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## GUIDELINES FOR COMPLETION OF THE NOTIFICATION/REGISTER OF DEATH/STILLBIRTH (BI-1663) FORM

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It is a medical practitioner's duty to complete a death notification without delay when a patient dies. In the case of a stillbirth, a registered midwife may complete the form.

### When is a BI-1663 required?

No form is needed in the case of an aborted non-viable fetus, but it is needed in the case of a stillbirth. The Births and Deaths Registration Act (Act 51 of 1992) defines a stillbirth as 'a child that had at least 26 weeks of intra-uterine life but showed no sign of life after complete birth'. A gestational period of 26 weeks is the legally defined point of viability. Any birth, live or dead, after 26 weeks' gestation requires registration of birth, and in the case of stillbirth, also of death. Any live birth, defined (Criminal Procedures Act, Section 239 (1) of Act 51 of 1977) as one where the child breathed, whether or not an independent circulation was established, requires registration of birth irrespective of the gestational period, and where appropriate, death certification with the BI-1663.

### Is the death natural or unnatural?

Section D of the BI-1663 requires the medical practitioner to choose one of two options:

- I, the undersigned, hereby certify that the deceased named in section A, to the best of my knowledge and belief, died solely and exclusively due to NATURAL CAUSES specified in section G.

or

- I, the undersigned, am not in a position to certify that the deceased died exclusively due to natural causes.

Therefore the medical practitioner must understand the concept of natural and unnatural death and make a decision between the two. This decision is not always straightforward, and what may appear as natural causes may not always be so, or *vice versa*.

Natural and unnatural death, with one exception, is not defined in existing legislation – therefore it is a medical function, based on medical evidence and opinion together with current values of society to decide upon this. The following definition of an **unnatural death** is therefore suggested as a general guideline:

- A death caused by the application of force or any other physical or chemical factors, direct or indirect, with or without complications.
- Any death, including a death that would normally be considered natural, but which, in the medical practitioner's considered opinion was caused by an **act** or **omission** on the part of somebody.
- A death in terms of Section 56 of the Health Professions Act, 1974 (this is that one exception), which states: 'If a person dies under the influence of a local or general anaesthetic or where the administration of such an anaes-

thetic may have played a role in the death of the deceased, such a death is not regarded as natural and must be reported to a police officer.' Note that there is no time limit in this definition. There is no '24-hour rule'.

- A sudden or unexpected death which is also unexplained and where the medical practitioner is therefore unable to state with certainty that the cause of death is entirely natural. In these circumstances, the death must be treated as unnatural until a cause of death is determined by further investigation such as an autopsy. The death may then be registered as natural or unnatural.

Establishing whether the cause of death is natural or unnatural often depends upon the circumstances in which the person has died, and the general view of the medical practitioner, who is influenced by his training and his attitude, and society in general.

The fact that a medical practitioner cannot make a definitive diagnosis regarding the cause of death is no reason for the practitioner automatically to assume the death to be unnatural, unless convinced that it is so. It is possible to state that the deceased to the best of the practitioner's knowledge and belief has died from natural causes, the exact cause being unknown. If, however, there is doubt, it is recommended that the death be classified as one that cannot be certified as resulting from natural causes.

### Formulation of the cause of death

Section G of the BI-1663 is the Medical Certificate of Cause of Death. The format of the cause of death statement is in compliance with currently internationally accepted norms.

There are two parts to the cause of death statement.

- Part 1 is a sequential statement of the disease, injuries or complications that caused the death with one condition per line, beginning with the final or terminal or most recent condition on the top line and ending with the underlying cause or initiating event on the bottom line. There may be a single or multiple lines.
- Part 2 requires the statement of other significant conditions, if any, that contributed to death but did not result in the underlying cause given in Part 1.

**Further Reading**

Dada MA, McQuoid-Mason DJ. *Introduction to Medico-Legal Practice*. Durban: Butterworths, 2001.

**ETHICAL ISSUES IN FORENSIC MEDICINE**

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In the apartheid era the role of district medical officers (district surgeons) and forensic pathologists was compromised by political pressures that resulted in breaches of ethical rules, violations of law and human rights in miscarriages of justice. For example, forensic medical practitioners falsified death certificates; collaborated with security officials in covering up unlawful assaults and torture; treated patients under cruel, inhuman and degrading conditions; and flagrantly breached the

confidentiality of their patients. Such incidents were subsequently revealed at the Truth and Reconciliation Commission.

The primary role of the forensic medical practitioner is to collect, document, preserve and interpret medical evidence and to present this to the court in an unbiased manner in order to assist in the administration of justice. At the same time, however, the forensic practitioner is required to maintain a doctor-patient relationship with individuals who have been the victims or perpetrators of alleged crime and remains bound by the ethical obligations of the medical profession.

**Ethical principles**

The ethical dilemmas in forensic medical practice can be related to the 4 bioethical principles of autonomy, beneficence, non-maleficence and justice.

**Autonomy** recognises the duty of doctors to respect the freedom of patients to make decisions for themselves concerning how they want their body to be treated and whether and to whom information about them is to be disclosed. This principle appears in the Constitutional provisions concerning bodily and psychological integrity and privacy (ss 12(2) and 14). It manifests itself in the requirements for informed consent and confidentiality imposed by the National Health Act (ss 7 and 14). It is also covered in respect of confidentiality in the ethical rules of the HPCSA (Rule 20).

**Beneficence** recognises the duty of doctors to do good for their patients and is found in the Constitution, which states that everyone must be provided with access to health care and emergency medical treatment (s 27). For example, prisoners and detainees must be given proper medical care and rape survivors should be provided with post-exposure prophylaxis for HIV where indicated.

**Non-maleficence** recognises the duty of doctors to prevent harm to,

and not to injure, their patients. It exists in the Constitutional provisions regarding the right of everyone to dignity and an environment that is not harmful to their health (ss 10 and 24). For example, forensic pathologists should treat bodies with dignity, and the confidentiality of persons should be maintained even after death (Ethical Rule 20 of the HPCSA).

The principle of **justice** recognises the duty of doctors to treat patients equally and fairly and is enshrined in the Constitutional provisions concerning equality and non-discrimination (s 9). For example, forensic practitioners should treat victims and alleged perpetrators of crimes with equal care. In all instances, priority must be given to the clinical needs of the patient (the principle of triage). Furthermore, considerations of a patient's or practitioner's race, religion, gender, sexual orientation, HIV status, etc. should not influence medical treatment.

**Dual loyalty**

Situations of dual loyalty arise where forensic practitioners who are employed by the state or a private institution are faced with a conflict of interests that arises between the interests of the employer and those of the patient. International ethical codes require that loyalty to patients should supersede the interest of third parties.

Examples of situations that may give rise to dual loyalty conflicts include:

- simultaneous, conflicting professional or social obligations (e.g. whether a doctor should report bullet wounds to the police)
- threats to clinical independence of the practitioner (e.g. the prison authorities refuse to provide appropriate drugs for prisoners)
- obligations to third parties (e.g. duty to warn an HIV-negative rapist that his victim is HIV-positive)
- interference with a patient's human rights (e.g. denial of access to treatment for a prisoner).

When faced with dual loyalty conflicts, forensic practitioners should put their patient's interest first, report the inci-

dent to the appropriate authorities and seek support from local and international professional organisations.

**Duty to the court**

Forensic practitioners have a duty to assist the courts in the administration of justice. This means that they must present evidence fairly and objectively, without supporting the cause of a particular party, in order to assist the court in coming to a proper decision.

Forensic practitioners should present their evidence in an unbiased manner and should not misrepresent their credentials, falsify reports or express opinions not based on the facts. Furthermore, reluctance or a refusal to examine abused children or rape survivors, or delayed or inadequately performed clinical examinations or autopsies may result in miscarriages of justice.

**Conclusion**

If forensic practitioners follow the basic ethical principles of respect for autonomy, beneficence, non-maleficence and justice, they will be complying with the provisions of the Constitution and the ethical codes of the profession. It will also enable them to overcome the dilemmas of dual loyalty and to carry out their duty to the court.

*Further reading available on request.*

**PROCEDURE-RELATED DEATHS – ASPECTS TO KEEP IN MIND**

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**Legal obligation**

Two Acts must be taken into consideration:

- Section 56 of the Health Professions

Act (Act 56 of 1974) states: ‘The death of a person whilst under the influence of a general anaesthetic or local anaesthetic, or of which the administration of an anaesthetic has been a contributory cause, shall not be deemed to be a death from natural causes as contemplated in the Inquests Act, 1959 (Act 58 of 1959), or the Births, Marriages and Deaths Registration Act, 1963 (Act 81 of 1963)’.<sup>1</sup>

- The Inquest Act 58 of 1959 Section 16.2.d states that the court must establish ‘whether the death was brought about by any act or omission prima facie involving or amounting to an offence on the part of any person’.<sup>2</sup>

It is therefore clear that all deaths that occur during, or shortly after, a medical procedure cannot be considered natural deaths and must be referred for medico-legal postmortem investigation.

**Important aspects to keep in mind**

- All local and general anaesthetic-related deaths should be reported, including details related to local, spinal and epidural blocks.
- Death can be delayed. Always consider the primary event and the terminal event. Example: Oesophageal intubation with anoxic brain damage (primary event) and death of the patient months later of bronchopneumonia (terminal event). There is a direct link between the anoxic brain damage and the secondary bronchopneumonia.
- There is no legal time frame between the procedure and the death. There is misconception that if death occurs within 24 hours after the administration of an anaesthetic, it is an unnatural death. There is no time limit in law.
- Referral guidelines:
  - What was the general condition of the patient on admission and just before surgery and anaesthesia?
  - Was there any event that occurred during or shortly after the procedure or anaesthesia that raises concern?

- Did the patient recover consciousness after the procedure and general anaesthesia to the same level as before the procedure?
- What possible causes and mechanisms of death are considered?
- If in doubt consult the regional state pathologist.

**Possible causes of death in procedure-related deaths**

Death can be directly related to:<sup>3,4</sup>

- The anaesthesia – e.g. hepatitis due to anaesthetic gases.
- The surgery – e.g. vascular injury during laparoscopic procedure, and hypovolaemic shock.
- The injury or disease that required the surgery in the first place – e.g. multiple injuries sustained during a motor vehicle accident or ruptured abdominal aortic aneurysm with death during surgery.
- Other underlying disease, known or unknown to the medical practitioner, e.g. myocardial ischaemia during amputation of a leg for peripheral vascular disease.
- Reactions to medication (e.g. penicillin).
- Complication of blood transfusion.
- Poor postoperative care.

**Why perform an autopsy?**

An autopsy should be performed:

- because it is mandated by law
- to establish and record the cause and mechanism of death
- to supply information to all relevant parties (often protecting practitioners against any potential medical negligence claims).

**Steps to follow**

- Consult with the local forensic pathologist/practitioner if there is any doubt regarding the case.
- If the case requires medico-legal referral you must notify the local SAPS branch to register the case and to be allocated a case number.
- Write the necessary referral to the local medico-legal/forensic pathology service using the prescribed format if required. (Some departments require a copy of the hospital folder,

- all radiographs, etc.)
- Retain all the medical apparatus on/ in the body.
- Do not issue the death notification (BI-1663). It will be issued by the forensic pathologist/ practitioner after completion of the autopsy.
- Notify the local medico-legal laboratory for admission. The body will not be admitted without proper written referral documentation and the allocation of a police case number.

**Inquest regarding medical negligence**

- Negligence by a medical practitioner is determined by the court.
- In the inquest court the following must be established:
  - the identity of the deceased
  - the time of death
  - the cause of death
  - whether the death was brought about by any act or omission

- prima facie involving or amounting to an offence on the part of any person.<sup>2</sup>
- During the inquest no person stands trial.
- The court must establish whether a person can be held responsible for the death of the deceased.
- Various expert witnesses may be called, e.g. surgeons, gynaecologists, trauma surgeons, etc.
- The court will also rely on the input of an assessor/s who in a professional capacity assists the court in the interpretation of the medical evidence.
- The court will consider the 'reasonable man test':<sup>3</sup>
  - What are the qualification, experience, knowledge and insight of the medical practitioner?
  - Could he/she foresee the potential complication, and what measures were taken to prevent such complications?

- His/her actions after the complication – did he/she act appropriately?
- Was the complication an error of judgement, ignorance or inconsideration?
- If it is clear from the findings at the inquest that there was no negligence, the case will be closed.
- If, during the inquest, the evidence points to negligence, the court can proceed to a trial.
- In cases of negligence the state must prove beyond any doubt that the actions of the doctor led to the death of the patient.
- Family members can proceed with civil claims against the medical practitioner. In civil cases the case is decided on by a balance of probabilities.

*References available on request.*

**SINGLE SUTURE**

**USE IT OR LOSE IT**

A new study published in the *Annals of Internal Medicine* shows that regular exercise can prevent dementia and Alzheimer's disease. Eric Larson and colleagues looked at 1 740 persons older than age 65 years without cognitive impairment who scored above the 25th percentile on the Cognitive Ability Screening Instrument (CASI) in the Adult Changes in Thought study and who were followed up biennially to identify incident dementia. In 6.5 years of follow-up, 158 of the trial participants developed dementia, of whom 105 developed Alzheimer's disease. The incidence of dementia among those who exercised 3 or more times a week was 13 per 1 000 person-years, compared with 19.7 per 1 000 person-years among those who exercised less than 3 times a week, a statistically significant difference. The study population already included many people who exercised regularly and the results give a fairly compelling suggestion that exercise really can prevent cognitive decline in old age.

Larson E, et al. *Ann Intern Med* 2006; **144**: 73-81.