

Life Extinct, Cause of Death Certificates and the Coroners Act 2003

Following the notification of the death of a patient, a General Practitioner (GP) could be asked to both confirm that death has occurred and complete a Cause of Death Certificate (Form 9). In situations where the GP is not comfortable with issuing a Cause of Death Certificate, the patient's death will need to be reported to the Coroner and the Police notified.

If there are any doubts regarding the death, the correct procedure is to contact the Queensland Police Service.

Assessment that death has occurred (Life is Extinct)

- The determination that death has occurred is a **clinical assessment process** that can be undertaken by a Registered Medical Practitioner or a Registered Nurse.
- Most Funeral Directors prefer that a health professional has made an assessment and documented that death has occurred, prior to the removal of the patient's body from the place of death, to the Funeral Home. The Coroner and Police procedures also require a determination that death has occurred (Life Extinct) in the case of a Reportable Death.
- In the event of the GP being unavailable to determine that death has occurred, a Registered Nurse may do so, provided they are willing and allowed by their organisation and the death is not deemed to be a Reportable Death.
- Currently, documentation in the patients chart that death has occurred, notification to the Funeral Director of the contact information for the patient's usual GP and of the expectation that a Cause of Death Certificate will be issued, should be sufficient to enable the patient to be transferred to a Funeral Home.
- An attendance by a GP to a patient at which time it is determined that death has occurred **can be** claimed under the appropriate **Medicare Benefits** attendance item. While Medicare Benefits are payable for the attendance, they are **NOT** payable for the writing of a Cause of Death Certificate.

Cause of Death Certificate (Form 9)

- The certification of death is a process by which the issuer of the certificate (a Registered Medical Practitioner) notifies the death and expresses an opinion as to the probable cause of the death. A Cause of Death Certificate is required before a death can be registered and a funeral can take place.
- If the GP or another person believes the cause of death is unclear, has concerns regarding the cause of death or the identity of the deceased person, the death should be reported. The Coroner may order an inquiry and request an autopsy. Depending on the circumstances and the cause of death, the Coroner may or may not order a coronial inquest.
- In these cases the Cause of Death Certificate should **NOT** be issued and the Queensland Police Service should be contacted. The GP may contact the Coroner to discuss the situation or concerns prior to notifying the Queensland Police Service.
- **(Refer to contact information over page)**
- A death in a **Residential Aged Care Facility (RACF)** is **NOT** classed as a 'death in care' and therefore not an automatically 'reportable death'. However the criterion as stated above does apply. Where the GP cannot express an opinion as to the probable cause of death, the RACF should report the death.
- The **Births, Deaths and Marriages Registration Act 2003**, allows a doctor to issue a Cause of Death Certificate **without** having seen the patient in the three months prior to their death. A doctor other than the usual attending GP can sign the certificate, if they are willing, have access to the patient's records and can express an opinion as to the probable cause of death.
- The Coronial Counselling Service and the Coronial Support Unit of the Queensland Police Service are available to provide assistance and information to the Coroner, family members and Health Professionals. **(Refer to contact information over page)**
- The previous 'Form D – Medical Certificate of the Cause of Death' remains acceptable, however the new form, (Form 9) includes the Cremation Risk Certificate. **(Copies of the Order Form are available from the Brisbane South website)**
- The **Coroners Act 2003**, commenced on 1 December 2003. A summary of some key elements follows.

Reportable Deaths

The "Notification of Reportable Death by Medical Practitioner and Authorisation of Coroner to Issue Cause of Death (Form 1A)", should be completed for all Reportable Deaths.

- A reportable death is defined as one in which the following circumstances apply:
 - It occurred in Queensland; or
 - The person ordinarily lived in Queensland; or
 - The person was on a journey to or from somewhere in Queensland; or
 - The death was caused by an event in Queensland.
- As well as satisfying this location test the death must also be one where:
 - It is not known who the person is; or
 - The death is a violent or unnatural death; or
 - The death was not reasonably expected to be the outcome of a health procedure; or
 - A *cause of death certificate* has not been issued (*and is NOT expected to be issued*); or
 - The death was a death in care; or
 - The death was a death in custody.

Determining a "reasonably expected outcome of a health procedure"

- The Act defines "health procedure" as a dental, medical, surgical or other health related procedure, including the administration of anaesthetic, analgesic, sedative or other drugs.
- To determine whether a death is a reportable death in this category, two issues need to be considered:
 - Did the health procedure cause the death?
 - Was the death an unexpected outcome?

If the answer to both of these questions is **yes**, then the death is **reportable**.

- In determining if the **health procedure caused the death**, doctors should consider the following:
 - Would the person have died if the procedure was not undertaken?
 - Was the procedure necessary for the person's recovery, rather than optional or elective?
 - Was the procedure carried out with reasonable care and skill?

If the answer to each of these questions is **yes** then the death is **not reportable**.

- In determining if the death was an **unexpected result**, doctors should consider the following:
 - Was the condition of the person such that the death was more likely than not to result from the procedure?
 - Was the decision to undertake the procedure a reasonable one, given the person's condition including their quality of life, if the procedure was not carried out?
 - Was the procedure carried out with all reasonable care and skill?
 - Did the decision to undertake the procedure consider the risk of death was outweighed by the potential benefits the procedure could provide?

If the answer to these questions is **yes**, then the death is **not reportable**.

- If a doctor or any other health professional has concerns that a death may fall into this category then it is appropriate to consult the Coroner for advice. If the Coroner considers that the death is not a reportable death they will provide the doctor with this advice on the *Form 27 – Advice to Doctor Whether Death a Reportable Death*.

A Death in Care

- A death in care is a death where the person:
 - had a disability such as an intellectual disability or an acquired brain injury and resided in a residential service provided by a government or non-government service provider;
 - had a disability such as an intellectual disability, an acquired brain injury or a psychiatric disability and lived in a private hostel (**not a residential aged care hostel**);
 - was being detained in, taken to or under going treatment in a mental health service;
 - was a child under the guardianship of the Department of Families, or in foster care.

These deaths **are reportable deaths** even if the death occurs at a place other than where the person lived.

Contact and Further Information:

Queensland Police Service Police Headquarters • Phone: (07) 3364 6464 (24 hour) Coronial Support Unit • Phone: (07) 3898 0305	Office of the State Coroner • Phone: (07) 3239 6193 (8.30 am – 4.30 pm) • After Hours: (07) 3247 5089 www.justice.qld.gov.au/contact.htm	Coronial Counselling Service • Phone: (07) 3274 9200 www.health.qld.gov.au.qhps/qhss/autopsies.htm Brisbane South Division of General Practice • Phone: (07) 3274 1886 www.brisbanesouth.com.au
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More Fact Sheets, Forms and Guidelines are available from www.justice.qld.gov.au/courts/coroner/home.htm and www.brisbane.south.com.au

This Fact Sheet was produced by Brisbane South Division of General Practice – Aged Care Program in consultation with Aged Care Queensland, the Office of the State Coroner, Coronial Counselling Service, Coronial Support Unit - Queensland Police Service, the Queensland Funeral Directors Association and the Australian Funeral Directors Association - Queensland. Information has also been sourced from the Office of the State Coroner Fact Sheets and the Medicare Benefits Schedule 2004.