

The Medical Certificate of Cause of Death:

Special situations and considerations

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IN PART 3 of the Medical Certificate of Cause of Death series, we investigate special situations and considerations that can arise as part of the process of completing a Medical Certificate of Cause of Death (hereafter 'death certificate'). The series was introduced in an editorial in the April 2026 issue of *Australian Journal of General Practice*,¹ with part 1 providing an introduction to the death certificate and outlining the decision to complete,² and part 2 covering accurate completion.³

Falls, trauma and fractures

Falls, trauma and fractures require careful consideration when related to the death of a person. It is helpful to consider these as direct or indirect causes.

Direct cause

Closed head injuries from falls or motor vehicle accidents are direct causes of trauma and must be reported to the coroner. The passage of time does not change the requirement to report. For example, a significant head injury as a teenager may mean an individual is bed bound (Box 1). Survival for decades is possible, but the death may relate to the immobility caused by the head injury. If the end of the causative chain is a traumatic injury, the death is more likely than not reportable to the coroner.

Indirect cause

The consequence of falls in the elderly is an example that would be familiar to many general practitioners (GPs). The debilitation associated with hip fractures and other

traumatic injuries that follow falls in the elderly is significant. Death may occur because of the resultant significant systemic insult or the associated systemic decline, which may lead to death from another cause (eg cardiac or respiratory causes) and should reliably be documented as a significant condition in 'other significant conditions' (Box 2).

The challenge in preparing the certificate is to reflect 'but for' the fall and traumatic

injury, would the death of this person have occurred in the same time frame? Jurisdiction will then determine if it is necessary to report the death to the coroner. For example, in Queensland the Coroners Act would usually require this death to be recorded as reportable but may not require investigation. In New South Wales, a specific exemption in the Coroners Act allows doctors to complete a death certificate

Box 1. Completion of Part 1 and 2 - Example 1

Scenario

A man aged 38 years has been living in an aged care facility for the past 18 years after obtaining an acquired brain injury in a motor vehicle accident. He has unstageable pressure injuries that have resisted all active intervention. He develops a fever and becomes unwell over the course of hours. His enduring power of attorney (health) has determined his ceiling of care to be limited to comfort measures only, and he is no longer to be transferred to hospital for active care. He dies in the nursing home, and the general practitioner is called to write a death certificate.

This is a reportable death.

PART I	CAUSE OF DEATH		Approximate interval between onset and death
Disease or condition directly leading to death	A	Sepsis	Hours
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	Pressure areas to both hips	Months
	C	Immobility and poor skin integrity	Years
	D	Closed head injury and brain damage	Years
	E	Motor vehicle accident	18 years

PART II

Other significant conditions contributing to the death but not related to the disease or condition causing it.

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without reporting the death when a person who is aged 72 years or older has an age-related accident (such as a fall) resulting in injury contributing to their death. The primary caveat is there must be no other ‘act or omission by any other person’ to exempt coronial reporting.

Deaths in care

Location of death is an important consideration as to whether the death requires reporting to the coroner before completing the death certificate.

Aged care facilities

For practical reasons, deaths in aged care facilities are not automatically reportable. Facilities with full-time nursing care need to consider issues of healthcare delivery or the quality of care provided. The Royal Commission into Aged Care Quality and Safety highlighted many issues experienced by those receiving care in aged care facilities and has driven legislative change through recommendations.⁴

Supported care facilities

Community-based facilities, such as those providing extensive care through the National Disability Insurance Scheme (NDIS), are staffed primarily by non-clinical carers. They cater for vulnerable individuals for whom the community expects a high standard of care. These facilities support people of all ages, are frequently located within metropolitan areas and are generally funded through government support. The diversity of the facilities, and the variety of systems in which they are managed, means scrutiny of the facility may be higher than for those with clinical staff.

Causes of death requiring careful reflection

Dementia

As a cause of death

Dementia is an acceptable cause of death on its own. If the specific diagnosis (eg vascular, Alzheimer’s disease, frontotemporal) is known, then this should be recorded on the death certificate. Duration of diagnosis is

important: all individuals are assumed to be of capacity under law until such time as they are diagnosed as not being of capacity. Such a diagnosis has implications for legal documents the person has authorised in their lifetime, particularly a will. The diagnosis on a death certificate with an overlapping duration of diagnosis is sufficient for someone to challenge the probity of such documents.

Inanition and dementia

The substantive mechanism of death in those with dementia is often self-neglect or refusal to eat or drink adequately. This may also occur in older individuals with capacity, and in such cases, it is easy to determine whether the person is able to make such decisions, including the refusal of all interventions. For those who lack capacity, another important step is required: their statutory health decision maker should consent that clinical inaction (better expressed as a focus on patient comfort) is a reasonable response that would align with the person’s wishes. The application of force to feed or hydrate such a patient is, in general, unreasonable.

Box 2. Completion of Part 1 and 2 – Example 2

Scenario

A lady aged 82 years admitted to hospital following a fall and fractured neck-of-femur undergoes surgical fixation and appears well in the immediate postoperative period. Her background history includes hypertension and coronary artery disease. A week after surgery, she complains of sudden-onset chest pain associated with electrocardiogram changes consistent with anterior myocardial infarction. She dies a few minutes later despite resuscitative efforts.

PART I		CAUSE OF DEATH	Approximate interval between onset and death
Disease or condition directly leading to death	A	<i>Myocardial Infarction</i>	<i>Minutes</i>
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	<i>Coronary artery disease</i>	<i>Years</i>
	C	<i>Hypertension</i>	<i>Years</i>
	D		
	E		
PART II		<i>Mechanical fall with right neck-of-femur fracture (surgically treated)</i>	<i>7 days</i>
Other significant conditions contributing to the death but not related to the disease or condition causing it.			

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Delirium

Delirium is an induced state of confusion secondary to another condition that may improve with treatment of that condition and on its own is not considered a cause of death. The cause of the delirium should be recorded as the cause of death.

Old age

There are arguments for ‘ageing’ to be incorporated into the death certificates for two main reasons. First, it is often difficult to determine the cause of death in an elderly person who has died without heralding symptoms or signs, or without significant past medical history. Second, there are many clinicians who would like to see ageing as a disease process and believe recording it as a cause of death may drive recognition of ‘old age’ as something to treat. There are, however, many disease processes that do not cause death that are recognised and treated.

That a person is elderly is not in itself a cause of death. ‘Elderly’ has varying definitions, from 55 years in some jurisdictions, while others are more comfortable considering this over the

age of 80 years.⁵ Old age is too relative to be well defined: in clinical decision making, biological age is now used to determine interventional suitability ahead of chronological age. Such clinical practice should then be reflected in what is recorded.

Old age is not appropriate as a standalone cause of death. Apart from not being found in the current International Classification of Diseases (ICD) coding system, 'old age' and 'frailty' need physiological processes assigned to be considered. It is best to consider causes of death that manifest in an unheralded fashion when identifying the 'probable' cause (Box 3).

Voluntary assisted dying

All states have voluntary assisted dying (VAD) legislation. Complementing this legislation have been changes to the Coroners Acts and Registries of Births,

Deaths and Marriages to exclude VAD deaths as reportable to the coroner and to prevent VAD being listed as a cause of death. Instead, it is mandated that the cause of death listed on the death certificate relates to the terminal illness that qualified the patient for the VAD process (Box 4).

Although VAD deaths are not reportable to the coroner, any misadventure or incorrect process in delivering VAD is reportable. A tragic case in Queensland is an example.⁶

Interstate deaths

If your patient dies interstate, then each state's Registry of Births, Deaths and Marriages legislation has provisions for the death to be registered in either state, depending on the circumstances of the death.

International deaths

Deaths of Australian residents occurring in another country are usually the responsibility of the jurisdiction in which they die. There are some exceptions, including military personnel.⁷ State legislation allows for other exceptions that 'may' be registered in that state. The full circumstances need to be explored before a doctor should issue a death certificate. Such deaths tend to attract the attention of various authorities and agencies, and you are most likely to be approached by a government organisation rather than by the family of the deceased regarding completion of the death certificate.

Should the person die on a vessel or aircraft leaving from, or returning to, Australia, then their death may be registered in Australia and a death certificate issued locally.^{8,9}

What do you do with the completed death certificate?

The completed death certificate needs to be sent to the Registry of Births, Deaths and Marriages. In practice, it is usual for the funeral director to facilitate this; however, it is advised that you confirm this with local policy.

Can a death certificate be amended?

Death certificates can be amended after registration with the Registry of Births, Deaths and Marriages by the original certifying doctor or by the coroner. If you are subsequently provided with new information that suggests the death may have been reportable, the coroner should be notified immediately. If you discover typographical errors or missing information, including underlying health conditions, you must apply to amend the certificate through the Registry of Births, Deaths and Marriages in your jurisdiction.

Documentation in medical records

It is important to document the process of completing the death certificate in the patient's record. This is particularly important if you are not able to complete a certificate because you are uncertain about the cause of death.

Box 3. Completion of Part 1 and 2 – Example 3

Scenario

A man aged 97 years who has lived in a nursing home for the past 7 years has required no medication or specific intervention in the past 3 years. He has intermittent confusion that may suggest some cognitive decline, but it is very mild. You are called as a general practitioner to provide a Medical Certificate of Cause of Death when he is found deceased in the morning in his bed. Nursing staff indicate that he appeared settled with no complaints the previous day.

The test for consideration is 'the balance of probabilities': the most likely cause of death with the information to hand. These circumstances represent an 'unheralded death' caused by a sudden physiological event that removed the ability to seek help, rouse from consciousness or in some way indicate a developing problem. Causes would include sudden cardiac events, such as a myocardial infarction, or a central event, such as a stroke.

PART I	CAUSE OF DEATH	Approximate interval between onset and death
Disease or condition directly leading to death	A Cerebrovascular accident	Immediate
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	
	C	
	D	
	E	

PART II

Other significant conditions contributing to the death but not related to the disease or condition causing it.

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Jurisdictional differences

The Medical Certificate of Cause of Death series highlighted a number of differences in processes across Australia’s states and territories. These have been summarised in Appendix 1 (available online only), which may be particularly helpful to GPs working across different jurisdictions.

Key points

- A history of trauma and falls requires careful consideration when completing a death certificate in terms of whether the death is reportable or the trauma or fall may have contributed to the death.
- Dementia is an acceptable cause of death, although it is important to take care with timelines and duration as the diagnosis has implications for legal documents the deceased may have authorised during life.
- Delirium is not an appropriate standalone cause of death; the underlying cause of the delirium should be identified.
- ‘Old age’ is not an appropriate standalone cause of death.

- VAD is not a reportable death and cannot be listed as a cause of death on the death certificate.
- Deaths of Australian residents occurring in another country are usually the responsibility of the jurisdiction in which they die, except for military personnel.
- A death certificate can be amended, when necessary, by the certifying doctor or coroner.
- Document the process of completing a death certificate in the medical notes, especially if you are not able to complete the certificate.

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Competing interests: AG and KR receive honoraria for teaching in medicolegal medicine from the Australasian College of Legal medicine. GH and MK have no competing interests.

Funding: None.

Provenance and peer review: Not commissioned, externally peer reviewed.

AI declaration: The authors confirm that there was no use of artificial intelligence (AI)-assisted technology for assisting in the writing or editing of the manuscript.

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References are available online only.

Box 4. Completion of Part 1 and 2 – Example 4

Scenario

Your patient of many years, a man aged 67 years, has required your care for his hypertension and diabetes. He has recently been diagnosed with recurrent glioblastoma multiforme and has elected to follow a voluntary assisted dying (VAD) pathway. You are called to complete a Medical Certificate of Cause of Death.

PART I	CAUSE OF DEATH	Approximate interval between onset and death
Disease or condition directly leading to death	A <i>Glioblastoma multiforme</i>	3 years
Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last.	B	
	C	
	D	
	E	
PART II	<i>Hypertension and diabetes</i>	<i>At least 7 years</i>
Other significant conditions contributing to the death but not related to the disease or condition causing it.		

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