OPINION FOR THE SOUTH AFRICAN MEDICAL RESEARCH COUNCIL ON THE ACCURATE RECORDAL OF CAUSE OF DEATH DATA

1 My advice is sought by the South African Medical Research Council ("MRC") on the accurate recordal of cause of death data which is first collected by the Department of Home Affairs ("DHA"), and thereafter processed (and eventually published) by Statistics South Africa ("StatsSA"). In particular, the MRC seeks advice on whether there are any legal barriers in the way of the accurate recordal of such data, and if so, how these barriers may be overcome.

2 I am advised that the medical certificate of cause of death ("Form DHA – 1663B") does not ordinarily capture the manner of death as the underlying cause, as the World Health Organization's ICD-10 guidelines require. What this means is that insofar as unnatural deaths are concerned, the actual cause of death is ordinarily captured inaccurately. This is well-demonstrated, for example, when surveillance data is compared with official StatsSA statistics.

2.1 A recently-published report titled *"A Profile of Fatal Injuries in Mpumalanga – 2018"*,[1] which is based on the National Injury Mortality Surveillance System, records the following breakdown of unnatural deaths in Mpumalanga in 2018:

2.1.1 Transport-related deaths: 36.5%;

[1] See https://www.samrc.ac.za/reports/national-injury-mortality-surveillance-system-nimss?bc=1889

2.1.2 Other unintentional deaths (such as burns, falls, poisoning, and drowning): 11.3%;

2.1.3 Homicides: 26.3%;

2.1.4 Suicides: 14.1%; and

2.1.5 Undetermined: 11.8%.

2.2 For the same time period, StatsSA recorded a very different picture:[2]

2.2.1 Transport accidents: 15.3%;

2.2.2 Other external causes of accidental injury: 72.3%;

2.2.3 Assault: 7.2%;

2.2.4 Intentional self-harm: 0.8%;

2.2.5 Undetermined intent: 3.1%; and

2.2.6 Complications of medical and surgical care: 1.3%.

3 I am advised that conducting a routine national survey requires a large fieldwork team to extract and capture the data, as well as a separate team to analyse the data. This is obviously an expensive and time-consuming way to capture data that could be captured accurately and routinely by way of the DHA – 1663B form. If this were done, it would result in significant savings to the fiscus.

4 I am also advised that forensic pathologists, who are responsible for completing DHA – 1663B forms when unnatural causes of death are suspected, may be reluctant to report the manner of death for fear of falling foul of section 20(4) of

[2] See "Mortality and causes of death in South Africa: Findings from death notification, 2018", available at https://www.statssa.gov.za/?page_id=1854&PPN=P0309.3&SCH=7923

the Inquests Act 58 of 1959 ("the Inquests Act"). A breach of that provision would constitute an offence. Section 20(4) provides:

> *"Any person who prejudices, influences or anticipates the proceedings or findings at an inquest shall be guilty of an offence and liable on conviction to a fine not exceeding R2 000 or to imprisonment for a period not exceeding six months or to both such fine and such imprisonment."*

5 But the *bona fide* recordal of the manner of death cannot amount to a breach of section 20(4), in large part because the primary purpose served by an inquest is *"making a determination whether or not the prosecution of any person for having brought about the death of the deceased is called for, and to consider and make an assessment of the available evidence for that purpose."*[3] If anything, an accurate recordal of the manner of death, done by a forensic pathologist, could only assist in ensuring that the inquest process runs its proper course.

6 What does appear to stand in the way of the accurate recordal of cause of death data is Form DHA – 1663B itself. In respect of deaths occurring after one week of birth,[4] the form only requires the following information pertaining to the cause of death to be provided:[5]

6.1 Part 1 starts by directing the person completing the form to *"[e]nter the disease, injuries or complications that caused the death"*, indicating that the mode of dying – *"such as cardiac or respiratory arrest, shock or heart failure"* – is not to be recorded.

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[3] See *Todd v Clanwilliam and Others* (19247/19) [2022] ZAWCHC 15 (23 February 2022) at para 19
[4] By definition, this excludes stillbirths and perinatal deaths.
[5] See item 77

6.2 In providing this information, the immediate <u>and</u> underlying causes are both to be given, with the immediate cause being the *"final disease or condition resulting in death"*, and the underlying cause being the *"[d]isease or injury that initiated events resulting in death"*.

6.3 Part 2 then calls for *"[o]ther significant conditions contributing to death but not resulting in [the] underlying cause given in **Part 1**"*.

6.4 One final question must be answered. In respect of the deaths of women, the form requires a yes or no answer to this question: *"was she pregnant at the time of death or up to 42 days prior to death?"*

7 The form itself provides no guidance on how to complete it, or on what level of detail to provide. It thus appears quite likely that the same cause of death could be recorded quite differently by different persons. If that is so, this would have significant ramifications for the integrity and value of the data collected.

8 My attention has been drawn to a StatsSA publication from 2012 titled *"Cause of death certification: A guide for completing the Notice of Death / Stillbirth (DHA-1663)"*.[6] Amongst other things, the guide – which was prepared by the MRC – notes the importance of recording the manner of an unnatural death accurately:[7]

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[6] See https://www.samrc.ac.za/sites/default/files/files/2017-07-03/CODcertificationguideline.pdf
[7] At p 73

> *"For unnatural deaths, it is important to know the specific external cause of injury as well as the manner of death (Table 5). The same external cause could cause death by different manners of death and may require different preventive interventions. For example, if a person died from drowning, it may be a case of (intentional) assault (X92), (intentional) suicide (X71), accidental drowning (W65-W74), or the circumstances might be unknown (Y21). Prevention of accidental drowning requires different interventions from drowning by suicide or assault. Similar examples are indicated by the shading in Table 5."*[8]

9 The guide makes it clear that *"[i]f the cause of death is unnatural …, the case should immediately be referred to Forensic Pathology Services for a medico-legal post mortem so that the manner of death (homicide, suicide or accident or natural in some cases) can be determined."*

10 Although a very helpful document, the guide appears to have been developed primarily as a training manual, and not as a tool for use by a forensic pathologist whilst completing a DHA – 1663B form. Its existence, therefore, does not do away with the need for a better-drafted form.

11 In what follows below, I deal with the following three issues in turn:

11.1 First, the legislative framework governing the recordal of cause of death data on Form DHA – 1663B,[9] which is to be completed by a medical practitioner, professional nurse, or forensic pathologist;

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[8] Table 5 is to be found at p 72 (my emphasis)

[9] This is part of Annexure 14 to the Regulations on the Registration of Births and Deaths, 2014.

11.2 Second, whether the legislative framework stands in the way of the accurate recordal of such data; and

11.3 Third, what steps could be taken to ensure that the accurate recordal of such data.

THE LEGISLATIVE FRAMEWORK

12 Three statutes govern the recordal of the data in question: the Births and Deaths Registration Act 51 of 1992 ("the Registration Act"); the Inquests Act; and the National Health Act 61 or 2003 ("the NHA").

12.1 While the Registration Act has been amended numerous times since coming into force on 1 October 1992, the key provisions of chapter III (which deals with the registration of deaths) remain in their original form. These include sections 15(3) and 16. (Section 32, which deals with the making of regulations, was amended with effect from 1 March 2014.[10])

12.2 The Inquests Act came into force on 1 January 1960. While it has been amended a number of times since then, it has only been amended twice since 1994, with neither of those amendments being relevant to this opinion. The key provisions in question, sections 2, 3, and 20, have not been amended since the early 1990s.

[10] Section 32 was substituted by section 19 of the Births and Deaths Registration Amendment Act 18 of 2010, which came into force on 1 March 2014.

12.3 Standing in stark contrast to these two pre-1994 statutes is the NHA, which only came into force on 2 May 2005. Of particular relevance are sections 66 and 68,[11] and section 90(1), which empowers the Minister to *"make regulations regarding … the rendering of forensic pathology, forensic medicine and related laboratory services, including the provision of medicolegal mortuaries and medicolegal services"*.

13 Two sets of regulations complete the legislative framework:

13.1 Regulations on the Registration of Births and Deaths, 2014 ("the Births and Deaths Regulations"), which were made in terms of section 32 of the Registration Act; and

13.2 Regulations Regarding the Rendering of Forensic Pathology Service, 2018 ("the Forensic Pathology Regulations"), which were made in terms of section 90(1) of the NHA.

14 Before considering the legislative framework in more detail, it is important to note that different provisions dealing with the same issue must be read, where possible, *"so that they do not contradict each other"*.[12] As Theron J explained in *Independent Institute of Education (Pty) Limited v Kwazulu-Natal Law Society*:[13]

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[11] Dealing respectively with post mortem examination of bodies, and regulations relating to tissue, cells, organs, blood, blood products and gametes.

[12] See *Centre for Child Law v Director General: Department of Home Affairs and Others* 2022 (2) SA 131 (CC) at para 33

[13] *Independent Institute of Education (Pty) Limited v Kwazulu-Natal Law Society* and Others 2020 (2) SA 325 (CC) at para 38, cited with approval in *Centre for Child Law v Director General: Department of Home Affairs* at para 33 (footnotes omitted)

> *"It is a well-established canon of statutory construction that 'every part of a statute should be construed so as to be consistent, so far as possible, with every other part of that statute, and with every other unrepealed statute enacted by the Legislature'. Statutes dealing with the same subject matter, or which are in pari materia, should be construed together and harmoniously. This imperative has the effect of harmonising conflicts and differences between statutes. The canon derives its force from the presumption that the Legislature is consistent with itself. In other words, that the Legislature knows and has in mind the existing law when it passes new legislation, and frames new legislation with reference to the existing law. Statutes relating to the same subject matter should be read together because they should be seen as part of a single harmonious legal system."*

15 Where this is not possible, does a later statute trump the provisions of an earlier one, in circumstances where it does not expressly repeal anything in the earlier statute? Subject to one exception, to which I return shortly, that is indeed the position in our law: *"that in general an earlier enactment is to be regarded as impliedly repealed by a later one if there is an irreconcilable conflict between the provisions of the two enactments."*[14]

16 But as Cameron J noted on behalf of a unanimous Constitutional Court in *Ruta v Minister of Home Affairs*,[15] *"[a] longstanding principle of statutory interpretation points to the conclusion that a later statute's general provisions do not derogate from a statute's specific provisions …."* In support of this qualification, he cited[16] the following passage from *Khumalo v Director-General of Co-operation and Development* with approval:[17]

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[14] *Khumalo v Director-General of Co-operation and Development* 1991 (1) SA 158 (A) at 164C
[15] 2019 (2) SA 329 (CC) at para 42 (footnotes omitted)
[16] See *Ruta* at note 112
[17] At 165E (my emphasis)

> *"[I]n the absence of an express repeal, there is a presumption that a later general enactment was not intended to effect a repeal of a conflicting earlier and special enactment. This presumption falls away, however, if there are clear indications that the Legislature none the less intended to repeal the earlier enactment. This is the case when it is evident that the later enactment was meant to cover, without exception, the whole field or subject to which it relates."*

17 So where does this leave us? The case law provides the following guidance:

17.1 The starting point is to determine if the various pieces of the legislative puzzle can be read together as a coherent framework.

17.2 But if there is an *"irreconcilable conflict"* between pieces of legislation, then, subject to the *"longstanding principle of statutory interpretation"* identified by Cameron J, the more recent enactment is to be regarded as having impliedly repealed the earlier one.

17.3 And as Cameron J reminds us in his reference to the *"longstanding principle of statutory interpretation"*, general provisions in a more recent enactment cannot be seen as having impliedly repealed specific provisions in an earlier one.

18 With these principles in mind, I now consider the various parts of the legislative framework in question.

19 The starting point is section 15 of the Registration Act, which deals with the issuing of the prescribed certificate stating the cause of death. Subsections (1)

and (2) both deal with deaths due to natural causes;[18] subsection (3), which deals with unnatural causes of death, provides:

> *"If a medical practitioner is of the opinion that the death was due to other than natural causes, he or she shall not issue a certificate mentioned in subsection (1) or (2) and shall inform a police officer as to his or her opinion in that regard."*

20 According to section 16 of the Registration Act, the police officer in question, having received such information,[19] *"shall act in terms of the provisions of section 3 of the Inquests Act, 1959 (Act 58 of 1959)."* Under the heading *"Investigation of circumstances of certain deaths"*, sections 3(1) to (3) of that Act provide:[20]

> *"(1) Subject to the provisions of any other law providing for an investigation of the circumstances of any death, any policeman who has reason to believe that any person has died and that such person has died from other than natural causes, shall –*
>
> *(a) investigate or cause to be investigated the circumstances of the death or alleged death; and*
>
> *(b) report or cause to be reported the death or alleged death to the magistrate of the district concerned, or to a person designated by that magistrate.*
>
> *(2) If the body of a person who has allegedly died from other than natural causes is available, it shall be examined by the district surgeon or any other medical practitioner, who may, if he deems it necessary for the purpose of*

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[18] Subsections (1) and (2) provide:

> *"(1) Where a medical practitioner is satisfied that the death of any person who was attended before his or her death by the medical practitioner was due to natural causes, he or she shall issue a prescribed certificate stating the cause of death.*
>
> *(2) A medical practitioner who did not attend any person before his or her death but after the death of the person examined the corpse and is satisfied that the death was due to natural causes, may issue a prescribed certificate to that effect."*

[19] Section 16 also applies in respect of the receipt of information mentioned in sections 14(3), 14(4), 18(4), and 18(5).

[20] My emphasis

ascertaining with greater certainty the cause of death, make or cause to be made an examination of any internal organ or any part or any of the contents of the body, or of any other substance or thing.

(3) For the purposes of any examination mentioned in subsection (2) –

(a) any part or internal organ or any of the contents of a body may be removed therefrom;
(b) a body or any part, internal organ or any of the contents of a body so removed therefrom may be removed to any place."

21 What section 3(1) makes clear is that if there is another law that deals specifically with investigations into the cause of any particular death, then the obligations imposed on police officers by section 3(1) must be read subject to that other law. And indeed, there is such a law: section 66 of the NHA (dealing with post mortem examinations of bodies), which is to read together with the Forensic Pathology Regulations. I return to these provisions later.

22 Read together, sections 3(1)(a) and (2) of the Inquests Act require a police officer to ensure that the body of a person who is suspected to have died from unnatural causes is the subject of a post mortem examination. This is consistent with section 66(1)(c) of the NHA, which requires *"a post mortem examination of the body of a deceased person … [to] be conducted if … such an examination is necessary for determining the cause of death."*

23 Regulation 4 of the Forensic Pathology Regulations states that *"[a]ll cases of unnatural death as defined in these Regulations must be referred to the Service."*

23.1 The Service is defined as *"the Forensic Pathology Service in a province, providing medico-legal investigation of death services as defined."*[21]

23.2 Medico-legal investigation of death is defined as *"the investigation into the circumstances, manner and possible causes of death which are or may have been due to unnatural causes as defined"*.[22]

23.3 For the purposes of a medico-legal investigation of death, an unnatural death is defined to include the following:[23]

> *"(a) any death due to physical or chemical influence, direct or indirect, or related complications;*
> *(b) any death, including those deaths which would normally be considered to be a death due to natural causes, which may have been the result of an act of commission or omission which may be criminal in nature;*
> *(c) any death as contemplated in section 56 of the Health Professions Act, 1974 (Act 56 of 1974);[24] and*
> *(d) any death which is sudden and unexpected, or unexplained, or where the cause of death is not apparent."*

24 There are two other definitions that may be of assistance:

24.1 post mortem examination, defined as *"an examination of a body, with the purpose of establishing the cause and circumstance of death and factors*

[21] Regulation 1
[22] Regulation 1
[23] Footnote added
[24] Section 56 of the Health Professions Act 56 of 1974 deals with the death of a person undergoing a medical procedure.

associated with the death, and in the context of these Regulations, for medico- legal purposes”;

24.2 autopsy, defined as *“the post mortem dissection of a body so as to determine the cause of death and the nature of injuries and disease processes which may be present”*.

25 What these two definitions make clear is that, for purposes of the legislative framework, a post mortem examination needn’t include an autopsy.

26 One final issue needs to be considered: the requirement in section 3(2) of the Inquests Act that *“the body of a person who has allegedly died from other than natural causes … shall be examined by the district surgeon or any other medical practitioner”*. Read in light of the case law to which I have already referred, this requirement can only mean that the examination contemplated by section 3 of the Inquests Act is a post mortem examination conducted by a forensic pathology officer, defined in regulation 1 of the Forensic Pathology Regulations as –

> *“a person appointed by the [relevant provincial] department [of health] to provide a medico-legal investigation of death service within their scope of practice”.*

27 As already noted, the DHA – 1663B form notes that it is to be completed by a medical practitioner, professional nurse, or forensic pathologist. It thus follows, in circumstances where a post mortem examination was required and has indeed been conducted, the cause of death form is to be filled out by the forensic pathologist who conducted the examination.

IS THE LEGISLATIVE FRAMEWORK A PROBLEM? WHAT STEPS COULD BE TAKEN TO ENSURE THE ACCURATE RECORDAL OF CAUSE OF DEATH DATA?

28 Having considered the legislative framework as a whole, the only barrier that appears to stand in the way of the accurate recordal of cause of death information is the DHA – 1663B form itself, which – as already noted – provides no guidance on how to complete the form, or on what level of detail to provide.

29 Put differently, there is nothing in the legislative framework that would preclude the form being amended so as to ensure that the appropriate information is provided, including information relating to the manner of death, at the level of detail required, in a standardised form, in line with the WHO's ICD-10 guidelines.

30 Because the form is an integral part of the Births and Deaths Regulations, it can only be amended by the Minister of Home Affairs, acting in terms of section 32 of the Registration Act. The Minister would ordinarily publish draft amendments for public comment before promulgating any such amendments.

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