Australasian Coroners' Society Conference – 1– 4 October 2003

Notification of Hospital Deaths

Synopsis

For the last decade or so, Christchurch Hospital has had a process of written notification of hospital deaths to the Coroner's Office.

Only that category of cases that are subject (or could be subject) to notification to the Coroner in terms of the Coroners Act are notified. The system of faxed notifications from a hospital to a Coroner's Office provides the Coroner with relevant and consistent information, and gives better protection to the health professionals.

The process also occurs in some other parts of New Zealand (for example, Ashburton and Invercargill) and Australia (for example, Victoria and Western Australia).

Approximately 7% of hospital deaths in New Zealand become subject to Coroner's jurisdiction. Less than 2% are subject to a Coroner's hearing. Many of these deaths that are subject to a hearing relate to unnatural or traumatic events that have occurred in the community. It is likely that considerably less than one-half of 1% of hospital deaths result in inquests that examine events that occur in hospital. Those that are subject to inquest hearing tend to be significant and substantial cases.[1]

This presentation will explain the process of notification of hospital deaths at Christchurch Hospital, the activities of the Mortality Co-ordinator/Duty Manager, the Mortality Review Committee's overview role, the reporting protocols, the Coroner's perspective, and a Christchurch Hospital overview.

Following refreshments in the Medici Café there will be a viewing of facilities including the Mortality Co-ordinator's office, the viewing room, a walk-through of the mortuary, and a brief pathological presentation in the mortuary precincts.

Richard McElrea
Christchurch Coroner

September 2003

[1] *Reporting of Hospital Deaths in New Zealand – A Coroner's Perspective*, Richard McElrea, Australian Coroners' Society Conference, Brisbane, November 2000.