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FINAL WORDS

DEATH AND CREMATION
CERTIFICATION IN NEW ZEALAND



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The Law Commission is an independent, publicly funded, central advisory body established by statute to undertake the systematic review, reform and development of the law of New Zealand. Its purpose is to help achieve law that is just, principled, and accessible, and that reflects the heritage and aspirations of the peoples of New Zealand.

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FOREWORD

The Law Commission has been asked to carry out a first principles review of the Burial and Cremation Act 1964 and its associated regulations, the Cremation Regulations 1973 and the Health (Burial) Regulations 1946. These laws and regulations provide the legal framework for protecting the private and public interests in the handling and final disposition of human remains after death.

The terms of reference for this review are wide ranging and require us to consider issues such as whether the Act in its current form is meeting New Zealanders' needs with respect to the custody, care and final disposition of the dead; whether local authorities should continue to have primary responsibility for the provision of cemeteries; and whether the current system of self-regulation of funeral directors should be continued or an alternative system of regulation considered.

Alongside these issues the review also requires us to examine the “adequacy and efficiency” of the current laws and regulations relating to death and cremation certification. The provisions relating to the certification of death were transferred from the Births, Deaths, Marriages and Relationships Registration Act 1995 to the Burial and Cremation Act in 2009. Because the issues relating to certification form a specialised and discrete part of the wider review, the Commission has produced this separate Issues Paper focused on certification.

Doctors involved in certifying deaths play a vital role as gatekeepers to the coronial system and so this review provides an important opportunity to review the interface between the new coronial system (the Coroners Act 2006) and the pre-existing death and cremation certification systems.

This discussion paper forms part of the Law Commission's preliminary consultation process and does not predetermine the direction we may take in our final report and recommendations to government. Rather, it is intended to help focus discussion and inform our research in this critical area.

The issues identified in this paper have arisen in the course of preliminary discussions with a number of stakeholders. These have included: the Chief Coroner, Judge Neil MacLean, and a number of other coroners; a consultation committee established by the Funeral Directors Association of New Zealand (FDANZ); the Health and Disability Commissioner; pathologists; doctors; and nurse practitioners. We have also sought feedback from a sample of medical referees, a little known group of medical practitioners who have the statutory responsibility for authorising all cremations in this country.

We have also had the benefit of consulting with Tom Luce, the former Head of Social Care Policy Department of Health, who chaired the 2003 Fundamental Review of Coroner Services and Death Certification in England, Wales and Northern Ireland (*Luce Report*).¹

1 Tom Luce et al, *Death Certification and Investigation in England, Wales and Northern Ireland The Report of a Fundamental Review* (United Kingdom, Home Office, CM3831, 2003) [*The Luce Report*].

A number of government departments have a close interest in death certification including the Ministry of Justice (with respect to the intersection with the Coroners Act 2006); the Department of Internal Affairs (with respect to the notification and registration of deaths) and the Ministry of Health (in its role as the department with responsibility for the Burial and Cremation Act and also with respect to the recording, analysis and international reporting of New Zealand mortality and cancer data). The New Zealand National Health Board also has an interest in the death and cremation certification provisions in the context of its on-going work in the areas of health workforce planning and development.²

Death and cremation certification is a notoriously difficult area in which to reach consensus, in part because the system serves a number of sometimes conflicting policy objectives. Those dealing with death as investigators, pathologists, coroners, doctors, health workers, care-givers or funeral directors are often working in highly charged situations. The knock-on effects of even quite minor changes within the systems and processes regulating death have the potential to cause major disruptions.

As a law reform body the Commission is charged with reviewing laws with a view to ensuring they are fit for purpose in the context of contemporary New Zealand.

This discussion paper is intended to provide a preliminary assessment of the strengths and weaknesses of the current death and cremation certification systems. Ultimately, however, the details of any changes to certificates and the certification processes will need the expert input of doctors, coroners and health epidemiologists.

Chapter 4 of this report contains questions relating to some preliminary options for reform. We welcome submissions on these options and would also be happy to meet to discuss these issues with stakeholder groups.

The Commissioner responsible for this Issues Paper is Warren Young and the senior researcher and policy adviser is Cate Honoré Brett.

Warren Young
Deputy President

2 For more information on this subject see www.nationalhealthboard.govt.nz.

Call for submissions

Submissions or comments on this Issues Paper should be sent to the Law Commission by **Friday July 1 2011**.

Death and Cremation certification

Law Commission

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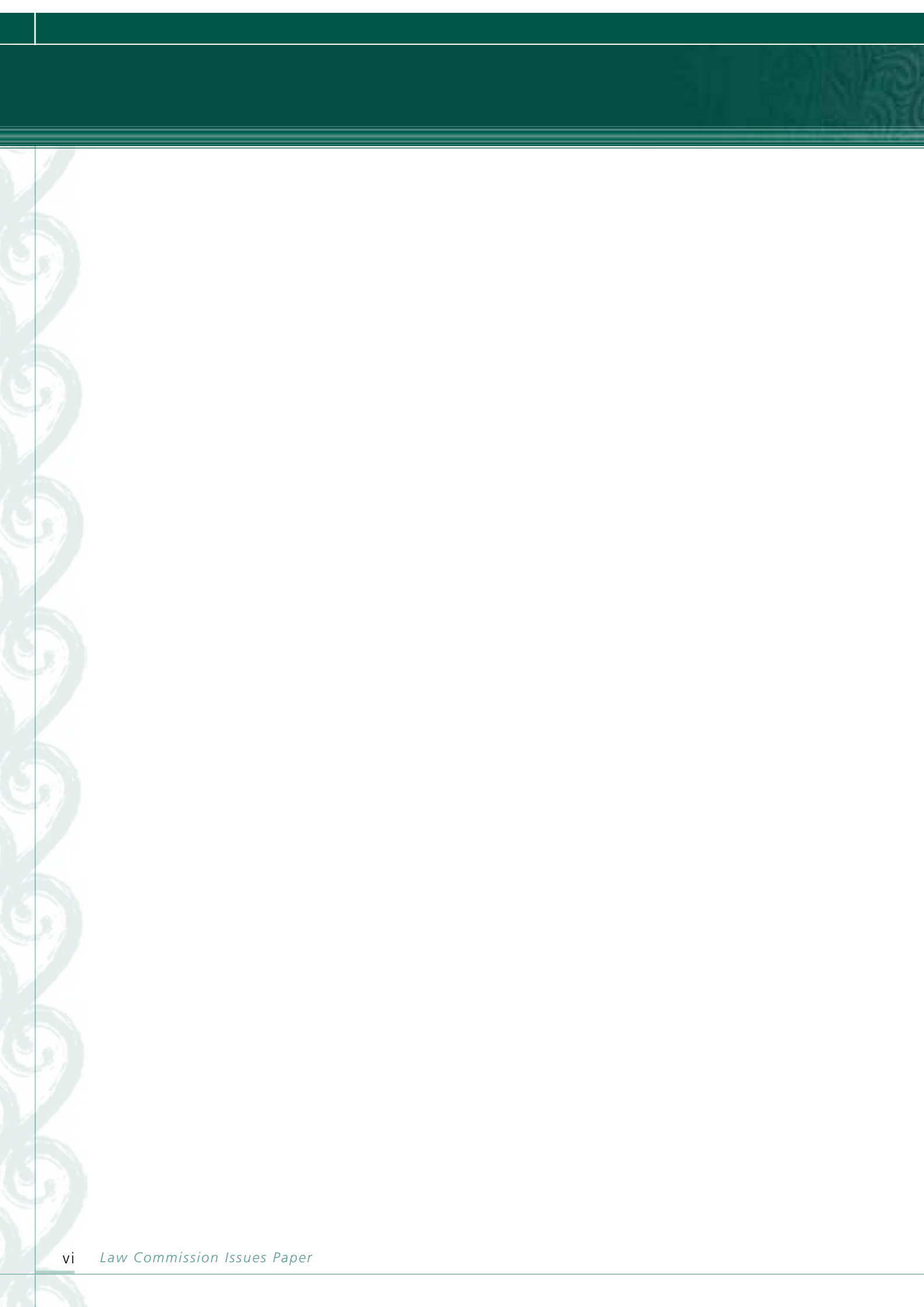
Chapter 4 of this Issues Paper contains a number of questions and preliminary options for reform on which we welcome your views.

It is not necessary to answer all questions. Your submission or comment may be set out in any format, but it is helpful to indicate the number of the question you are discussing, or the paragraph of the Issues Paper to which you are referring.

This Issues Paper is available on the Law Commission's website www.lawcom.govt.nz

Official Information Act 1982

The Law Commission's processes are essentially public, and it is subject to the Official Information Act 1982. Submissions to the Law Commission will normally be made available on request, and the Commission may refer to submissions in its reports. Any request for withholding of information on grounds of confidentiality or for any other reasons will be determined in accordance with the Official Information Act 1982.

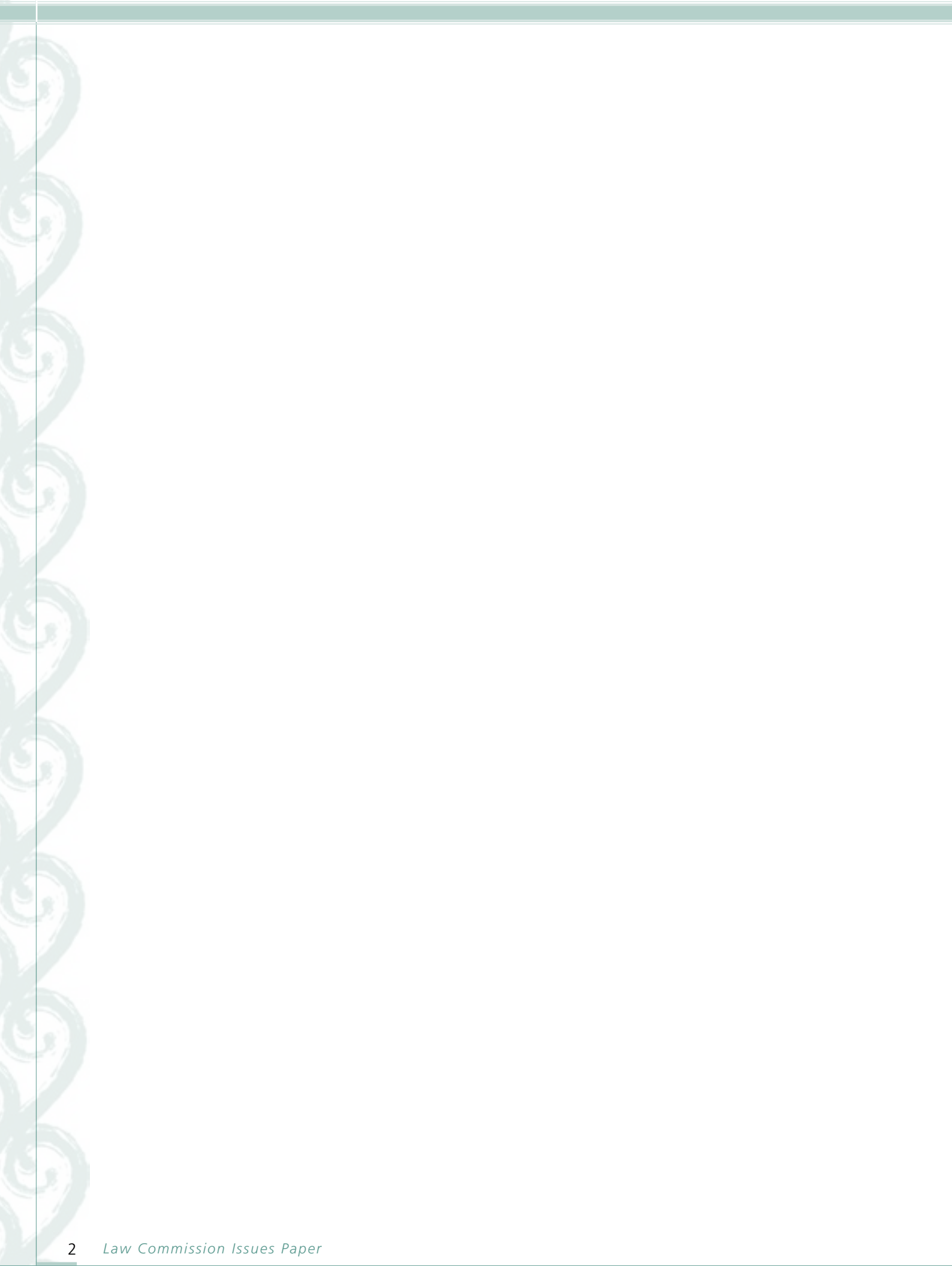


Final Words

Death and Cremation certification in New Zealand

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Chapter 1

Introduction

THE CONTEXT OF THIS REVIEW

- 1.1 In New Zealand, as in Britain and Australia, it is unlawful to bury or dispose of a body until a doctor or coroner has established why that person died. This requirement dates back at least as far as the mid-1800s when, under English common law, it was a requirement for all registered doctors to provide a written statement of the cause of death.³
- 1.2 In effect the completion of what is known as the Medical Certificate of Cause of Death (MCCD), or a coroner's authorisation, provides the legal trigger for all the processes which take place from the time of death until burial or cremation.⁴
- 1.3 The final service a doctor will perform for his or her patient is to determine whether their death was natural, and can be certified, or whether the death was unexplained, (and may have been wrongful or preventable), and therefore requires further investigation by the coroner.
- 1.4 How these decisions are made, by whom and in what circumstances, is set out in two parallel statutes: the Coroners Act 2006, which determines the scope of deaths which must be investigated, and the Burial and Cremations Act 1964 which determines how natural cause deaths are to be dealt with.
- 1.5 Over the past decade the New Zealand coronial system has undergone significant modernisation and reform. However, despite the dependencies between the two, the provisions regulating death and cremation certification have not been subject to the same fundamental review.
- 1.6 In undertaking this review we have been able to draw on the very extensive research and analysis undertaken in the United Kingdom and Australia as a response, in part, to the catastrophic failure of the death and cremation certification system represented by Dr Harold Shipman.

3 Davis GG "Mind your manners Part 1: History of death certification." (1997) 18 Am J Forensic Med Pathol 219–223.

4 Section 46AA (1) of the Burial and Cremation Act 1964 provides that: "A body must not be buried, cremated, or otherwise disposed of unless the person in charge of the disposal has obtained a doctor's certificate or a coroner's authorization".

- 1.7 Harold Shipman was a respected and trusted English doctor who, in January 2000, received a life sentence after being found guilty of 15 counts of murder. Dame Janet Smith, the Appeal Court Judge who headed the Commission of Inquiry into these deaths, and how they had gone undetected for more than two decades, concluded that the actual number of wrongful deaths was between 215–260.⁵
- 1.8 The first person known to have died under Shipman's care was a woman with terminal cancer who was killed by a lethal dose of opiates. Injecting lethal doses of opiates remained Shipman's *modus operandi* throughout his 24 year career, but he did not stop at mercy killing. Indeed many of his victims were well and active up until the hour of their death.
- 1.9 In her first report, published in July 2002, Dame Janet suggested the esteem in which Shipman was held in the community, and in particular by his elderly patients, provided part of the explanation as to why these murders went undetected for so long:⁶

It is deeply disturbing that Shipman's killing of his patients did not arouse suspicion for so many years. The systems which should have safeguarded his patients against his misconduct, or at least detected misconduct when it occurred, failed to operate satisfactorily. The esteem in which Shipman was held ensured that very few relatives felt any real sense of disquiet about the circumstances of the victims' deaths. Those who did harbour private suspicions felt unable to report their concerns.

- 1.10 Nor did the systems of death and cremation certification provide any clue to Shipman's activities. The inquiry found that Shipman personally completed all but three of the Medical Certificates of Cause of Death (MCCD) for those he killed. Despite the fact that the circumstances in which these patients died often involved sudden and unexpected deaths at home, Shipman managed to avoid referral to the coroner in almost all cases simply by claiming to have determined the cause of death himself.
- 1.11 Most of the deceased were cremated, a process which at that time required three different medical signatures: the first, that of the attending doctor who completed the MCCD; the second, that of a (nominally) independent medical practitioner confirming the cause of death, and finally, that of a third doctor, a medical referee, authorising the cremation after checking the paper work provided by the other two.
- 1.12 Despite this onerous three-tiered system, Shipman's actions went undetected:⁷

These procedures are intended to provide a safeguard for the public against concealment of homicide. Yet, even with these procedures in place, Shipman was able to kill 215 people without detection. It is clear that the procedures provided no safeguard at all.

5 Dame Janet Smith, *The Shipman Inquiry. First Report – Death Disguised* (2002) at 14.2 [*The Shipman Inquiry*].

6 *Ibid*, at 14.15.

7 *Ibid*, at 14.16.

- 1.13 While the certification system failed to catch Shipman, a retrospective audit of the number of deaths he had certified compared with other general practitioners working in comparable practices revealed his abnormally high death rates. However no such system of auditing was in place in England at the time Shipman was practising.⁸
- 1.14 Dame Janet's far reaching inquiry called for a radical overhaul of the English coronial and death certification systems. Many of her recommendations for reform were echoed in the Home Office's own parallel review of death certification, the *Luce Report*, which also concluded that the system was fundamentally flawed.⁹
- 1.15 The conclusion reached by these two reviews was that the checks and balances built into the death and cremation certification processes had been systemically undermined and no longer provided a meaningful safeguard. In particular, Dame Janet drew attention to the fact families had no input into the certification process which had effectively become a closed information circuit without any meaningful auditing.
- 1.16 The exhaustive reviews that took place in the wake of Shipman brought England and Wales to the brink of legislative reform with the passage of Part 1 of the Coroners and Justice Act 2009 which provided for a new coronial system and the introduction of a new regime for death certification to be overseen by a newly conceived role of expert Medical Examiners. Implementation was to occur in 2012.
- 1.17 Because of the fiscal constraints facing Britain's new coalition government after the 2010 election, a decision was taken not to proceed with the main structural changes in the England and Wales coronial system, including in particular the introduction of a Chief Coroner post. However, preparations for the parallel reforms of death certification, including the introduction of Medical Examiners, are proceeding as described later in this paper.

The need for review

- 1.18 New Zealand's death and cremation certification systems share many of the features of the pre-reformed British systems, including a reliance on a single certifying doctor and an absence of any nationalised system of monitoring or auditing.
- 1.19 This lack of auditing means there is an absence of empirical data on the efficacy of the current regime. This presents an immediate challenge when attempting to assess its strengths and weaknesses.
- 1.20 However it is significant that the Chief Coroner, Judge Neil MacLean, representatives of the funeral industry, and those within the Ministry of Health responsible for compiling national cause of death data, all believe a review of the current system is overdue.

⁸ Ibid, at 14.19.

⁹ Tom Luce et al, *Death Certification and Investigation in England, Wales and Northern Ireland The Report of a Fundamental Review* (United Kingdom, Home Office, CM3831, 2003) [*The Luce Report*].

- 1.21 In an interview with *New Zealand Doctor* in 2010 Judge MacLean described the different laws affecting doctors, undertakers and coroners as “an unholy mish-mash of overlapping and incompatible legislation”.¹⁰
- 1.22 While the coronial system has been subject to major reform, there appears to have been little attention given to the system of death certification, despite the close dependencies between the two.¹¹
- 1.23 In 2008, at the instigation of the Department of Internal Affairs, the death certification provisions were transferred from the Births, Deaths, Marriages and Relationships Registration Act 1995 to the Burial and Cremation Act 1964, bringing them under the administration of the Ministry of Health. It is our understanding the decision to transfer the provisions was largely motivated by administrative efficiency and involved some limited consultation with stakeholder groups.¹² The legal provisions themselves were not subject to any first principles scrutiny at that time.
- 1.24 This discussion paper offers a provisional analysis of the strengths and weakness of this system, drawing on our preliminary consultation and research.
- 1.25 We then tease out the key public policy questions which will determine what, if any, reforms are required:
- What standards of certainty and accuracy do we require from our death and cremation certification systems?
 - What level of monitoring and auditing – if any – is required for the system to provide the appropriate safeguards?
- 1.26 Having posed these questions we then examine a number of options for reform, drawing on the recent work that has been done in England and Wales and also in the Australian states of Queensland and Victoria.
- 1.27 The options canvassed in this discussion paper range from reasonably major changes to the certification processes through to less difficult – but arguably no less contentious – changes to the form and content of the death certificates themselves, including the options of integrating the death and cremation certificates into a unified form which is completed on-line.
- 1.28 It is important to note the dependencies between the various preliminary options put forward for discussion. For example, if New Zealand were to introduce some form of national auditing of death certification there may be less reason to consider changes to the system of single doctor certification.

10 Amanda Cameron “Death certificate rules vex GPs” *New Zealand Doctor* (New Zealand, 8 September 2010) at 6.

11 New Zealand’s coronial system underwent sweeping reforms following a 2000 Law Commission report and the subsequent passage of the Coroners Act 2006. The Act both modernised and professionalised coronial services in this country, establishing the role of Chief Coroner overseeing the work of a small bench of full-time lawyer-qualified coroners. The reforms also placed a great emphasis on making the service more accessible and responsive to the public and in particular to the cultural needs of grieving families.

12 Email from the Department of Internal Affairs to the Law Commission (15 December 2010).

- 1.29 Feedback from stakeholders will determine which if any of these proposals are put forward for more detailed consideration in the Commission's final report on the review of the Burial and Cremation Act 1964.
- 1.30 We begin with a brief discussion of the public policy interests in death and cremation certification.

The purpose of death certification

- 1.31 While there can be no doubt that the Shipman case eroded public trust in both doctors and the coronial system in the United Kingdom, providing the spur for change, some commentators have suggested that the scale of the reforms recommended by the Shipman Inquiry were perhaps an over-reaction to an outlier case.¹³ Shipman, they pointed out, was a murderer who happened to be a doctor.¹⁴
- 1.32 This is, of course, true. But it also misses the critical lesson to emerge from the Shipman case. From a policy perspective, the concern is not that the medical profession is riddled with would-be murderers, but rather that an elaborate system of safeguards intended to detect a wide range of conscious or unconscious abuses or errors was seen to utterly fail. This failure owed much to the fact that there was no meaningful system of independent monitoring or auditing.
- 1.33 Tom Luce, author of the *Luce Report* describes death certification as a "triage system" which sorts deaths arising from natural causes from those which require further inquiry by coroners, pathologists, or the police.
- 1.34 At the moment of death it is the doctor who is called upon to make the critical decision as to whether their patient has died as a natural result of an illness, or whether there is something about the circumstances or manner of the death which requires further investigation. In making this decision the doctor is performing a medico-legal role which will determine the level of scrutiny the death receives before the body is buried or cremated. A great weight therefore rests on a doctor's decision as to whether or not they are able to certify the cause of a person's death.
- 1.35 It is important to note that the category of deaths which may justify further investigation before burial is much broader than the very rare occurrence of murder or manslaughter. It extends for instance to unexplained and preventable deaths and deaths which may have resulted from acts or omissions during medical treatment or care.
- 1.36 An important policy question for this review is how well this triage system is working and, specifically, whether preventable or unexplained deaths are in fact being appropriately referred to the coroner for further investigation.

13 See Victorian Parliament, Law Reform Committee, *Inquiry into the Review of the Coroner's Act 1985*, at 79.

14 R Wyndham, "Second Opinion", (2000) BMA News Review at 35.

- 1.37 Another set of policy questions pertain to those deaths which are from natural causes and which therefore require no further investigation – as is the case in an estimated 80 % of all deaths. In these circumstances doctors have a statutory duty to determine, to the best of their ability, the actual medical causes of their patient's death. This final service fulfils both a public and a private objective.
- 1.38 Cause of death information is a vital source of information for health researchers, analysts, planners and funders, allowing them to monitor trends in population health and determine health priorities. But it also performs an important private function for the families of the deceased, helping them to understand why a loved one has died and allowing them to access insurance or other benefits dependent on a determination of the cause of death.
- 1.39 It is clear from the above discussion that there are two distinct, but related, policy objectives underpinning the legal requirements regulating the disposal of bodies:
- Firstly, the decision whether or not the death requires further investigation (i.e. whether a Medical Cause of Death Certificate can be confidently issued) provides a safeguard against the disposal of bodies in circumstances where the death may have been preventable, or may have arisen as a result of some wrongful or negligent act or omission.
 - Secondly, where the death is determined to be natural, there is both a public health interest and a private interest in determining the actual cause of death.
- 1.40 A major challenge for policy makers lies in determining the standards of accuracy and certainty required to satisfy these separate but related objectives.
- 1.41 For example from a justice perspective there is a powerful public interest in ensuring our systems are capable of detecting wrongful and preventable deaths. But when a death is neither preventable nor wrongful, the cost/benefits associated with achieving greater accuracy in determining the precise cause of death are arguably much more finely balanced.
- 1.42 However these two issues are not always easily separated. Inevitably there will be a correlation between the rigour and standards of accuracy in death certification and the rate of referral of suspicious or preventable deaths to the coroner. The lower the standards of accuracy and auditing of death certification the greater the chance that preventable or wrongful deaths will go undetected.
- 1.43 As the following chapters will illustrate, determining the appropriate level of accuracy – and scrutiny – required when certifying deaths and authorising cremations involves the careful weighing of different public and private interests.

Chapter 2

Death Certification in New Zealand

HOW THE SYSTEM WORKS

Triaging “natural” and “unnatural deaths”

- 2.1 Each year approximately 29,000 New Zealanders die – the vast majority from natural causes. But, unlike earlier generations, when most died in their own homes, now an estimated 65 % die in a hospital or residential care facility. As a result, hospital doctors are responsible for certifying the majority of deaths.
- 2.2 Over 85 % of deaths in this country are deemed to be of “natural” causes. Compared with England and Wales, where it is estimated 45 % of all deaths are referred to the coroner, New Zealand doctors refer on average just 20 % of deaths.¹⁵ In part, the differences in rates of referral reflect the different legal requirements for reporting deaths in each country. For example different statutory requirements as to which medical deaths, or deaths in care, are required to be reported to the coroner will have a significant impact on referral rates. The wider the category of deaths which are legally defined as “reportable”, the fewer the deaths doctors will be required to certify.
- 2.3 “Reportable” deaths are those where the state has a particular duty towards the deceased (including those in custody or care) or deaths which occur in circumstances where there is a strong public interest in establishing how a death occurred in order to prevent others dying in similar circumstances e.g. suicides and accidental trauma deaths such as road fatalities.
- 2.4 In New Zealand the requirement to review such deaths lies with coroners whose role as defined in the Coroners Act 2006 is to:¹⁶
 - establish the identity of the deceased;
 - establish the fact, cause and circumstance of their death;

15 Information provided to the Law Commission by the Coronial Services Unit February 2, 2010. It should be noted that the Coroner will not accept jurisdiction in a significant proportion of cases discussed with the coroner’s office. On average 13 % of deaths become subject to coronial inquiry. A smaller number, approximately 11 %, are subject to autopsy, which is in line with autopsy rates in Australia and the United States of America.

16 Coroners Act 2006, s 4 (2) (a)–(c).

- make recommendations to reduce the chances of other deaths occurring in similar circumstances;
 - determine whether the death should be investigated by other authorities.
- 2.5 The Act also defines the circumstances in which there is a statutory duty on a doctor (or any other person) to report a death to a coroner. Included in this list are:¹⁷
- deaths which appear to have been “without known cause, or suicide, or unnatural or violent”;
 - deaths during medical, surgical, or dental operation or treatment, including any death that occurs while a person is under or affected by anaesthetic;
 - deaths that occur while a person is in official custody or care including a prisoner and any child or young person in the custody or care of a social service;
 - deaths that occur while the woman concerned was giving birth, or that appear to have been the result of that woman being pregnant or giving birth.
- 2.6 In addition to the prescribed list of reportable deaths there is a general provision which requires doctors to refer all deaths to the coroner if they are not satisfied that the person’s death was a “natural consequence” of their diagnosed illness. Similarly, if no doctor has issued an MCCD within 24 hours of a death, the law technically requires that the death be referred to a coroner.¹⁸
- 2.7 However not all deaths which are reported to the coroner will end up under coronial jurisdiction. Nor will all coronial inquiries result in full investigations or inquests.
- 2.8 For example in 2010 New Zealand’s coroners, who now offer a 24 hour, seven-day-a-week service, dealt with 5,645 inquiries regarding deaths where there was some uncertainty as to whether or not the doctor could, or should, complete the MCCD. This equates to about 20 % of all deaths.
- 2.9 However only 3,343 of those referrals resulted in the coroner accepting jurisdiction over the death. In the remaining 2,302 cases the discussion between the doctor and the coroner resulted in the doctor issuing the MCCD without any further involvement from the coroner.
- 2.10 The critical point however is that, except in cases where it is immediately obvious that the death is unnatural or in some way suspicious, both the coroner and police are to a large extent dependent on the doctor as the gatekeeper to the coronial and criminal systems.¹⁹

17 Coroners Act, 2006 s 13.

18 Burial and Cremation Act 1964, s 46B (3).

19 Section 14 of the Coroners Act 2006 requires that reportable deaths be notified to the Police. In practice however the Chief Coroner notes that with the introduction of a 24 hour service doctors are increasingly discussing deaths directly with the Coroner’s office and Police are not automatically involved unless the coroner decides that is necessary. Consideration as to whether the Coroners Act should be amended to recognise and affirm alternative channels of reporting is included in the options for reform in Chapter 4 of this paper.

Who can certify a death and in what circumstances?

- 2.11 Another factor which influences rates of referral to the coroner is the list of statutory requirements that a doctor must meet before he or she is authorised to complete an MCCD. England and Wales regulations have for a long time required a certifying doctor to have seen the patient within 14 days before death, or alternatively to view the body.²⁰ If a doctor could not satisfy that requirement the death was automatically referred to the coroner.
- 2.12 New Zealand's Burial and Cremation Act 1964 is less restrictive. The statutory duty to complete a doctor's certificate "immediately after learning of the death" lies first with the doctor who "attended the person during the illness."²¹
- 2.13 This wording, and the earlier iterations of these provisions, reflected the expectation that those dying of natural causes would typically be under the care of a 'family doctor' during their illness and may well have died in their own home, attended by that doctor.²² In other words it presupposed a level of familiarity with the deceased's medical history and the circumstances leading to their death.
- 2.14 The Act does not specify how recently the certifying doctor must have seen the patient alive. Nor, perhaps surprisingly, does it require the doctor to have examined the body after death if the deceased is to be buried. (The Cremation Regulations 1973 require all bodies to be seen before cremation.)
- 2.15 Under the current Act it is theoretically possible for a person to die, and be buried, without any formal identification or 'verification of life extinct' or physical examination of the body.
- 2.16 The same does not, however, apply in situations where the doctor certifying the death is not the usual doctor who attended the deceased during their illness.
- 2.17 In response to changes in the delivery of health care, including the introduction of shared-care offered by group general practices and the team approach to hospital care, the legislation was amended in 1995 to allow for a substitute doctor to complete the certificate.²³
- 2.18 They may only do so if the treating doctor is unavailable, or is not likely to become available for 24 hours, or has failed to complete an MCCD 24 hours after the death.²⁴ (Technically, if no doctor has issued a certificate and more than 24 hours have passed, the coroner must take custody of the body.)
- 2.19 When a 'stand in' doctor completes the MCCD they must only do so after having assessed the circumstances in which the death occurred and:
- viewed the person's medical notes and
 - viewed the deceased's body.

20 The British authorities have recently consulted on whether this interval should be retained, increased to 28 days or possibly abolished altogether.

21 Burial and Cremation Act 1964, s 46B.

22 See for example s 25 (1) of the now repealed Births and Deaths Registration Act, 1951.

23 Births, Deaths and Marriages and Relationships Registration Act 1995, s 37.

24 Burial and Cremation Act 1964, s 46B (3).

- 2.20 As well as responding to the realities of modern medical practice, these changes were also intended to help expedite the rapid release of bodies from hospital mortuaries and into the custody of funeral directors (or others) for burial preparation.²⁵
- 2.21 Like a number of the reforms to the Coroners Act 2006, the changes also reflected an increased sensitivity to the cultural concerns surrounding death for Māori, and other ethnic groups who shared a strong cultural imperative to take custody of the body immediately after death.

Accidental deaths in the elderly

- 2.22 Alongside the increased flexibility around who is qualified to certify deaths, the Burial and Cremation Act 1964 effectively allows deaths resulting from accidents in those aged over 70 to bypass coronial investigation and be certified by a doctor.²⁶
- 2.23 This provision recognises that falls are common in very elderly and frail populations and, even after surgery, often have a cascading effect on general health, resulting in death. The ability for a doctor to certify such deaths is qualified by a number of provisions to exclude accidental deaths in the elderly which may be suspicious or unusual or have been caused by an act or omission of any other person.

IS IT BROKEN?

- 2.24 Our preliminary consultation and research indicates a range of concerns about the current death and cremation certification systems. These reflect the quite distinct needs and policy interests of the various stakeholder groups.
- 2.25 For example, representatives of the Funeral Directors Association of New Zealand (FDANZ) have told us that the unavailability of doctors and consequent delays in certification continue to cause real difficulties – particularly with respect to deaths occurring in the community over weekends and in some aged care facilities where a doctor may not be available to certify a death for some time.
- 2.26 Conversely, preliminary consultation with the Royal Australasian College of General Practitioners suggests some doctors feel the legal requirement that an MCCD be issued “immediately” on learning of a death, can create unreasonable expectations and pressures, particularly for those working in rural and sole practices.²⁷

25 In law there is nothing to prevent a funeral director or any other person responsible for the deceased’s burial from uplifting the body before an MCCD has been provided but the body cannot be embalmed or buried or cremated until the MCCD or coroner’s authority has been granted.

26 This was first provided for in s 38 of the Births, Deaths, Marriages and Relationships Registration Act 1995. In 2008 that was repealed and replaced with an equivalent provision in s 46C of the Burial and Cremation Act 1964.

27 The Act currently provides a 24 hour window within which an MCCD must be provided. Although the Act provides for an alternative doctor to certify, that doctor must have access to the patient’s medical notes and also view the body. Hence the alternate doctor provision does not always offer a practical solution. In some cases a doctor who is unable to attend a death within this time frame, but who is satisfied he or she can certify the cause of their patient’s death, will indicate to a funeral director that the certificate will be forthcoming. However in May 2010 the FDANZ advised its members not to uplift a body without the MCCD after the Wellington Coroner Ian Smith publicly criticised a funeral director for commencing embalming a body on the understanding that the MCCD would be forthcoming when in fact the death was ultimately reported to the Coroner. We address this issue in chapter 4 of this paper.

- 2.27 On the other hand, the FDANZ has also made strong representations to us about the risks inherent in the current law which allows a person to be buried without any formal identification and without the body being examined by a doctor.
- 2.28 The Chief Coroner, Judge Neil MacLean, has concerns about weaknesses in the system as a filter for coronial cases, resulting in *both* under and over reporting of deaths as a consequence of knowledge gaps within the medical workforce and inconsistencies in interpretation of the legislative requirements.
- 2.29 For their part, doctors have told us of inconsistencies in the way coroners from different parts of the country (any one of whom may have to deal with a death outside their region when on-call) interpret the Act and in particular in what circumstances they will accept jurisdiction over a death where there is real uncertainty about the cause of death, but no obvious suggestion of misadventure. Concerns have also been raised about the availability of coroners and the extent to which the service is actually providing doctors with meaningful after-hours access.²⁸
- 2.30 And, as the “end user” of the MCCD, those within the Ministry of Health responsible for collating national health and mortality statistics have raised concerns with us over the variable quality of death certification and lack of national quality controls.²⁹
- 2.31 At an operational level, funeral directors, doctors and medical referees, have pointed out the arcane language used in cremation forms; the difficulty some doctors have in correctly determining the different levels of causation they are required to record; and the seemingly unwarranted duplication between the various forms they are required to complete.
- 2.32 There is also ongoing concern over the lack of clear and consistent policies for remunerating doctors for death certification as the Act specifically excludes the Crown from any liability for meeting these costs despite the fact that certification fulfils important public policy objectives, as outlined earlier.³⁰
- 2.33 The concerns expressed by these different stakeholders illustrate the fundamental tension between the competing policy interests surrounding death certification: speed and efficiency on the one hand; and rigour, safety and accuracy on the other.
- 2.34 In the following discussion we examine the strengths and weaknesses of the system from these different policy perspectives and ask what evidence there is to suggest the current certification system is not meeting the policy objectives to an acceptable level.

28 For example some doctors query the usefulness of the National Initial Investigation Office which provides after-hours coverage for coroners, as doctors were often still faced with waiting until office hours before they were able to discuss a case directly with a coroner and hence make a decision as to whether or not they were able to certify a death.

29 The Mortality Collection classifies the underlying cause of death for all deaths registered in New Zealand, and all registerable stillbirths, (foetal deaths). MORT was established to provide data for public health research, policy formulation, development and monitoring, and cancer survival studies.

30 See Burial and Cremation Act 1964, s 46D.

CATCHING
'REPORTABLE
DEATHS' –
HOW GOOD IS
OUR SYSTEM?

- 2.35 In New Zealand a doctor's decision whether or not to certify a death is the lynch pin on which much of the coronial system rests. This is not the case in all jurisdictions.
- 2.36 In the United Kingdom, for example, the legal onus to report certain categories of deaths to the coroner rests with the Registrar of Deaths.³¹ Similarly in the Australian State of Victoria, the Registrar of Births, Deaths and Marriages refers about 500 cases to the coroner every year when the recorded cause of death suggests the death was reportable.^{32 33}
- 2.37 New Zealand's Births, Deaths, Marriages and Relationships Registration Act 1995 contains provisions which, in theory, empower the Registrar to investigate the circumstances of a death.³⁴ However, in practice, death registration is a mechanical process with little or no capacity to test the cause of death information provided for registration.³⁵
- 2.38 In practice here, as in Australia and the United Kingdom, the vast majority of referrals to the coroner come via the police and medical professionals.³⁶
- 2.39 In deciding whether or not they are able to certify a death, doctors are required to interpret the relevant provisions of *both* the Burial and Cremation Act 1964 and the Coroners Act 2006. Together, these two pieces of legislation establish the parameters within which deaths can be considered "natural" (and therefore certifiable) or "unnatural" or "unexpected" (and therefore reportable).
- 2.40 As outlined at paragraph 2.5 the Coroners Act 2006 requires a significantly wider category of deaths to be reported than those which may be regarded as "suspicious." The coroner is mandated to investigate sudden and unexpected deaths, including suicides, deaths that occur in the course of medical treatment, and deaths which are "without known cause" such as Sudden Infant Death Syndrome (SIDS).

31 Registration of Births and Deaths Regulations 1987, (UK) reg 41.

32 Ian Freckelton, Kerry Petersen (Eds) *Disputes & Dilemmas in Health Law* (The Federation Press, Sydney, 2006) at 301.

33 In its submission to Victorian Parliament Law Reform Committee Review of the Coroners Act 1985 the Victorian Institute of Forensic Medicine noted that in most cases referred by the Registrar the body had already been buried or cremated. The number of cases referred for investigation by the Registrar had increased substantially over the past decade as a result of an agreement between the State Coroner and the Registrar to subject the registered cause of death to greater scrutiny in the wake of the Shipman case.

34 Births, Deaths, Marriages and Relationships Registration Act 1995, s 82 (1) (c).

35 The Chief Coroner notes that occasionally the Registrar will raise areas of concern where a doctor appears to be certifying inappropriately. The Department of Internal Affairs' Register may itself be alerted to errors or shortcomings in death certificates through the Ministry of Health's Mortality Collections coders. In the course of preliminary consultation the Department of Internal Affairs informed the Law Commission that the number of errors identified by the Ministry of Health have been in the range of 35 to 63 per quarter. Other errors are identified by funeral directors and/or family members when they receive a death certificate.

36 Under the England and Wales 2009 legislation reform it is intended to lay a specific statutory duty to report on doctors, replacing a long-standing but rarely invoked general duty to report in the common law.

- 2.41 As well as establishing the cause and circumstances of these deaths, a key objective of the coronial inquiry is to identify deaths that were, or may be, *avoidable* and to alert the relevant authorities to steps that should be taken to prevent future deaths.
- 2.42 Trust plays a vital role in the relationship between doctor and patient in life and, conceptually, there is no reason why that trust relationship should not extend to the final service the doctor performs for their patient – the decision whether or not to certify their death or to refer the death for further investigation.
- 2.43 It makes sense, therefore, that the primary responsibility for both death certification, and the identification of cases that require referral to the coroner, rests with the doctor who had the immediate, or most recent care, of the patient.
- 2.44 However, giving doctors sole responsibility for these decisions, without any external monitoring or review, carries risks. In the following discussion we examine the nature and significance of those risks.
- 2.45 A useful starting point is the consideration of three New Zealand cases involving wrongful or potentially avoidable deaths.

Keith Ramstead

- 2.46 In 1993 British cardio-thoracic surgeon Keith Ramstead was the subject of an extensive peer review following the deaths of a number of patients during surgery at Christchurch Hospital.³⁷
- 2.47 As well as competency issues, the Royal Australasian College of Surgeons' review panel also considered whether the surgical deaths had been appropriately reported to the coroner and certified. The review panel found two instances where there was evidence to suggest misleading reporting of the deaths to the coroner. In one instance this meant no coroner's post mortem was held when in the committee's view it should have been. In the other case a post mortem occurred only after the intervention of another specialist. In that instance an anaesthetist who learned that there was to be no coronial autopsy into a death on the operating table after the surgeon had discussed the death with the coroner, made an independent report of the circumstances of the death to the coroner thereby ensuring an autopsy was carried out.
- 2.48 There was also evidence of incorrect cause of death information being entered in a death certificate. In this instance the patient had died from a massive haemorrhage and exsanguination during surgery, however the death certificate stated the cause of death as myocardial infarction.

37 In 1996 Mr Ramstead was tried on three counts of manslaughter in relation to the surgical deaths. The High Court trial resulted in a guilty verdict on one charge of manslaughter but the verdict was later quashed by the Privy Council because the judge failed to disclose to counsel a note in the form of a rider to the proposed verdicts before the jury announced its verdicts. See *Ramstead v R* [1999] NZLR513 (PC).

- 2.49 The Ramstead case graphically demonstrated the coroner's dependence on the integrity of the medical profession and their explanation of the circumstances of a death. It also illustrated the vulnerability of junior medical staff who are commonly left to complete MCCD and cremation certificates on behalf of senior clinicians and consultants.
- 2.50 Equally though, the Ramstead inquiry illustrated the safeguards implicit in hospital settings where doctors and nurses work in interdependent teams and, as happened in this case, are able to alert authorities when significant breaches of professional standards occur.

Dr Colin Bouwer

- 2.51 In 2001 a South African-born psychiatrist, Dr Colin Bouwer, received a life sentence for murdering his wife by the prolonged and carefully managed administration of hypoglycaemic drugs. Bouwer's 47-year-old wife died at the couple's Dunedin home in January 2000. Bouwer attempted to avoid an autopsy by asking a medical colleague, who had overseen Annette Bouwer's hospital treatment, to complete the MCCD.
- 2.52 However Dr Andrew Bowers³⁸ regarded Annette's death as unexpected and was concerned it may have been associated with major surgery she had undergone at Dunedin Hospital some months earlier. Consequently he told Bouwer he intended to report the death to the local coroner and would not certify without a full autopsy.
- 2.53 At this point Colin Bouwer attempted to pressure Bowers to sign the MCCD, claiming his wife was Jewish and that an autopsy would be repugnant to her and that according to Jewish traditions the body must be cremated and interred within 24 hours.³⁹
- 2.54 The acting coroner twice declined to authorise an autopsy, only agreeing after the hospital's chief pathologist reported that he could not determine the cause of death from serum samples and stomach scrapings and requesting a forensic autopsy. The results of this would eventually provide the evidence which led to Bouwer's conviction.
- 2.55 In this case, without the dogged persistence of Dr Andrew Bowers and the eventual authorisation of a forensic autopsy, Annette Bouwer's murder would almost certainly have gone undetected.

Dorothy Beryl Campbell

- 2.56 Most recently, a last minute murder confession halted the cremation of the body of an 84-year-old Auckland woman whose death had been certified as due to natural causes. Dorothy Campbell suffered from a number of chronic conditions but her death in her own home in February 2008 was unexpected. Police found

38 No relation.

39 Andrew Bower's suspicions were further aroused when Annette's funeral was conducted in a Christian church. He also became aware that cremation is not accepted by the Jewish faith.

nothing to suggest the death was suspicious. However attempts to obtain the MCCD were delayed because Mrs Campbell's GP was away tramping in the South Island.

- 2.57 When finally contacted by the police, Mrs Campbell's GP was initially reluctant to certify because he had seen her recently and regarded her death as unexpected. Police then reported the death to the duty coroner who then called the GP to discuss why he was unwilling to certify. There are divergent views as to what positions were adopted by the doctor and coroner but the upshot was that the GP agreed to complete the MCCD when he returned to Auckland. Because Mrs Campbell was to be cremated it was also necessary for him to complete the cremation certification and view the body. This was arranged via the funeral directors who brought the already embalmed body to the doctor's surgery for inspection en route to the crematorium. The cause of death was recorded as myocardial infarction.
- 2.58 However in the interim Mrs Campbell's neighbour, who suffered from a psychiatric illness, confessed to her murder. The cremation process was halted and police took custody of the body which was then subject to an external examination by forensic pathologists who found evidence of ligature marks on the neck and were able to confirm her death had been caused by compression to the neck.

Strengths and weaknesses of the current system

- 2.59 These three disparate cases can quite legitimately be regarded as rare examples of deliberate abuse or accidental failure of the system. Instances where doctors use their medical knowledge to cause deliberate harm to another, such as in the case of Colin Bouwer, are exceptionally rare and while it is critical that the system is capable of detecting such cases, it is clearly not sensible to subject all deaths to forensic examination.
- 2.60 The vigilance and integrity of medical colleagues were critical factors in bringing to light both the Ramstead and Bouwer cases.
- 2.61 However the experience of these cases and the feedback we have received in the course of our preliminary consultation points to a number of issues with the current system which might contribute to both under-reporting and over-reporting of deaths.
- 2.62 These issues include:
- the single certifying doctor and the ability to certify without examining the body;
 - professional and organisational conflicts of interest, and
 - the dependence on finely balanced professional judgements.

1. The single certifying doctor and the requirement to "view" the body

- 2.63 The last minute detection of a homicide in the case of Dorothy Campbell illustrates the risks associated with the provisions in the current legislation which allow a single doctor to certify a death and cremation. In this particular instance the killer had gone to considerable lengths to make the death appear natural, explaining why police failed to treat the death as suspicious from the outset.

- 2.64 Nonetheless, an external autopsy clearly revealed ligature marks on the neck even after the body had been embalmed and prepared for viewing. Given the GP's initial reluctance to certify the death, based on his recent knowledge of his patient's state of health, it is likely that had he been required to conduct a thorough physical examination of the body before agreeing to complete an MCCD he may well have detected the ligature marks.
- 2.65 The case also illustrates the sometimes pro-forma approach to completing the medical certificate for cremation. As outlined earlier, the Cremation Regulations 1973 require the doctor completing this certificate to "see and identify" the body before completing this form. In this case the body was only seen fully clothed and after embalming. While fulfilling the regulatory requirements, "seeing" the body in such circumstances does not appear to add any real value to the process.
- 2.66 Moreover, as the law currently stands, if Mrs Campbell had elected to be buried rather than cremated, it would have been legally possible for her doctor to certify her death without viewing the body at all or conducting any physical examination.
- 2.67 Exceptional circumstances surrounded this homicide and help explain why it came close to going undetected. In the wake of these events family members suggested any unexpected death of a person alone in their own home should be subject to autopsy.⁴⁰
- 2.68 There is no doubt that such a requirement would have detected Harold Shipman's activities very early on. More realistically it may also help detect less sinister but nonetheless currently unlawful practices such as assisted suicides.
- 2.69 However such an extreme policy response to detect rare abuses can clearly not be justified given the costs, delays and distress associated with such a proposal.
- 2.70 Nonetheless it would appear that the current requirements, particularly with respect to certification of deaths in burial cases, lean perhaps too far towards expediency over safety.
- 2.71 However it is also clear from the British experience that simply adding layers of bureaucracy into the death and cremation certification process does not, of itself, necessarily improve the safety of the system. For example, requiring a second doctor to review the original death certificate before burial or cremation will only add value if a) that doctor is genuinely independent of the first and b) that doctor has access to relevant information against which to audit the certificate, including, for example medical notes, autopsy reports and/or information from family members or care givers.
- 2.72 Similarly, while there may well be a case for requiring doctors to view a body in all circumstances before certifying, this may not improve rates of detection of reportable deaths unless doctors undertake a thorough external examination of the body, including, in some circumstances, obtaining minimum samples for toxicological analysis.

40 Edward Gay/NZPA "Victim's family: Do autopsies on all who die alone" (New Zealand Herald 5 February 2011)

- 2.73 Finally, it is arguable that the risks associated with the single certifying doctor are amplified in this country by the lack of national auditing of death certification. Such a system of auditing would be capable of retrospectively detecting unusual patterns of certification and could provide an effective deterrent for abuse.

2. Professional & organisational conflicts of interest

- 2.74 A second, more significant risk, inherent in the current system is the potential for doctors to be confronted with conflicts of interest.
- 2.75 In some instances a doctor's statutory duty to report unexpected deaths may conflict with their own personal interest in protecting themselves, or others, from the scrutiny of the police, peers or the coroner.
- 2.76 In such circumstances, as Australia's Queensland Public Hospitals Commission of Inquiry (*the Davies Report*) noted in 2005, the system's reliance on a single certifying doctor can be seen as both a strength and weakness:⁴¹

As the Queensland State Coroner has pointed out, the person best placed to make the assessment as to whether or not a death was a reasonably expected outcome from a health procedure, is the person who knows the most about the patient's condition leading up to death. However, he or she is also usually the person whose performance will be scrutinised if a Coroner investigates the death. He or she, therefore, might not be seen as sufficiently impartial to make an independent judgment of these issues.

- 2.77 Very rarely, as in the Ramstead case, there may be questions about the standard of care provided by the doctor responsible for reporting or certifying the death. In the absence of any form of independent auditing or review, the system currently depends on the scrutiny of peers to safeguard the public interest. But these internal systems sometimes fail.
- 2.78 For example the *Davies Report* provides a detailed and compelling analysis of how the clinical failings of one doctor can go unchallenged over a long period, and at a number of different sites, when the overall system is strained by funding pressures and managerial shortcomings.⁴²
- 2.79 The report documented 13 deaths in which an alleged "unacceptable level of care, on the part of Dr xxxx*", contributed to the adverse outcome."⁴³ Seven or eight of these deaths involved what investigators described as "absolutely non-defendable processes" and yet only two of the deaths were initially referred to the coroner. The inquiry concluded that this was able to occur, in part at least, because:⁴⁴

At the Bundaberg Base Hospital and, perhaps, generally within Queensland Health, there appeared to be no adequate system of audit or review of deaths to ensure there were no instances of misstatement or mis-diagnosis of deaths or whether treatment may have caused or contributed to any death.

* Name omitted.

41 Hon Geoffrey Davies Queensland Public Hospitals Commission of Inquiry Report (2005) 524, at [7.14] [*The Davies Report*]

42 Ibid.

43 Ibid, 521 at [7.1].

44 Ibid, 521 at [7.8].

- 2.80 In New Zealand there is currently no mandatory nationalised system for auditing or reviewing the *certification of deaths* in either hospitals or the community although a number of hospitals have developed their own internal quality assurance systems.⁴⁵ One such example is Canterbury District Health Board's Mortality Review Committee which was established in the wake of the Keith Ramstead inquiry and which has been operating for 23 years.⁴⁶
- 2.81 One of the strengths of the Canterbury system is that clinicians reviewing the death certificates have access to each patient's clinical notes and so have the critical information required to assess the accuracy of the MCCD and to determine whether or not the death was reportable.
- 2.82 Independent of this, the recently established Health Quality & Safety Commission, now requires all DHBs in New Zealand to capture and report all unexpected deaths which occur as a result of an "adverse sentinel event" while in a public hospital.⁴⁷ An "adverse sentinel event" is defined as an occurrence that was "actually or potentially preventable" and which was life threatening or which led to an unanticipated death or major loss of function.
- 2.83 Clinical management problems, including procedural and medication errors, failures in referrals, leading to delays in diagnosis and treatment, and failure to detect deterioration in patients, emerged as recurrent themes in the 2009/ 2010 report.⁴⁸
- 2.84 While not all of the deaths linked to sentinel adverse events would necessarily meet the criteria for reporting deaths under s 13 of the Coroners Act 2006, it is evident from reviewing the DHBs' précis of these deaths that many would. DHBs are required to state what actions have been taken to reduce the risks of similar failures in the future but they are not currently required to indicate whether or not the death was referred to the coroner and/or the Health and Disability Commissioner. (Nor are they required to report whether and how the sentinel event was recorded on the MCCD in cases where the death was not deemed to be reportable.)
- 2.85 Because the information supplied to the Commission by the DHBs is stripped of any patient identification it is not currently possible to match this data against the coronial case data base.
- 2.86 Given that both the Commission and the coroners are concerned with reducing "preventable deaths" there may be a case for better information sharing between the two, including perhaps the inclusion of a mandatory question regarding reporting deaths resulting from sentinel events in hospitals to the coroner.

45 Hospital deaths are however routinely subject to peer review by clinicians from the relevant medical department as part of clinical learning and auditing processes.

46 For details of the Canterbury District Health Board system see Appendix 1.

47 The Health Quality & Safety Commission was established on 1 December 2010, under the New Zealand Public Health and Disability Amendment Act 2010. Its goal is to improve service safety and quality and therefore outcomes across the public and private health and disability sector.

48 Health Quality & Safety Commission *Making Our Hospitals Safer: Serious and Sentinel Events 2009/2010* (Wellington November 2010).

- 2.87 Equally, if there is no change to the system of “single certifying doctor” there may be a case for mandating a clinical review of death certification, similar to that used by the CDHB, in all public and private hospitals to provide an independent check on whether or not reportable deaths in care are in fact being appropriately referred to the coroner.

3. *Finely balanced professional judgements*

- 2.88 While the circumstances of a death will often immediately indicate the need for a coronial inquiry, in other cases the decision to refer a death to the coroner will require finely balanced professional judgements on the part of both doctors and coroners. In such cases coroners rely on the diligence, honesty and frankness of doctors. Critically, they also depend on doctors to bridge the very considerable gap between the medical and legal worlds. Equally, doctors depend on coroners to provide them with consistent support and advice when they are confronted with real uncertainty or unresolved concerns about a death.
- 2.89 Inevitably too there will be occasions when both parties may experience levels of internal and external conflict or professional disagreements in determining how to treat a death. These tensions and potential failings in the system may arise from a variety of sources including:
- (a) inadequate knowledge of the legal and regulatory requirements;
 - (b) scope and interpretation problems;
 - (c) diagnostic uncertainty;
 - (d) systemic and cultural/social resistance to post mortems and coronial investigations.

a) *Inadequate knowledge of the legal requirements*

- 2.90 Chief Coroner Judge Neil MacLean suggests that while understanding of the Act’s requirements has improved since the 2006 reforms of the coronial system, anecdotal evidence suggests there are on-going problems with both under-reporting and over-reporting of deaths to coroners.
- 2.91 He suggests that an increasing reliance on overseas-trained resident medical officers (junior doctors) in hospitals throughout the country may have contributed to the problem of over-reporting as these doctors may be unfamiliar with the requirements of the Coroners Act and if working in remote areas may not always have immediate access to the advice and support of senior medical staff to guide them through death certification processes.

b) *Scope and interpretation problems*

- 2.92 Problems in making judgements about whether or not a doctor should certify a death are sometimes exacerbated by the uncertain nature and differing interpretations of the current legal requirements. While the legislative parameters are clear at both ends of the spectrum, there are inevitably areas of uncertainty and interpretation problems at the interface between the Burial and Cremation Act 1964 and the Coroners Act 2006.

- 2.93 While we are not aware of any New Zealand research into the extent of the problem, a 2003 Australian study detected “significant ‘under-reporting’” of deaths to the coroner in two major public hospitals in Victoria.⁴⁹
- 2.94 The 2003 Melbourne study involved a retrospective medical record review of 229 in-patient deaths at two major public hospitals in Victoria. Researchers found that of these deaths, 58 met the criteria of a “reportable death” under the Victorian Coroners Act 1985. However only 22 (37.9%) were actually reported. The majority of cases that doctors failed to report involved older females and the deaths were more likely to have occurred between midnight and six am.
- 2.95 The researchers concluded:⁵⁰
- If coroners are to optimize their potential to contribute to public health and safety, doctors reporting deaths and coroners must share a common understanding of which deaths are ‘reportable’. Whether this is achieved by revising the current reporting criteria, initiating a process of death certification auditing or by other means are still important issues requiring further discussion in the healthcare community.
- 2.96 Anecdotal evidence suggests that in New Zealand too there may not always be a “common understanding” as to which deaths should be reported and it would appear that there remain significant grey areas where subjective, and not always consistent, judgements are made by both doctors and coroners as to how broadly Parliament intended s 13 (1) of the Coroners Act to be interpreted.
- 2.97 The Act currently requires doctors to report deaths where there is either a causal or a temporal link to medical treatment (surgical or pharmacological) but the Chief Coroner believes some doctors assume the death must only be reported if there is an *unanticipated causal* link between an *invasive procedure* and the death.
- 2.98 Conversely, doctors face difficult judgement calls as to when deaths associated with common pharmacological regimes, such as those resulting from massive haemorrhaging in patients being treated with the common anti-coagulant warfarin, should be referred to the coroner. Haemorrhaging is a well-known risk associated with warfarin treatment, however a broad interpretation of the Act would require such deaths to be referred to the coroner. (A practical compromise reached by the Christchurch clinicians in consultation with the coroner is to refer only the subset of such deaths where the levels of anti-coagulant are above the therapeutic range.)
- 2.99 This example underscores the difficulties that can arise at the coronial and clinical interface, and suggests why there is an increasing recognition in jurisdictions such as Britain and some Australian states, of the need for coroners to have access to independent medical advisers to help bridge the cultural and knowledge gap between the medical and legal worlds.

49 Amanda Charles, David Ranson, Megan Bohensky and Joseph E.Ibrahim “Under-reporting of deaths to the coroner by doctors: a retrospective review of deaths in two hospitals in Melbourne, Australia” (2007) 19 International Journal for Quality in Health Care at 232.

50 Ibid, at [235].

Accidental deaths in the elderly

- 2.100 Another area where preliminary consultation has revealed some concern and variability in practice relates to accidental injury deaths in the elderly population. Deaths which result directly or indirectly from an accident or injury are reportable under the Coroners Act but s 46C of the Burial and Cremation Act provides an exception in cases where the deceased was aged over 70 years provided there were no unusual or suspicious circumstances surrounding the death.
- 2.101 This is a discretionary power and we have been told that there is some variability in approach around the country as to whether coroners wish to be informed, for example, when a fall in a hospital or residential care precipitates a pneumonia death.
- 2.102 And while s 46C can be seen as a sensible response to the prevalence of falls in the elderly, it is also the cause of some disquiet given the vulnerability of the elderly population.
- 2.103 For example Clinical Advisor to the Health and Disability Commissioner, Dr David Maplesden, has identified rest homes as a particularly fraught area of primary care involving a “risky population...where co-morbidities and polypharmacy are common” and where “acute diseases or injuries may present in a subtle or atypical fashion...and unwell patients may rapidly become dehydrated.”⁵¹
- 2.104 Dr Maplesden says decision making around patient care can be further complicated by deafness and dementia in the patient and/or when there is conflict between family members over the appropriate level of care (e.g. intervention vs. palliative care). There is often “no established relationship between the GP and the patient or the patient’s family” and doctors contracted to rest homes are often expected to see multiple complex-need patients in a short period of time, adding another layer of risk to an already challenging situation.
- 2.105 He notes that the incidence of un-witnessed falls is high in rest home patients and significant injury often results, but is not always detected. Cases he has reviewed have included delayed or unsuspected diagnoses of neck, hip and arm fractures. Poorly managed pressure sores are another common source of complaints where conservative management has gone on too long, resulting in the need for extensive surgery including amputation once specialist referral was finally made, or death from sepsis in more severe cases.
- 2.106 In the course of investigating complaints relating to patient care HDC reports occasionally note that the causes of death recorded by the certifying doctor do not appear to accurately reflect the clinical picture at death.⁵²
- 2.107 Given ongoing concerns about the adequacy of medical monitoring and care in some sectors of the aged-care industry it may be timely to reconsider whether protocols around reporting accidental injury deaths in the elderly need to be revisited.

51 Personal communication from Dr David Maplesden, Medical Advisor to the Health and Disability Commissioner to the Law Commission, (16 December 2010).

52 See for example decision 05HDC11908 at www.hdc.org.nz/decisions--case-notes/commissioner's-decisions/2008/06hdc12164.

c) Diagnostic uncertainty

- 2.108 Doctors completing an MCCD are required to certify that the information they provide as to the causes of death is “true to the best of [their] knowledge and belief, and that no relevant information has been omitted.”⁵³
- 2.109 However doctors may face real dilemmas balancing their statutory duty to obtain as accurate a picture of the causes of death as possible against both the need for expediency and the practical limitations on how much accuracy can be achieved without resorting to expensive and invasive autopsies.
- 2.110 A qualitative study of a group of New Zealand GPs, carried out in 2004 by a consultant in palliative care and two other medical professionals, found two key factors influenced the doctors’ approach to death certification: the level of clinical uncertainty attached to the death and the attitude of the patient’s family.⁵⁴
- 2.111 The study, published in the *British Journal of General Practice*, found some doctors questioned the need for clinical certainty about the precise cause of death in cases where a patient’s death followed a long period of illness involving multiple chronic conditions, as illustrated by this extract from the focus group discussion:

Wearing my geriatric hat, I should have had, you know, all the hospital tests, and the diagnoses there in front of me. But very often there were people who had given up on rehabilitation long ago, and um, with sitting around in hospital, and...a pulmonary embolism or a bronchopneumonia seemed to be the likely cause. And certainly once they got to that stage you wouldn’t be throwing x-rays and scans at them to try to find out why they were suddenly going off.

- 2.112 For the doctors participating in the research “diagnostic uncertainty” was a constant factor in treating patients during their lives and this uncertainty often lingered in death, as illustrated in this quote:

...having discussed things with the coroner over the years...some people who are ill in a general sense, and losing weight, and just unwell – he’s happy to take that as bowel cancer, as indeed is the Cancer Society...even though there has never been a proctological, pathological or even clinical diagnosis of cancer. So if it works, it works in death as well. It’s inaccurate.

- 2.113 The study also found “ [t]he older the patient, the less likely a diagnosis was pursued in life and the more likely management was guided by symptoms and overall comfort” as illustrated by this quote from a doctor:⁵⁵

...I had to fill one in at the rest home the other day. And...she had heart failure for a while...I actually don’t know what her heart failure was from. And then I thought she was getting better with my frusemide (sic). And then she suddenly died in the night. Well, I mean, um, you know...I sort of made something up to put on the form.

53 See the Ministry of Health’s Medical Certificate of Causes of Death HP4720.

54 Carol McAllum, Ian St George and Gillian White “Death certification and doctors’ dilemmas: a qualitative study of GPs’ perspectives” (2005) 55 *British Journal of General Practice* 677.

55 *Ibid* at 679.

- 2.114 Some displayed what researchers described as a “degree of cynicism” about the process of certification describing how they would resort to a handful of predictable causes of death depending on the circumstances:⁵⁶

All those deaths are “myocardial infarction”. All older people are “bronchopneumonia”; and everybody else has got “secondary cancers”.

And another:

...the last three elderly people that died of mine, all just decided that they had had enough. But you know, you lie and say that they had, you know, heart attack or something like that, but...[it] gives more work for the National Heart Foundation.

- 2.115 The cost of autopsies and toxicology screening, access to mortuaries and pathology services, and the inconsistent approaches different coroners adopted in cases of clinical uncertainty were all cited as factors impacting on doctors’ decisions whether or not to issue an MCCD without further investigation.
- 2.116 Given these constraints on what may be regarded as “best practice” some doctors felt a more realistic approach would be to allow them to record deaths where there are no suspicious circumstances but no definitive cause of death as “natural but unspecified causes”.
- 2.117 Finally, because doctors rarely received feedback and often had no knowledge of how the MCCD was used, they were not aware of any problems with the system – beyond their own disquiet at sometimes having to sign a document with little evidence to back their “best guess.”

d) Societal and cultural pressures

- 2.118 Alongside the practical constraints doctors confront in deciding how to treat a patient’s death, there is also some evidence to suggest that there may at times be a more general reluctance to embark down the coronial route.
- 2.119 The path of least resistance, where the doctor certifies a death without referring it to the coroner, or where the coroner discusses a death with a doctor but declines jurisdiction, avoids upsetting grieving families and delaying funeral arrangements, and avoids the costs and complications associated with autopsies and clinical reviews.
- 2.120 A number of international studies support the view that doctors may sometimes be reluctant to report deaths. Among these is a 1995 Australian study involving resident medical officers (RMOs are junior hospital doctors), specialists, surgeons and general practitioners working in non-metropolitan Victoria.⁵⁷ This study, cited in the Victorian Parliament Law Reform Committee 2005 discussion paper on the Coroners Act 1985, found that 20 % of the doctors surveyed were willing to alter a death certificate to avoid involving the coroner.⁵⁸

⁵⁶ Ibid at 680.

⁵⁷ D Brumley “Death Certification by Doctors in Non-Metropolitan Victoria” (M.Sc Thesis, Flinders University of South Australia, 1995).

⁵⁸ This was consistent with a British study by Maudsley and Williams which found 17.2 % of general practitioners surveyed would alter certificates to avoid referral to the coroner.

2.121 While these findings cannot simply be transposed to this country, the qualitative study of New Zealand GPs' attitudes towards certification cited earlier, highlights the social and cultural pressures that can be brought to bear on doctors when weighing up whether or not to refer a death to the coroner.

2.122 Any delay to the release of bodies to funeral directors and/or families can often cause distress to grieving relatives. In addition, many Māori and some other religious and ethnic groups object to the use of invasive post mortems, as evidenced by the following verbatim comments from the doctors' focus group:⁵⁹

We all have the pressure, and particularly among Māori people, very much a pressure than not, that there's not to be a post mortem.

Another doctor commented:

With the Māori patient it really is like that. You just don't get a coroner... a coroner's case out of it, even if you would like to, and you're not sure.

2.123 Improving the responsiveness of the coronial system to the cultural and spiritual needs of grieving relatives was a key objective of the coronial reforms. However, as the Bouwer case illustrates, there will be rare occasions where cultural and religious imperatives, real or assumed, may be used in an attempt to avoid scrutiny of a death. In such cases the system depends on the good judgement and independence of the doctor called upon to certify the death.

STRIKING A BALANCE

2.124 These very practical concerns about the emotional and resource costs of investigating deaths, must be balanced against the need to ensure wrongful or preventable deaths do not go undetected. As discussed earlier, there is inevitably a correlation between the levels of accuracy required in death certification and the system's ability to detect wrongful or preventable deaths.

2.125 Permitting deaths to be certified as "natural, but without known cause" may be a sensible and efficient way of resolving the current dilemma doctors face in certifying many deaths of elderly patients with multiple chronic conditions. Arguably though, it also increases the potential for wrongful deaths to go undetected.

2.126 For example in the course of preparing this discussion document a coroner outlined to us a current case which involves the death of a 74-year-old woman who had been ill for some time but whose death was nonetheless regarded as unexpected by her GP.

2.127 A post mortem was carried out and the interim result found to be ischaemic heart disease, as was indicated by the woman's medical history and macroscopic examination. However toxicology results revealed that the death was not in fact due to natural causes but to the combined (toxic) respiratory suppressant effects of morphine and the common sedative Zopiclone. Further investigations have been directed by the Coroner and are presently being conducted by the Police.

59 Carol McAllum, Ian St George and Gillian White "Death certification and doctors' dilemmas: a qualitative study of GPs' perspectives" (2005) 55 *British Journal of General Practice* at 680.

2.128 At the other end of the spectrum Judge MacLean told the Commission he was also concerned that some Sudden Unexpected Deaths in Infancy (SUDI) are being diverted away from the coronial system by doctors who decide to treat the death as “natural cause” and issue an MCCD without any further investigation.

2.129 While this course of action may be a compassionate response to the extreme distress associated with SUDI deaths, it is not in fact lawful and the Chief Coroner is concerned it may also deny the grieving family, and the wider public, vital information about SUDI deaths:

I am aware this has led to occasions particularly with infant deaths where in response to family objections to post mortems an autopsy has been dispensed with and the exclusion of hitherto unknown misdiagnosis of causative factors has been frustrated.

2.130 Finding the correct balance between the needs of grieving families and the need for better knowledge about the leading causes of preventable deaths in this country presents a difficult policy challenge.

2.131 The preceding discussion focused on the pivotal role doctors play in sorting “natural” deaths from those which are reportable to the Coroner. As discussed, the medical judgements doctors make about cause of death, and whether or not they are able to issue an MCCD, are critical to the functioning of the coronial investigation process.

2.132 The great majority of deaths are of course natural and do not require investigation. There are however important public interests in ensuring that these “natural cause” deaths are correctly described and certified. As outlined in the McAllum research discussed earlier, the MCCD has a number of important functions, including;⁶⁰

- to monitor trends and patterns in disease;
- to guide health promotion, resource allocation, service planning, priority determination;
- research and epidemiology; and
- settlement of estates, welfare and pension entitlements and insurance payments.

2.133 The MCCD form used in New Zealand has been designed by the Ministry of Health to conform with the World Health Organisation’s own categorisation and codification of mortality and morbidity data, allowing for internationally consistent disease monitoring and reporting. The process is designed to distinguish the primary underlying cause of death from proximate and contributory causes.

2.134 As discussed above, a failure to correctly diagnose the underlying cause of death can lead to reportable deaths being overlooked. More commonly, however, it is likely that mistakes in how natural cause deaths are certified are likely to involve a failure to correctly identify or distinguish between underlying and proximate cause of death, or a lack of specificity in describing the disease processes leading to the death.

60 C McAllum, I St George and Gillian White “Death certification and doctors’ dilemmas: a qualitative study of GP’s perspectives”(2005) 55 British Journal of General Practice 677 at 677.

- 2.135 Because no agency has statutory responsibility for the monitoring and auditing of death certification we do not know how significant a problem this might be in New Zealand.
- 2.136 However a “mini audit” of 1,313 MCCDs submitted to the Ministry of Health during 12 separate months in 2009 and 2010 found errors in 310 certificates (24%). The errors, detected by former nurses and doctors now working as mortality coders within the Ministry, ranged from non-specific cause of death, a failure to correctly differentiate between underlying, proximate and contributory causes of death and failure to provide critical information such as the primary site of cancer.⁶¹
- 2.137 Similarly in 2010 the Canterbury District Health Board’s Mortality Review Committee detected errors in 105 (9.5%) of the 1102 MCCDs it reviewed from the five CDHB hospitals. Again, these errors ranged from a failure to correctly identify or specify the primary cause of death to errors in how the secondary and contributory causes were recorded.
- 2.138 In New Zealand the potential for errors in the certification and subsequent registration of cause of death is increased as a consequence of the systems we have adopted for transferring the information from the MCCD to the Department of Internal Affairs for death registration. It is a requirement of the Births, Deaths, Marriages and Relationships Registration Act 1995 that every death in New Zealand must be notified and registered.⁶² Once notification has been received, the death is registered by the Department of Internal Affairs and, if requested, an official Death Certificate is then issued.
- 2.139 However each of these steps depends to a large extent on the information provided by the certifying doctor on the MCCD. So for example, funeral directors, who are typically responsible for completing the “Notification of Death for Registration” must first decipher and accurately transcribe the cause of death information from the doctor’s MCCD in order to complete the online notification of death.
- 2.140 This information is then transferred to the register of deaths and ultimately to any Death Certificate issued by the Department of Internal Affairs. Thus a doctor’s “best guess” becomes the legally recognised cause of death for every purpose from insurance claims to a family’s medical history.
- 2.141 The FDANZ reference group reported to us that this luddite system was a cause of considerable frustration to many of their members who not infrequently found themselves having to “Google” doctors’ names and diagnoses in an attempt to decipher barely legible hand writing and impenetrable abbreviations.

61 This audit was overseen by Christine Fowler, acting manager Classification and Terminology, National Collections and Reporting, Information Delivery and Operations Ministry of Health. It was provided to the Law Commission as indicative research only of the possible scale of reporting errors. February 1 2011.

62 Births, Deaths, Marriages and Relationships Registration Act 1995, s 34.

2.142 Evidence of these difficulties was found in the mini-audit of 1,313 MCCDs conducted by coders at the Ministry of Health referred to earlier. Comparing the doctors' original MCCDs with the information transcribed by funeral directors into the on-line death notification form, analysts found 76 transcription errors in the sample.

2.143 These ranged from spelling errors, to causes of death being transcribed in the wrong sequence or missed out altogether, with the result that for some deaths the actual underlying cause of death will not show on the Internal Affairs' death register and will not appear on any official Death Certificate generated from that register. Clearly, a system which relies on medically untrained personnel to interpret the often hastily and imperfectly completed certificates of doctors whose signatures are sometimes indecipherable is a system with quite fundamental flaws.

What price accuracy?

2.144 In this chapter we have highlighted some fundamental conflicts between the policy and practices underpinning death certification and its role in regulating the disposal of bodies.

2.145 On the one hand there is a strong policy argument for ensuring the systems of certification are robust and independently audited to guard against both conscious and unconscious error or abuse.

2.146 In addition there is both a public and private interest in establishing with reasonable accuracy the *actual* cause of death in the vast majority of natural-cause deaths.

2.147 And yet, for grieving families the prospect of unwarranted delays and additional cost and bureaucracy before they are able to bury their loved one can often be hard to justify. Hence doctors frequently face considerable pressure to arrive at a cause of death and complete certification very quickly.

2.148 In addition, even in circumstances where there may be real uncertainty about the cause of death, the decline in pathology services and the cultural aversion to invasive post mortems, mean doctors often have little or no access to investigative resources or support in making their judgement calls.

2.149 And, despite the pivotal role they play in determining whether or not to certify a death, doctors receive no recompense from the state for carrying out this critical statutory function.

2.150 Any attempts to improve the MCCD process will need to first resolve these public policy questions, most critically the price we are willing to pay for improved accuracy and monitoring.

Chapter 3

Cremation: real or illusory safeguards?

CREMATION REGULATIONS 1973

"A medical referee must not authorise a cremation unless satisfied that the fact and cause of death have **definitely** been ascertained."⁶³

HOW THE SYSTEM WORKS

Regulating cremation in New Zealand

- 3.1 Historically, New Zealand, like many other jurisdictions, has required additional scrutiny of deaths involving cremation. New Zealand does not collate national cremation statistics, but the funeral industry estimates that 65–70 % of those dying each year are cremated.⁶⁴
- 3.2 Because cremation is an irreversible process that reduces the body to ash, destroying any medical or forensic evidence regarding the identity of the deceased and their cause of death, the law requires additional scrutiny of these deaths. The language and crafting of the questions included in cremation authorisation forms in many jurisdictions reflects the quasi-investigative purposes of these processes.⁶⁵
- 3.3 The legal requirements governing cremation are set out in the Cremation Regulations 1973. As well as obtaining an MCCD, those applying for the cremation of a body must obtain a *second medical certificate* containing additional

⁶³ Cremation Regulations 1973, reg 7 (5).

⁶⁴ However a survey of local authorities carried out by the Law Commission in relation to the broader review of the Burial and Cremation Act revealed marked regional differences in the percentage opting for cremation over burial. These regional differences reflect a number of factors including the availability of crematoria in the local authority area and the geographic and demographic characteristics of the area. For example many rural communities have no easy access to crematoria while some cities, including Christchurch and Wellington, have a number of competing crematoria. And while cremation has been practised in New Zealand for more than a century, for some religious and ethnic groups burial remains the preferred, or in some cases only, acceptable form of disposal. Funeral directors working in parts of Auckland for example pointed out that in many Pacific Island and Māori communities cremation is rare. Cremation is also unacceptable to many people of Jewish and Muslim faith because of the belief in bodily resurrection.

⁶⁵ See Appendix 2.

information about the circumstances surrounding the death and alerting crematorium officials to the presence of any biomedical aids (such as pacemakers) which may present a risk during cremation.

- 3.4 New Zealand differs from many other jurisdictions in allowing the same doctor who completes the MCCD to also complete the medical certificate for cremation. (Cremation regulations in England and Wales for example stipulate that for deaths which occur in the community, the medical referee cannot authorise a cremation unless a second doctor, independent of the original certifying doctor, has examined the body and confirmed the cause of death.⁶⁶)
- 3.5 Prior to 2009 the New Zealand Cremation Regulations required that the doctor who completed the medical certificate for cremation had to be the doctor who attended the deceased during his or her illness **and** he or she was also required to have viewed the body.⁶⁷
- 3.6 In 2008 the Cremation Regulations were aligned with the Burial and Cremation Act 1964, allowing doctors who had viewed the body, but not treated the deceased, to sign both the MCCD and the cremation certificate.
- 3.7 Under the regulations the certificate completed by the medical practitioner, together with the application for cremation, must be checked by a “medical referee” who has the statutory responsibility for authorising all cremations.
- 3.8 Medical referees are nominated by those who operate crematoria and must be registered medical practitioners of at least five years standing. Their appointment is subject to the approval of the Ministry of Health.
- 3.9 There is no central register of medical referees, no formal training for the role and no professional body to support or monitor their work (although an advisor at the Ministry of Health can provide limited advice if a referee requests assistance during working hours). Typically they may work for a number of crematoria and are paid varying rates per set of papers approved.

Standards of evidence

- 3.10 In theory at least, there is a greater chance of detecting a wrongful or reportable death when a body is to be cremated than when it is to be buried.
- 3.11 In principle, if a doctor fails to identify a suspicious or reportable death it is the job of the medical referee to detect such cases and delay, or prevent, cremation until any concerns have been addressed.

⁶⁶ The Cremation (England and Wales) Regulations 2008 Regulation 16 – (1).

⁶⁷ See Cremation Amendment Regulations 2008 at reg 8 (1)(a).

- 3.12 In practice however this seldom happens and it is arguable that, in its current form, the two-tier cremation certification process offers little protection, except to the extent that medical referees identify deaths that should have been reported to the coroner or some other irregularity in the paper work.
- 3.13 It is also arguable, for reasons discussed below, that medical referees do not currently have the opportunity or the information necessary to fulfil their statutory obligations which dictate that before authorising a cremation they must be “satisfied that the fact and cause of death have **definitely** been ascertained.”⁶⁸
- 3.14 Significantly, and problematically, this imposes a higher standard on medical referees than on the doctors and coroners supplying them with information about the death. Also, as discussed earlier, in some cases it is not possible to ascertain the cause of death with such a high degree of certainty, even if a post mortem is conducted.
- 3.15 Doctors completing the mandatory MCCD and the “certificate of medical practitioner” required when the deceased is to be cremated, must certify that the answers they have provided are “true and accurate” to the best of their “knowledge and belief.”
- 3.16 Similarly when a coroner has undertaken some form of inquiry into a death and is ready to release the body for burial or cremation, they are only required to inform the medical referee that they “satisfied that there are no circumstances likely to call for an examination or, as the case may be, a further examination, of the body.”
- 3.17 In theory a medical referee is mandated by the regulations to “make any inquiry with regard to the application and any certificate that he may think necessary” and also to refuse to authorise a cremation for any reason whatsoever.⁶⁹
- 3.18 In practice however it would appear that most medical referees satisfy their duty by simply auditing the set of papers required by law to be completed before a cremation can be authorised.
- 3.19 These include:
- an application for cremation completed by the executor of the deceased’s estate or the deceased’s next of kin;
 - in cases that have not been referred to the coroner, a doctor’s certificate completed by a doctor authorised to complete the MCCD and who has seen the body of the deceased (typically this form is completed by the same doctor who completes the MCCD but occasionally may be completed by another doctor, particularly in hospitals);
 - in cases that have been referred to the coroner, a form from the coroner stating there is no need for any further examination of the body.
- 3.20 As well as providing the critical factual information pertaining to the deceased’s identity and circumstances of the death, the forms completed by the next of kin and the doctor contain a number of questions intended to highlight any concerns about the death or any circumstances which may require further investigation by the coroner or police.

⁶⁸ Cremation Regulations 1973, reg 7.

⁶⁹ Ibid at reg 7 (4) (a).

- 3.21 For example the doctor is asked whether, in view of their “knowledge of the deceased’s habits and constitution” they “feel any doubt whatever as to the character of the disease or the cause of death?” They are also asked to declare whether they have any reason to suspect the “death of the deceased was due, directly, or indirectly to violence, poison, privation or neglect or illegal operation.”⁷⁰
- 3.22 Any doctor answering “yes” to any of these questions would, of course, have been prevented from completing the MCCD in the first instance and would instead have been under a statutory obligation to refer the death to the police and or coroner.
- 3.23 As part of the research for this paper we conducted a small survey of medical referees working in different parts of the country and followed this with more in depth interviews with three referees.⁷¹ While limited in size, the survey did reveal widely divergent circumstances and views among those sampled.
- 3.24 Many medical referees are either practising GPs or retired or semi-retired hospital clinicians. Although the Ministry of Health must approve any doctor appointed to act as a referee, the Ministry plays no part in training or monitoring their work. In effect the doctors are contracted by and act for one or more crematoria on a fee-for-service basis. Fees are not set by regulation and our survey revealed that payment for each set of papers approved ranged from a low of \$10, to a high of \$85. In some instances the medical referee set the fee, in others it seemed to be determined by the crematorium or was incorporated into the funeral director’s fees.
- 3.25 Workloads appear to vary greatly from a low of four to a high of 300 authorisations per month depending on the size of the community in which the referees were located and the number of crematoria for whom they were authorised to work.
- 3.26 Our survey was designed to ascertain whether medical referees felt the current system was working, and in particular whether the processes and documentation provided to them allowed them to carry out their statutory duties with confidence.
- 3.27 Views tended to be quite sharply polarised between those who believed the system to be working well and those who felt it had significant flaws and was in need of major reform. Although it is difficult to generalise from a small sample, it appeared those most happy with the system tended to be based in smaller communities where they might only be authorising a dozen or fewer cremations a month. One such referee commented: “I think the system works quite well in a small town like ours with a stable medical workforce.”
- 3.28 This suggests high levels of trust – and perhaps even personal knowledge – of the medical and funeral industry personnel providing the original documentation to the medical referees. For example, in response to a survey question asking how they were able to verify the information they had been provided by the doctor, one referee responded: “information is accepted as truthful”.
- 3.29 However, in situations where medical referees were dealing with large numbers of applications, including a high percentage certified by junior hospital doctors, there was sometimes greater concern expressed about the completeness of the

⁷⁰ See Appendix A.

⁷¹ 20 surveys were sent out to a medical referees working in different sized communities. Ten surveys were completed.

information and the extent to which the doctor fully understood what was being asked for. (This concern in part at least arises from the antiquated legalistic language still used in the cremation form.)

- 3.30 When the documentation was complete and consistent, referees reported spending as little as five minutes completing the paper audit. However when information was incomplete, or contained obvious errors or inconsistencies, the referee could spend many hours tracking down the certifying doctor for clarification.
- 3.31 Common reasons for delay in authorising cremations cited by referees included:
 - inadequate “cause of death” information;
 - lack of clarity about whether the coroner had, or ought to have been, involved;
 - failure of the certifying doctor to personally identify and examine the body;
 - no information about whether or not a pacemaker has been removed.
- 3.32 Some were acutely aware that the extent of their audit function was to check for incomplete or internally inconsistent information but, beyond that, they had no way to verify that the original information provided in the documentation was in fact accurate.
- 3.33 In some cases medical referees had used their regulatory powers to require crematoria or funeral directors to provide them with the MCCD as well as the other prescribed documentation. This meant they at least had access to the cause of death as officially recorded and a basis for comparison with the doctor’s cremation certificate. However this did not appear to be a universal practice.
- 3.34 One referee noted that typically he would encounter “several sets of paper per month” where the death should have been referred to the coroner but had not been.
- 3.35 A number of medical referees expressed dissatisfaction with respect to their role in authorising the cremation of bodies released by the coroner’s office. In these cases there is no MCCD (because the doctor could not certify) and so the medical referee is dependent on whatever documentation the coroner might provide.
- 3.36 Some coroners routinely provide an interim cause of death and post mortem reports, others do not. In any event if a coroner has provided a certificate stating the body is no longer required for examination the medical referee is able to authorise cremation – even if the cause of death has not been definitely established by the coroner.
- 3.37 This perhaps raises the question as to whether medical referees need to be involved in authorising deaths investigated by the coroner, as they are effectively simply acting on the Coroner’s instructions to allow cremation to proceed.

Clash of cultures

- 3.38 Waitemata District Health Board emergency medicine specialist, Dr Gerry Clearwater, who authorises an average of 300 cremations a month, believes flaws in the current system reflect a more fundamental clash between the medical and legal cultures. In essence he believes the certification process for cremation is poorly aligned with the systems and culture of the medical profession.

- 3.39 He is particularly critical of the out-dated and legalistic language used in the forms, the ambiguity of many of the questions and the degree of duplication between the MCCD and the doctor's cremation certificate. These two certificates are most commonly completed by the same doctor and involve answering in total 51 separate questions, many of which cover the same ground and 10 of which are duplicated on both forms.
- 3.40 More fundamentally, Dr Clearwater points out that the medical referee system is dependent on the quality and accuracy of the information provided by the certifying doctors and in his experience "doctors generally view cremation paper work as unimportant and often write brief, inaccurate, "sloppy" answers reflecting this disregard."
- 3.41 Nor does he believe the medical referee system is set up to deal effectively with the shortcomings in the certification processes. He argues the payment system "discourages full active scrutiny" by referees and that some less scrupulous members of the funeral industry can "shop around" for a referee who "suits their needs" – a euphemism, he says, for a referee who is less likely to delay the process by seeking too many clarifications from certifying doctors.
- 3.42 He also argues that the lack of professional training, practice guidance and oversight by an independent body capable of auditing the system is a fundamental problem which needs to be addressed. Currently the cremation forms are returned to the cremation authority where they are stored but they are never subject to external audit.
- 3.43 At a very minimum Dr Clearwater recommends that the cremation forms should be modernised in consultation with doctors and consistent training provided to all those required to completed them. He also recommends a national review of medical referees and the establishment of a national body to ensure support, training and consistent practice among referees.
- 3.44 Finally, and perhaps most fundamentally, he recommends a review of death certification and an analysis of the feasibility of introducing random audits as part of a move towards greater accuracy.
- 3.45 Wellington medical referee Dr Hans Snoek expressed similar concerns with the efficacy of the current system but also believed the system merited reform:⁷²

I believe that, with all its flaws and frustrations the external medical referee model is the basis of an excellent system of scrutiny of deaths. I feel that all deaths ought to be so examined, that the data needs for burial sign-off be the same as for cremation and that the forms should be aligned to avoid duplication. I feel that medical referees ought to be formally trained and audited and that they would then be able to provide a real scrutiny of the whole process of death certification.

72 Email from Dr Hans Snoek to the Law Commission regarding medical referee reforms (20 April 2011).

Summary of the problems

Death Certification and Cremation

DEATH CERTIFICATION

The key issues emerging from preliminary consultation

- 1 The system depends on a single certifying doctor.
- 2 There is currently no statutory agency charged with the monitoring and auditing of the death certification system.
- 3 There is no general or targeted auditing of death certification.
- 4 The fact that the law currently permits the burial of a person without being examined or formally identified by a doctor, regardless of the length of time since they were last seen by the doctor, creates a range of potential risks including mistaken identity and failure to detect reportable deaths.
- 5 Preliminary evidence suggests both over and under-reporting of reportable deaths to coroners.
- 6 There is confusion and inconsistency among both some doctors and some coroners as to the boundaries for reporting certain deaths which may be related to medical treatment and reporting deaths from unknown causes.
- 7 There are inconsistencies in the treatment of accident-related deaths in those over 70 years of age and the circumstances in which such deaths should be reported to the coroner, particularly when they result in hospitalisation before death.
- 8 There are ongoing delays in obtaining MCCDs in some circumstances.
- 9 Preliminary research suggests significant error rates in MCCDs, some of which originate from the current practice whereby funeral homes are responsible for transcribing doctors' hand-written MCCDs to the Department of Internal Affairs' electronic notification of death forms.
- 10 There is currently no recognised process by which family members can be informed about or comment on the contents of the MCCD.
- 11 There is on-going concern at the lack of a standardised payment for doctors completing MCCDs.

CREMATION

- 1 The current “on the papers” audit undertaken by medical referees depends, again, on the accuracy of the information provided by the single certifying doctor.
- 2 A single doctor can complete both the MCCD and the cremation certificate, providing no opportunity for independent verification of the identity of the deceased, or the cause of death.
- 3 Because medical referees work in isolation, typically receive minimal payment and are effectively contracted by the crematoria, and frequently do not have access to the necessary information, there are significant questions about their ability to fulfil their statutory obligations to “definitely” establish the cause of death.
- 4 There are significant issues relating to the lack of monitoring, training and support for medical referees and the extent to which the second tier audit adds real value to the system.
- 5 The cremation certification is not standardised nationally and its language is archaic and contains significant overlap with the MCCD.
- 6 There is no auditing of medical referees.

Chapter 4

Preliminary options for reform

THE STATUS QUO

“It is possible to become so familiar with the failings of old, established systems that we forget to notice them. The derelict systems that result were originally devised to protect patients but end up as dangers to their safety.”⁷³

THE POLICY DILEMMAS

- 4.1 Our preliminary consultation and research have revealed a broad spectrum of issues and concerns about the functioning of the death and cremation certification system in New Zealand. These range from the relatively simple operational weaknesses in the certification forms themselves, and the means by which information is transferred to different users, through to more fundamental and far reaching questions about the adequacy of the current safeguards around death and cremation certification.
- 4.2 In order to answer such fundamental questions we need to return to the public interests death and cremation certification are designed to protect: the detection of wrongful or preventable deaths, and the provision of both individual and population health information.
- 4.3 However, as is evident from this discussion paper, these twin objectives can lead in different policy directions and can sometimes involve different standards of accuracy and certainty. For example, in dealing with a death of “unknown cause” a coroner may simply be satisfied if she or he can *exclude* the possibility that the death was suspicious or preventable rather than *definitely establishing* the specific cause of death – something which may only be discovered by autopsy, and in some cases not even then.

⁷³ R Baker “Implications of Harold Shipman for general practice” (2004) *Postgrad Med Journal* 80 at 3003.

- 4.4 Yet, as we have seen, before authorising a cremation, a medical referee, is legally bound to *definitely* establish the cause of death. Logically, “definitely establishing” the cause of death is in fact the only fail safe way to detect all wrongful or preventable deaths, but to do so would of course require post mortems to be carried out on a very much broader category of deaths. This would be neither acceptable nor feasible.
- 4.5 Mortality coders and insurers are also intent on establishing with as much accuracy as possible the specific cause of death, but currently have little or no opportunity to monitor or audit the information they receive from doctors.
- 4.6 And doctors themselves may well be conflicted by their role as the triage agent, deciding which deaths to certify and which to refer for further investigation. As illustrated in the McAllum research, the voice of the deceased can sometimes be lost in the competing claims of funeral directors and families pressing for the early release of bodies.⁷⁴ Moreover the state currently refuses to recompense a doctor for certifying a death, despite the fact it is a statutory duty.⁷⁵
- 4.7 Underpinning the triage system itself are some important policy questions about precisely where as a society we wish to see the coroner’s jurisdiction begin and end. Specifically, where do we wish to draw the boundary for investigating “deaths that appear to be without known cause”, and how far should jurisdiction extend into the increasingly complex arena of medical treatment or the fraught and complex area of geriatric and end of life care? For example, as a society do we want to know when a terminally ill person’s death is accelerated by medication or dehydration?⁷⁶

74 Carol McAllum, Ian St George and Gillian White “Death certification and doctors’ dilemmas: a qualitative study of GPs’ perspectives” (2005) *British Journal of General Practice* 55, 677–683.

75 Doctors do however frequently receive a fee for completing the Medical Practitioners cremation certificate. Payments range from a few dollars to as much as \$75 per certificate depending on the arrangements made by different crematoria and funeral directors. Some hospitals have stopped junior doctors from receiving the money but in other instances we are told it continues to be paid.

76 For example under s 164 of the Crimes Act 1961 a person may be found guilty of culpable homicide if they;
 “...by any act or omission causes the death of another person kills that person, although the effect of the bodily injury caused to that person was merely to hasten his death while labouring under some disorder or disease arising from some other cause”.

- 4.8 Some may argue that identifying systemic problems in the provision of health care is more properly the role of statutory bodies such as the Health and Disability Commissioner, or one of the several mortality review committees or the recently established Health Quality and Safety Commission.⁷⁷
- 4.9 However the Health and Disability Commissioner is a complaints-driven body charged with investigating breaches of patient care rather than investigating deaths (although the one may lead to the other) while the Health Quality Commission is charged with improving the quality and efficiency of health and disability services at a national level and works with anonymised incident data rather than individual cases.
- 4.10 The coroner, in contrast, works from the *particulars of an individual* case to see what, if any, generalised lessons may be learned to prevent deaths in similar circumstances. Unlike the various review committees the coroner also has custody of the body and is therefore able to draw evidence from the body before it is finally disposed of. The coroner's inquest is conducted in an inquisitorial manner and the coroner is specifically prohibited from determining questions of "civil, criminal or civil liability."⁷⁸ This model of inquiry may be seen as particularly appropriate for investigating deaths involving questions of standards of care and medical treatment.
- 4.11 Any decision to extend the coroner's jurisdiction by making more deaths reportable, or "reviewable", would of course have potentially significant implications for resourcing and may also raise the question that has surfaced a number of times in the course of the preliminary consultation about the need for coroners to have 24 hour access to independent medical advice to help them bridge the gap between the medical and legal cultures.
- 4.12 Almost invariably, widening coronial jurisdiction would also involve revisiting our attitudes towards autopsy, as this remains the critical tool for unravelling suspicious or "unknown cause" deaths.

77 The Health Quality and Safety Commission's role is to spear head improvements in safety and quality across both the private and public health and disability sector. Specifically, the Commission has been charged with:

- providing advice to the Minister of Health to drive improvement in quality and safety in health and disability services;
- leading and coordinating improvements in safety and quality in health care;
- identifying data sets and key indicators to inform and monitor improvements in safety and quality;
- reporting publicly on the state of safety and quality, including performance against national indicators;
- disseminating knowledge on and advocating for safety and quality.

In addition a number of national mortality review committees have been charged with monitoring and analysing deaths in vulnerable demographics. These include;

- the Child and Youth Mortality Review Committee (CYMRU) an advisory committee which reviews all deaths of children aged from 28 days to 24 years, with a view to reducing the number of deaths in this group and to continuous quality improvement through the promotion of quality assurance programmes;
- the Family Violence Death Review Committee, an independent committee that reviews and advises the Minister of Health on how to reduce the number of family violence deaths;
- the Perinatal and Maternal Mortality Review Committee which reviews and reports to the Minister of Health on New Zealand's perinatal and maternal deaths, with a view to reducing the numbers of preventable deaths in these groups;
- the Perioperative Mortality Review Committee, a committee which reviews and reports on national perioperative mortality to the Minister of Health with a view to reducing these deaths and continuously improving the quality of the health system and, therefore, outcomes for patients.

78 Coroners Act 2006, s 4 (e)(i).

- 4.13 In a health system already struggling to reconcile ever growing demand with finite physical and human resources it may be difficult to make a case for diverting resources away from the living to the dead. And yet, as outlined at the beginning of this discussion paper, the living have a very real interest in ensuring we learn all we can from those who die before us. In this sense, any reform which leads to greater insights into how and why we are dying is an investment in the health and wellbeing of future generations.
- 4.14 The following options are designed to help promote discussion rather than provide a blueprint for change. They range from relatively straightforward proposals to modernise and simplify the documentation involved in death and cremation certification to more ambitious options around the extension of the medical referee system to cover all community deaths.
- 4.15 In considering these reforms it is also important to note the dependencies between the various options. For example, the introduction of a national system of random or targeted auditing of death certification may lessen the case for changes to the current single certifying doctor system. Similarly, giving explicit statutory recognition to the rights of any member of the public to directly discuss a death with the coroner may provide an important safeguard in a system reliant on a single certifying doctor.
- 4.16 Ultimately these questions involve a careful weighing of the costs and benefits attached to any proposed reforms. However it is arguable that an informed policy debate on these issues cannot take place until the current system has been subjected to a more rigorous audit – a key recommendation of this paper.

LESSONS FROM OTHER JURISDICTIONS

The revised system for death certification in England and Wales

- 4.17 *The Shipman Inquiry* concluded that certification of the cause of death by a single doctor was no longer acceptable and that the current system of cremation certification, despite its three layers, was not in fact providing the safeguards it was designed to provide.
- 4.18 *The Luce Report* arrived at the same conclusion and was particularly perturbed by the lack of administrative oversight of death certification.⁷⁹
- 4.19 The proposed reforms recommended by these two reviews differed in some respects, but both reviews reached broadly similar conclusions regarding the critical features of any new system. These included:
- the need for genuine independence in any system involving peer reviewing of certification;
 - the need for family members and other caregivers to be consulted and informed about the death certification process;
 - the need for coroners to have access to expert medical advice to assist in assessing the information they receive about the circumstances of death;
 - the importance of those involved in death certification and the reviewing of certification to have access to accurate and timely medical information;

⁷⁹ Tom Luce et al, *Death Certification and Investigation in England, Wales and Northern Ireland The Report of a Fundamental Review* (United Kingdom, Home Office, CM3831, 2003) [*The Luce Report*] 16 at [4.b].

- the importance of there being a statutory body with responsibility for administering, monitoring and auditing all death certification.
- 4.20 The major reforms recommended by Dame Janet in the *Shipman Inquiry* included:
- abolishing the distinction between “natural” and “unnatural” deaths and giving coroners initial jurisdiction over all deaths;
 - transferring the responsibility for all death certification to coroners;
 - introducing a new role of medically qualified coroner’s investigators who would be responsible for reviewing doctors’ preliminary assessment of the likely cause of death, including consulting with family and other care givers, and assessing whether further investigation was required or whether there was sufficient certainty to issue the MCCD;
 - introducing a separate process for recording the fact of death and circumstances of the death. This would be the first statutorily prescribed step in the death certification process and would have to include a physical examination of the body for signs indicative of violence or neglect. It could be completed by a doctor, accredited nurses, and paramedics;
 - replacing the dual certification systems for burial and cremation with one unified certificate;
 - introducing a random audit of certified deaths and giving the Coroner’s office the power to instigate targeted audits.
- 4.21 The rationale for this approach rested heavily on Dame Janet’s conviction that doctors were often unsuccessful in recognising deaths that were reportable to the coroner but were best placed to assess the likely cause of their patient’s death.
- 4.22 The system she proposed retained the deceased’s doctor as the critical source of information about the death, but relieved the doctor of having to determine whether or not the death was reportable. It was also seen to provide families and other care givers with an independent forum for raising any concerns they may have had in relation to the deaths. By centralising death certification in one statutory body, the system would also allow for the collection of accurate data and the means of conducting both random and targeted audits.
- 4.23 The *Luce Report* shared many of the features of the system recommended by Dame Janet. The critical difference was that the Luce Report argued that the statutory responsibility for death certification should properly remain, in the first instance, with the patient’s doctor as the person best placed to determine the cause of death.
- 4.24 Luce did not believe it was either necessary or wise to remove the core responsibility for death certification from doctors. He argued that trust was a vital ingredient in the patient doctor relationship and while cases like Shipman shook that public trust, it did not destroy it to such a degree as to require a complete change in approach. He referred instead to the need for “monitored trust.”⁸⁰

80 Tom Luce “Death Certification and the Coroner Service” (2004) 44 Med. Sci Law at 287.

- 4.25 However the report recommended abolishing the system which allowed a single doctor to certify the cause of death and instead recommended that all deaths be reviewed by a second independent doctor who would be appointed by and answerable to a newly created role of “statutory medical assessor” based in the Coroner’s Office.
- 4.26 Hospital deaths would be subject to review by another hospital clinician of consultant status who had not played in part in the patient’s care and who was approved for the role by the statutory medical assessor.
- 4.27 Like the *Shipman Inquiry*, the *Luce Report* recommended abolishing the separate medical cremation certification process and replacing it with a single certifying system for all deaths.
- 4.28 Doctors completing the MCCD would be required to have either seen the body or attended the deceased within 28 days of their death. The requirement to view the body would only apply in circumstances where there was uncertainty regarding the cause of death or the family was expressing concern.
- 4.29 However both the *Luce Report* and Dame Janet Smith recommended that all deaths should be verified and the body viewed by suitably qualified personnel (not necessarily doctors) in a process distinct from and prior to the certification of cause.

The proposed British model

- 4.30 As discussed earlier, following the 2010 British elections the incoming government decided to abandon the plans for a totally reformed and restructured coronial system which had many of the features of New Zealand’s professionalised service, headed by a Chief Coroner.
- 4.31 However the decision was made to proceed with the planned reforms to death certification, including the appointment of Medical Examiners to oversee death certification.
- 4.32 Under the new model doctors would have the statutory responsibility for certifying deaths and notifying the coroner of suspicious or unexplained deaths. However before the cause of death is confirmed and before preparation of the body for burial commences, all deaths will be reviewed by a “Medical Examiner” who will have access to the deceased’s medical notes or discharge summary, and who will be the final arbiter of whether a death should be referred to the coroner. Families and other caregivers will have access to the Medical Examiner and be able to report any concerns directly to them.
- 4.33 The Medical Examiner will also be available to provide advice to doctors regarding the cause of death and whether the death should be referred to the coroner. Their role as scrutineer of all deaths would effectively remove the need for the separate system of medical referees overseeing cremation deaths.
- 4.34 The two-tier scheme will apply to all deaths, regardless of whether the body is to be buried or cremated and will be largely self-funding, as the Medical Examiner’s fee of 100 pounds will be met by families.

OPTIONS FOR
NEW ZEALAND

1. What level of scrutiny is appropriate?

- 4.35 In Tom Luce's opinion any reform of New Zealand's death certification system must address what he regards as two fundamental flaws: the single doctor certification of burial cases and the lack of active monitoring and auditing of death certification.⁸¹
- 4.36 Luce argues it is vital that some public authority assumes responsibility and accountability for the proper functioning of the certification of non-coronial deaths. This leads him to the conclusion that there needs to be a two-tier system whereby the person providing the audit role is not a sole practitioner or a medical colleague but rather a medically trained person answerable to the body overseeing death certification.
- 4.37 Luce's comments raise two separate issues for consideration. Firstly, at an operational level, is there a need to give statutory authority to a government department, such as the Ministry of Health or the Coronial Services Unit within the Ministry of Justice, for the oversight of death and cremation certification? This function might include responsibility for both random and targeted auditing of death and cremation certification in order to better detect unusual patterns of certification or the failure to report certain categories of deaths to the coroner.
- 4.38 Secondly, is New Zealand content to retain the single certifying doctor for cases involving burial? Up to 70 % of all deaths are already subject to the two-tier medical referee system, so extending their jurisdiction to all deaths would not necessarily create undue delay or additional bureaucracy.⁸²
- 4.39 However, while extending the medical referee's audit role to all deaths may ensure more reportable deaths are detected, it would not prevent deliberate or unconscious errors made by the original certifying doctor, as medical referees do not currently either view the body or undertake any independent investigations such as accessing patient medical notes.
- 4.40 Short of requiring a second doctor to review an MCCD and medical notes, consideration may be given to less fundamental changes which may nonetheless improve the system.
- 4.41 For example representatives of the funeral industry reference group strongly advocate that the person certifying a death must *in all cases* identify and physically examine the body of the deceased – irrespective of whether the person has elected to be buried or cremated.
- 4.42 At the very minimum, if stakeholders do not support making it mandatory for all bodies to be physically examined before certification, it would seem prudent to require doctors who are completing an MCCD without examining the body to have seen the patient within a specified period of time before their deaths, as is the case in the United Kingdom.

81 Tom Luce in interview with Cate Brett, Auckland 24 November 2010.

82 If the auditing of death certification in hospitals is standardised there may also be a case for restricting the role of medical referees to reviewing all deaths that occur in the community or in residential care facilities. This would further reduce their work load.

Q1 Should a statutory body have the responsibility for the monitoring and oversight of death and cremation certification in New Zealand? Is there a case for that responsibility to lie with the Ministry of Justice, which also has responsibility for the coronial system?

Q2 Should random and targeted auditing of death and cremation certificates be undertaken by the body with statutory responsibility for certification?

Q3 Should a single doctor continue to be permitted to complete the Medical Certificate of Cause of Death without any independent scrutiny or review?

Q4 Or should all deaths be subjected to some form of independent review before final disposition, irrespective of whether the deceased is to be cremated or buried?

Q5 Should a doctor be required to physically examine the body of every deceased person before completing the Medical Certificate of Cause of Death, irrespective of whether the deceased is to be buried or cremated?

Q6 If not, should there be a temporal restriction on a doctor signing the certificate of a patient who has died and who has not been examined after death – e.g. the doctor must have seen the patient within 14 days of the death? (this provision would only apply when the doctor certifying had been treating the person during their last illness)

Certifying deaths in hospitals

- 4.43 Given that over 60 % of all deaths are certified in hospitals or aged-care facilities it is arguable that the greatest potential for improvement in the system lies within the public health service.
- 4.44 The Chief Coroner has already taken steps to ensure that every District Health Board requires its doctors to complete a standardised *Record of Death (and Notification of Death to the Coroner if required)* to improve the consistency in identifying reportable deaths. Essentially this provides hospital doctors with a check list to assist them in identifying reportable deaths before they consider completing the MCCD or cremation certificates. It also provides a record of any conversations between the certifying doctor and the coroner with respect to the death and any decisions regarding the requirement for a post mortem.
- 4.45 It is also clear from the long-running mortality review system in place at Christchurch Hospital that is feasible to implement some form of independent, clinician-led quality control without unwarranted bureaucracy and cost.

- 4.46 As a first step towards improving death certification and ensuring all reportable deaths are reported to the coroner, it may be feasible to require all District Health Boards (and possibly all hospital level aged-care and dementia facilities) to implement some form of approved, timely, and independent clinical auditing of all death certificates completed in their facilities. These reports could be provided to both the Ministry of Health's health information teams and to the Chief Coroner.
- 4.47 In addition to any internal quality controls, it appears that the levels of expertise and advice available to assist junior doctors in completing death certification is quite variable. If consideration is given to providing expert independent medical advice to all coroners, it may be that these coronial medical advisers could also provide advice to doctors who are uncertain whether, or how, to certify a death. Alternatively this may be an appropriate role for hospital pathologists.
- 4.48 In the past the Ministry of Health also published "A Guide to Certifying Causes of Death" which provided doctors with useful examples and explanations. This has not been updated since 2001 and while some DHBs, such as Capital & Coast, provide comprehensive guides for staff, GPs do not necessarily have access to the same information. A strong case can be made for updating and expanding the guide and distributing it to all medical practices, hospitals and aged residential care facilities.

Q7 Should all public hospitals be required to carry out regular internal audits of all Records of Death and MCCDs completed by their doctors to ensure deaths which should be referred to the coroner are referred and to improve the accuracy of death certification?

Q8 Should all doctors who are required to complete MCCDs have access to independent expert advice?

Q9 Should the Ministry of Health Guide to certifying deaths be updated and expanded to include a guide to reportable deaths?

2. Improving the interface between the Coroners Act 2006 and the Burial and Cremation Act 1964.

- 4.49 As discussed, one of the key policy objectives of death certification is to filter deaths which are of "natural causes" from "unnatural deaths", including those which require further investigation either by the police or a coroner.

Clarifying coroners' current jurisdiction

- 4.50 Our preliminary inquiry has revealed some concerns and inconsistencies as to when a coroner will want to take jurisdiction – or at least consider taking jurisdiction – of deaths that are "without known cause" or deaths which occur "during medical, surgical, or dental operation, treatment, etc."⁸³ It has also revealed inconsistencies in how doctors and coroners interpret the need to report

⁸³ Coroners Act 2006 s 13.

and review deaths that may have some link to the drug treatment a patient was receiving. Similarly, there appear to be inconsistencies in how accidental deaths in the elderly population are being reported.

- 4.51 These issues were considered as part of the British reforms and have also been recently reviewed in the context of the respective Coroners Acts of Queensland and Victoria.
- 4.52 While the scope of this paper does not allow a detailed discussion of the various legislative approaches adopted in these jurisdictions, it is perhaps worth noting some of the key features of the Queensland and Victorian Acts.
- 4.53 The Coroners Act 2003 (Queensland) includes in its definition of an “unnatural” and therefore reportable death “the death of any person who dies at any time after receiving an injury that caused the death or that contributed to the death and without which the person would not have died.”⁸⁴
- 4.54 The Act provides examples of “unnatural deaths” which would satisfy this definition:
- a person’s death from pneumonia suffered after fracturing the person’s neck of femur;
 - a person’s death caused by a subdural haematoma not resulting from a bleeding disorder.
- 4.55 The Queensland legislation also requires “health care related deaths” to be reported to the coroner.⁸⁵ It defines these as deaths which occur when:
- (a) the provision of health care caused or contributed to, or is likely to have caused or contributed to, the death and;⁸⁶
 - (b) immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person’s death.
- 4.56 An “independent person” is defined as someone appropriately qualified in the relevant area of health care and who has regard to the underlying health of the deceased, and the clinically accepted range of risk associated with the procedure, and the circumstances in which the treatment was sought.
- 4.57 Victoria’s Coroners Act 2008 also adopts the concept of “no reasonable expectation” of death as a criterion for when a death that occurs during or after a medical procedure should be reported to the coroner.
- 4.58 The Victorian legislation is unique in that it is able to incorporate and draw on the considerable expertise and services of the statutorily established Victorian Institute of Forensic Medicine. This resource has been critical to the evolution of coronial services in the state of Victoria and allows coroners considerable scope in their approach to investigating deaths.

84 Coroners Act 2003 Queensland s 5.

85 Health care is defined in the Act as “any health procedure” or any “care, treatment, advice, service or goods provided for or purportedly for the benefit of human health.”

86 Ibid at s 10 AA.

- 4.59 For example the Coroners Act 2008 (Vic) empowers coroners and other medical investigators (typically pathologists) to carry out ‘preliminary investigations’ such as visual examinations of a body, the taking and testing of samples of bodily fluids including blood, urine and mucus and the imaging of the body with x-rays or ultrasounds and magnetic resonance imaging.
- 4.60 While some pathologists question the value of such “preliminary examinations”, describing them as “autopsy lites”, such measures can provide important information to families, doctors and coroners when trying to determine the cause of death and whether or not there is a need for a full autopsy and/or coronial inquiry. They also offer an alternative investigative strategy in cases where there are strong cultural objections to invasive autopsies.

Extending coronial jurisdiction

- 4.61 As well as considering the approaches adopted by these Australian states to medical deaths, it might also be appropriate to consider whether there is a public interest in extending the coroner’s jurisdiction to encompass a broader range of deaths where the circumstances might suggest a *prima facie* case for additional scrutiny.
- 4.62 For example the *Luce Report* recommended extending reportable deaths to include:⁸⁷
- any death from a range of communicable diseases defined from time to time by the Coronal Council as needing investigation by the coroner;
 - any death in which occupational disease may have played a part;
 - any death in which lack of care, defective treatment, or adverse reaction to prescribed medicine may have played a part, or unexpected deaths during or after medical or surgical treatment;
 - any death which is the subject of significant unresolved concern or suspicion as to its cause or circumstances on the part of any family member, or any member of the public, any health care, funeral services or other professional with knowledge of the death;
 - any death in respect of which the Registrar has significant continuing concern.
- 4.63 The Chief Coroner’s “Record of Death” which is used in all public hospitals to alert doctors as to which deaths must be reported, already contains a question asking whether the doctor is “aware of any person expressing concern as to the cause of death or hospital treatment of the deceased.”
- 4.64 However answering in the affirmative to this question does not automatically necessitate referring the case to the coroner. Nor is there any obligation on the doctor, or medical referee, to consult with family members or caregivers when completing these forms.

87 Tom Luce et al, *Death Certification and Investigation in England, Wales and Northern Ireland The Report of a Fundamental Review* (United Kingdom, Home Office, CM3831, 2003) [*The Luce Report*] at 36.

Improving interface between coronial service and other review bodies

- 4.65 As discussed at paragraph 2.81 New Zealand now has a number of bodies which have as part of their function reviewing preventable deaths, including the Health Quality and Safety Commission, the Health and Disability Commissioner and the various national mortality review committees. While not all the deaths considered by these bodies are reportable under the Coroners Act, many are.
- 4.66 In some instances there already exist memoranda of understanding and information sharing protocols between these groups and the Coroner's Office. However there may be further gains to be made from improving information sharing and data collection. For example, requiring DHBs to broaden their adverse sentinel events reporting to include information about the reporting of deaths to the coroner could provide a useful internal audit tool.

Q10 Do the circumstances in which doctors are required to report deaths which are "without known cause" or deaths which occur "during medical, surgical, or dental operation, treatment, etc." to a coroner need to be better defined in the Coroners Act 2006?

Q11 Are there grounds for extending the coroners' jurisdiction to a broader category of deaths? If so which deaths? Where there are unresolved concerns about a death by family members or care givers should it be mandatory for these deaths to be discussed with the coroner?

Q12 Should s 14 of the Coroners Act be amended to explicitly permit funeral directors, health care workers, relatives of the deceased or any other person with relevant information to report deaths directly to the coroner?

Q13 Is there a case for making the Coroner's Record of Death certificate a statutory declaration used for all deaths (rather than hospital deaths only)?

Q14 Is there a case for introducing a second-tier of "reviewable" deaths, such as deaths arising from accidents in the elderly, which do not involve a full coronial inquiry but may involve a preliminary examination and possible referral to another authority such as the Health and Disability Commissioner?

Q15 Is there merit in reviewing the interface between the Coroner's Office and the various bodies charged with reviewing deaths and improving standards of health care?

Q16 Should consideration be given to appointing medical advisors to the Coronal Services Unit to ensure coroners have access to expert medical advice in making assessments as to whether to accept jurisdiction of "unknown cause" and deaths in health care?

3. Cremation and the role of the medical referee.

- 4.67 While a large proportion of deaths certified in the community are subject to a second-tier review by medical referees (because the body is to be cremated) there are significant weaknesses in the system which raise fundamental questions about its real value as a safeguard.
- 4.68 Medical referees are often highly experienced professionals but under the current system their expertise is not fully utilised, partly because they do not always have access to the information required to carry out their statutory role and partly because their role has become perfunctory and undervalued.
- 4.69 Irrespective of whether or not the medical referee system is extended to all deaths in the community, there may be real benefit in addressing some of these current weaknesses.
- 4.70 Genuine independence is vital in any auditing system and there may be a case for bringing medical referees under the authority of the Chief Coroner and the Coronial Services Unit. Currently, there is no centralised management or oversight of medical referees and while appointments must be approved by the Ministry of Health it is arguable the only real accountability is to the crematorium authorities or funeral directors for whom they work.
- 4.71 Given that New Zealand already has an established network of medical referees and deputy referees providing 24 hour seven-day-a-week cover for death certification, it makes sense to consider whether the role of medical referee could be extended to provide expert medical advice to both coroners and doctors in respect of death certification.⁸⁸
- 4.72 At a minimum, medical referees could be provided with the MCCD for all deaths they are required to certify and should also have direct access to the doctor who completed the MCCD and to any additional reports or information. It may also be appropriate for families or any other concerned person to have direct access to medical referees in instances where there is some concern about the death and whether it may be reportable or reviewable.
- 4.73 If medical referees remain the nominal responsibility of the Ministry of Health there should at least be a more active approach to their management and accountabilities, including recruitment, training, a standard fee structure and routine reporting and auditing.

88 The medical referee appointed by and answerable to Coroner's office could have objectives and functions similar to those outlined by Luce as the second certifiers working under the Statutory Medical Assessors:

- they should be experienced clinical doctors, chosen for their skills and professional independence. They could still be in clinical practice or recently retired from it;
- should be given some initial training, and some continuing training periodically after appointment;
- they should concern themselves both with the safety of the certification process – i.e. the safeguarding against certifying deaths which should be investigated by the coroner or the police – and with the accuracy and suitability of the disease data given in the certificate;
- they should invariably speak to the first certifier, and see some of the clinical case notes, including the note of the last occasion the first certifier treated the patient, any recent hospital discharge note or other note authenticating the diagnosis relevant to the death, and the list of medicines prescribed for the patient in the period preceding death;
- they should be available to talk to or see members of the deceased's family.

- 4.74 Our discussion also highlights the anomaly in the level of certainty medical referees are required to obtain before authorising cremations. Given the demise of the medical autopsy it would seem inappropriate to require this level of certainty of medical referees, particularly when the same standard is not necessarily always achieved by coroners and certifying doctors when there is no autopsy.

Q17 In its current form is the medical referee system providing sufficient safeguards as to justify its continued existence?

Q18 Is there a case for strengthening the medical referee system and extending it to all deaths?

Q19 Would the medical referee system be strengthened by ensuring referees have access to patient notes and to the person completing the MCCD?

Q20 Is there a case for exempting coronial cases from the medical referee system?

Q21 Is there a case for exempting hospital deaths from the medical referee system?

Q22 Could the role of medical referee be extended to include an advisory function for coroners and doctors in relation to death certification?

Q23 Should the regulation requiring medical referees to “definitely” establish the cause of death before authorising cremation be amended to reflect the actual level of certainty attainable without autopsy?

Q24 Should medical referees receive standardised training, payment and monitoring under a centralised administration? If so should that be the Coroner’s Office?

4. The case for separating “cause of death” certification from “verification of life extinct”

- 4.75 The previous discussion has focused on ways in which the processes of death certification can be improved. A common theme in much of this discussion is the need to balance the requirements for efficiency and responsiveness against the need for accuracy and safety. The law requires doctors to “give a doctor’s certificate” “immediately” on learning of the death (or for a proxy to complete the form in the doctor’s absence). This certificate becomes the legal trigger for the removal of a body and the preparation of the body for burial, including, embalming, and burial or cremation.

- 4.76 Funeral directors not infrequently find themselves caught between these legal requirements and the needs of families or care providers to deal rapidly with the deceased. Similarly doctors can be pressured to attend the deceased and sign MCCDs in situations where they do not necessarily have the information to properly assess the cause of death.
- 4.77 The doctor's primary role at the moment of death is to confirm that life is extinct and to ensure the death was natural – i.e. to rule out the possibility that it was a suspicious or unexplained death that warrants further investigation before the body is released to those responsible for burial or cremation.
- 4.78 It is arguable therefore that the processes of positively identifying the deceased, examining the body, verifying life extinct and ensuring there is no *prima facie* cause to notify the coroner could be separated from the process of completing the MCCD. If there were any doubts or concerns about the death it may be possible to authorise blood or urine samples to be taken from the deceased before the body is released, as per the provisions for preliminary investigations contained in the Victoria's Coroners Act discussed in paragraph 4.57.
- 4.79 A number of overseas jurisdictions already operate a two-step system allowing paramedics, and a range of other health care professionals to complete the initial documentation confirming identity and the fact of death. This allows for the body to be removed from the place of death and passed into the custody of the family or funeral director.
- 4.80 A doctor (or potentially nurse practitioner) would remain under a statutory obligation to view the body and complete an MCCD but this could then be done at a more measured pace and after any further information had been supplied.
- 4.81 In the course of preliminary consultation a number of funeral directors expressed concern about the current absence of a formal process of identification of the deceased and provided examples of “near misses” where the wrong body had been uplifted from an aged-care facility after a doctor certified without personally viewing the deceased.⁸⁹ The growth in unregulated businesses providing funeral services from private homes particularly in Auckland was also seen to increase the risks around loose identification and verification of life extinct.
- 4.82 It is possible the Coroner's Record of Death form could be adapted to suit these purposes. A copy of the Record of Death would accompany the body and another be sent to the Coroner's Office for auditing purposes and also to the deceased's next of kin. It would contain the contact details of the local coroner's office in the event any relative wished to discuss the circumstances of the death with the coroner.

Who can certify?

- 4.83 Under the current legislation only a registered medical doctor is authorised to complete the MCCD and medical certificate for cremation.

89 “Wrong body in coffin” *Waikato Times* (New Zealand, 18 July 2008).

- 4.84 A review of the roles that are legally restricted to medical practitioners is currently underway in this country as part of health workforce planning. In the context of this review policy makers are exploring whether it may be appropriate to authorise nurse practitioners (NPs) to complete death certification. A nurse practitioner is the legally recognised title for a nurse who has completed advanced medical training in a specialist area and who is qualified to diagnose and treat in their area of specialisation.
- 4.85 Nurse practitioners working in the areas of neonatology and gerontology explained to us that the current restrictions on who may certify can lead to distressing delays for families at a time of considerable stress. Given their close and extended involvement in the treatment of those who died under their care they also argued they would be as well positioned, if not better positioned, than a junior doctor, to complete the MCCD.
- 4.86 Deborah Harris, a nurse practitioner currently working in Waikato Hospital's neonatology unit, and former deputy chair of the Perinatal Mortality Review Committee, believed death certification was an important part of the final care offered to grieving families and should not be done in a perfunctory manner. While the cause of death in a premature baby would often be readily diagnosed, there were occasions where the cause was simply unknown. In such instances she encouraged families to agree to an autopsy because the knowledge gained from this not only helped them understand why the death had occurred but could also be invaluable with respect to planning future pregnancies.
- 4.87 There are currently fewer than 100 nurse practitioners practising in New Zealand, 27 of them in primary care, so extending death certification rights to this group of health workers would not immediately alleviate the pressures sometimes experienced by the funeral industry with respect to releasing bodies. However as the numbers of nurse practitioners increase it has the potential to help address these problems.

Q25 Is there a case for replacing the Medical Certificate of Cause of Death as the document which allows the removal of the body with a new Record of Death Notification to be completed by a doctor authorised under the Burial and Cremation Act or a nurse practitioner or nurse manager. (The Record of Death would include verification of identity of deceased, verification of life extinct, and preliminary assessment of whether the death is reportable or requires further investigation. The person completing this form would be obliged to undertake a physical examination of the body.) Doctors would remain under a statutory obligation to complete the MCCD within a prescribed period.

Q26 Should the authority to complete MCCDs be extended to nurse practitioners in circumstances where they have been the deceased's lead carer?

5. The case for simplifying and unifying the certificates

- 4.88 Irrespective of what other changes are considered we found universal support for redrafting and modernising the cremation certificates and to the degree possible, simplifying the MCCD.
- 4.89 Consideration may also be given to attempting to combine in one, or possibly two, forms – the information that is currently gathered through the Record of Death (used in hospitals only), the MCCD and the medical cremation form.
- 4.90 At the same time the consideration should be given to allowing doctors to complete the MCCD in electronic form and sending this directly to the Ministry of Health and to the funeral director or person responsible for arranging the deceased’s funeral. Currently the majority of funeral directors already complete the Department of Internal Affairs’ “notification of death” on line so there should be little difficulty in extending this to the MCCD.
- 4.91 Finally the question of how certification is funded must be addressed – particularly if expectations of accuracy and timeliness are to be raised. The new two-tier death certification system in the process of being introduced in the United Kingdom is to be funded by the families of the deceased. However as this paper has demonstrated the doctor who attends a death is performing both a public and a private function and so there may be a case for a subsidy from the state.
- 4.92 Nor is it clear why doctors frequently receive fees for completing the medical certificate for cremation but not for completing the MCCD itself, despite the fact both certificates are prescribed in law.
- 4.93 Any move to introduce a unified certificate covering cremation and burial would also offer an opportunity to re-examine the actual costs involved in these processes and to ensure greater transparency and uniformity in how those costs are met.

Q27 Does the Medical Certificate of Cause of Death require simplification?

Q28 Does the doctors’ medical certificate for cremation require simplification and modernisation?

Q29 Should these two certificates be amalgamated – e.g. a perforated portion at the base of the MCCD that can be provided to the funeral director or crematorium?

Q30 Who should bear the cost of death certification?

Appendices



Appendix 1

The Canterbury Mortality Review Committee

For a 12 month period following the Keith Ramstead inquiry the then Christchurch Coroner, Mr MacLean (now, Chief Coroner, Judge Neil MacLean) required the Canterbury District Health Board to fax through notification of every hospital death for the coroner to determine whether any further inquiry was required. The hospital deals with more than a thousand deaths a year so this arrangement did not prove practical.

In its place the coroner worked with hospital clinicians to devise a new form, known as the *Record of Death (and Notification of Death to the Coroner if required)* which is completed for every hospital death and which provides a check list to assist the doctor in identifying reportable deaths. At the instigation of the chief coroner this form has now been standardised and adopted for use in every public hospital in New Zealand.⁹⁰

Alongside this, many (but not all) hospitals have devised their own systems of auditing and quality control around death certification. One of the longest standing and most comprehensive operates at Christchurch hospital where senior clinicians review the medical notes and death certificates of every hospital death.⁹¹

The group, known as the Mortality Review Committee, was set up in 1993, in the wake of the Ramstead inquiry, at the initiative of two senior pathologists from the Christchurch School of Medicine, Dr Martin Sage and Professor Boswell. The committee is made up of four senior clinicians who are elected by, and report to, the hospital's (senior) Medical Staff Association.⁹²

90 See Appendix B for copies of this and other forms currently in use.

91 The Commission is aware that other District Health Boards will have their own review processes including mortality reviews managed by different medical departments. However at the time of writing the Canterbury initiative was the only systematised audit of death certification of which we were aware.

92 The Mortality Review Committee also reports to the hospital's clinical board.

Current chair, Physician Martin Searle, explains the committee has the five following objectives:

- to ensure appropriate and correct notification of hospital deaths to the coroner;
- to ensure that Certificates of Causes of Death and the Record of Death forms accurately represent the clinical course of the deceased patient as documented in the hospital patient's notes (and that these notes show that the "clinical fact of death" was properly established);
- to provide amendments to death certificates to New Zealand Health Information service for statistical purposes;
- to establish a database to allow analysis of the accuracy of reporting of deaths, including indices of clinic-pathological correlation based on autopsy and clinical records;
- to provide feedback to certifying doctors and Clinical Directors for purposes of education and audit.

In the year to 30 April 2010 the committee reviewed 1102 deaths from the five CDHB hospitals (910 deaths from Christchurch Hospital). Of this total, 262 (24 %) were referred to the coroner at the time of the death with the coroner accepting jurisdiction of just 96 cases (8.7 %). The coroner required autopsies in 81 of these cases and in the other 15 he issued a 'certificate in lieu' of an autopsy report.

Dr Searle estimates that on average the committee refers ten deaths a year to the coroner after a review of the case reveals it was a reportable death but was not appropriately notified. It was now much less common to find deaths which should have been reported to the coroner, but were not. In part he believes this is due to the "pre-auditing" of death certification which is undertaken by the CDHB's experienced Mortality Co-ordinator, Marion Dever, who would reject, or query, three or four certificates a week even before the committee conducts its own twice-weekly review.

In the 2010 year the committee also detected errors in the completion of 105 (9.5 %) of the completed certificates. In each of these cases the committee wrote to the certifying doctor, explaining the preferred wording for the MCCD and asking whether they would be prepared to accept the proposed changes. The committee received an 80 % response rate to their recommendations with 95 % of those accepting the proposed amendments.

New MCCDs are not typically issued unless there is a gross error, but the recommended changes are forwarded to the Ministry of Health so that coding changes can be made, thereby improving the accuracy of the country's mortality statistics.

Appendix 2

Examples of certificates

Cor 28

RECORD OF DEATH (and Notification of Death to the Coroner if required)

Hospital name:	SURNAME:	NHI No:
	OTHER NAMES:	
	SEX : M / F	AGE:
	ADDRESS:	DOB:

(or attach patient label)

Date of death:		How long was the patient in hospital during this admission?		Days / Hours / Weeks / Months
Time of death: (24 hr clock)		How long was the patient in your care?		Days / Hours / Weeks / Months
Transferred from:		Consultant: (with whom you discussed this death)		
Did the patient undergo surgical or dental operation, or a medical procedure, or a procedure requiring anaesthesia, during this admission or prior to transfer?			YES / NO	Date and time of operation:
If YES specify operation etc:				

Account of this admission (<50 words – please print clearly)

In your opinion, what was the cause of death?	

(Circle one option)

Unknown cause, Suicide, Unnatural, etc	Was the death: without known cause / suicide / unnatural / violent / due to injury or was patient admitted due to injury? (If YES, indicate which of the above applies)	YES	NO
Medical/Dental treatment, Care, Pregnancy, Childbirth	Did the death occur during operation or procedure noted above?	YES	NO
	Does death appear to be result of that operation or procedure or other treatment?	YES	NO
	Did the death occur while the person was under anaesthetic (or does it appear to have been the result of administration of anaesthetic) ?	YES	NO
	Was the death while giving birth, or a result of being pregnant or giving birth?	YES	NO
Drugs and Alcohol	Was admission and/or death due to drug or substance abuse?	YES	NO
	Was patient detained in an institution under Alcoholism and Drug Addiction legislation?	YES	NO
Official Custody or Care	Was patient admitted from custody of Police / Prison / Security Officer?	YES	NO
	Was patient a child or young person in official custody or care?	YES	NO
	Was patient subject to compulsory treatment order under Mental Health legislation?	YES	NO
	Was patient in compulsory care under Intellectual Disability legislation?	YES	NO
Certificate	Are you/any medical practitioner prepared to sign a doctor's certificate (HP4720)?	YES	NO
Police	If not signing doctor's certificate (HP4720), have the Police been notified?	YES	NO

Any response in the grey boxes means the death MUST be reported to the Coroner.
(If you are in any doubt or have any reservations about this death please discuss the matter with the Coroner.)

Are you aware of:-

(a). Any person expressing concern as to cause of death or hospital treatment of the deceased?	YES	NO
(b). Any reason (such as ethnic origins, social attitudes or customs, or spiritual beliefs) the requirement of a post-mortem examination might cause distress to persons connected with the deceased?	YES	NO
(c). Any member of deceased's family expressing the wish that a post-mortem should be performed?	YES	NO

Contact Details:	Cellphone:	Locator:	Fax:
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Reporting Medical Officer (Please use capitals)

Signature (must be medical practitioner)

Date & Time (24 hr clock)

For Hospital use only				For Coroner's Use only			
Faxed to Coroner?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Discussed with Doctor?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Received back from Coroner?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Name of Doctor:	Time:		
Clinical team notified of response?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Coroner's Jurisdiction?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
GP Notified ?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Post-mortem (subject to objection)?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Family notified of death?	<input type="checkbox"/> YES	<input type="checkbox"/> NO		Doctor's report in-lieu of PM?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
				Coroner:	Date:	Time:	

Sept 09



Burial and Cremation Act 1964

HP4721

Medical Certificate of Causes of Fetal and Neonatal Death

This certificate should be completed for stillbirths and for liveborn infants dying within 28 days of birth, and given to the funeral director or other person in charge of the body without delay

Certification status

Tick one: ☐ **Stillbirth** (a dead fetus that weighed 400g or more when issued from its mother or issued from its mother after the 20th week of pregnancy) ☐ **A liveborn infant dying within 28 days of birth**

NOTE: a midwife may certify a certificate in respect of a stillbirth if there was no medical practitioner in attendance

Infant

Name of infant (if given)
Surname or family name First or given name(s)

Infant's NHI number (if available)

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Sex ☐ Female ☐ Male ☐ Indeterminate

Ethnic group(s) ☐ New Zealand European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan

Mark the space or spaces that apply ☐ Niuean ☐ Chinese ☐ Indian ☐ other (such as DUTCH, JAPANESE, TOKELAUAN). Please state:

--

Birthweight (excluding placenta) grams Number of completed weeks in utero weeks

Date and time of birth / / at am / pm
day month year

If born alive, date and time of death / / at am / pm Place of death
day month year

If born dead, infant died: ☐ Before labour ☐ During labour ☐ Not known

↓
 Date last thought to be alive: / / or ☐ Not known
day month year

Single or multiple birth ☐ Single ☐ Multiple → Number of babies Birth order (1st, 2nd, 3rd, etc)

Mother

Name of mother
Surname or family name First or given name(s)

Mother's NHI number (if available)

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Place of delivery Expected date of delivery / /
day month year

Mother's date of birth / / First day of last menstrual period / /
day month year

Number of previous pregnancies ending: after 20 completed weeks → before 20 completed weeks →

Did the mother receive ante-natal care? ☐ No ☐ Don't know ☐ Yes

Delivery ☐ Normal spontaneous vertex ☐ Other → Specify
Method Presentation

Causes of Death

(a) Main disease or condition in fetus or infant

(b) Other diseases or conditions in fetus or infant

(c) Main maternal disease or condition affecting fetus or infant

(d) Other maternal diseases or conditions affecting fetus or infant

(e) Other relevant circumstances

Post-mortem examination ☐ Will be done ☐ Requested — consent not given ☐ Not requested

I certify that the particulars and causes of death shown above are true to the best of my knowledge and belief, and that no relevant information has been omitted and that the death is not required to be reported to a coroner under the Coroners Act 2006. If required by the Director-General, Ministry of Health, I am prepared to provide additional information as to the cause of death, where available, for the purpose of allocating a more precise statistical classification.

Printed name of practitioner Qualifications Health Practitioner Index - Common Person Number (HPI-CPN)

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Address Signature Date / /

Medical Certificates of Causes of Fetal and Neonatal Deaths

Note: Certificates are to be signed by the medical practitioner or midwife and must be given to the funeral director or person in charge of the body without delay.

This form is to be completed for stillbirths and for liveborn infants dying within 28 days of birth. Indicate clearly which category applies. A midwife may complete a certificate for a stillbirth if no doctor attended the birth.

Accurate and consistent mortality statistics are essential for monitoring specific causes of death and the effectiveness of health programmes. The International Certificate of Cause of Perinatal Death was designed to achieve this end and its success depends upon the willingness of the medical practitioner to fill in the information correctly on the form.

Definition of 'Stillbirth' - Births, Deaths, Marriages and Relationships Registration Act 1995

- Stillbirth 'Stillborn child means a dead fetus that -
(a) weighed 400g or more when it issued from its mother; or (b) issued from its mother after the 20th week of pregnancy'

World Health Organization (WHO) definitions observed in New Zealand

- **Live Birth** 'Live birth is the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such birth is considered liveborn.'
- **Fetal Death** 'Fetal death is death prior to the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.'
- **Neonatal Death** Death of a liveborn infant during the first 28 completed days of life.
- **Birthweight** The first weight of the fetus or newborn obtained after birth. For live births this weight should preferably be measured within the first hour of life before significant postnatal weight loss has occurred.
- **Low Birthweight** Less than 2500 grams (up to and including 2499 grams).

Directions for filling in the Medical Certificate of Causes of Fetal and Neonatal Death

- Before completing a Certificate, please ensure that the back cover/writing shield is in position to avoid damage to the sets underneath. When completed detach the top copy only. The bottom copy is to remain in the book.
- From the point of view of legal and statistical requirements please complete the Certificate accurately and fully.
- Please print clearly. State dates and times precisely.
- Complete a separate Certificate for each stillbirth or neonatal death in multiple pregnancies.
- Where possible record the ethnic group(s) of the infant as determined by the parent(s).
- Avoid the use of abbreviations of medical terms as these can be interpreted in different ways by different people.
- The New Zealand Medical Certificate of Causes of Fetal and Neonatal Death HP4721 closely follows the international form. As a member state of WHO New Zealand has a commitment to classify cause of fetal and neonatal death in the manner described by WHO.
- **Causes of Death section**

Infant diseases or conditions: sections (a) and (b)

In section (a) enter the single most important disease or condition causing the death of the fetus or infant. Be specific. A term such as 'Prematurity' should not be used unless it was the only condition known. If no major disease or anomaly is found this should be stated. Indicate specific type of congenital condition, where present.

In Section (b) enter other diseases or conditions in the fetus or infant.

Maternal diseases or conditions: sections (c) and (d)

In section (c) enter the single most important disease or condition of the mother, pregnancy, labour and delivery, placenta and cord, which in the certifier's opinion had some adverse affect on the infant or fetus.

In section (d) enter other maternal diseases or conditions affecting fetus or infant.

Other relevant circumstances: section (e)

Section (e) is provided for the certifier to report any other circumstances that have a bearing on the death but cannot be described as a disease or condition of the infant or mother, such as unattended delivery.

Burial and Cremation Act 1964 (1964 No 75) as from 25 January 2009

The information below outlines the requirements of doctors and midwives in relation to deaths and still-born children in Sections 46A and 46B of the Act, and the associated definitions.

“coroner’s authorisation”, in relation to a body, means an authorisation by a coroner under section 42 of the Coroners Act 2006 for the release of the body

“dead foetus” has the meaning given to it in section 2 of the Births, Deaths, Marriages, and Relationships Registration Act 1995

“disposal” includes burial and cremation

“doctor’s certificate”, in relation to a death or a body, means a doctor’s certificate referred to in section 46B or 46C relating to the cause of death or, as the case may require, the cause of death of the person whose body it is

“give a doctor’s certificate”, in relation to a person’s death, means complete and sign a doctor’s certificate and give it to the person having charge of the person’s body

“still-born child” has the meaning given to it in section 2(1) of the Births, Deaths, Marriages, and Relationships Registration Act 1995.

“unavailable” means dead, unknown, missing, of unsound mind, or unable to act by virtue of a medical condition.

46A Still-born children

- (1) A still-born child must not be buried, cremated, or otherwise disposed of unless the person in charge of the disposal has obtained—
 - (a) a written certificate relating to the cause of the still-birth signed—
 - (i) by a doctor who was present at the birth or examined the child after birth; or
 - (ii) if no doctor was present at the birth or examined the child after birth, by a midwife; or
 - (b) a statutory declaration, made by the person or 1 of the persons required under the Births, Deaths, Marriages, and Relationships Registration Act 1995 to notify the birth, to the effect that the child was born dead, and that—
 - (i) no doctor or midwife was present at the birth; or
 - (ii) it is impossible to obtain a certificate under paragraph (a) from a doctor or midwife present at the birth; or
 - (c) a coroner’s authorisation.
- (2) The person in charge of the disposal must send a copy of the certificate, statutory declaration, or coroner’s authorisation to the department administering this Act.

46B Doctor’s certificate in relation to illness

- (1) Subsections (2) and (3) apply if a person dies after an illness.
- (2) A doctor who attended the person during the illness must, if (and only if) satisfied that the person’s death was a natural consequence of the illness, give a doctor’s certificate for the death immediately after the doctor learns of the death.
- (3) However, a doctor other than a doctor who attended the person during the illness may give a doctor’s certificate for the death if (and only if) satisfied that the person’s death was a natural consequence of the illness and that—
 - (a) the doctor who last attended the person during the illness is unavailable; or
 - (b) less than 24 hours has passed since the death, and the doctor who last attended the person during the illness is unlikely to be able to give a doctor’s certificate for the death within 24 hours after the death; or
 - (c) 24 hours or a longer period has passed since the death, and the doctor who last attended the person during the illness has not given a doctor’s certificate for the death.
- (4) Subsection (3)(b) and (c) do not apply if the doctor who last attended the person during the illness has refused to give a doctor’s certificate for the death because that doctor was not satisfied, or was not yet satisfied, that the death was a natural consequence of the illness.
- (5) A doctor must not give a doctor’s certificate under subsection (2) or (3) if the death—
 - (a) must be reported to the New Zealand Police because section 13 (except subsection (1)(b)) of the Coroners Act 2006 applies; or
 - (b) has been reported to a coroner under section 15(2) of that Act.
- (6) A doctor may give a doctor’s certificate despite subsection (5) if a coroner has decided not to open an inquiry into the death.
- (7) A doctor who must give a doctor’s certificate under subsection (2), but knows that since he or she attended the person concerned some other doctor attended the person, must not give the certificate without taking all reasonable steps to consult the other doctor.
- (8) A doctor must not give a doctor’s certificate under subsection (3) unless the doctor has—
 - (a) had regard to the medical records relating to the person concerned of the doctor who last attended the person during the illness; and
 - (b) had regard to the circumstances of the person’s death; and
 - (c) examined the person’s body.



Burial and Cremation Act 1964

HP4720

Medical Certificate of Cause of Death

This certificate must be given to the funeral director or other person in charge of the body without delay

The information recorded on this certificate will be used in the compilation of cause-of-death statistics

Please print clearly, and do not use abbreviations

Surname of deceased	Sex	<input type="radio"/> Female	<input type="radio"/> Male								
First or given name(s) of deceased											
Deceased's National Health Index (NHI) number (if available)	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>									Tick one <input type="radio"/> Discussed with coroner		
Date of birth / /	<input type="radio"/> I consider this death is not reportable under the Coroners Act 2006										
Date of death as stated to me / /											
Last seen alive by me / /	Tick or <input type="radio"/> I did not see the deceased alive and the doctor who last attended the deceased is unavailable, and having regard to the medical records of the unavailable doctor and having examined the body, giving regard to the circumstances of death, I am satisfied the death is not required to be reported to the Coroner.										
Body seen by me after death	<input type="radio"/> Yes <input type="radio"/> No											
Place of death in full	Tick any that apply <input type="radio"/> Pregnant at time of death										
Post-mortem examination	<input type="radio"/> Will be done <input type="radio"/> Requested — consent not given <input type="radio"/> Not requested	<input type="radio"/> Not pregnant, but pregnant within 42 days of death (specify below) <input type="radio"/> Not known if pregnant at time of death or within 42 days of death										

Cause of death

		Approximate interval between onset and death
Part I		
Disease or condition directly leading to death*	(a)..... due to (or as a consequence of)
Antecedent causes: Morbid conditions, if any, giving rise to the above cause.	(b)..... due to (or as a consequence of)
Enter the underlying cause (disease or injury which initiated the train of morbid events leading to death) on the last used line in Part I	(c).....

*This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury or complication that caused death.

Part II		
Other significant conditions contributing to the death, but not related to the disease or condition causing death

Accident to Elderly Person

When issuing a certificate under Section 46C of the Burial and Cremation Act 1964 if death was the result of injury provide details about how and where the injury occurred in **Cause of death, Part I (c)** above.

If the deceased was at the time of death suffering from an infectious disease, whether or not covered above, name the disease(s)
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I certify that the particulars and causes of death shown above are true to the best of my knowledge and belief, and that no relevant information has been omitted. If required by the Director-General, Ministry of Health, I am prepared to provide additional information as to the cause of death, where available, for the purpose of allocating a more precise statistical classification.

Printed name of practitioner

Qualifications

--	--	--	--	--	--	--	--

Health Practitioner Index - Common Person Number (HPI-CPN)

Address

Signature

Date



HP4720

Medical Certificates of Cause of Death

Note: Certificates are to be signed by the medical practitioner and must be given to the funeral director or person in charge of the body without delay.

This form is to be completed for deaths of persons over 28 days of age. Medical Certificates of Causes of Fetal and Neonatal Death (HP4721) should be completed for infants dying within 28 days of birth.

The requirements surrounding completion of medical certificates of cause of death are set out in Sections 46B and 46C of the Burial and Cremation Act 1964. The relevant sections of this legislation are reproduced on the reverse side of the cover.

Before completing a Certificate the doctor should consider whether or not the death needs to be reported to the coroner under the Coroners Act 2006.

Directions for filling in the Medical Certificate of Cause of Death

- Before you commence writing please ensure that the back cover/writing shield is in position to avoid damage to the sets of certificates underneath. When completed detach the top copy only. The bottom copy is to remain in the book.
- From the point of view of legal and statistical requirements please complete each Certificate accurately and fully. Please print clearly.
- Avoid the use of abbreviations of medical terms as these can be interpreted different ways by different people.
- Accurate and consistent mortality statistics are essential for monitoring specific causes of death and the effectiveness of health programmes. The International Form of Medical Certificate of Cause of Death has been designed to achieve this end and its success depends upon the willingness of doctors to fill in the information correctly on the Certificate.
- The New Zealand Medical Certificate of Cause of Death (HP4720) closely follows the international form. As a member state of the World Health Organization (WHO) New Zealand has a commitment to classify causes of death to the **underlying cause** in the manner described by WHO. This is:

“The disease or injury which initiated the train of morbid events leading directly to death,
or,
the circumstances of the accident or violence which produced the fatal injury”.

The certifying doctor has responsibility for deciding which condition led to death and what antecedent conditions were present.

- The **Cause of Death** section on the certificate has two parts:

Part I is subdivided into (a), (b) and (c)

The most important information to be recorded in Part I is the disease or injury which initiated the train of events leading to death (the underlying cause of death).

This may be a sole entry in (a), or a train of events. **On no account must the starting point of the sequence be entered in Part II because of lack of space in Part I.**

Do not enter the mode of dying such as collapse, respiratory failure or syncope.

Part II is for entry of any other conditions, which, though not part of the causal sequence in Part I, are considered by the certifying doctor to have contributed to the fatal outcome.

- The panel requesting details of infectious disease is included to assist the Funeral Director to meet reporting obligations set out by section 85 of the Health Act 1956 and its Regulations.

Burial and Cremation Act 1964 (1964 No 75) as from 25 January 2009

The information below outlines the requirements of doctors in relation to deaths in Sections 46B and 46C of the Act, and the associated definitions, (excluding stillbirths).

“doctor’s certificate”, in relation to a death or a body, means a doctor’s certificate referred to in section 46B or 46C relating to the cause of death or, as the case may require, the cause of death of the person whose body it is

“give a doctor’s certificate”, in relation to a person’s death, means complete and sign a doctor’s certificate and give it to the person having charge of the person’s body

“unavailable” means dead, unknown, missing, of unsound mind, or unable to act by virtue of a medical condition.

46B Doctor’s certificate in relation to illness

(1) Subsections (2) and (3) apply if a person dies after an illness.

(2) A doctor who attended the person during the illness must, if (and only if) satisfied that the person’s death was a natural consequence of the illness, give a doctor’s certificate for the death immediately after the doctor learns of the death.

(3) However, a doctor other than a doctor who attended the person during the illness may give a doctor’s certificate for the death if (and only if) satisfied that the person’s death was a natural consequence of the illness and that—

- (a) the doctor who last attended the person during the illness is unavailable; or
- (b) less than 24 hours has passed since the death, and the doctor who last attended the person during the illness is unlikely to be able to give a doctor’s certificate for the death within 24 hours after the death; or
- (c) 24 hours or a longer period has passed since the death, and the doctor who last attended the person during the illness has not given a doctor’s certificate for the death.

(4) Subsection (3)(b) and (c) do not apply if the doctor who last attended the person during the illness has refused to give a doctor’s certificate for the death because that doctor was not satisfied, or was not yet satisfied, that the death was a natural consequence of the illness.

(5) A doctor must not give a doctor’s certificate under subsection (2) or (3) if the death—

- (a) must be reported to the New Zealand Police because section 13 (except subsection (1)(b)) of the Coroners Act 2006 applies; or
- (b) has been reported to a coroner under section 15(2) of that Act.

(6) A doctor may give a doctor’s certificate despite subsection (5) if a coroner has decided not to open an inquiry into the death.

(7) A doctor who must give a doctor’s certificate under subsection (2), but knows that since he or she attended the person concerned some other doctor attended the person, must not give the certificate without taking all reasonable steps to consult the other doctor.

(8) A doctor must not give a doctor’s certificate under subsection (3) unless the doctor has—

- (a) had regard to the medical records relating to the person concerned of the doctor who last attended the person during the illness; and
- (b) had regard to the circumstances of the person’s death; and
- (c) examined the person’s body.

46C Doctor’s certificate in relation to accidents to elderly persons

(1) A doctor may give a doctor’s certificate for the death of a person even though a death may have been reported to the New Zealand Police under section 14 of the Coroners Act 2006 if the person was 70 years of age or older and, in the opinion of the doctor,—

- (a) the death was caused by injuries, or injuries contributed substantially to it; and
- (b) the injuries were caused by an accident; and
- (c) the injuries, the accident, or both arose principally by virtue of infirmities that were attributes of the person’s age; and
- (d) the accident was not suspicious or unusual; and
- (e) the accident was not caused by an act or omission of any other person; and
- (f) except to the extent that the death involved injury by accident, it was not violent, unnatural, or in some way a death in respect of which the Coroners Act 2006 requires an inquiry to be conducted.

(2) If a doctor is aware that a death has been reported to a coroner under section 15(2) of the Coroners Act 2006, the doctor must not give a doctor’s certificate under subsection (1) without first obtaining the agreement of the designated coroner.

Schedule 1

Form A The Cremation Regulations 1973

Application for Cremation

Consecutive number [to be inserted on receipt of application]

I, [Full name of applicant], [Address], [Occupation], apply to the crematorium authority of the Crematorium (or as the case may be) to undertake the cremation of the body of [Full name of deceased], [Address], [Occupation], [Age], [Sex], [relationship status, ie, whether the deceased was or had been married, in a civil union, or in a de facto relationship; or was the surviving spouse or partner of a marriage, civil union, or de facto relationship; or had never been married, in a civil union, or in a de facto relationship].

The true answers to the questions set out below are as follows:

1. Are you an executor of the deceased?
2. Are you a relative of the deceased? If so, state the relationship If you are not an executor or a near relative*, state why this application is being made by you and not by an executor or a near relative*:
3. Have the near relatives* of the deceased been informed of the proposed cremation?
4. If the application is not made by an executor, is there an executor of the deceased? If there is an executor has he been informed of the proposed cremation?
5. To the best of your knowledge and belief has any near relative or executor of the deceased expressed any objection to the proposed cremation? If so, on what ground?
6. What, to the best of your knowledge and belief, was the date and hour of the death of the deceased? Date Hour
7. Where did the deceased die? [Give address, and say whether own residence, lodgings, hotel, hospital, nursing-home, etc.]
8. Do you know or have you any reason to suspect that the death of the deceased was due, directly or indirectly, to—
 - (a) Violence
 - (b) Poison
 - (c) Privation or neglect
 - (d) Illegal operation?
9. Do you know any reason whatever for supposing that an examination of the body of the deceased may be desirable?
- [9A. Do you know or have you any reason to suspect that the body of the deceased contains a cardiac pacemaker or other biomechanical aid?]
 10. Give the name and address of the ordinary medical attendant of the deceased:
 11. Give the names and addresses of all the medical practitioners who attended the deceased during his (or her) last illness:
 12. Who were the persons (if any) present at the time of death?

13. Was the deceased a member of a religious denomination whose tenets require the burning of the body to be carried out as a religious rite elsewhere than in an approved crematorium? If so, give the name by which that religious denomination is known

I hereby certify, with a view to procuring the cremation of the body of the abovenamed deceased, that all the particulars stated above are true, and that to the best of my knowledge and belief no material particular has been omitted.

Date:

Signature:

Witness to signature:

Name:

Occupation:

Address:

*NOTE—The term “near relative” as used in this form means

- (a) the spouse, civil union partner, or de facto partner of the deceased, but only if the spouse, civil union partner, or de facto partner was living together with the deceased immediately before his or her death; and
- (b) a parent of the deceased; and
- (c) any child of the deceased who is aged 16 years or over; and
- (d) any other relative of the deceased who usually resided with him or her.

- Form A, Question 9A was inserted, as from 1 November 1980, by regulation 5 Cremation Regulations 1973, Amendment No 1 (SR 1980/208).
- Form A was amended, as from 26 April 2005, by section 12 Relationships (Statutory References) Act 2005 (2005 No 3) by substituting the words “relationship status, ie, whether the deceased was or had been married, in a civil union, or in a de facto relationship; or was the surviving spouse or partner of a marriage, civil union, or de facto relationship; or had never been married, in a civil union, or in a de facto relationship” for the words “Whether married, widow, widower, or unmarried”.
- Form A was amended, as from 26 April 2005, by section 12 Relationships (Statutory References) Act 2005 (2005 No 3) by substituting all the words in the note after the words “The term ‘near relative’ as used in this form, means”.

Form AB The Cremation Regulations 1973

Certificate in relation to Pacemakers and Other Biomechanical Aids

I HEREBY certify that I have examined the body of [Full name],
[Address], [Occupation].

* I am satisfied that the body does not contain a cardiac pacemaker or any other biomechanical aid.

* I have removed from the body a cardiac pacemaker or other biomechanical aid, namely

Signature:

Address:

Date:

Registered Qualifications:

* Delete whichever is inapplicable.

- Schedule 1, form AB was inserted, as from 1 November 1980, by regulation 6 Cremation Regulations 1973, Amendment No 1 (SR 1980/208).
- Schedule 1 form AB heading: amended, on 20 November 2008, by regulation 7 of the Cremation Amendment Regulations 2008 (SR 2008/410).

Form B
The Cremation Regulations 1973

Certificate of medical practitioner

I AM informed that application is about to be made for the cremation of the body of *[Full name of deceased]*, *[Address]*, *[Occupation]*.

As a medical practitioner who is required or permitted by section 46B or 46C(1) of the Burial and Cremation Act 1964 to give a doctor's certificate (as defined in section 2(1) of that Act) for the death, and who has seen and identified the body after death, I give the following answers to the questions set out below:

- 1. On what date and at what hour did he (or she) die? ...
- 2. Where did the deceased die? *[Give address and say whether own residence, lodgings, hotel, hospital, nursing-home, etc]*
- 3. Are you a relative of the deceased? ... If so, state the relationship. ...
- 4. Have you, so far as you are aware, any pecuniary interest in the death of the deceased? ...
- 5. Were you the ordinary medical attendant of the deceased? ... If so, for how long? *[State how many weeks, months, or years.]*
- 6. Did you attend the deceased during his (or her) last illness? ... If so, for how long? *[State how many hours, days, weeks, or months.]*
- 7. If you attended the deceased during his or her last illness, when did you last see the deceased alive? *[Say how many hours or days before death.]*
- 8.
 - (a) How soon after death did you see the body? ...
 - (b) What steps did you take to satisfy yourself as to the fact of death? ...
 - (c) How did you establish the identity of the deceased person? ...

9. What were the causes of death? Period elapsing between onset of each condition and death (*years, months, or days*).

Immediate cause—

the disease, injury, or

(a) complication which
caused death?.....

Morbid conditions (if any) giving rise to the immediate cause

(b) (place the conditions in chronological order beginning with the most recent)?.....

(c) Other conditions (if)

any) contributing to
death—pregnancy,
parturition, over-
exertion, dangerous
occupation?.....

State how far your answers as to the causes of death and the duration of such causes are founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased ...

- 10. What was the mode of death? [*Say whether syncope, coma, exhaustion, convulsions, etc*] ... What was its duration? [*State number of days, hours, or minutes; and state how far your answer as to the mode of death is founded on your own observations or on statements made by others. If on statements made by others, give their names and their relationship to the deceased.*]
- 11. Did the deceased undergo any operation during the final illness or within a year before death; if so, what was its nature, and who performed it? ...
- 12. By whom was the deceased nursed during his (or her) last illness? [*If the death occurred in a hospital, this question may be answered by referring generally to the nursing staff in a specified ward, but otherwise give names and say whether professional nurse, relative, etc. If the illness was a long one, this question should be answered with reference to the period of four weeks before death.*]
- 13. By what medical attendants (besides yourself, if applicable) was the deceased attended during his (or her) last illness? ...
- 14. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death? ...
- 15. Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to—
 - (a) Violence: ...
 - (b) Poison: ...
 - (c) Privation or neglect: ...
 - (d) Illegal operation: ...
- 16. Have you any reason whatever to suppose a further examination of the body to be desirable? ...
- 17. Have you given the doctor's certificate (as defined in section 2(1) of the Burial and Cremation Act 1964) for the death? ...

I hereby certify that the answers given above are true and accurate to the best of my knowledge and belief, and that there is no circumstance known to me which can give rise to any suspicion that the death was due wholly or in part to any other cause than disease (or accident) or which makes it desirable that the body should not be cremated.

Signature:.....

Address:.....

Registered Qualifications:.....

Date:.....

NOTE—This certificate must be handed or sent in a closed envelope by the medical practitioner who signs it to a Medical Referee.

- Schedule 1 form B: amended, on 25 January 2009, by regulation 8(2)(a) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 25 January 2009, by regulation 8(2)(b) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 20 November 2008, by regulation 8(1)(a) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 20 November 2008, by regulation 8(1)(b) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 20 November 2008, by regulation 8(1)(c) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 20 November 2008, by regulation 8(1)(d) of the Cremation Amendment Regulations 2008 (SR 2008/410).
- Schedule 1 form B: amended, on 20 November 2008, by regulation 8(1)(e) of the Cremation Amendment Regulations 2008 (SR 2008/410).

Form C Coroner's certificate

Regulation 7(1)(b), Cremation Regulations 1973

I certify that—

- (a) a death has been reported under the Coroners Act 2006 to a coroner, and the details of the death are as follows:
 - Full name of deceased:
 - Late of: *[full residential address]*
 - Occupation:
 - Sex: *[male or female]*
 - Date of birth:
 - Date of death:
 - Place of death:
- (b) I am satisfied that there are no circumstances likely to call for an examination or, as the case may be, a further examination, of the body.

Signed

Signed at *[location]* on *[date]*

Signature:

Name:

(Coroner)

-
- Schedule 1 form C: substituted, on 20 November 2008, by regulation 9 of the Cremation Amendment Regulations 2008 (SR 2008/410).

Form D The Cremation Regulations 1973

[Revoked]

- Schedule 1 form D: revoked, on 20 November 2008, by regulation 10 of the Cremation Amendment Regulations 2008 (SR 2008/410).

Form E The Cremation Regulations 1973

Certificate after post-mortem examination

I HEREBY certify that, acting under the instructions of * ..., a Medical Referee under the Cremation Regulations 1973, I made a post-mortem examination of the body of *[Full name]*, *[Address]*, *[Occupation]*

The result of the examination is as follows:

I am satisfied that the cause of death was...*(and that there is no reason for making any toxicological analysis or for reporting the death to the Coroner)*.†

Signature: ...

Address: ...

Date: ...

Registered Qualifications: ...

* Where the Medical Referee himself gives the certificate, strike out the words “on the instructions of” and insert “as”.

† The words “for making any toxicological analysis or” should be deleted where a toxicological analysis has been made and its result is stated in this certificate or in a certificate attached to it, and the words “or for reporting the death to the Coroner” should be deleted if the death has already been so reported.

Form F The Cremation Regulations 1973

Permission to cremate

WHEREAS application has been made for the cremation of the body of *[Full name]*, *[Address]*, *[Occupation]*

And whereas I have satisfied myself—

- 1. That all the requirements of the Burial and Cremation Act 1964 and the Cremation Regulations 1973 have been complied with; and
- 2. * That the cause of death has been definitely ascertained (or that a Certificate in form C has been given by a Coroner); and
- 3. That no reason exists for any further inquiry or examination:
Now, therefore, I hereby permit the cremation authority of the crematorium at ... to cremate the said body.

Date: Signature: ...

...

*Medical Referee (*or* Deputy Medical Referee *or* Second Deputy Medical Referee *or* Medical Officer Of Health).

NOTE—

- 1. Delete all inappropriate alternatives in both places where an asterisk appears.
- 2. This permission should be signed in duplicate; one copy to be retained with the application papers and the other sent by the Medical Referee to the attendant at the crematorium. The Medical Referee should attach to the application papers a statement of any special inquiries which he may have seen fit to make before issuing the permission to cremate.

Form G
The Cremation Regulations 1973

Reg
4(2)
and
11(2)

Permission to cremate elsewhere than in an approved crematorium

WHEREAS application has been made for the cremation of the body of [*Full name*], [*Address*], [*Occupation*]:

And whereas I have satisfied myself—

- 1. That all the requirements of the Burial and Cremation Act 1964 and the Cremation Regulations 1973 have been complied with; and
- 2. *That the cause of death has been definitely ascertained (or that the child was still-born or that a certificate in form C has been given by a Coroner); and
- 3. That no reason exists for any further inquiry or examination:

And whereas it has been represented to me that the said deceased belonged to a religious denomination whose tenets require the burning of the body to be carried out as a religious rite elsewhere than in an approved crematorium:

Now, therefore, I hereby permit the body of the said deceased to be cremated at ... subject to the following conditions:

CONDITIONS

Date: ...

Signature: ...

Medical Officer of Health

NOTE—

1. Delete all inappropriate alternatives where the asterisk appears.
2. This permission should be signed in duplicate; one copy to be retained with the application papers and the other delivered to the person or persons signing the application.

Form H
The Cremation Regulations 1973

Reg
9(1)

Register of cremations

Consecutive number of application for cremation

Full name of deceased
Sex
Age
Date of Death
Place of death
Date of Medical Referee's permission or other authority
Date of Cremation
Method of disposal of ashes
Date of disposal of ashes
Signature of person receiving ashes
Ground of recipient's claim. (ie *Applicant for cremation; relative of deceased—
relationship to be stated, etc*)

