

# Medical-setting deaths and the coroner: laws, penalties and guidelines

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The reporting of medical-setting deaths to the Coroner has come under scrutiny in recent years.<sup>1-5</sup>

An increasing body of research points to the widespread underreporting of such deaths<sup>6-11</sup> and high rates of error in the completion of cause of death certification.<sup>8,12-14</sup> Doctors' lack of understanding of their reporting obligations is thought to be central to the problem,<sup>2,3</sup> particularly when responsibility for death certification is often delegated to junior medical staff.<sup>15,16</sup>

Against this backdrop, recent amendments to the Coroners Acts in Queensland, Victoria and New South Wales have sought to provide better definition around the circumstances in which medical-setting deaths must be reported.<sup>17</sup> However, these jurisdictions have not adopted a uniform approach, meaning that, in combination with the approaches in the other states and territories, there exists substantial variation in the reporting requirements for medical-setting deaths throughout Australia.<sup>17</sup> These differences are not limited to the legislative definitions of "reportable death" but also extend to the penalties that attach to non-compliance with coronial reporting obligations.<sup>17</sup>

Our aim is to highlight these variations in coronial laws by describing a hypothetical patient death (Box) and then analysing how it would be dealt with under the various Coroners Acts. The differing penalties that would apply for failure to report the death are also considered. We go on to consider the role of coroners' guidelines for health practitioners and argue for their development in all states and territories.

## Is it reportable?

In Tasmania, the Northern Territory and Western Australia, the death described in the Box does not fall into the medical-setting category of reportable death as it did

### Hypothetical case

A 23-year-old woman with cystic fibrosis (CF) presents to the emergency department with a pneumothorax. She is well known to both the adult and paediatric CF services and has had over 100 admissions to date. She has significant end-stage organ dysfunction and clinicians have had end-of-life discussions with her and her family. She is oxygen-dependent, housebound and receives oral morphine for chronic pain. At the current admission, a chest drain is inserted with relief of symptoms. Three days later, with the intention of the chest drain being removed, the drain is clamped and a chest x-ray is planned for 4 hours later. The request for x-ray is not received and no x-ray is done. That night, a cardiac arrest call is made for the patient. A tension pneumothorax is diagnosed and the drain is unclamped. The patient requires full resuscitation including ventilation and inotropes. She is transferred to the intensive care unit. Two days later a hypoxic brain injury is confirmed. Treatment is withdrawn and the patient dies. Following discussion with the family, the treating medical team decides not to refer the case to the coroner as the patient's death from her end-stage CF was expected.

The clinical cause of death was thought to be hypoxic brain injury secondary to cardiac arrest caused by tension pneumothorax from the clamping of the chest drain. ♦

### Summary

- We examine the law governing the reporting of medical-setting deaths to the Coroner throughout the Australian states and territories.
- We use a hypothetical case report to explore the different legal requirements for reporting a medical-setting death and the varying penalties that apply for failing to report a reportable death.
- It is important for health practitioners to understand the law that applies in the state or territory in which they practise.
- Knowing when to report a medical-setting death requires not only medical knowledge but also legal analysis. On this basis, we recommend the development of coroners' guidelines in all jurisdictions to assist health practitioners in complying with their coronial reporting obligations.

not occur during or as a result of an anaesthetic (*Coroners Act 1995* [Tas], *Coroners Act 1993* [NT], *Coroners Act 1996* [WA]). The death may still be reportable, but only under a more general category of reportable death, most aptly that the death was "unexpected". However, in an area where there is little case law guidance, complex questions can arise with regard to what exactly constitutes an unexpected death.<sup>18</sup> The patient was undoubtedly expected to die from end-stage cystic fibrosis, but was she expected to die in this manner? The answer to this depends on whose expectation is relevant and when. Without doubt, the patient's death would have been expected by intensive care unit consultants before the withdrawal of treatment, but death in this manner would not reasonably have been expected by the patient, family or medical staff at the time of admission, or even on the ward when the chest drain was clamped. The degree of certainty required to say that death is expected is also unclear: must death be a possibility, a probability or a near certainty?

In contrast, in the Australian Capital Territory, the death would be reportable, without any regard to the actual cause of the death or its unexpectedness, simply because it occurred within 72 hours of "an invasive medical procedure" — the insertion of the chest drain (*Coroners Act 1997* [ACT]). South Australia adopts a similar approach, but because the death was not within the 24-hour prescribed time frame in that state, it must have occurred "as a result of" the invasive medical procedure (*Coroners Act 2003* [SA]). Whether the procedure in question — the insertion of the chest drain — resulted in the patient's death for the purposes of this provision is debatable. Arguably, the death was the result of the subsequent clamping of the drain (a non-invasive act) and/or the subsequent failure to unclamp or remove the drain (an omission). As the South Australian legislation does not include deaths resulting from medical omissions in its definition of reportable medical-setting deaths, this

death is probably only reportable in SA if it comes within the category of “unexpected” death.

In NSW, the death would be reportable if it “was not the reasonably expected outcome of a health-related procedure” (*Coroners Act 2009* [NSW]). This formulation still presents problems with what is “reasonably expected” (by whom, when and to what standard), but it does specify that the death need only be an *unexpected outcome* of the procedure; no direct causal connection is required. Thus, if we accept that the patient was not reasonably expected to die when the chest drain was inserted, this case is reportable.

The Victorian definition of a medical-setting reportable death also focuses on whether the death was reasonably expected (*Coroners Act 2008* [Vic]). However, unlike its NSW counterpart, the Victorian legislation specifies that the relevant expectation is that of a “registered medical practitioner” immediately before the “medical procedure” was undertaken. It is also necessary that the death “is or may be causally related” to the procedure. As the death was causally related to the insertion of the chest drain (as the first event in a chain of events leading to the patient’s death), the problem with the direct cause of death being a postprocedure medical omission is overcome.

The difficulty with the role of medical omission is least problematic in Qld (*Coroners Act 2003* [Qld]). Here a reportable medical-setting death expressly includes the situation where a patient dies after *failing to receive health care*, provided that: (i) this failure is likely to have caused or contributed to the death; and (ii) when the health care was sought, an independent person would not have reasonably expected that there would be a failure to provide health care that would cause or contribute to the person’s death. Interestingly, the wording of the provision suggests the situation where health care was sought but not provided, as opposed to sought and delivered but with medical error by omission arising in the course of its delivery. In any event, the death would be reportable on the basis that the patient died “at any time after receiving health care that ... contributed to ... the death” where immediately before receiving the health care, “an independent person would not have reasonably expected that the health care would ... contribute to the person’s death”.

### What is the penalty for not reporting the case?

If we accept that this case is reportable, then by failing to report the death the treating doctors are committing an offence. The provisions creating these offences and the associated penalties also vary greatly.

The Coroners Acts of the NT, Vic and WA impose a specific duty on doctors present at or after a reportable death to report it within a prescribed time. In these jurisdictions the offence is committed based purely on a physical act (the failure to report). The doctor’s state of mind is only relevant if raised in the context of the defence of an honest and reasonable mistake of fact. This defence might apply where the doctor formed an honest but erroneous belief in the cause of death or that the death had already been reported. In the other jurisdictions, a doctor’s duty to report is subsumed within the obligation imposed on

the community at large. Both a physical act (failure to report) and a mental element (a reasonable knowledge or belief that the death is reportable and has not been reported) are required.

Fines apply in all states ranging from a maximum penalty of \$1000 in WA to \$10000 in SA, where 2 years imprisonment can be imposed in the alternative. A prison sentence may also be given in the ACT, where the penalty is \$7000 and/or 6 months imprisonment. Issuing a cause of death certificate for a reportable case can result in an additional penalty in Qld (\$11 000), Vic (\$1732.32) and SA (\$1250) (*Coroners Act 2003* [Qld], *Births, Deaths and Marriages Registration Act 1996* [Vic], *Births, Deaths and Marriages Registration Act 1996* [SA]).

Additionally, in all jurisdictions, failure to report a reportable death may constitute professional misconduct. Any adverse finding of such by the Australian Health Practitioner Regulation Agency can lead to disciplinary sanctions including suspension from practice.

### Discussion

Under the Coroners Acts, doctors are required to exercise professional judgement in determining whether a case is reportable. Should their judgement be wrong, they may be guilty of an offence. Yet, as seen, the determination of whether a death falls within a particular definition of reportable death relies as much on legal analysis as medical judgement. The question of whether a medical-setting death is reportable may give rise to complex legal issues including reasonable expectation, acts versus omissions, and causation. In an area where there may be reasonable disagreement between lawyers, and even coroners, it is not surprising that doctors can face difficulty deciding whether or not to report a death. Standing back, there is no doubt that the hypothetical scenario represents a case that should be reported to the coroner; a preventable death caused by an adverse event. Despite whatever audit systems a hospital may have in place, the coronial system provides a vital independent avenue for investigation of such deaths. Importantly, coroners have the power to make broad-ranging recommendations with respect to public health or safety.<sup>19</sup>

What is perhaps most concerning is that the legislation leaves room for doubt that this case is reportable. This comes down to the legislative definitions. Clearly, part of the solution is to refine the definitions to remove ambiguities and provide clarity.<sup>1-3</sup> However, even with a best-model legislative definition, a clinician will still have to apply the legal definition to the facts surrounding a death in determining whether that death is reportable. In our view, it is not realistic to expect doctors, and often junior ones at that, to engage in this kind of legal analysis without further guidance or assistance. While coroners courts generally welcome, and indeed encourage, doctors to contact them if in doubt about a death, we believe that if the current underreporting of medical-setting deaths is to be rectified, coroners’ guidelines need to be available in all jurisdictions. Currently, such guidelines only exist in Qld, Vic and NSW.<sup>20-22</sup> The Qld guidelines, in particular, have been applauded for their focus on

“establishing, through a series of questions, whether the health procedure caused the death and whether the death was the unexpected outcome of the procedure”.<sup>3</sup> While reserving our judgement on the efficacy or otherwise of existing guidelines, it is pertinent to note that if the Qld guidelines are applied to this case study, it is immediately apparent that the death is reportable: the health care was not “carried out with all reasonable care and skill”, and before the health care was provided, the patient’s condition was not such that death was foreseen as more likely than not to occur.<sup>20</sup>

It is important to understand that guidelines are, as the name suggests, merely a guide to the law; they do not affect legal obligations. So for guidelines to be effective: (i) the law itself must be clear and (ii) the guidelines must accurately encapsulate the law while being presented in a manner that can be easily understood by a medical audience. Ideally, then, guidelines should be developed by lawyers, doctors and coroners working in conjunction. Further, where the existing law is unclear, legislative amendment should occur hand in hand with the development of guidelines.

Other measures might also help to create more accurate reporting of deaths to the coroner,<sup>23</sup> not least of all reforming the death certification process itself.<sup>1,3,4</sup> In this regard we agree with Cordner that “correctly certifying the cause of death or deciding to report the death to the coroner should be an explicit responsibility of the senior, not the junior, doctor”.<sup>24</sup> However, to date, Australian governments have shown little interest in changing the death certification process, citing problems of cost, inconvenience and delay.<sup>2,25</sup> Equally, there has been no interest in a referral of powers by the states to the Commonwealth to allow for a uniform national approach. In light of this, coroners’ guidelines offer a practical and inexpensive measure that might go some way towards creating better accuracy in reporting.

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