

Reporting of COVID-19 deaths to the Coroner

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For use by	Local Health Districts, Specialty Health Networks, Other Health Providers and Medical Practitioners

NSW Health endorses advice released from the NSW State Coroner

The State coroner has released advice regarding when a COVID-19-related death is reportable to the coroner.

NSW Health endorses this advice which can be found below.

When is a COVID-19-related death reportable to the NSW Coroner?



Health
Pathology

A death that results from COVID-19 is considered a natural cause death. It is expected that in most of these cases a *Medical Certificate of Cause of Death (MCCD)* will be issued and the death will not be reported to the Coroner.

It is however anticipated that there will be instances where a deceased has not been diagnosed with COVID-19 and may have displayed symptoms of COVID-19 and a Death Certificate is not issued. As with any case where a *Medical Certificate of Cause of Death (MCCD)* is not issued, the death is reportable to the Coroner.

It is important to remember that contact by the deceased person with a suspected or confirmed COVID-19 infected patient is not sufficient reason for referral to the Coroner. The death must be reportable to the Coroner as defined within Section 6(1) of the Coroners Act 2009.

In essence, where a death occurs from a natural disease unrelated to COVID-19 and the Medical Practitioner is willing to issue a *Medical Certificate of Cause of Death (MCCD)* no referral to the Coroner is required even if the deceased had contact with a suspected or confirmed patient with COVID-19.



OFFICE OF THE NSW STATE CORONER

STATE CORONER'S BULLETIN No 11

17 March 2020

Corona Virus (COVID-19)

Deaths as a result COVID-19 are regarded as a natural cause death and therefore it is expected that in most cases a Death Certificate will be issued and the death is not reported to the Coroner.

It is however anticipated that there will be instances where a deceased has not been diagnosed with carrying the virus and may have displayed symptoms of COVID-19 and a Death Certificate is not issued. As with any case where a Death Certificate is not issued, the death is reportable to the Coroner.

It is important to remember that contact by the deceased with a suspected or confirmed infected patient is not sufficient reason for death referral to the Coroner. The death must be reportable to the Coroner as defined within *Section 6(1) of the Coroners Act 2009*.

In essence where a death occurs from a natural disease unrelated to COVID-19 and the Medical Practitioner is willing to issue a Death Certificate no referral to the Coroner is required even if the deceased had contact with a suspected or confirmed patient with COVID-19.

Forensic and Scientific Services have advised the NSW State Coroner of newly implemented 'COVID-19 Post Mortem Procedures' which will apply statewide to their facilities.

The aim of these procedures is to allow for early identification and screening of suspected cases and the appropriate handling of the deceased including post mortem procedures.

Two risk assessments as to suspected COVID-19 cases will be undertaken.

- The first risk assessment will be undertaken by attending NSW Police if they suspect COVID-19 infection of a deceased. NSW Police will distribute a Risk Assessment Checklist to their staff to complete when attending death scenes and on completion NSW Police will email the check list to the relevant forensic facility.

- The second risk assessment will be made by the forensic staff member admitting the body to the Forensic Medicine facility.
- Those deaths where it is suspected of COVID-19 virus, swabs will be taken and analysed to ascertain the presence or otherwise of the COVID-19 virus.
- Swabs will be taken pursuant to *Section 88A* (preliminary examinations) and will not require a direction from the Coroner.
- No Post Mortem direction or examination will commence until the results of the test are received.
- It is unlikely that the information will be available for regional cases at the time of RCD as screening will only happen on admission of the bodies to a forensic facility following triage.
- Where results are available at the time of triage, the information will be disclosed to the coroner as part of the decision making process to determine the most appropriate medical examination.
- There may however be instances where results only become available at a later stage during the examination process and results will then be made available in the autopsy report to the Coroner as for all other results.

The State Coroner asks that I remind you that when the Coroner is making a decision regarding an appropriate forensic examination, that the least invasive examination that is considered appropriate in the circumstances should be applied.

Her Honour has also asked that where appropriate due consideration be given to the issuing of a Coroners Certificate to limit unnecessary invasive examinations.

Information for Funeral Directors COVID-19 Related Death

Forensic & Scientific Services (FASS) have distributed an 'Advice to Funeral Directors' which I have attached with this Bulletin. The advice has been provided to the Funeral Director Associations for their members by FASS. As the State Coroners Court has received multiple inquiries from funeral directors regarding this issue, the advice may be of benefit for regional courts that may receive similar inquiries.

Notification of Acceptance/Refusal of Death Certificates by a Regional Coroner

The State Coroner directs that for those regional courts whose catchment is the Newcastle Department of Forensic Medicine, that when a Death Certificate is accepted or rejected by a Coroner, that the Newcastle DOFM is to be immediately informed by email of the acceptance or refusal of the Certificate by the Coroner. The contact email addresses for Newcastle DOFM are:

NSWPATH-FASSNewcMedicine@Health.nsw.gov.au

NSWPATH-FASSNewcForensicCaseCoord@health.nsw.gov.au

Unfortunately Newcastle DOFM have had a number of instances where they have not been informed whether the Coroner accepts or refuses the Death Certificate which has caused some confusion. Adherence to this direction by the State Coroner will avoid such confusion in the future.

