

### **Medicolegal Death Investigation in Victoria**

For many years, reporting a death to a coroner resulted almost always in performance of an autopsy by a pathologist. New legislation in many jurisdictions has permitted more formal processes for next of kin to object to the coroner's decision to have an autopsy performed. Many such objections have been based around religious beliefs and cultural values and often such objections have been made without any clear recognition of the potential broad benefits to the community and the family of an autopsy being performed.

A coroner's autopsy must be clearly distinguished from a clinical autopsy that is conducted on a medical basis in hospital. A clinical autopsy can only be performed with the consent of the next of kin. In contrast a coroner's autopsy does not require the consent of any member of the family but rather is conducted at the direction of, and under the authority of, the coroner. Despite there being no requirement for the coroner to obtain consent, many coroner's officers do contact families prior to autopsy and discuss with them the nature of the procedure and explain to them their legal rights with regard to objecting to the autopsy. This conversation prior to any autopsy also provides an opportunity for communication with the family regarding matters such as the timing of the coroner's investigation, release of the body for burial or cremation, the possible need to retain body tissues for diagnosis, the possibility of collecting and retaining body tissues for transplantation and research, concerns that the family may have regarding the circumstances of the death and the availability of counselling and bereavement services. Even when a family is provided with the information regarding their right to object to an autopsy, the majority do not object and many families, when asked in a therapeutic environment, are in fact willing to donate tissue collected during an autopsy for therapeutic and research purposes.

Deaths, which are reportable to the coroner, are listed under Part 1, Section 3 of the Coroners Act 1985 (Victoria). Amongst others, these categories of deaths include those:

- that appear to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury
- that occur during an anaesthetic
- that occur as the *result* of an anaesthetic *and* are not due to natural causes (emphasis added)
- of persons who immediately before death were persons held in care
- where a death certificate has not been completed

Recent discussions concerning the workings of the Act have highlighted difficulties in interpretation of some of the terms used. In particular, confusion or uncertainty can occur over the precise meaning of 'unexpected', or even what constitutes an anaesthetic. These difficulties may lead to errors and inconsistencies in the reporting of some categories of deaths to the coroner, and occasionally, rejection of Death Certificates by the Registrar of Births Deaths and Marriages.

It is hoped that the current State Parliamentary Review of the Coroners Act will address some of the current difficulties experienced by clinicians. In addition, The Victorian Institute of Forensic Medicine (VIFM) has published advice concerning the completion of Death Certificates, which is available on the website of the Medical Practitioners Board of Victoria ([www.medicalboardvic.org.au](http://www.medicalboardvic.org.au)). Perhaps most importantly, The Office of the Coroner and pathologists from the VIFM are always available to give advice and assistance if required.

A provision in the Act not commonly appreciated by clinicians concerns the statutory right (under s. 29) for the senior next of kin to ask a coroner not to direct an autopsy. Section 29 objection to autopsy applications have risen five-fold in the past six years and now comprise almost 15% of all coronial cases. A statement notifying the coroner of the family's objection and the reasons for the objection is required to be submitted to the coroner's office. The case is then referred to a pathologist who will then review the available information (including a summary of circumstances prepared by the police, clinical notes, and if available, a medical deposition), perform an external examination of the body and then prepare a report for the coroner, which may include advice as to whether or not an autopsy and/or ancillary investigations are advisable.

In deciding whether or not to accede to the request, the coroner has regard to his/her statutory obligations (which include finding, if possible, how death occurred and the cause of death) and the stated wishes of the next of kin. If the coroner refuses the request, then the next of kin have 48 hours to appeal the decision to the Supreme Court.

Section 28 of the Act provides that *any person* may ask the coroner to direct that an autopsy be performed. If the coroner refuses this request, written reasons must be given immediately, and the person making the request then has 48 hours to appeal to the Supreme Court.

For reportable deaths, which occur in hospital, a medical deposition is required to be completed and submitted to the coroner's office by medical staff involved in the patient's care. The medical deposition is an important document containing information which coroners and pathologists use in evaluating the circumstances surrounding a death, and which is taken into consideration when arriving at a decision as to whether an autopsy is required in a particular case. Although there is some variation in the forms used from hospital to hospital, all depositions have space for treating clinicians to provide a case summary as well as an opinion as to the cause of death. Many deposition forms also provide a space to document issues to be addressed at autopsy.

In some circumstances, although a death is reportable to the coroner, the coroner may decide that an autopsy may not be necessary to address issues of medicolegal significance. Examples include severe pre-existing natural disease complicating management of accidental trauma (such as ischaemic heart disease in the setting of a fractured neck of femur sustained in a fall), deaths due to identified natural disease occurring under an anaesthetic (such as ruptured abdominal aneurysm), or deaths which occur a significant period of time following a reportable event.

Clearly, however, there are times when issues of importance to treating clinicians can only be fully and adequately addressed if an autopsy is performed. On occasions, clinicians have expressed disappointment when an autopsy is not conducted, or the autopsy report appears not to directly address their particular concerns. In order that instances of this kind are minimised the following suggestions are made:

- **Medical depositions should be completed as comprehensively and explicitly as possible, stating the issues, which are deemed to require attention at autopsy.**
- **Discussions should be conducted with bereaved next of kin by clinicians involved in the care of the deceased regarding the necessity and potential benefits of an autopsy.**
- **Direct communication with pathologists at the VIFM, particularly if the clinical course and treatment modalities have been complex and require detailed explication.**
- **If clinicians believe that there are issues of importance, which require an autopsy, they should inform the coroner's office directly, as this will formally constitute a request for autopsy under s. 28 of the Act.**

Finally, it should be noted that clinicians involved in the care of the deceased may be able to attend the autopsy if they wish, particularly in complex cases, and this is often of great benefit to both the clinicians and pathologists alike.

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