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How to complete a death certificate

A guide for GPs

This article forms part of our 'Paperwork' series for 2011, providing information about a range of paperwork that general practitioners complete regularly. The aim of the series is to provide information on the purpose of the paperwork, and hints on how to complete it accurately. This will allow the GP to be more efficient and the patient to have an accurately completed piece of paperwork for the purpose required.

This article discusses some questions that frequently arise in general practice with regard to the completion of death certificates.

Keywords: medicolegal; death certificates

Case study

The general practitioner received a telephone call from the police asking if she could write a death certificate for a patient who had attended the practice. The man, 83 years of age, had been found dead in bed by his wife that morning. One of the GP's colleagues had looked after the patient for about 10 years, but the colleague was currently overseas and not contactable.

On review of the medical records, the GP noted that the patient had a history of ischaemic heart disease, having suffered a myocardial infarct 8 years earlier. The patient had undergone coronary artery stenting 3 years ago. According to the medical records, the GP's colleague had last seen the patient about 2 months before his death. At this time, the patient was well and he had attended for repeat prescriptions of his cardiac medications.

According to the police officer, the patient's wife reported that her husband had been well since his visit to the GP and he had not seen any other doctors or attended hospital since this time. On the night before his death, the patient said he felt unwell and had some chest pain for which he had taken Anginine.

The GP was not sure if she could write a death certificate for the patient in this situation and contacted her medical defence organisation for advice. The medicolegal adviser informed the GP that if she was 'comfortably satisfied' as to the cause of the patient's death, then on the basis that she was responsible for the management of her colleague's patients in his absence, she was authorised to provide a death certificate. If the GP wanted to discuss the situation further, she could also obtain telephone advice from the Coroner's office about whether she should write the death certificate.

What is the purpose of a death certificate?

The Medical Certificate of Cause of Death (the 'death certificate') is an important legal document. The completion of a death certificate by a medical practitioner is a vital part of the notification process of a death to the Registrar of Births, Deaths and Marriages in the relevant state or territory in which the death occurred, and enables an authority to be provided to the funeral director to arrange disposal of the body.

Medical practitioners have a professional responsibility to ensure the accurate completion of death certificates. Accurate cause of death information is important:

- for legal purposes – for example, the information may be relevant to the determination of the validity of a will, or life insurance payment
- for statistical and public health purposes – the information recorded on death certificates is coded by the Australian Bureau of Statistics and is the major source of Australia's mortality statistics, which enable the evaluation and development of measures to improve the health of Australians
- for family members – to know what caused the death and to be aware of conditions that may occur in other family members.

The death certification process is also an important safeguard against the disposal of bodies without professional scrutiny of the requirement for further investigation, particularly in relation to suspicious deaths. The need for public confidence in the death certification process was recently highlighted by the investigation into the actions of the British general practitioner, Dr Harold Shipman, who was convicted of murdering 15 of his patients.[1]

Who can complete a death certificate?

The medical practitioner who was either responsible for the deceased person's medical care during their last illness or immediately before death, or who examined the body of the deceased person after death can complete the death certificate, provided the medical practitioner is 'comfortably satisfied' as to the cause of the death and no other circumstances are present which require the death to be reported to the Coroner. This means that when a deceased patient's 'treating' GP is absent or unavailable, another GP in the practice can complete the death certificate provided they have sufficient information to do so, and the death is not required to be reported to the Coroner.

In what situations should GPs not complete a death certificate and instead report the death to the Coroner?

In each Australian state and territory there is coronial legislation that outlines the circumstances in which a person's death must be reported to the Coroner; this is commonly referred to as a 'reportable death'. It has been estimated that approximately 15% of deaths are reported to the Coroner and in the hospital setting there may be significant under-reporting of deaths to the Coroner by doctors.[2] It should be noted that completing a death certificate and reporting a death to the Coroner are mutually exclusive exercises; that is, if a person's death is reported to the Coroner, a death certificate should not be completed.

The coronial legislation in each state and territory varies and a detailed discussion of this legislation is beyond the scope of this article. However, in general, a death should be reported to the Coroner in the following circumstances:

- the cause of death is unknown (that is, the GP is not 'comfortably satisfied' as to the cause of death)
- the cause of death is unnatural, violent, suspicious or unusual
- the death resulted directly or indirectly from an accident or injury (in New South Wales, only if the person was less than 72 years of age)
- the death occurred when the person was in police, or other lawful, custody; or where the person was held in care (eg. in a mental health facility or residential service, including children)
- the death was within 24 hours (in the Australian Capital Territory within 72 hours) of a surgical procedure, or invasive medical or diagnostic procedure, or under or as a result of an anaesthetic
- in NSW, Queensland and Victoria, if the death was not a reasonably expected outcome of a health related/medical procedure, or healthcare caused/contributed to the death and the death was not expected by an independent person
- only in ACT and NSW, if the person was not attended by a medical practitioner within 3 months (ACT) or 6 months (NSW) immediately before death.

If a GP is unsure whether a death should be reported to the Coroner, advice should be sought from the GP's medical defence organisation and/or the Coroner's office. The contact details for the Coroner's offices in each state and territory are listed in *Table 1*.

What should the GP do with the completed death certificate?

Once completed, the medical practitioner should forward the completed death certificate to the Registrar of Births, Deaths and Marriages (except in Western Australia where the responsibility for notifying the registrar of a death falls to the funeral director or other person who arranges for the disposal of the remains). In South Australia, Tasmania and Victoria, the legislation also requires the medical practitioner to provide the certificate to the funeral director or person disposing of the remains, as well as forwarding the certificate to the registrar. In Tasmania and Victoria certificates are in triplicate to enable this to occur, but in SA, certificates are in three parts which can then be torn apart (one part for the funeral director, one part for the registrar and one part for the doctor).

Where do GPs obtain blank Medical Certificate of Cause of Death forms for completion?

Blank Medical Certificate of Cause of Death forms can be obtained from the Registry of Births, Deaths and Marriages. *Table 2* lists the contact details of registries in each state and territory.

Are death certificates different from state-to-state?

The format of the cause of death part of the death certificate is based on that recommended by the World Health Organization, as outlined in *Figure 1*, however there are some minor variations in the certificates between each state and territory.

What is the format of the death certificate and what information do GPs need to complete the form?

Medical Certificate of Cause of Death forms contain demographic details of the deceased person including:

- full name
- gender
- date of death
- place of death
- age at death
- Aboriginal or Torres Strait Islander origin.

The death certificate also includes the cause of death details as outlined in *Figure 1*. This includes information in Part I about the disease or condition directly leading to death; that is, the disease, injury or complication that caused the death (not only the mode of dying). Examples of diagnoses that are appropriate as diseases or conditions directly leading to death in Part 1 include 'coronary occlusion' or 'pneumonia' rather than heart failure or respiratory failure (the mode of dying). There must always be an entry on Part I line (a) of the death certificate. Part I also includes any antecedent causes which are the conditions giving rise to the disease or condition directly leading to death.

Part II of the cause of death form is for any other significant conditions contributing to the death, but not related to the disease or condition causing it.

The approximate interval between the onset of each of these conditions and the date of death should also be recorded in the appropriate column in the cause of death section of the certificate. Where the time or date of onset is not known, the best estimate should be made. Importantly, the unit of time (eg. hours, months, years) should be entered in each case.

In a correctly completed death certificate, the duration entered for Part I (a) will never exceed the duration entered for the condition on line I (b), (c) or (d), nor will the duration for (b) exceed that for (c) or (d) and so on. For example:

Cause of Death
Part I
(a) Renal failure 6 months
(b) Nephritic syndrome 3 years
(c) Diabetes mellitus 20 years.
Part II
Ischaemic right foot 3 months
Alcoholism 20 years.

Table 1. Australian Coroners' offices

State/territory	Address	Telephone	Website
Australia Capital Territory – Coroner's Office	Magistrates Court Building 4 Knowles Place Canberra City ACT 2601	02 6207 1754	www.courts.act.gov.au/magistrates/coronerscourt/coroner.html
New South Wales – State Coroner's Court	44–46 Parramatta Road Glebe NSW 2037	02 8584 7777	www.lawlink.nsw.gov.au/coroners
Northern Territory – Coroner's Office	Magistrate Courts Nichols Place Cnr Cavanagh Street and Harry Chan Avenue Darwin NT 0800	08 8999 7770	www.nt.gov.au/justice/courtsupp/coroner
Queensland – Office of the State Coroner	Level 1, Brisbane Magistrates Court 363 George Street Brisbane QLD 4000	1300 304 605	www.courts.qld.gov.au/129.htm
South Australia – State Coroner's Office	302 King William Street Adelaide SA 5000	08 8204 0600	www.courts.sa.gov.au/courts/coroner/index
Tasmania – Coroner's Office	21 Liverpool Street Hobart TAS 7000	03 6233 3257 or 03 6233 6202	www.magistratescourt.tas.gov.au/divisions/coronial
Victoria – State Coroner's Office	Level 11, 222 Exhibition Street Melbourne VIC 3000	1300 309 519	www.coronerscourt.vic.gov.au
Western Australia – Coroner's Court of WA	Level 10, Central Law Courts 501 Hay Street Perth WA 6000	08 9425 2900 or 1800 671 994	www.coronerscourt.wa.gov.au

Table 2. Australian Registries of Births, Deaths and Marriages

Australian Capital Territory	
Address	GPO Box 158 Canberra City ACT 2601
Telephone	02 6207 0460
Website	www.ors.act.gov.au/bdm
New South Wales	
Address	GPO Box 30 Sydney NSW 2001
Telephone	1300 655 236
Website	www.bdm.nsw.gov.au
Northern Territory	
Address	GPO Box 3021 Darwin NT 0801
Telephone	08 8999 6119
Website	www.nt.gov.au/justice/bdm/
Queensland	
Address	PO Box 15188 City East QLD 4002
Telephone	1300 366 430
Website	www.justice.qld.gov.au/justice-services/births-deaths-and-marriages
South Australia	
Address	GPO Box 1351 Adelaide SA 5001
Telephone	08 8204 9599
Website	www.ocba.sa.gov.au/bdm
Tasmania	
Address	GPO Box 198 Hobart TAS 7001
Telephone	1300 135 513 03 6233 3793
Website	www.justice.tas.gov.au/bdm
Victoria	
Address	GPO Box 5220 Melbourne VIC 3001
Telephone	1300 369 367
Website	www.bdm.vic.gov.au
Western Australia	
Address	PO Box 7720 Cloisters Square WA 6850
Telephone	1300 305 021
Website	www.bdm.dotag.wa.gov.au

International Medical Certificate of Causes of Death

Part I	**Cause of death**	**Approximate interval between onset and death**
*Disease or condition dierctly leading to death**	(a)	.....
	due to (or as a consequence of)	.....
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last	(b)	.....
	due to (or as a consequence of)	.....
	(c)	.....
	due to (or as a consequence of)	.....
	(d)	.....
	due to (or as a consequence of)	.....
Part II		
Other significant conditions contributing to the death, but not related to the disease or condition causing it. * This means the disease, injury or complication which caused the death NOT ONLY for example, the mode of dying such as 'heart failure, asthenia' etc.	.....	.....
	.....	.....
	.....	.....
	.....	.....

Figure 1. Death certificate

Perinatal deaths

It is important to note that in all states and territories, there is a separate Perinatal Death Certificate which should be completed in respect of a child not born alive, of at least 20 weeks gestation or 400 g weight, or a live born child who dies within 28 days after birth.

Where can GPs obtain further information about completing the Medical Certificate of Cause of Death?

To improve the accuracy and quality of statistics derived from death certificates, the Australian Bureau of Statistics has produced a booklet for the guidance of medical practitioners in completing death certificates.[3] The booklet stresses the need for legibility, suggesting the use of block letters, and the avoidance of abbreviations on death certificates.

Another common problem encountered in coding information from death certificates is incomplete information. In this regard the booklet recommends:

- neoplasms should be classified according to histology and primary site. If the primary site is unknown, this should be recorded
- the site and causative organism (if known) of an infection should be included on the death certificate.

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References

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