Act
- BUT s 46C of the Burial and Cremation Act provides an exception for cases where the deceased 70+ provided there were no unusual or suspicious circumstances surrounding the death.
- This gives a discretionary power.
- Section 46C a pragmatic response to prevalence of falls in elderly but caution needed considering vulnerability of elderly (think of *Shipman*)

Accidental Deaths in the Elderly Cont…

- Rest-homes an area of concern – issues surrounding quality of care and treatment of elderly
- Doctors contracted to rest-homes often required to see multiple complex-need patients in short time
- Any concerns of family an important consideration but often no established relationship between GPs and family (and sometimes families may have own agenda)
- HDC reports in the course of investigating complaints have occasionally noted that the CoD recorded by the certifying doctor do not accurately reflect the clinical picture at death

Record of Death (ROD) Form

- Prompts consideration of key matters under Coroners Act
- Have been concerns about under-reporting
- Form slowly being adopted across all DHBs in hospitals
- Aiming for streamlined, consistent approach
- Suggested that GPs and community doctors should follow same process



AUCKLAND DISTRICT HEALTH BOARD
Te Toka Tumai

Record of Death

SURNAME _____ NHI _____
FIRST NAME: _____
DOB: _____ SEX _____
Please ensure patient details are completed here

To be completed for ALL deaths

Date of death: | Ward/unit where death occurred:
Time of death: | Registrar / Consultant (with whom you discussed this death):

		(circle one option)	
In your opinion, what was cause of death?			
ADHB review	Was the death unanticipated?	YES	NO
Unknown cause, suicide, unnatural, etc	Was the death: without known cause / suicide / unnatural / violent / due to injury or was patient admitted due to injury? If YES, indicate which of the above applies (circle)	YES	NO
Medical/dental treatment, pregnancy, childbirth	Did the death occur during a surgical or dental operation or a medical procedure?	YES	NO
	Does death appear to be result of a surgical / dental procedure, or other medical treatment (including the administration of a medicine)?	YES	NO
	Did the death occur while the person was clinically affected by an anaesthetic (or does it appear to have been the result of administration of anaesthetic medication)?	YES	NO
	Was the death while giving birth, or a result of being pregnant or giving birth?	YES	NO
Drugs and alcohol	Was admission to hospital and/or death due to drug or substance abuse?	YES	NO
	Was the patient detained in an institution under Alcoholism and Drug Addiction legislation?	YES	NO
Official custody or care	Was the patient admitted from custody of police / prison / security officer?	YES	NO
	Was the patient a child or young person in official custody or care?	YES	NO
	Was the patient subject to compulsory treatment order under Mental Health legislation?	YES	NO
	Was the patient in compulsory care under Intellectual Disability legislation?	YES	NO
Medical Certificate	Is a doctor prepared to sign a Medical Certificate of Causes of Death (HP4720)?	YES	NO

Any response in the grey boxes means the death MUST be reported to the Coroner. (If uncertain, discuss with the Coroner)
Answer the questions below, provide a brief clinical summary and contact the Coroner
If not a coronial case, sign below and file in the clinical record.

How long was the patient in hospital during this admission?		Days / Hours / Weeks / Months	
How long was the patient under your team's care?			
Did the patient undergo surgical or dental operation, or a medical procedure, or a procedure requiring anaesthesia, during this admission or prior to transfer to this hospital?	YES / NO	Date and time of procedure:	
If YES specify operation or procedure(s) :			

Clinical summary:

Are you aware of:		
(a) Any person expressing concern as to cause of death or hospital treatment of the deceased?	YES	NO
(b) Any reason (such as ethnic origins, social attitudes or customs, or spiritual beliefs) the requirement of a post-mortem examination might cause distress to persons connected with the deceased?	YES	NO
(c) Any member of deceased's family expressing the wish that a post-mortem should be performed?	YES	NO

Contact Details: | Cellphone: | Locator: | Fax:

Reporting medical officer (Please use capitals) | Signature | Date & time (24 hr clock)

For duty manager use only

Faxed to coroner?	YES	NO
Coronial decision received?	YES	NO
If coroner case, police contacted?	YES	NO
Clinical team notified of response?	YES	NO
Family notified of death?	YES	NO

Auckland coroners: Tel (09) 916 9419 (office hours)
Auckland coroners: Fax (09) 916 9387
On call coroner: Tel (0800) 266 800 (after hours)
On call coroner: Fax (09) 969 6569 (after hours)
Police: (09) 309 2402 or, if after hours (09) 571 2800

For coroner's use only

Discussed with doctor?	YES	NO
Name of doctor:	Time:	
Coroner's jurisdiction?	YES	NO
Post-mortem (subject to objection)?	YES	NO
Doctor's report in-lieu of PM?	YES	NO

Coroner: Date: Time:

RECORD OF DEATH

CR2204

ROD Form Detail

In your opinion, what was cause of death?		(circle one option)	
ADHB review	Was the death unanticipated?	YES	NO
Unknown cause, suicide, unnatural, etc	Was the death: without known cause / suicide / unnatural / violent / due to injury or was patient admitted due to injury? If YES, indicate which of the above applies (circle)	YES	NO
Medical/dental treatment, pregnancy, childbirth	Did the death occur during a surgical or dental operation or a medical procedure?	YES	NO
	Does death appear to be result of a surgical / dental procedure, or other medical treatment (including the administration of a medicine)?	YES	NO
	Did the death occur while the person was clinically affected by an anaesthetic (or does it appear to have been the result of administration of anaesthetic medication)?	YES	NO
	Was the death while giving birth, or a result of being pregnant or giving birth?	YES	NO
Drugs and alcohol	Was admission to hospital and/or death due to drug or substance abuse?	YES	NO
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Medical Certificate	Is a doctor prepared to sign a Medical Certificate of Causes of Death (HP4720)?	YES	NO

Any response in the grey boxes means the death MUST be reported to the Coroner. (If uncertain, discuss with the Coroner)
Answer the questions below, provide a brief clinical summary and contact the Coroner
If not a coronial case, sign below and file in the clinical record.

"If uncertain, discuss with the Coroner"

ROD Form Detail Cont...

Any concerns expressed by family about care of treatment an important consideration

Are you aware of:		
(a) Any person expressing concern as to cause of death or hospital treatment of the deceased?	**YES**	**NO**
(b) Any reason (such as ethnic origins, social attitudes or customs, or spiritual beliefs) the requirement of a post-mortem examination might cause distress to persons connected with the deceased?	**YES**	**NO**
(c) Any member of deceased's family expressing the wish that a post-mortem should be performed?	**YES**	**NO**

Contact Details:	Cellphone:	Locator:	Fax:

....

Reporting medical officer (Please use capitals) Signature Date & time (24 hr clock)

For duty manager use only

Faxed to coroner?	☐ **YES**	☐ **NO**
Coronial decision received?	☐ **YES**	☐ **NO**
If coroner case, police contacted?	☐ **YES**	☐ **NO**
Clinical team notified of response?	☐ **YES**	☐ **NO**
Family notified of death?	☐ **YES**	☐ **NO**

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Police: (09) 309 2402 or, if after hours (09) 571 2800

For coroner's use only

Discussed with doctor?	☐ **YES**	☐ **NO**
Name of doctor:	Time:	
	☐	☐
Coroner's jurisdiction?	☐ **YES**	☐ **NO**
Post-mortem (subject to objection)?	☐ **YES**	☐ **NO**
Doctor's report in-lieu of PM?	☐ **YES**	☐ **NO**

Coroner: Date: Time:

Discussing the Death with the Coroner

- COD certificate is a doctor's responsibility
- A Coroner has no legal authority over the death until he or she takes jurisdiction for a case
- Coroner can 'advise' as to jurisdiction
- Contact the coroner for advice or clarification if unsure whether or not to certify the death
- **If in doubt, err on the side of over-reporting**
- **The more information you have, the more helpful the discussion will be**

Reporting the Death Cont…

- Information Coroner likely to discuss (note that this is similar to the information on the ROD form):
  - Basics - name / date of death / age / living circumstances
  - Circumstances of death
  - Clinical history
  - Treatment (consent/risks)
  - Were police called or involved at scene?
  - NOK – Involvement? Issues?
  - Certification?

After-hours service – NIIO 24/7

- NIIO – National Initial Investigation Office
- Based in Ellerslie, Auckland and covers after-hours.
- A Coroner is always on-call and available to discuss the death
- Recently has become a 24/7 service
- Deals with all initial notifications of deaths
- Provides an around-the-clock point of contact for doctors with an on-call Coroner

Coroner Accepts Jurisdiction

- If Coroner takes jurisdiction s/he will ask police to attend and carry out sudden death procedures
  - POL 47 – report to Coroner
  - Life extinct form
  - ID form
  - Body to mortuary
- Police are ‘agents’ of Coroner for sudden deaths and will attend at place of death

Areas of Potential Tension between Doctors and Coroners

- Doctors may feel pressure to certify deaths
- Resentment of Police involvement
- Lack of familiarity with legal obligations re issuing MCCD and Coroners Act requirements (following ROD form can assist with this)
- Time pressures
- Delay in provision of medical information
- Desirability of early electronic access to information for pathologist and/or Coroner
- Unavailability

If Deceased is for Cremation…

- Doctor who signs as to cause of death **must** have seen deceased when alive **and** viewed body after death
- Does not apply if burial (except if substitute doctor)
- Medical referee supposedly an important ‘check’ or ‘audit’. Is that the reality?

‘Substitute Doctors’

- A doctor who did not attend the person during the illness and is substituting for the doctor who did attend the deceased during the illness
- Substitute doctor **cannot** issue death certificate if primary doctor has refused
- Substitute doctor **can** issue a death certificate if:
  - the original doctor is ‘unavailable’; or
  - Doctor who last attended is unlikely to be able to certify within 24 hours of death; or
  - 24 hours or more has passed since death and original doctor has not issued certificate

‘Substitute Doctors’ Cont…

- In order to certify the causes of death, the substitute doctor **must:**
  - Have regard to medical records of doctor who last attended person during their illness
  - Have regard to circumstances of person’s death
  - Have examined the person’s body
- Can only issue certificate if he or she:
  - Is satisfied that death was natural consequence of the illness
  - Has reviewed attending doctor’s medical records
  - Is aware of person’s cause of death
  - Has examined person’s body

Other Issues to Consider

- Doctors as gatekeepers to coronial process
  - Doctors have important responsibility in coronial process
  - 'Under-reporting' a real concern
  - Reform of coronial system in UK prompted by extreme example of Harold Shipman, a doctor who murdered many patients and then signed the death certificates - no obligation to report the deaths to the Coroner
- Lack of knowledge about the deceased patient and/or family issues
- Remember that Coroners Act 2006 prescribes new rights for families
  - There is a right to object in some cases

Other Issues to Consider Cont...

- Delayed reporting (to the Coroner and to the police)
- Implications when doctors do not make cover arrangements when away
  - Lack of access to the clinical record
  - Difficult to ascertain detailed medical history of deceased
  - Coroner cannot make decision as to jurisdiction
  - Holds up process for grieving family
- Undertakers often anxious to embalm

Law Commission Report – Burial and Cremation Act

- Burial and Cremation Act 1964 is substantially unchanged for nearly half a century
- Acts main purpose to ensure provision is made for burial of dead in a controlled and respectful manner
- Also contains legal provisions governing death certification
- Law Commission report identified issues with current death certification and cremation practices
- Received 44 submissions in response to first Issues Paper and in process of drafting a second

Law Commission Report –
Key issues with death certification practices:

- Person can currently be buried without being examined of formally ID'd by doctor
- Confusion and inconsistency among doctors re reporting of:
  - Deaths related to medical treatment
  - Deaths from unknown causes
  - Deaths related to accidents in people aged over 70
- Significant error rates in MCCDs (attributed in part to practice of funeral homes transcribing doctor's handwritten MCCDs to Dept of Internal Affair's electronic system)
- No current process whereby families have opportunity to comment on contents of MCCD

Law Commission Report – Key issues with cremation practices:

- Current ‘on the paper’s audit by medical referee depends on accuracy of info provided by single certifying doctor.
- Single doctor can complete both MCCD and cremation certificate (no independent ID of deceased or CoD).
- Medical referees often work in isolation – often no access to necessary info and heavy burden of statutory obligation to “definitely” establish the CoD.
- Lack of monitoring, training and support for medical referees
- No standard cremation certificate used nationally.
- No auditing of medical referees.

Case Example 1

- 85 year old woman, dementia unit resident
- No medical diagnosis except Alzheimer's dementia
- Usually ‘well’ although needing full time care
- Found dead in her bed one morning
- What happens?

Case Example 2

- 80 year old man, rest home resident
- Parkinson's disease. Past Hx of IHD with MI aged 65 but no symptoms since
- Becomes suddenly and non-specifically unwell
- Decreased consciousness, not eating or drinking
- No investigation or hospital referral after discussion with family
- No specific diagnosis. Presumed to have had acute coronary event but no evidence to support that
- Died within 24 hours. No suspicion of unnatural causes
- What happens?

Case Example 3

- 75 year old patient with dementia
- Pushed over by another dementia unit resident
- Knocked head but no clear loss of consciousness
- Became increasingly unwell over following days
- Drowsy, poor eating, off her food
- Suspicion of intracerebral injury, possibly subdural haematoma
- Family decline further investigation
- Dies within 1 week
- What happens?

Case Example 4

- 75 year old patient with dementia
- History of falls
- Tripped and fell (witnessed) knocked head but no clear loss of consciousness
- Became increasingly unwell over following days
- Drowsy, poor eating, off her food
- Suspicion of intracerebral injury, possibly subdural haematoma
- Family decline further investigation
- Dies within 1 week
- What happens?

Case Example 5

- 75 year old Maori man living with family collapses and dies at home on Saturday of long weekend
- Family tell Police he has extensive medical history, including diabetes, heart disease. Saw his GP regularly
- Family wants to take body to marae ASAP
- Police can't get hold of GP – message on answer phone advising practice reopens on Tuesday
- What happens?

Case Example 6

- 73 year old history of throat cancer. Had been in remission but returned and declined further treatment. Also had COPD.
- Dies at home on Sunday
- GP not contactable
- GP's practice contracted by Coroner on Monday
- Usual GP "off sick"
- Another GP in practice, hasn't attended patient, has access to clinical records
- What happens?

Case Example 7

- 88 year old Maori Kaumātua
- Hasn't seen doctor for at least 20 years – didn't believe in doctors or western medicine
- Had been seeing a Tohunga (traditional Maori healer)
- Complaints of chest pains, oedema in both legs, deteriorating eyesight, giddy spells
- Found dead in bed in morning
- Family object to PM and want body back today
- What happens?