



Appendix 1

**This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.**

Appendix to: Neate SL, Bugeja LC, Jelinek GA, et al. Non-reporting of reportable deaths to the coroner: when in doubt, report. *Med J Aust* 2013; 199: 402-405. doi: 10.5694/mja13.10246.

Appendix 1: Example: Minor change to cause of death

Figure 3 shows the cause of death assigned by the medical practitioner on the death certificate submitted to BDM as subarachnoid haemorrhage and subdural bleed. It was both the subarachnoid haemorrhage and subdural bleed that prompted BDM to report the death to the Coroner for investigation.

PART THREE – Cause of Death		
15.1	Description of disease, injury or condition	Duration between onset & death
Disease or condition directly leading to death. Note: Please specify the disease, injury or condition which led directly to the death not only the mode of dying such as heart or respiratory failure.	a) Subarachnoid haemorrhage	
	Subdural bleed	
Antecedent causes Note: If the direct cause of death as described in line a) was due to, arose as a consequence of another disease, injury or condition, this should be reported in line b). Similarly, if the condition on line b) was due to another condition, report this on line c) and so forth.	b)	
	c)	
	d)	
15.2	Description of disease, injury or condition	Duration between onset & death
Other significant conditions Note: Provide details of any other significant condition(s) contributing to the death but not related to the disease, injury or condition causing it.	e)	

Figure 3: Replication of Victorian Medical Certificate Cause of Death completed by the medical practitioner and submitted to the Registry of BDM

Investigation revealed that the deceased had a fall in a high-level care residential facility sustaining a head injury. The deceased’s conscious state deteriorated rapidly and a CT scan revealed extensive traumatic subdural and subarachnoid bleeding and death rapidly ensued. .

Based on the medical review, the coroner completed a finding, determining the cause of death as 1(a) Subarachnoid haemorrhage and subdural haematoma from a head injury sustained in a fall.

CAUSE OF DEATH	
1 (a)	Subarachnoid haemorrhage & subdural. haematoma from a head injury from a fall.
1 (b)	
1 (c)	
1 (d)	
2	

Figure 4: Replication of review checklist completed by the consultant physician and forensic pathologist for the coroner