



CORONIAL SERVICES
OF NEW ZEALAND
Purongo O te Ao Kakarauri

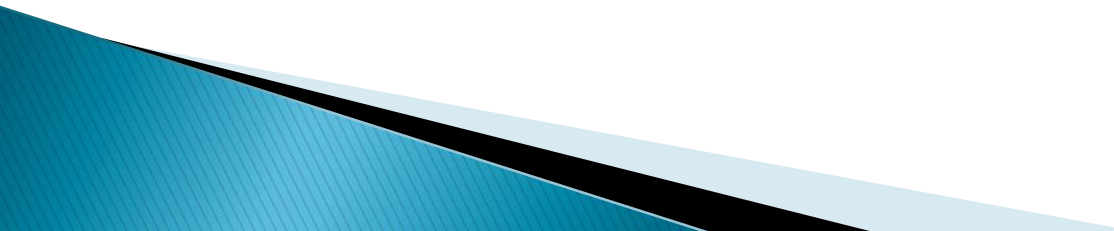
Certifying death – a Coroner's Perspective

Judge Deborah Marshall
Chief Coroner
11 April 2019

Topics covered

- The Role of a Coroner
 - The Coroners Amendment Bill 2014
 - Reporting Deaths
 - Certifying deaths
 - Conclusion
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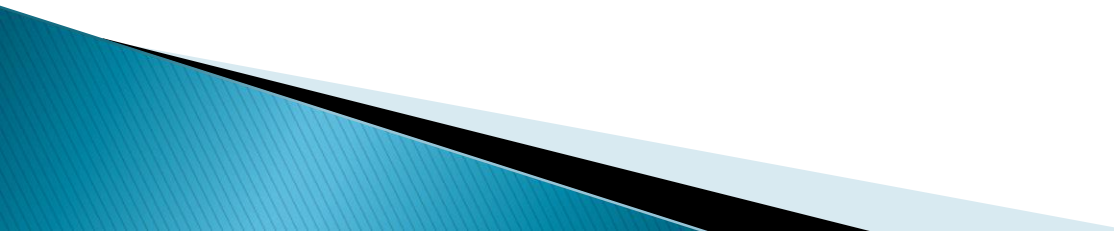
The Role of a Coroner

- ▶ Coroners are independent judicial officers with a legal background who investigate sudden, unexplained or suspicious deaths.
 - ▶ Coroners investigate a death to establish the cause and circumstances of the death and to help prevent similar deaths occurring in the future by making recommendations and comments.
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Role of Duty Coroner

- ▶ Reportable deaths sent to duty coroner who makes decisions on:
 - Whether to take jurisdiction;
 - Is a post mortem necessary;
 - If post mortem is necessary – what kind?;
 - Identification of deceased;
 - Release of body.

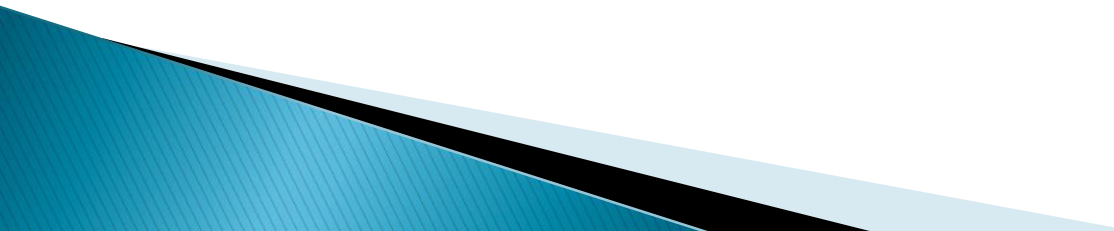
Coronial Statistics

- ▶ 2017–2018
 - 5608 deaths were reported to the Duty Coroner;
 - 3579 cases where coroner took jurisdiction; of those
 - 53% were found to be due to natural causes
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The Coroners Amendment Bill 2014

- Targeted review of Coroners Act 2006 announced 31 July 2012.
- Cabinet paper identified some ambiguity and confusion about certain kinds of reportable deaths.
- Coroners Amendment Bill came into force on 22 July 2016 amending the Coroners Act 2006.
- One of the aims of the Bill was to:
 - Clarify the rules surrounding reporting

Reducing unnecessary reporting and investigations

- Up to 80% of deaths happen when someone dies after an illness and where their doctor is able to issue a certificate of cause of death.
 - Hospital deaths do not have to be reported unless the death was “medically unexpected.”
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Pre-amendment

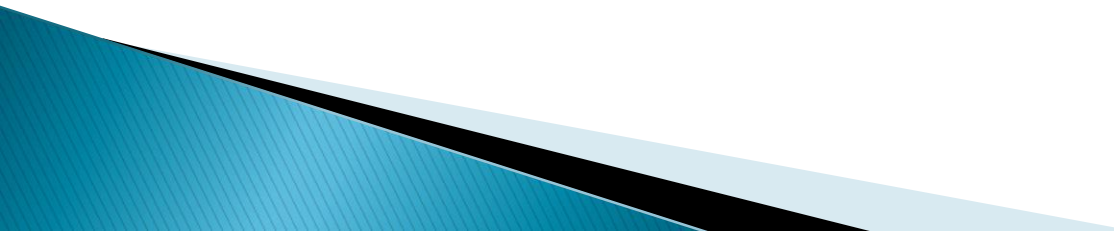
13 Deaths that must be reported under section 14(2)

- (1) This section applies to the following deaths if, and only if, they are deaths to which subsection (2) applies:

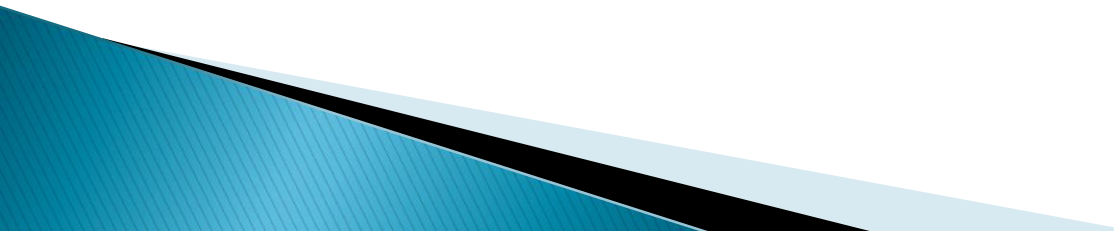
- Without known cause, suicide, or unnatural or violent*
- (a) every death that appears to have been without known cause, or suicide, or unnatural or violent:

- For which no doctor's certificate given*
- (b) every death in respect of which no doctor has given a doctor's certificate (as defined in section 2(1) of the Burial and Cremation Act 1964):

Reporting deaths

- ▶ Sections 14 and 15 of the Coroners Act state that a death must be reported if:
 - the death appears to have been without known cause, or self-inflicted, unnatural, or violent;
 - the death occurred during, or appears to have been the result of, a medical procedure/affected by anaesthetic and death was medically unexpected.
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Deaths that must be reported cont

- ▶ Death of a woman that occurred while the woman was giving birth;
 - ▶ Death in official custody or care (even from natural causes).
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Medically unexpected deaths

- Where a death would not be “reasonably expected” by a health practitioner who –
 - (a) was **competent** to carry out the procedure, or administer the anaesthetic in question; and
 - (b) had **knowledge** of the dead person’s medical condition before the procedure began.”
- The required standard to certify is being satisfied as to “the probable cause of death”.
- The change to reporting provisions requires *practitioners* to make a **clinical judgment** as to whether a death was medically unexpected.

Example

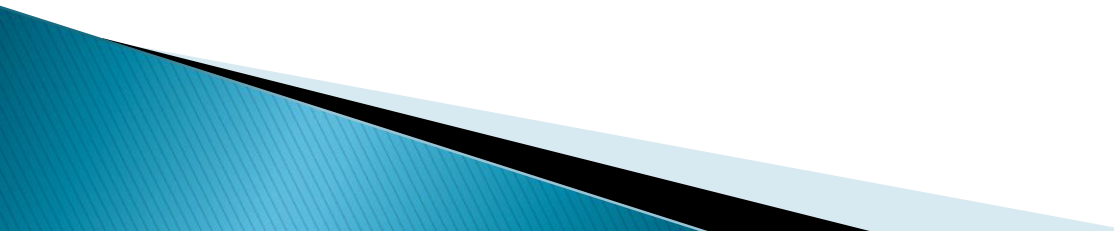
A patient with ischemic heart disease undergoes an operation that has a known and appreciated risk of death. Although the operation is properly indicated and competently performed, the patient dies.

- Under the old Act, the death **must** be reported as it occurred during/as a result of a medical procedure.
- Under the current Act, the death **does not need** to be reported unless there was anything unnatural/unusual about the procedure or death.
- Note: If there was an issue with the procedure, the doctor who contacts the coroner must have the requisite competency and knowledge of the procedure to report the death.

Nurse Practitioners

- ▶ “Nurse practitioners are qualified in a similar way to medical practitioners to issue these certificates through their training in diagnosis and their position as lead healthcare providers. I can tell you that certifying death is not as simple as it may sound.”
 - Hon Dr Jonathan Coleman (Minister of Health)

Myths

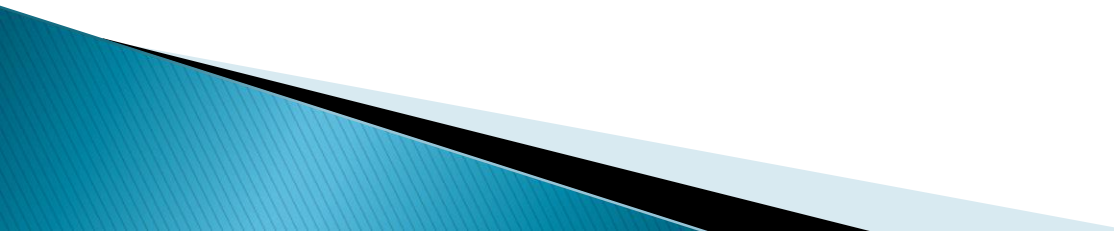
- ▶ The death must be within a certain time period after person has seen their nurse practitioner or medical practitioner;
 - ▶ You need to discuss a death with a coroner if you are signing a cremation certificate;
 - ▶ You need to refer a death to a coroner if the person has only been in hospital for 24 hours.
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Burial and Cremation Act 1964

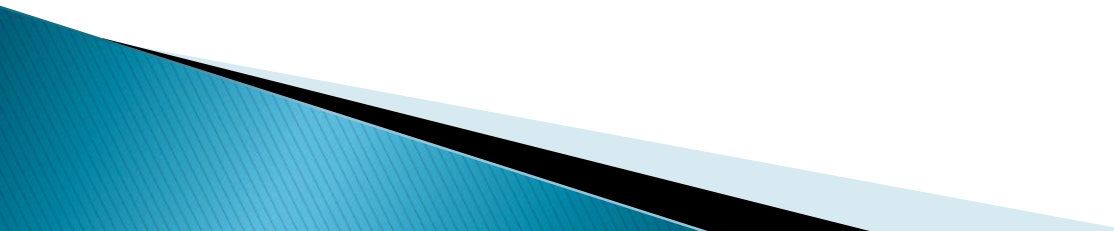
46B Certificate of cause of death in relation to illness

- (1) This section applies if a person dies after an illness.
- (2) A medical practitioner or a nurse practitioner who attended the person during the illness must, immediately after learning of the person's death, give a certificate of cause of death for the person's death if the practitioner—
 - (a) is satisfied that the person's death was a natural consequence of the illness; and
 - (b) has taken reasonable steps to consult with any health practitioner known to have subsequently attended the person during the person's illness.
- (3) Any other medical practitioner or nurse practitioner may give a certificate of cause of death for the person's death if (and only if) the practitioner is satisfied that the person's death was a natural consequence of the illness and—
 - (a) a medical practitioner or nurse practitioner who attended the person during the person's illness is unavailable; or
 - (b) less than 24 hours has passed since the death, and a medical practitioner or nurse practitioner who attended the person during the person's illness is unlikely to be able to give a certificate of cause of death for the person's death within 24 hours after the death; or
 - (c) at least 24 hours have passed since the person's death, and a medical practitioner or nurse practitioner who attended the person during the person's illness has not given a certificate of cause of death for the person's death.
- (4) Subsection (3)(b) and (c) does not apply if a medical practitioner or nurse practitioner who attended the person during the person's illness has refused to give a certificate of cause of death for the person's death because the practitioner was not satisfied, or was not yet satisfied, that the death was a natural consequence of the illness.
- (5) A medical practitioner or nurse practitioner must not give a certificate of cause of death under subsection (3) unless the practitioner—
 - (a) has regard to the medical records relating to the person concerned of the health practitioner who last attended the person during the illness; and
 - (b) has regard to the circumstances of the person's death; and
 - (c) has examined the person's body.
- (6) A certificate of cause of death must not be given under subsection (2) or (3) if—
 - (a) the death—
 - (i) must be reported to the New Zealand Police because [section 13](#) (except subsection (1)(b)) of the Coroners Act 2006 applies; or
 - (ii) has been reported to a coroner under [section 15\(2\)](#) of that Act; and
 - (b) the coroner has decided to open an inquiry into the death.

What is the test ?

- ▶ If *satisfied* the person's death was from natural causes.
 - ▶ No statutory definition of *satisfied*. In Queensland they refer to being “comfortably” satisfied about the cause of death;
 - ▶ In civil law – satisfied on the balance of probabilities means “more likely than not”
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Conclusions

- ▶ The vast majority of deaths are due to natural causes;
 - ▶ Nurse Practitioners must give a certificate if satisfied death was a natural consequence of an illness;
 - ▶ Currently too many natural cause deaths end up in the coronial jurisdiction.
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Questions?