Interpreting the Coroners Act at the bedside: how do junior doctors know they are doing it correctly?

To the Editor: Interpreting coronial legislation can prove challenging for junior doctors at the bedside, with significant local variation in interpretation.[1] The Victorian Coroners Act (*Coroners Act 2008* [Vic]) has recently undergone changes that have coincided with a decline in numbers of reported cases,[2] with the Coroners Court raising the question of whether there was "unintentional under-reporting of reportable deaths".[2] What constitutes a reportable death under that Act is summarised in the Box.

Austin Health has a well established medicolegal support for junior doctors (formal education sessions, internal website and medical administration advice available 24

Reportable deaths as outlined in the *Coroners Act 2008* (Vic)*

A death is considered reportable if:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the cause of the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death;

And:

- the death appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or
- the death occurred during a medical procedure; or following a medical procedure where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death to occur; or
- the death is of a person who immediately before the death was a person placed in "custody or care"; or
- the death is of a person who immediately before death was a patient under the *Mental Health Act 1986* (Vic); or
- the death is of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force; or
- the death is of a person who is subject to a non-custodial supervision order under section 26 of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic); or
- the identity of the person is unknown; or
- the death occurs in Victoria and a medical practitioner has not signed and is not likely to sign a death certificate certifying the cause of death; or
- the death occurs outside Victoria and the cause of death is not certified by a person authorised to certify that death and the cause of death is not likely to be certified; or
- the death is of a prescribed class of persons that occurs in prescribed circumstances.

* There will be minor differences in reportable deaths between states. ◆

hours a day). However, it was unclear whether there was a failure to report reportable deaths, leading to unintentional underreporting of deaths to the Coroner.

Austin Health was involved in 82 coroners' cases in 2011, of which 68 were reported directly by Austin Health. In addition to our usual clinical review of all reported coroners' cases, the 14 cases that were externally referred (including from Births, Deaths and Marriages Victoria) were specifically analysed for any reasons that may have contributed to unintentional underreporting.

Cases were reviewed by the Clinical Risk Registrar (PV). A variety of specialty units were involved, with a variety of causes of death. Documented Coroners Court discussions were noted in two of the 14 cases.

Unintentional underreporting had occurred in all 14 cases, which were reportable by the criteria below.

- Under the "accident or injury" definition:
  - falls (seven deaths);
  - spinal cord injury from motor vehicle accidents, although death occurred many years afterwards (two deaths);
  - conditions that may arise from trauma, even if no traumatic event is documented (two deaths associated with subdural haemorrhage).
- Under the "unexpected, unnatural causes" definition:
  - medication overdoses, even if a result of pre-existing renal impairment (one death, associated with opioid overdose);
  - causes of death with less than 24 hours between onset and death (one death from cardiogenic shock, and one from acute pulmonary oedema).

Austin Health has integrated these findings into the organisation's standardised mortality tool, within junior doctor education programs, and in individual feedback to internal units and feedback provided to the Victorian Coroner.

This audit is an example of a brief, practical method for doctors and hospitals to confirm that coronial interpretation at the beside is occurring as intended, and is adaptable to other health services, general practices or health centres within Victoria or other states under the governance of coronial reporting frameworks.

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1 Delaney RJ, Roberts IS. Implementation of the 2005 Coroners Rules Amendments: a survey of practice in England and Wales. *J Clin Pathol* 2007; 60: 419-421.
2 Coroners Court of Victoria Annual Report 2010–2011. Melbourne: Coroners Court of Victoria, 2012. http://www.coronerscourt.vic.gov.au/find/publications/coroners+court+of+victoria+annual+report+2010-11 (accessed May 2013). ❑