G120 When Hospitals Fail to Report Deaths in Medical Examiner Jurisdiction: What Are We Missing?

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After attending this presentation, attendees will be able to identify categories of deaths that hospitals often fail to report to medical examiners/coroners (ME/C). Attendees will understand the impact that the lack of reporting may have on the legal and public health systems.

This presentation will impact the forensic science community by allowing death investigators to recognize which types of deaths are often not reported to the medicolegal death investigation system; understanding these categories will allow death investigators to develop targeted educational outreach within community healthcare facilities in order to maximize reporting of appropriate deaths.

Although laws governing medicolegal death investigation vary among jurisdictions, reportable deaths generally include deaths of children, sudden and unexpected deaths, and deaths resulting from physical or chemical injury. However, some hospital deaths that should come within ME/C jurisdiction are not reported, either because of lack of knowledge on the part of healthcare providers, or in some instances because of religious or cultural beliefs and misconceptions about the consequences of reporting. When hospitals fail to report deaths to the ME/C, the cost is delayed law enforcement investigation, inaccurate death certification, and missed opportunities to collect evidence from decedents.

This study undertakes this prospective to ascertain the types of deaths that are not reported and to identify areas for targeted quality improvement efforts, e.g., education and development of guidelines. The study is a five-year longitudinal descriptive analysis of non-reported deaths that were in medical examiner jurisdiction. It is impossible to determine the total number of such deaths in any jurisdiction; however, we were able to identify 71 cases. The deaths were discovered after days to years' delay. The deaths were often discovered because of calls from family or lawyers regarding the death certificate, calls from funeral homes, from police, or from the bureau of vital statistics when a community physician completed the death certificate. Almost 60% were decedents over 60 years of age; not surprisingly, this category included those who died from injuries sustained in falls (e.g., hip fractures and subdural hematomas). In some cases, elements of neglect were also suspected. Smaller percentages of cases were identified in which cultural or religious factors may have influenced the medical facility's decision to not report. Unexpectedly, in 7% of the cases, the manner of death was ultimately either classified as homicide or classified as undetermined where homicide was suspected but investigative elements were lacking. The majority of the cases, 82% were accidents, and 11% were suicides. That none of these deaths were ultimately classified as natural may reflect relatively less cases in this category (i.e., that most natural deaths were appropriately reported), or may reflect a lack of means of identifying these cases. In 21% of these cases the death came to the attention of the medical examiner before the body was buried or otherwise disposed, and therefore direct examination was possible. If each of the 71 deaths had been reported in a timely fashion 44% would have been autopsied, while the other 56% would have been released following an external examination. Based on this experience, strategies are being developed to reduce the incidence of these failures, specifically by pursuing ongoing educational efforts in local hospitals to address reporting issues. A key finding is that healthcare providers require additional and more concrete guidelines for determining which deaths fall within ME/C jurisdiction.

Some interesting trends and surprising categories within the data set will be presented. Some case examples will illustrate these points. Quality improvement initiatives will be presented that can be implemented within any medicolegal death investigation system to reduce the incidence of jurisdictional lapses.

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