

The final referral: A 1-year retrospective review of death referrals through the lens of forensics

S van der Merwe,¹ MB ChB; FCFORPath ; I Mentoor,¹ MSc (Physiological Sci), PhD (Physiological Sci) 
N-K Mould-Millman,² MD (Emerg Med), PhD (Emerg Med) ; J Verster,¹ FCFORPath; MMed (Forensic Path) 

¹ Division of Forensic Medicine, Department of Pathology, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa
² Department of Emergency Medicine, School of Medicine, University of Colorado Anschutz Medical Campus, Aurora, USA

Corresponding author: S van der Merwe (suzahnvdm@sun.ac.za)

Background. Under South African (SA) law, all unnatural, sudden and unexpected deaths, as well as procedure-related deaths, must be reported to the SA Police Service and referred to the Forensic Pathology Service (FPS). In the Western Cape Province, referrals to FPS require completion of the FPS100 form by a senior medical practitioner.

Objective. To assess the appropriateness, completeness and legibility of FPS100 referral forms submitted to Tygerberg Forensic Pathology Services over the course of 1 year in the Western Cape Province, and to evaluate whether the suspected presumed cause of death was in line with the World Health Organization's standards.

Methods. This was a cross-sectional retrospective review of all FPS100 referral forms submitted to the Tygerberg Forensic Pathology Mortuary over 1 year. An experienced forensic pathology medical practitioner reviewed the appropriateness, completeness, legibility, commissioning status and accuracy of presumed cause-of-death classifications reflected on the FPS100 referral forms received.

Results. Of the 1 252 cases accompanied by a referral form, 81.6% were deemed incomplete, with 22.3% uncommissioned, rendering them inadmissible in court. Even though most of the referrals were legible, over 43% indicated misclassified formulations of the presumed causes of death.

Conclusion. The study revealed significant deficiencies in FPS referrals, including incomplete or uncommissioned forms and frequent misclassification of presumed causes of death. These shortcomings undermine the legal validity of the referral forms, and may delay medicolegal processes and even result in direct subpoenas to referring medical practitioners. The findings highlight the urgent need for strengthened training for medical practitioners across all levels of experience, and for the implementation of standardised referral protocols. Equally important is enhancing awareness of the medicolegal value of FPS involvement, and the critical impact of accurate, high-quality referrals.

Keywords: autopsy, cause of death, forensic pathology, unnatural death referrals

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According to the South African Births and Deaths Registration Act 51 of 1992,^[1] a medical practitioner in both state and private sector healthcare facilities must issue a death notification form for natural deaths. In contrast, under the National Health Act 61 of 2003^[2] and the Inquests Act 58 of 1959,^[3] all suspected unnatural deaths – including those due to physical, thermal, or chemical violence; sudden and unexpected deaths; and procedure-related deaths as outlined in the Health Professions Amendment Act (29 of 2007)^[4] – must be reported to the South African (SA) Police Service, which then refers the case to the Forensic Pathology Service (FPS).^[1,5] FPS is responsible for determining the approximate time of death, assisting the SA Police Services with the identification of the deceased and determining the cause of death.^[1-3,5] Through conducting both external and internal postmortem examinations, sometimes using specialised techniques such as radiological imaging, histopathology and toxicology, forensic medical practitioners aim to determine the cause of death beyond a reasonable doubt before the death notification form is completed.^[1-3,5]

In the Western Cape Province of SA, healthcare facility referrals for suspected unnatural deaths require the completion of the FPS100 referral form, similar to the GW24/7 previously used in SA, by a senior medical practitioner responsible for the patient's care.^[2,4-6] This form is designed to provide forensic medical practitioners with

essential clinical information in regard to the decedent's medical history and in-hospital management. In this way, the referring medical practitioners support both medicolegal and judicial processes through enabling the forensic medical practitioner to optimally plan postmortem procedures, specific to each case investigation. Despite this framework, the FPS referral process is frequently hampered by incomplete, illegible, or unsubstantiated referrals and presumed causes of death.^[6,7] These challenges delay autopsies and the finalisation of medicolegal reports, especially when special investigations are required.^[6,8,9] Medical practitioners, who serve as the gatekeepers for FPS referrals,^[10] often report feeling underprepared to classify deaths appropriately,^[11] and may complete death notification forms without examining the deceased, particularly when the decedents are transported to healthcare facilities for death certification.^[12] In rural areas, the absence of trained medical practitioners can lead to death notification forms being completed by tribal leaders.^[12] These factors may lead to suspected unnatural deaths being missed, and subsequent contravention of the law.^[1,3] Additionally, incomplete referrals to FPS may persist owing to misconceptions about FPS referrals being linked to negligence or misconduct.^[11] These issues are compounded by resource constraints, poor healthcare facility documentation practices, poor interdepartmental co-operation and a general lack of feedback to medical practitioners.^[8,10,11,13]

Persistent errors in death certification, such as misclassifications and omissions, raise concerns regarding the quality of cause-of-death data in SA.^[10] A 2004 study at a tertiary hospital in Cape Town found that 98.4% of death notification forms had at least one minor error, and 45.4% had major errors, including missing or conflicting causes of death.^[14] These inaccuracies affect mortality statistics critical to public health surveillance, and may result in unnatural causes of death being erroneously classified as natural, resulting in missed FPS referrals^[14] and contravention of the law.^[1,3] Although the International Classification of Diseases (ICD-10) was introduced to improve standardisation, suboptimal reporting, particularly in injury-related deaths, remains a challenge.^[14]

This study aimed to assess the appropriateness, completeness and legibility of FPS100 referral forms submitted to Tygerberg FPS over the course of 1 year in the Western Cape Province, and to evaluate whether the suspected cause of death was in line with the World Health Organization (WHO)'s standards.^[15,16] The study assessed the quality of the referrals, specifically in terms of completeness, across healthcare facilities with varying levels of experience outlined by the National Department of Health.^[17] Ultimately, this research seeks to improve referral practices, ensure accurate medicolegal documentation, streamline forensic processes and enhance collaboration among healthcare professionals and forensic practitioners to support judicial outcomes and provide closure to families.

Methods

Study design and setting

This study is a retrospective, cross-sectional descriptive analysis utilising a convenience sampling approach at the Tygerberg FPS Mortuary. Classified as an M6-grade facility per the National Code of Guidelines for FPS Practice in SA, it performs 3 500 - 4 500 medicolegal postmortems annually. Cases were referred directly to the FPS Mortuary by the SA Police Services via healthcare facilities in the Eastern Metropolitan areas of the City of Cape Town.

Sample population

Eligible cases for this study included all referrals to Tygerberg FPS Mortuary, accompanied by FPS100 forms, between 1 January 2022 and 31 December 2022. The 1-year study period provided a complete, balanced and recent dataset that was representative, while ensuring the feasibility of a manual review of the eligible referrals by a single reviewer. These included complete, partially completed and outdated referral forms. Exclusion criteria encompassed referrals with no FPS100 form, including those with dead-on-arrival forms or other healthcare facility-specific death documentation.

Data collection

Data were collected from archived FPS100 referral forms housed at the Division of Forensic Medicine, Stellenbosch University, which maintains both hard copy and electronic versions through the Western Cape Department of Health's database (Enterprise Content Management; OpenText, Canada). A single experienced forensic medical practitioner, with >4 years of clinical and academic experience in forensic pathology, manually extracted data according to predefined categories (Fig. 1), from the available FPS100 referral forms submitted between January and December 2022. The reviewer was not involved in the completion of any of the forms assessed, thereby reducing potential bias.

A standardised data extraction template was used to promote consistency and objectivity throughout the process. The extracted variables (seen in Fig. 1) included demographic details (healthcare

facility type and level of referral^[17]), submission of the FPS100 form, its completeness, and case appropriateness for FPS investigation.^[1-3,5] Specific focus was placed on the completion of the form's subsections, including patient details, time of death, history, clinical course, interventions and special investigations. An acceptable presumed cause of death, according to WHO guidelines,^[16] and the provision of legible contact details of the referring authorised medical practitioner were also assessed. If any required section was incomplete, the form was classified as incomplete. A single experienced forensic medical practitioner subjectively assessed the handwriting on each form as either clearly legible/readable or illegible/unreadable. The commissioning of the forms was assessed in terms of whether or not the form was commissioned, and if so, whether it was deemed valid. Validity of commissioning would imply that forms were commissioned by someone other than the referring medical practitioner and included all the required commissioning details, such as the name, designation and signature of the commissioner. The data were compiled into an Excel (Microsoft, USA) spreadsheet and securely stored on a password-protected computer and a cloud-hosting platform (OneDrive; Microsoft, USA).

Data analysis

It was expected that ~1 000 FPS100 referral forms would be available for inclusion in the study. It was anticipated that ~70% of these would originate from state sector healthcare facilities, and the remaining 30% from the private sector. A sample size of 700 state-sector and 300 private-sector cases achieved 80% power to detect a difference of -9.7% between the two groups. The proportion of incomplete forms was expected to be 56.3% in the state sector and 66% in the private sector under the alternative hypothesis.

Categorical variables were summarised as counts and percentages. Chi-squared tests were used to examine the association between categorical variables. Data were analysed using Stata version 17 (Stata, USA).

Ethical considerations

Ethics approval was granted by the Human Research Ethics Committee of the Faculty of Medicine and Health Sciences at Stellenbosch University (ref. no. S23/04/090), which also waived individual informed consent due to the de-identification of cases. Authorisation was obtained from the Western Cape Department of Health (ref. no. WC_202305_031) and Tygerberg Forensic Pathology Service to conduct the study and access the archived FPS100 referral forms.

Results

In 2022, Tygerberg FPS Mortuary performed 3 929 medicolegal postmortem examinations, of which 1 355 (34%) were referred from surrounding healthcare facilities. Among these, 1 252 (92.4%) were accompanied by an FPS100 referral form, while 103 (7.6%) were not, leading to their exclusion from the study (Fig. 1). Cases were referred from both state and private sector healthcare facilities in the Cape Town Eastern Metropole, and from emergency medical services (EMS), facilitating transport between healthcare facilities.

Healthcare facility type and level from which referrals were received

Of the 1 252 FPS-referred cases, 9.1% ($n=114$) were from private sector healthcare facilities, and 90.9 ($n=1 138$) were from the state sector. Referrals were mainly from tertiary-level healthcare facilities (62.2%, $n=779$), followed by primary level, secondary level and direct EMS referrals (Table 1).^[17]

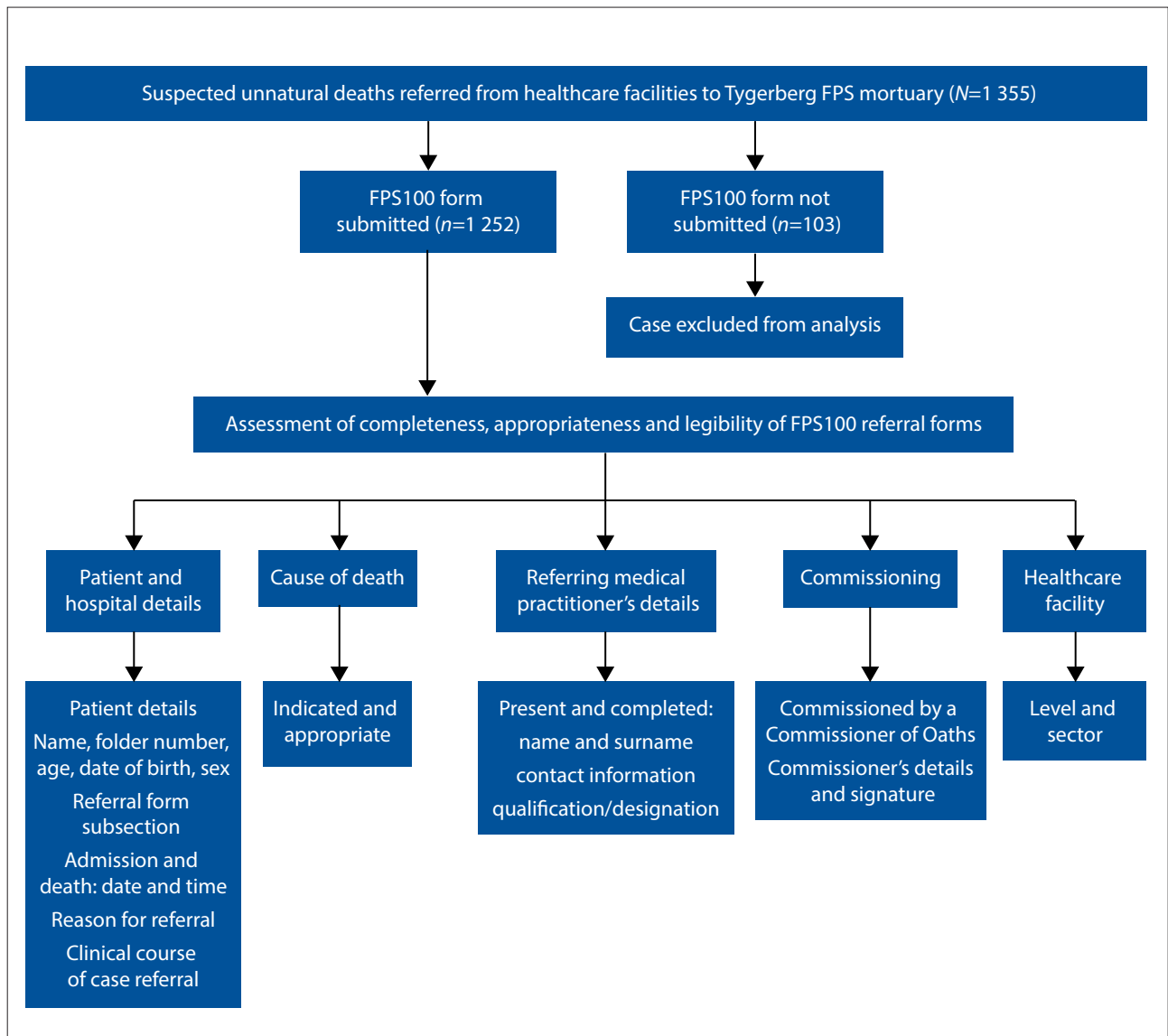


Fig. 1. FPS100 referral form analyses and data extraction. (FPS = Forensic Pathology Service.)

Completeness of FPS100 referral forms submitted

Table 1 shows that of the 1 252 referral forms submitted, only 18.4% (n=230) were complete. It is noteworthy that 79.8% and 81.8% of the FPS100 referral forms received (n=1 252) from the state and private sector healthcare facilities, respectively, were incomplete (Table 1). As shown in Fig. 2, the majority of incomplete FPS100 referrals were submitted from tertiary-level healthcare facilities: 7.2% (n=90) from the private and 43.2% (n=540) from the state sector. No FPS100 referrals were received from private primary-level healthcare facilities. Secondary-level healthcare facilities in the private sector submitted equal numbers of complete and incomplete forms. State sector primary-level healthcare facilities submitted more incomplete forms than secondary-level facilities.

A χ^2 test found no significant association between private- and state-sector healthcare facilities and FPS100 completeness ($\chi^2=0.272$, $df=1$, $p=0.602$), or healthcare facility levels and completeness ($\chi^2=1.075$, $df=2$, $p=0.584$).

Completeness of FPS100 referral form subsection

Several subsections of the referral form were incomplete (Fig. 3). The subsection with the highest number of incompleteness was

the medical examiner's email address (61.9%, n=774). Of these, 12.9% (n=161) were incomplete due to the use of outdated referral forms, which did not specifically request email addresses. The medical practitioner's contact number was incomplete in 31.1% (n=389) of forms received. Only 77.7% (n=973) of the forms were commissioned. Of these, 23.6% (n=295) were deemed invalid because they lacked commissioning data or were commissioned by the referring medical practitioner, which is prohibited (Table 1). The commissioner's designation (22.9% (n=287)), followed by the commissioner's signature (22.6% (n=283)) and the commissioner's name (22.2% (n=278)), were sometimes incomplete. Several other subsections were often incomplete, including special investigations and medical interventions (Fig. 3).

Legibility of the FPS100 referral forms

The medical history, clinical findings, clinical course and medical interventions were mostly legible. The legibility of the medical practitioner's details could not be assessed in 0.3% (n=3) of the forms as these details were not provided; however, in the majority of these cases, the details were legible (Table 1).

Table 1. Total number of healthcare facility referrals, legibility, completeness, acceptability and medical practitioner designation of submitted FPS100 referral forms (N=1 252)

Cases referred, n (%)	n=1 355
Healthcare sector	
Private	115 (8.5)
State	1 240 (91.5)
Healthcare facility level	
Primary	357 (26.3)
Secondary	208 (15.4)
Tertiary	786 (58)
EMS	4 (0.3)
Referral forms submitted, n (%)	n=1 252
Completeness of referral	
Complete	230 (18.4)
Incomplete	1 022 (81.6)
Completeness of referral, by healthcare sector	
Private (n=114)	
Complete	23 (20.2)
Incomplete	91 (79.8)
State (n=1 138)	
Complete	207 (18.2)
Incomplete	931 (81.8)
Completeness of referrals from different facility levels	
Primary (n=270)	
Complete	44 (16.3)
Incomplete	226 (83.7)
Total/1 252	270 (21.6)
Secondary (n=203)	
Complete	37 (18.2)
Incomplete	166 (81.8)
Total/1 252	203 (16.2)
Tertiary (n=779)	
Complete	149 (19.1)
Incomplete	630 (80.9)
Total/1 252	779 (62.2)

(continued)

Table 1. (continued) Total number of healthcare facility referrals, legibility, completeness, acceptability and medical practitioner designation of submitted FPS100 referral forms (N=1 252)

Referral forms submitted, n (%)	n=1 252
Commissioning of forms (n=1 252)	
Commissioned	973 (77.7)
Not commissioned	279 (22.3)
Commissioning valid	957 (76.4)
Commissioning invalid	295 (23.6)
Overall legibility (n=1 252)	
Legible	1 239 (99)
Illegible	10 (0.8)
Not complete	3 (0.3)
Medical practitioner details (n=1 252)	
Legible	1 245 (99.5)
Illegible	4 (0.3)
Not complete	3 (0.3)
Reason for referral (n=1 252)	
Acceptable	1 134 (90.6)
Not acceptable	118 (9.4)
Presumed suspected cause of death (n=1 252)	
Acceptable	697 (55.7)
Not acceptable	549 (43.8)
No cause of death indicated	6 (0.5)
Medical practitioner designation (n=1 252)	
Medical intern	56 (4.5)
Medical officer	584 (46.6)
Medical registrar	483 (38.6)
Specialist	124 (9.9)
Not complete	5 (0.4)

EMS = emergency medical services; included as a direct referral source.

Appropriateness of the case referral and the suspected cause of death

The reason for suspecting an unnatural cause of death, and the subsequent FPS case referral, was appropriate according to SA legislation^[1,5] in 90.6% (n=1 134) of cases, and inappropriate, stating suspected causes of death that are deemed to be natural, in 9.4% (n=118). The formulation of the presumed suspected cause of death reflected on referrals was acceptable as outlined by the WHO guidelines^[16] in 55.7% (n=697) of cases. No suspected cause of death was provided in 0.5% (n=6) of cases (Table 1).

Designation of the referring medical practitioner

Table 1 shows the referring medical practitioners' designations. Most of the forms were completed by a medical officer or a medical registrar; medical interns and specialist referrals contributed to a minority of cases. A χ^2 test showed no significant association between the completeness of the FPS100 referral form and the medical practitioner's designation ($\chi^2=4.886$, df=4, $p=0.550$).

Fig. 4 illustrates that the majority of FPS100 referral forms included an acceptable suspected cause of death. Among the fully

completed forms with an acceptable suspected cause of death, 0.5% (n=6) were completed by medical interns, 6.2% (n=78) by medical officers, 4.1% (n=52) by medical registrars and 1.8% (n=22) by specialists. In contrast, among the incomplete forms that still provided an acceptable suspected cause of death, 2.3% (n=29) were completed by medical interns, 21.6% (n=270) by medical officers, 15% (n=188) by medical registrars and 4.6% (n=57) by specialists. Medical practitioner designations were not provided in 0.4% (n=5) of complete and incomplete forms.

There was a significant association between the medical practitioner's designation and the acceptability of the suspected cause of death ($\chi^2=16.810$, df=8, $p=0.032$).

Discussion

In this study, we reviewed all available archived FPS100 referral forms (N=1 252) for suspected unnatural deaths submitted to the Tygerberg FPS Mortuary during 2022. The key findings revealed that the majority of forms (81.6%) were incomplete. Commissioning guidelines were frequently not followed, compromising the legal admissibility of these documents in court. Additionally, the contact details of the medical practitioners were often omitted, which hinders effective interdisciplinary communication. Continued submission of incomplete forms may be the result of perceptions that medical practitioners may have that FPS is under-resourced, resulting in a lack of feedback to referring medical practitioners, and that referrals may lead to allegations of negligence and medical misconduct.^[10,11]

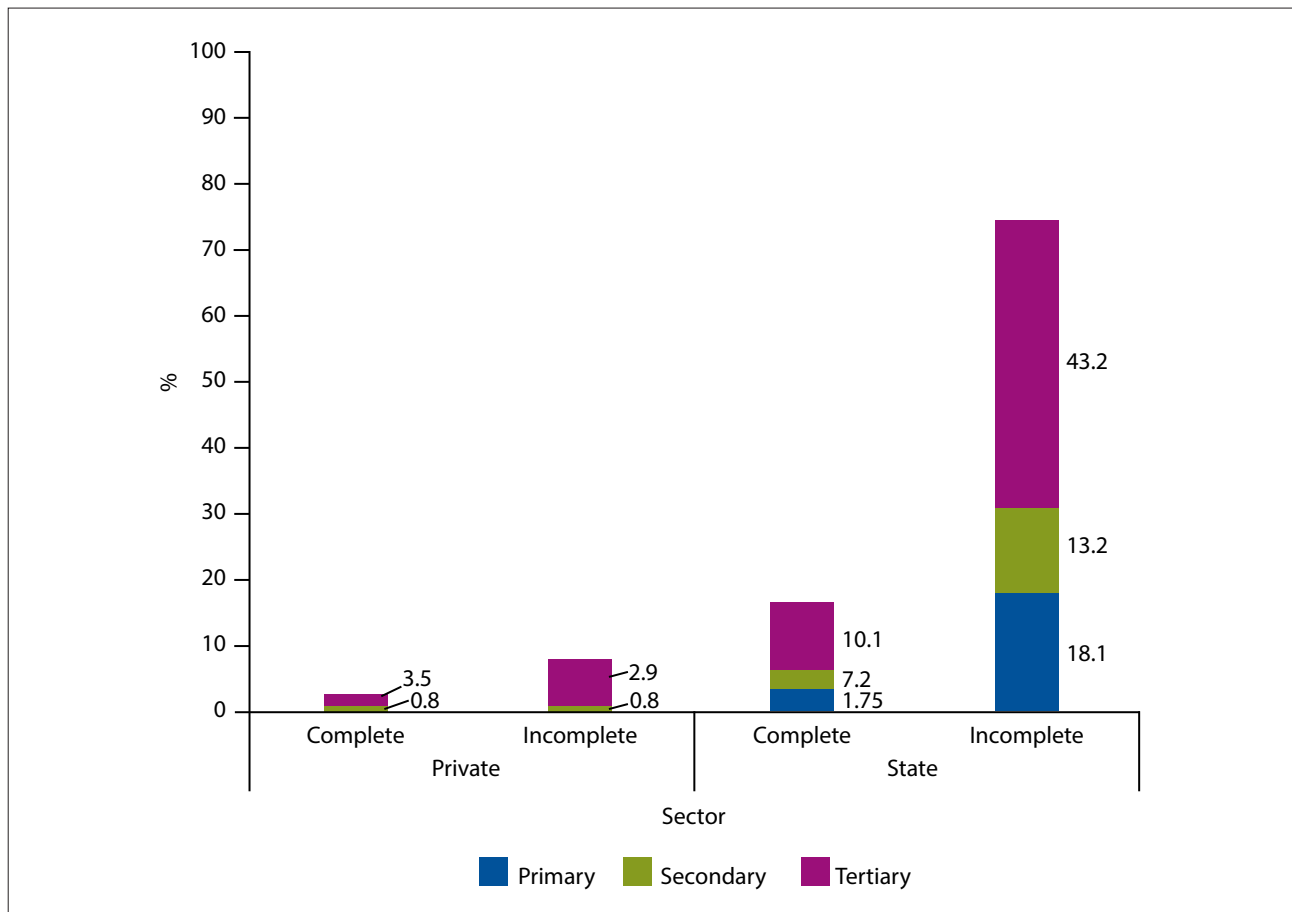


Fig. 2. Complete and incomplete FPS100 referral forms received from different healthcare facility levels in the state and private sector (N=1 252).

Most referrals originated from state-sector healthcare facilities, and the majority of the forms were completed by junior medical practitioners, many of whom misclassified the formulated presumed cause of death, in a manner inconsistent with WHO guidelines.^[16]

Notably, some of the most critical omissions on the FPS100 referral forms were the suspected cause of death, medical practitioner contact details and the required commissioning signatures. As the FPS100 referral form is the primary mode of communication between medical practitioners and forensic medical practitioners, these omissions may delay and unnecessarily complicate autopsy processes and medicolegal reporting. The information provided on the FPS100 referral form is indispensable, as it guides the planning and case-specific tailoring of the postmortem examination.^[5] Moreover, while hospital records are routinely reviewed where available, omissions or poorly completed forms often necessitate a far more intensive and time-consuming review of such folders, which are often disorganised or, at times, missing altogether.^[5,6,8] Such inefficiencies also lead to the overuse of ancillary investigations, consuming limited resources within FPS, in an attempt to establish the most probable cause of death beyond a reasonable doubt.^[9]

Furthermore, the absence of relevant clinical information may result in forensic medical practitioners overlooking specific concerns related to the cause of death, as certain medical interventions or pathological conditions require specialised dissection techniques or imaging modalities to be implemented prior to the postmortem examination to ensure the preservation of critical evidence.^[18] It must be emphasised that an incomplete FPS100 referral form significantly restricts the ability to provide meaningful feedback to medical practitioners, hindering interdisciplinary communication

and limiting the information available to families and the judicial system.^[8,15] This, in turn, prevents clarification of the circumstances surrounding the cause of death, which is crucial during medicolegal proceedings and morbidity and mortality meetings.^[7,9]

Additionally, 22.3% of forms were not commissioned, and others were commissioned by the referring medical practitioner, which, under the Criminal Procedure Act 51 of 1977,^[19] renders them inadmissible in court.^[3,19] Incomplete referral forms and non-commissioning practices have significant legal ramifications, as the FPS100 referral form constitutes an affidavit, and becomes part of the SA Police Service case docket, which is used during inquests and criminal proceedings.^[3,19] This can lead to legal delays and result in direct subpoenas for the treating clinician, the nurses, or even the entire medical team to testify, often regarding the details that could have been clarified through proper documentation and referral to FPS.^[3,9,19] This situation places an additional burden on the healthcare system, already strained by limited resources^[20,21] and staffing shortages, and on medical practitioners, who often fear engagement with the judicial system.^[11] The lack of an FPS100 referral form may even lead to unnatural deaths not being admitted to the FPS service, as the law dictates that all suspected unnatural death referrals from hospitals have to be accompanied by such referral forms.^[6] These potential non-admissions directly contravene the Births and Deaths Registration Act, and may result in criminal prosecution or a fine.^[1]

Most referrals were from state-sector tertiary-level healthcare facilities,^[17] which serve the majority of South Africans (80%),^[20,22] and face more resource constraints than the private sector.^[20,22] Despite this, the majority of referrals (91.5%) originated from the

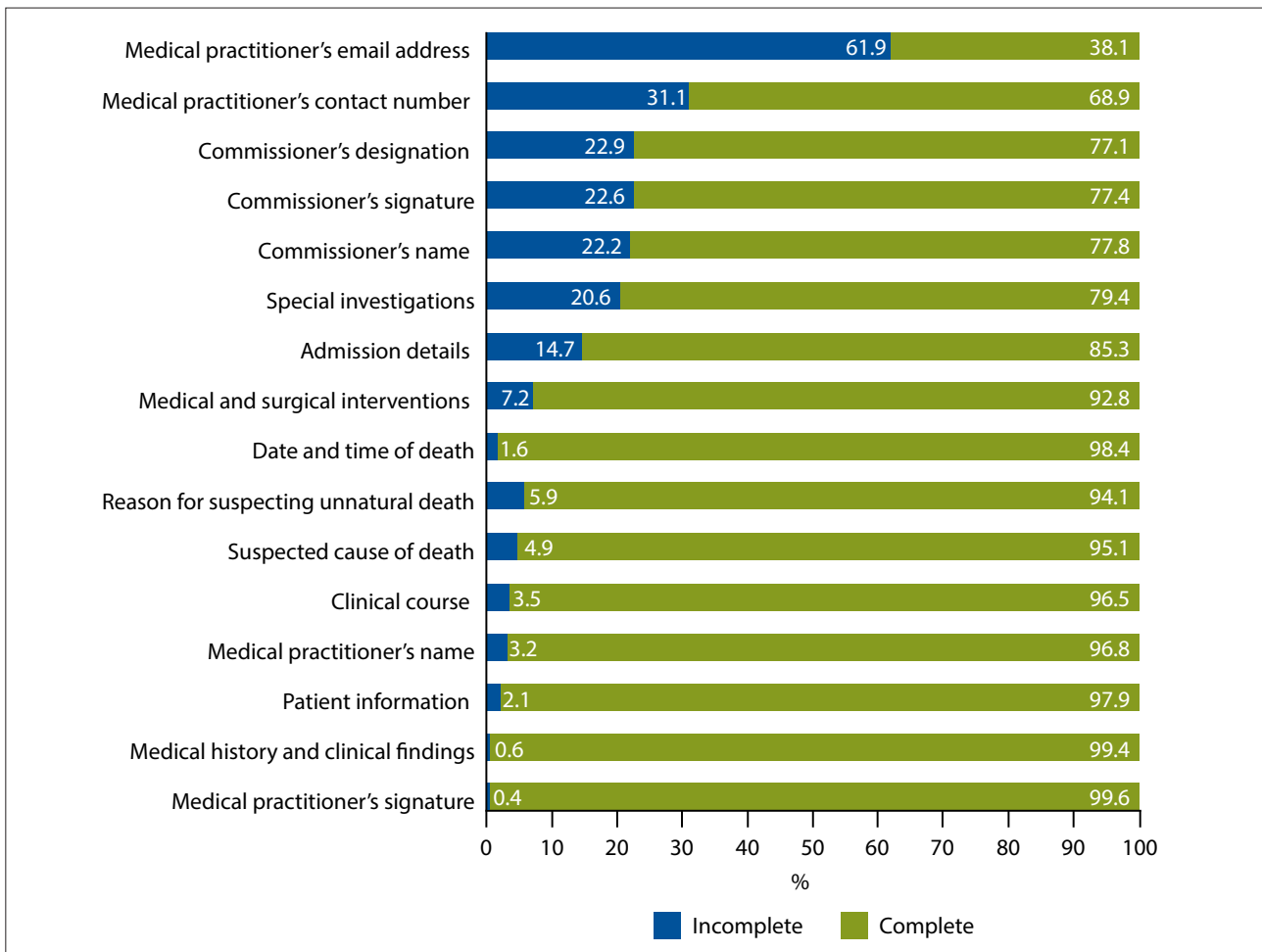


Fig. 3. Completeness of subsections of FPS100 referral forms (N=1 252).

state sector, which contradicts the literature reports that state-sector medical practitioners are reluctant to refer cases to FPS owing to a perceived lack of resources within the service.^[10] Referral completion varied by authorised medical practitioner designation; incomplete form submissions were more frequent among junior medical practitioners, predominantly in the state sector, with limited training or experience.^[10,22] This phenomenon is not surprising, as the state sector relies heavily on junior colleagues and trainees, such as interns and registrars, who make up the majority of the state-sector workforce.^[22,23] This shows that, although the law requires senior doctors to complete FPS100 forms,^[4,5] in practice, junior doctors often do so instead, pointing to poor awareness of the legislation.^[10,14,15]

In 5.9% of cases, the reason for suspecting an unnatural death was not provided, and 9.4% were deemed inappropriate referrals as they reported natural causes of death. Misclassification of the cause of death is well documented in SA,^[13,15] which is supported by the finding that 43.8% of referrals listed unacceptably formulated presumed causes of death.^[16] A significant association was found between medical practitioner designation and the formulation of the presumed cause-of-death acceptability. Medical officers and registrars more frequently reported unacceptable causes of death, frequently listing mechanisms of death, while specialists showed better formulation accuracy. This finding supports the literature, which suggests that medical practitioners feel underprepared to classify deaths appropriately.^[11] Additionally, if these inaccuracies are mirrored on death notification forms for natural deaths, the national

mortality data used by Statistics South Africa for health policy planning and preventive strategies will be undermined.^[11,13,14]

Through the implementation of quality assurance measures in FPS referrals, gaps between clinical disciplines and FPS might be bridged, fostering better co-operation and providing the opportunity for continued training. Although the literature reports that medical practitioners are open to training,^[10] communication is hampered by the absence of contact details of the referring medical practitioner on the FPS100 forms, such as email addresses and phone numbers. The use of outdated forms further impedes feedback, as relevant contact details are not requested.

To address these critical gaps, the referral process must be standardised and embedded in training for medical practitioners. An urgent need exists for increased awareness among medical practitioners regarding the forensic significance of FPS100 forms. Structured educational interventions, the inclusion of medicolegal training in medical curricula and providing structured feedback across hospital sectors are recommended to address these deficiencies. Strengthening the quality of FPS referrals and promoting the national standardisation of the FPS100 referral form as a template will enhance medicolegal documentation, promote uniformity across provinces and improve the accuracy of mortality data, forensic death investigations and legal outcomes in SA. Further research is recommended to explore the underlying causes of referral lapses, and the quality of information provided on referral forms, which may guide future reforms. Correlating the formulated presumed cause of death, as stated on the referral forms, with the information provided in hospital folders

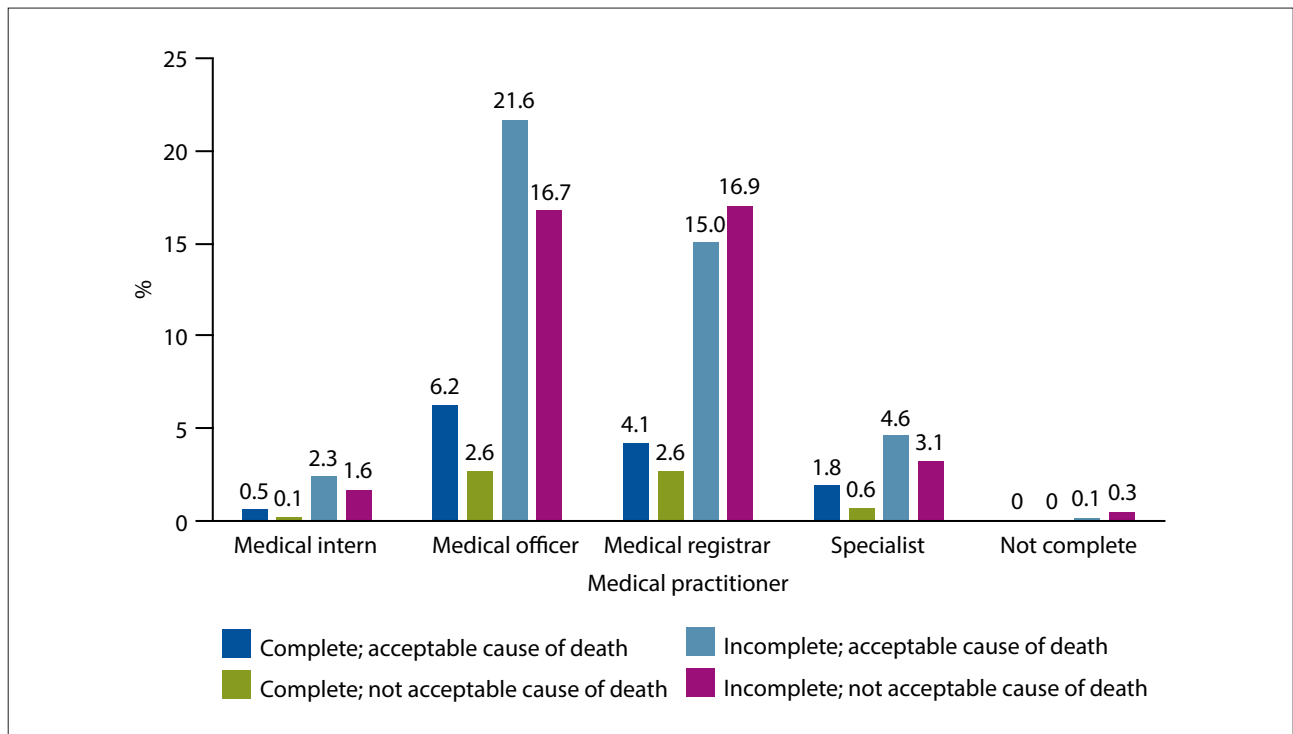


Fig. 4. FPS100 referral forms completed by different designated medical practitioners with or without an acceptable cause of death (N=1 252).

may also shed light on continued misclassified formulations of cause-of-death statements and inappropriate FPS referrals.

Study limitations

Limitations of this study include its restriction to a single FPS mortuary in the Eastern Metropole of the City of Cape Town, limiting the generalisability of these findings. The subjective nature of legibility assessment by a single reviewer is a limitation, as the potential for bias is introduced and reproducibility is hampered. Furthermore, the inclusion of the outdated forms used sheds light on the potential of the underlying systemic issues in the referral process. However, it is noted that, as the reasons for the use of outdated forms were not explored, our ability to contextualise this finding or to determine and address the potential underlying systemic or procedural issues is limited.

Overall, the findings reveal substantial deficiencies in FPS100 form completion. Poor use of referral tools may reflect fears of legal repercussions, deficiencies in training, or a lack of awareness among medical practitioners regarding FPS’s role and the law.^[10,14] Inaccurate or incomplete referrals jeopardise the medicolegal investigation, delay judicial proceedings, increase public health system costs and, most critically, fail to serve the deceased and their families’ best interests.^[7]

Conclusion

Analysis of 1 252 cases revealed significant deficiencies, where some referrals lacked the mandatory FPS100 form, which serves as an affidavit, while others were uncommissioned and therefore legally invalid. The failure to commission referrals, coupled with a general disregard for the legal requirements pertaining to FPS referral, may result in an increased likelihood of medical practitioners being subpoenaed to court, thereby exacerbating the already heightened fear of medical practitioners regarding judicial proceedings. Incomplete documentation was found to be widespread, with a significant number of referrals containing misclassified formulations of presumed causes of death, as guided by the WHO guidelines.

If these misclassifications are mirrored on death notification forms for natural deaths, mortality data will be greatly compromised. All these discrepancies have the potential to delay not only the FPS process but also the coupled legal and estate processes. The high volume of cases from tertiary state-sector healthcare settings, serving the majority of the SA population, likely contributes to some of these oversights, potentially impacting the efficiency, quality and reliability of medicolegal investigations. These findings highlight the need for improved training of medical practitioners across all levels of experience, emphasising the importance of high-quality referrals and their impact on the critical role of FPS in the medicolegal death investigation system.

Data availability. The data supporting the findings of this study are available from the corresponding author upon reasonable request. Anonymised and coded datasets can be shared; however, due to privacy and confidentiality constraints, the full dataset cannot be made publicly available. All requests will require a formal data use agreement.

Declaration. This article was submitted by SvdM in partial fulfilment of the MMed degree in the Division of Forensic Medicine, Stellenbosch University.

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Author contributions. SvdM conducted the study, reviewed the FPS100 referral forms accompanying hospital-referred cases to the FPS mortuary, analysed the data and drafted the manuscript. IM and JV supervised the study, approved the study design and assisted with the editing and review of the manuscript. NKMM provided critical feedback on the final draft prior to submission. All authors approved the final version of the manuscript.

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AI contribution. During the preparation of this manuscript, ChatGPT and Grammarly (v1.2.149.1641) were implemented by the authors to occasionally assist with the grammar, cohesion and clarity of the text. Mendeley Cite and Reference Manager version 2.108.0 were used to assist with generating citations, in-text referencing and the compilation of the reference list. After using all of these tools, all content was reviewed and edited by the authors as needed. The authors take full responsibility for the content of the final manuscript.

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