Under-reporting of deaths to the coroner by doctors: a two hospitals in Melbourne, Australia

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Citation Report

#	Article	IF	CITATIONS
1	Non-referral of unnatural deaths to coroners and non-reporting of unnatural deaths on death certificates in Taiwan: implications of using mortality data to monitor quality and safety in healthcare. International Journal for Quality in Health Care, 2008, 20, 200-205.	1.8	14
2	Forensic investigation of medical treatment related deaths. Legal Medicine, 2009, 11, S71-S75.	1.3	11
3	The impact of a clinical team assisting the Coroner's investigation of healthcare-related deaths: Reflections on six-years of service. Legal Medicine, 2010, 12, 28-34.	1.3	3
4	Impact of coronial investigations on manner and cause of death determinations in Australia, 2000–2007. Medical Journal of Australia, 2010, 192, 444-447.	1.7	19
5	The mortuary as a source of injury data: Progress towards a mortuary data guideline for fatal injury surveillance. International Journal of Injury Control and Safety Promotion, 2011, 18, 127-134.	2.0	6
6	Nonâ€reporting of reportable deaths to the coroner: when in doubt, report. Medical Journal of Australia, 2013, 199, 402-405.	1.7	19
7	Nature and Extent of Externalâ€Cause Deaths of Nursing Home Residents in Victoria, Australia. Journal of the American Geriatrics Society, 2015, 63, 954-962.	2.6	32
8	Necessity of including medico-legal autopsy data in epidemiological surveys of individuals with major trauma. Injury, 2015, 46, 1515-1519.	1.7	6
9	Comparison of the Victorian Audit of Surgical Mortality with coronial cause of death. ANZ Journal of Surgery, 2016, 86, 437-441.	0.7	2
10	Calling for advice: Aspects of telephonic consultation in post-mortem examinations. Journal of Clinical Forensic and Legal Medicine, 2017, 48, 55-60.	1.0	1
11	Incidence of fatal snake bite in Australia: A coronial based retrospective study (2000–2016). Toxicon, 2017, 131, 11-15.	1.6	22
12	Intensive care admissions due to poisoning. Acta Anaesthesiologica Scandinavica, 2017, 61, 1296-1304.	1.6	12
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14	What do clinicians understand about deaths reportable to the Coroner?. Journal of Clinical Forensic and Legal Medicine, 2017, 51, 76-80.	1.0	4
15	What do clinicians understand about deaths reportable to the coroner – Use of clinical scenarios to enhance learning. Journal of Clinical Forensic and Legal Medicine, 2018, 56, 37-41.	1.0	0
16	Drugs in fall versus non-fall accidents with major trauma – A population-based clinical and medico-legal autopsy study. Forensic Science International, 2019, 296, 80-84.	2.2	0
17	Deaths due to thermal injury from cigarette smoking in a 13â€year national cohort of nursing home residents. International Journal of Older People Nursing, 2019, 14, e12233.	1.3	5
18	Variations in death notification of nursing home residents to Australian Coroners. Injury Prevention, 2019, 25, 357-363.	2.4	O

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19	Using the WHO International Classification of patient safety framework to identify incident characteristics and contributing factors for medical or surgical complication deaths. Applied Ergonomics, 2020, 82, 102920.	3.1	7
20	Legal Frameworks: A Starting Point for Strengthening Medicolegal Death Investigation Systems and Improving Cause and Manner of Death Statistics in Civil Registration and Vital Statistics Systems. Academic Forensic Pathology, 2021, 11, 103-111.	0.3	0
21	Changes in fall-related mortality in older adults in Quebec, 1981–2009. Chronic Diseases and Injuries in Canada, 2013, 33, 226-235.	1.3	8
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