

Chapter Seven – Amendments to the Coroners Act 2003

'This isn't my fault. This has nothing to do with my surgery'

[attributed to Dr Patel during the second operation on Mr Kemps]¹

Medical non-reporting of deaths to the coroner

Unexpected deaths resulting from surgery at Bundaberg

- 7.1 As I have said in Chapter Three, Dr Woodruff identified 13 deaths of patients in which an unacceptable level of care, on the part of Dr Patel, contributed to the adverse outcome.² Ten of those deaths occurred within 30 days of surgery;³ a period which Dr Woodruff referred to as the peri-operative period.⁴ Six of the 13 deaths had terminal pathology but did not present in extremis.⁵
- 7.2 Twelve of the 13 deaths arose out of elective surgery in the sense used by the Australian Institute of Health and Welfare, and adopted by Queensland Health for funding purposes; namely, care that, even if necessary, in the opinion of the treating physician, could have been delayed for at least 24 hours without adverse consequences.⁶ Even in the one trauma case, the case of Mr Bramich, the patient did not, in the opinion of Dr Woodruff, present in extremis.⁷
- 7.3 Dr Woodruff said that Dr Patel's level of care in each of those cases fell short of the reasonable standard expected from a surgeon and that that level of care was a contributing cause to the deaths.⁸ Dr Woodruff said that treatment in seven or eight of them involved 'absolutely non-defendable processes'.⁹
- 7.4 There were a further four deaths of patients without terminal pathology in which Dr Woodruff said doctors, other than Dr Patel, had a significant

¹ T2206 line 15

² T4284 line 10-30, Exhibit 283 Statement Woodruff, Tables B3, C3, and D3

³ T4284 line 15

⁴ T4273 line 15, 55, 4284 line 15

⁵ Exhibit 283 Statement Woodruff, attachment PWHW3 Table B3

⁶ Exhibit 326 para 7 Statement Zanco

⁷ Exhibit 283 Statement Woodruff, attachment PWHW3 Table C3

⁸ T4284 line 20-25

⁹ T4282 line 55

contributing role and which were not caused by an iatrogenic process.¹⁰ There were also four deaths of patients without terminal pathology in which Dr Woodruff said that unacceptable care on the part of Dr Patel may have contributed to the outcome.¹¹

- 7.5 Dr de Lacy said any death resulting from elective surgery is a disaster¹² and very rare.¹³ The reason for this is understandable. There is ample time to assess the patient, arrive at a treatment path, and decide whether the local hospital has adequate supporting structures for the path envisaged.¹⁴

The failure to report the deaths to a coroner

- 7.6 Of the 13 patients in respect of which an unacceptable level of care on the part of Dr Patel contributed to the adverse outcome, only the trauma case of Mr Bramich¹⁵ and the case of Mr Nagle¹⁶ were initially reported to a coroner. The other 11 deaths together with the four deaths in which doctors other than Dr Patel had a contributing role and the further four deaths in which an unacceptable level of care on the part of Patel may have contributed to the outcome, each of which were elective surgery patients, were not reported, at least, not before investigation into Dr Patel, to a coroner. In the case of Mr Bramich which was reported, the report was made by Nurse Hoffman.¹⁷
- 7.7 It was not only Dr Patel who had a duty under the *Coroner's Act 2003* to report a reportable death of a patient upon whom he had operated. Under s7 of the Act, the duty to immediately report a death was imposed upon all who became aware of a death that appeared to be reportable and who did not reasonably believe that someone else had already reported or was reporting it.
- 7.8 At the Bundaberg Base Hospital and, perhaps, generally within Queensland Heath, there appeared to be no adequate system of audit or review of deaths to ensure there were no instances of misstatement or mis-diagnosis of deaths or whether treatment may have caused or contributed to any death. There were instances where particular deaths were reviewed, for example, the deaths of Mr Bramich and Mr Kemps,¹⁸ but these seemed limited and arose because of complaints about them.

¹⁰ Exhibit 283 Statement Woodruff, attachment PWHW3 Table B2; T4279 line 50

¹¹ Exhibit 283 Statement Woodruff, attachment PWHW3 Table C2

¹² T3602 line 50, 3603 line 5

¹³ T3602 line 50

¹⁴ T 3602 line 40 - 50

¹⁵ T1414 line 40

¹⁶ T3995 line 50

¹⁷ T1414 line 40, 1415 line 25

¹⁸ Chapter 3

Current reporting requirements for health procedure deaths

- 7.9 Whether a death enters the coronial system or not is dependant upon whether a doctor is able to issue a cause of death certificate without involving a coroner under s30(1) of the *Births Deaths and Marriages Registration Act* 2003. A doctor may do so if the doctor is 'able to form an opinion as to the probable cause of death'. By s26(5) of the *Coroner's Act* 2003, a cause of death certificate must not be issued if the death 'appears to the doctor to be a reportable death unless a coroner advises the doctor that the death is not a reportable death'. A coroner may do this if the coroner comes to the view that the death is not a reportable death and accepts that the doctor has sufficient basis for the proposed diagnosis.
- 7.10 As I have said, under s7 of the *Coroners Act* 2003, a person, who becomes aware of a death that appears to be a 'reportable death', and the person does not reasonably believe that someone else has already reported or is reporting the death, is obliged to immediately report the death.¹⁹ If the death is a death in custody, the report must be made to the State Coroner. Otherwise it is made to a coroner or a police officer who must, in turn, report it to a coroner.²⁰
- 7.11 A 'reportable death' is defined by s8 of the Act. By s8(1), a person's death is a reportable death only if the death is a death to which s8(2) and (3) both apply. The provisions of s8(2) are concerned with jurisdictional matters; the death must be connected with the state of Queensland.²¹ Section 8(3) provides for a list of circumstances where a death is a 'reportable death'.
- 7.12 Queensland is one of only two Australian jurisdictions that has a special category for deaths related to medical procedures, the other being the Australian Capital Territory.²² In Queensland, s8(3)(d) provides that a death is a 'reportable death' if 'the death was not reasonably expected to be the outcome of a health procedure'. A 'health procedure' is defined in Schedule 2 of the Act. It means 'a dental, medical, surgical or other health related procedure, including, for example, the administration of an anaesthetic, analgesic, sedative or other drug'.

Problems with current requirements

- 7.13 The current requirement under s8(3)(d) that a death be reported to a coroner if 'it was not reasonably expected to be the outcome of a health procedure', replaced an earlier requirement in the *Coroner's Act* 1958 to report deaths that

¹⁹ *Coroners Act* 2003, s7(1) and (2)

²⁰ s7 s (2) and (3)

²¹ ie the death happened in Queensland or, although it happened outside Queensland, the body is in Queensland, the person ordinarily lived in Queensland, person was on a journey to or from Queensland or the event that caused the death happened in Queensland

²² *Coroners Act* 1997 (ACT) ss13(1)(e), 77(1)

occurred while the deceased was 'under an anaesthetic in the course of a medical, surgical or dental operation'. The provisions removed the focus away from when the death occurred to why it occurred. The shift in focus, however, has brought with it a number of problems.

Dependent upon the integrity and care of a certifying doctor

- 7.14 First, the effectiveness of the system of reporting is dependant upon a doctor correctly identifying deaths which should be reported and then notifying a coroner of those deaths. This gives rise to the risk of concealment of medical error or neglect or, more seriously, as occurred in the case of Dr Shipman in the United Kingdom, crime or other wrongdoing by that doctor. As the Queensland State Coroner has pointed out,²³ the person best placed to make the assessment as to whether or not a death was a reasonably expected outcome from a health procedure, is the person who knows the most about the patient's condition leading up to death. However, he or she is also usually the person whose performance will be scrutinised if a Coroner investigates the death. He or she, therefore, might not be seen as sufficiently impartial to make an independent judgment of these issues.
- 7.15 Dr Patel has shown that it is easy for a doctor to avoid reporting a death to the Coroner and thus also to avoid any official inquiry into the death of a patient. There was evidence before the Commission of Dr Patel asking junior doctors to certify deaths. Indeed, there was evidence that it was the usual practice for the most junior doctor on the team to complete the death certificate.²⁴ It would take little for a dishonest doctor to try and persuade a junior doctor to certify a false cause of death so as to avoid it being reported to a coroner. It would be very hard for a junior doctor to withstand that sort of pressure. The risk also is that a dishonest doctor may seek to have another doctor less familiar with the case state a cause of death which is not true, and thereby avoid suspicion by others, including hospital administrators and family members.
- 7.16 In the case of the death of Mr Kemps, who died as a result of an oesophagectomy performed by Dr Patel in Bundaberg, the death certificate was completed by Dr Athanasiov, a junior doctor who was not making clinical decisions, whose role in the operation was not doing much more than holding the retractor and who was involved in his first oesophagectomy.²⁵ The unexpected nature of Mr Kemps' death was evident from the agitation and repeated protestations by Dr Patel during the second operation on Mr Kemps that the bleeding which could not be stemmed had nothing to do with the

²³ para 10 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

²⁴ Athanasiov T2066 line 5, 2067 line 20; Kariyawasam T3091 line 45

²⁵ Athanasiov T2066 line 10 – 15

oesophagectomy he had performed earlier that morning.²⁶ Dr Athanasiov said he discussed the cause of death with Dr Patel. Dr Patel told him what the cause of death was and then he filled in the gaps.²⁷ He said that he had earlier been concerned enough to ring the coroner's office after the operation to clarify the requirements for reporting a death.²⁸ He said he was told that if the cause of death was known or if it was an expected outcome of surgery, then no report to the coroner was required.²⁹ The first limb of this advice, if it was given as Dr Athanasiov said, of course, was erroneous. But, in any event, Dr Athanasiov said that when he told Dr Patel this, Dr Patel explained that he knew what the cause of death was; it was a thoracic aortic bleed. Dr Patel said that, because Mr Kemps had previously had problems with his aorta having had an abdominal aortic aneurysm repaired, the aneurysm must have started bleeding higher up in the lower thorax area.³⁰ Dr Kariyawasam who was also present said Dr Patel had said that, because he knew the cause of the bleeding, the case did not need to be reported to a coroner.³¹ Dr Athanasiov³² and Dr Kariyawasam³³ both said it would be better if the person doing the operation was responsible for signing the death certificate.

- 7.17 There are other indications in Australia, aside from Dr Patel, that doctors may not be reporting all cases of reportable deaths. The Victorian Parliament Law Reform Committee in its recent Discussion Paper relating to reform of the Victorian *Coroners Act 1985*³⁴ cites a study involving doctors practicing in non-metropolitan Victoria including Resident Medical Officers, hospital doctors, specialist physicians, surgeons and general practitioners which found 27 percent of certificates inaccurately represented the cause of death, with a higher inaccuracy rate of 51 percent for Resident Medical Officers. It also found that 20 percent of doctors involved in the survey would be prepared to alter certificates to avoid the involvement of the coroner. The Committee noted that this figure was consistent with a study in the United Kingdom which found that 17.2 percent of general practitioners who were surveyed would alter certificates to avoid referral to the coroner.³⁵

²⁶ T2206 (Ms Law); Exhibit 160 para 15

²⁷ Athanasiov T2066 line 20

²⁸ T2064 line 40

²⁹ T2064 line 45

³⁰ T2065 line 40

³¹ T3090 line 20 - 60

³² T2067 line 5, 30

³³ T3091 line 20

³⁴ p25 Victorian Parliament Law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 available at <http://www.parliament.vic.gov.au/lawreform/coroner>

³⁵ Also Ranson D *How Effective? How Efficient? The Coroner's Role in Medical Treatment related Deaths* (1983)23 *Alternative Law Journal* 284 and other studies cited by Victorian Law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 note 90

Ambiguous

7.18 Secondly, the meaning of 'reasonably expected' is unclear. It is unclear on whose expectation and to what standard the outcome must have been unreasonable. Is it the person in the street, the family or relatives of the deceased, the general practitioner, the specialist practitioner, a coroner, or some other body? The view taken by the author of the State Coroner's Guidelines, probably correctly, is that it means an independent medically qualified person apprised of all the circumstances of the case.³⁶ However, even within that class, there are varying degrees of medical qualification and independence.

Complexity of issues of causation

7.19 Thirdly, a determination as to whether the outcome was 'reasonably expected' involves complex issues of causation. The language leaves open a significant degree of difference of opinion and debate about whether or not the health procedure was the cause of the death, rather than the underlying condition that made it necessary. Often there is a coincidence of factors.

7.20 The *State Coroner's Guidelines* suggest that in determining whether a death is reportable under this provision, coroners should, in consultation where necessary with an independent medical practitioner (eg a pathologist skilled in coroner's autopsies), consider the following questions:³⁷

- i. 'Did the health procedure cause the death?
- ii. Would the person have died at about the same time if the procedure was not undertaken?
- iii. Was the procedure necessary for the patient's recovery, rather than optional or elective?
- iv. Did the death result directly from the underlying ailment, disease or injury?
- v. Was the procedure carried out with all reasonable skill and care?

If 'yes' to all – the procedure didn't cause the death

- i. Was the death an unexpected outcome?
- ii. Was the condition of the patient such that death was foreseen as more likely than not to result from the procedure in question?
- iii. Was the decision to undertake the procedure anyway, a reasonable one in the circumstances having regard to the patient's condition including his/her quality of life if the procedure was not carried out?

³⁶ *State Coroner's Guidelines* 2003 p3.9 available at <http://www.justice.qld.gov.au/courts/pdfs/guidelines.pdf>

³⁷ *State Coroner's Guidelines* 2003 p3.9

- iv. Was the decision to undertake the procedure based upon the assessment that the risk of death was outweighed by the potential benefits the procedure could provide?
- v. Was the procedure carried out with all reasonable care and skill?

If yes to all – death was not an unexpected outcome.’

Whether a pathologist skilled in autopsies is the correct standard against which reasonableness should be adjudged highlights the uncertainty I referred to earlier. But leaving that aside, these questions, which are relevantly formulated, are not easily answered. They involve difficult issues of causation. In many cases, the answer will permit many differing opinions and views from differing persons and from differing standpoints. In discussions with doctors, the State Coroner also has suggested doctors determine whether a medical practitioner familiar with the condition of the patient before the procedure that led to the death would feel obliged to warn the patient or his or her family that there was a real and substantial risk of death rather than the ordinary risk that accompanies the procedure.³⁸ However, in my view, this still allows too much latitude for differing views.

Anomaly of independent cause

- 7.21 There is also the anomaly that the circumstance may arise where the risks of a particular health procedure are so high that death is an expected outcome but not in the particular manner in which it subsequently occurs. For example, an elderly patient with a delicate heart may have such high risks associated with anaesthetic that the probability of death is so high as to be an expected outcome but, because the procedure is potentially lifesaving, the risks are taken. In that case, the death of the patient may not be reportable even though he or she dies as a result of something other than the anaesthetic, such as blood loss or falling off the operating table.

Degree of certainty

- 7.22 Finally, the Act does not give an indication of the degree of certainty required for a determination that a death was not reasonably expected. The question that arises is when does the possibility of death reach a high enough degree as to become expected. Some assessment systems may enable outcomes to be expressed in terms of a percentage. But at what percentage does a death become reasonably expected: 10%, 25%, 50% or more? As Dr Kariyawasam

³⁸ para 5 Submission Michael Barnes State Coroner 14 October 2005 (Final Submission Vol No2)

said,³⁹ any operation that involved general anaesthetic may involve the possibility of death.

Lack of audit

7.23 These problems are exacerbated by the lack of any check on the truth or accuracy of a certification once a doctor has certified the cause of death. As I have said, no system of auditing those cases where a doctor certifies the cause of death, and does not report the death to the Coroner, so far as I am aware, exists.

7.24 The relatives of the deceased person may agitate the possibility of a report to the Coroner, or the possibility of an autopsy. However, it would be understandable if families were inclined to avoid such processes because of the possibility of a disrupted burial and the trauma associated with an autopsy.

The experience elsewhere

7.25 The problems have been considered elsewhere. Recently, they were considered by a number of Commissions of Inquiry in the United Kingdom brought about by the murder conviction of Dr Harold Shipman a family general practitioner, who as part of his practice made house calls to his elderly patients. They have also recently been the subject of consideration by the Victorian Parliament Law Reform Committee.

7.26 In the public inquiry known as the Shipman Inquiry into how Dr Shipman, remained undetected by the United Kingdom authorities in the mass murder of 215 of his patients over 20 years, Dame Janet Smith, in her 3rd Report,⁴⁰ proposed a number of changes to the English systems of medical certification of death, and investigation by the Coroner's Service. She found that the English procedures, because they were dependent upon the integrity and judgment of a single medical practitioner, failed to protect the public from the risk that, in certifying a death without reporting it to the Coroner, a doctor might successfully conceal homicide, medical error or neglect leading to death.⁴¹ She recommended that, in recognition of the difficulty of determining, or of effectively separating unexpected deaths that warranted some investigation from expected deaths, all deaths should be reported to the Coroner, and that the Coroner would be responsible for certifying all deaths.⁴² She recommended that there should be both medical coroners and judicial

³⁹ T3090 line 5

⁴⁰ United Kingdom, *Death Certification and the Investigation of Death by Coroners* (Cm 5854, 2003) (known as the Shipman Inquiry's 3rd Report) available at: <http://www.the-shipman-inquiry.org.uk/reports.asp>

⁴¹ pp3, 118-9 Shipman Inquiry 3rd Report;

⁴² pp 27, 129, 502-7 Shipman Inquiry 3rd Report

coroners to scrutinise the cause of the death.⁴³ Doctors could express an opinion only as to the cause of death.⁴⁴ Dame Janet Smith referred to the research which had shown that some doctors were willing to modify what they believe to be the true cause of death in order to avoid a report to the coroner⁴⁵ and that even when making a proper effort to reach the right decision, doctors failed to do so in an unacceptably high proportion of cases.⁴⁶

- 7.27 In an allied review⁴⁷ into death certification and the Coroner's Service in England, Wales and Northern Ireland conducted by Mr Tom Luce, the same problem was canvassed. The Luce Report found that there was no reliable mechanism to check that the deaths which should be investigated by the Coroner are reported to him.⁴⁸ Mr Luce recommended that all deaths be subject to a second certification by a doctor, who has not been involved in the treatment of the deceased,⁴⁹ and the creation of a new post in the Coroner's office filled by a doctor, who would audit deaths certificates relating to deaths, not reported to a Coroner, to ensure the criteria for reporting deaths were being observed.⁵⁰
- 7.28 In 2004, in response, the Home Office published a Discussion Paper⁵¹ which has proposed the implementation of a system similar to the Luce recommendations except that it has recommended that the second certifier be attached to the Coroner service so that every death was examined and not just those reported. To my knowledge, no legislation or draft bill on the reforms has yet been enacted or introduced.
- 7.29 In April 2005, the Victorian Parliament Law Reform Committee published a Discussion Paper⁵² inviting comments and submissions about matters which could inform its recommendations for amendment of the Victorian *Coroners Act* 1985 including the death certification system. The options it is considering are those recommended in the Shipman and Luce inquiries and the United Kingdom Home Office discussion paper.⁵³ It noted the opinion of the Director of the Victorian Institute of Forensic Medicine that the certification system in Victoria, which is similar to that in Queensland in that it relies wholly upon the

⁴³ pp 25, 490-2 Shipman Inquiry 3rd Report

⁴⁴ pp 27, 499 Shipman Inquiry 3rd Report

⁴⁵ pp121-2 Shipman Inquiry 3rd Report

⁴⁶ pp 123-5 Shipman Inquiry 3rd Report

⁴⁷ United Kingdom, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review* (Cm 5831, 2003) (known as the Luce report) available at: <http://www.archive2.official-documents.co.uk/document/cm58/5831/5831.htm>

⁴⁸ p 16 Luce Report

⁴⁹ p 221 Luce Report

⁵⁰ p 220 Luce Report

⁵¹ United Kingdom, *Reforming the Coroner and Death Certification Service* (Cm 6159, 2004)

⁵² Victorian Parliament law Reform Committee *Coroner's Act 1985 Discussion Paper* April 2005 available at <http://www.parliament.vic.gov.au/lawreform/coroner>

⁵³ pp xv, 31-2

integrity of the certifying doctor, would not have detected the Shipman killings.⁵⁴

Proposals for change

Need for reform

7.30 In my view, the present position under s8(3)(d) of the *Coroner's Act* 2003 whereby, in effect, a single medical practitioners decides whether a death, particularly one arising from elective surgery in a public hospital, was a reasonably expected outcome of a health procedure, is in need of amendment. Obviously, deaths which are, or might be caused or contributed to by medical error or neglect, should be investigated by a coroner and, as Dr Patel has shown, at present the reporting of such deaths may be able to be avoided.

Options for reform

7.31 The advantage of the operation of s8(3)(d) of the Act, no doubt, is that it is speedy, cheap and convenient. The completion of the relevant certificate can occur quickly. To the extent possible, any proposed changes should strive to minimise affecting this feature. But that feature also gives rise to the main disadvantage; its dependency upon the integrity and honesty of a single medical practitioner for a determination as to whether that death should be reported to the Coroner.

7.32 If reforms to s8(3)(d) are to be proposed, they sensibly should deal not only with respect to deaths resulting in hospitals, but also more broadly with deaths resulting from health procedures generally. As the State Coroner points out,⁵⁵ the potential for apparent conflict of interest is not limited to post operative hospital deaths. It exists also in the case of general practitioners or other health service professionals treating patients in their surgeries or patients' homes. Reforms need to be broad enough and robust enough to capture all cases of medical errors, neglect and misconduct leading to death by health service practitioners.

7.33 There are a number of options for reform. The most obvious are to adopt the recommendations, or variations of the recommendations of each of the Shipman Inquiry, Luce Inquiry or the United Kingdom Home Office in its position paper. Essentially these options, which are the ones being considered by the Victorian Parliament Law Reform Committee, are as follows:

⁵⁴ p 31

⁵⁵ para 11 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

- (a) (the Shipman Inquiry) to require all deaths resulting from a health procedure to be reported to a coroner so that the certification as to the cause of death or, alternatively, at least a certification audit and any decision about which deaths should be investigated is determined by a coroner. The health practitioner's involvement would be effectively limited to providing a medical opinion on the cause of death;
- (b) (the Luce Inquiry) to require a second health practitioner, preferably a more senior practitioner in the line of management or of equal standing also to certify the cause of death and to continue to require a coroner to be notified only of reportable deaths as presently defined;
- (c) (United Kingdom Home Office) to require that the cause of death be certified by two doctors but have the second doctor attached to the coroner's office. This would ensure impartiality and allows the coroner's office to scrutinise all deaths.

7.34 My main concern about option (a), the Shipman Inquiry option, is that the State Coroner and other coroners in Queensland would require substantial support and resources to enable such an extensive certification and/or examination process to occur. The consequence of requiring the reporting of deaths without the early certification by a doctor that it was not an unreasonably expected outcome is that it would be necessary to ensure that the State Coroner, and other coroners, throughout the State are able to determine such questions promptly.

7.35 The submission of the State Coroner⁵⁶ reveals that there are already deficiencies in the extent to which the State Coroner is able to appropriately investigate medical deaths. The difficulty is that a determination as to whether or not a reportable death should be extensively investigated needs to be made with the assistance and input of a doctor. At present, a doctor who seeks the authorisation of a Coroner to issue a cause of death certificate in relation to a reportable death must complete a form that requires the doctor to provide information about the circumstances of death, and to submit a draft cause of death certificate for the consideration of the Coroner. However, the difficulty pointed out to me by the State Coroner⁵⁷ is that he or she must rely upon the advice of the treating health practitioners that nothing untoward occurred, and that no aspects of death warrant investigation. He seeks to augment that advice by discussing questionable cases with one of the forensic pathologists from the John Tonge Centre. Even at present, therefore, there is a need for the State Coroner and other coroners to have a dedicated medical officer to review medical charts and to assist in determining whether a cause of death

⁵⁶ paras 25 – 33, Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁵⁷ para 23, Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

certificate should be issued without further investigation of the death. If it were to be the case that all deaths were referred to a coroner, the need for such assistance would be substantially greater. The time constraints of this Inquiry have not enabled me to examine closely the full requirements and ramifications of such a change to the system. Presently, in any event, I am not convinced such a dramatic change is necessary.

- 7.36 The difficulty I see with option (b), the Luce Inquiry option, is that, although the risk of dependence is lessened, it is not, in my view, sufficiently removed. The opportunity will still exist for a dishonest health practitioner to seek co-signature of a dishonest or careless colleague. The proposal by the Luce Inquiry that the second certifier only be persons approved by the coroner service will not eliminate this opportunity merely because of the magnitude of numbers of second certifications required. Health practitioners in remote locations also may experience difficulty obtaining a co-signatory, particularly of another medical practitioner whose impartiality can be seen to exist. In the case of public hospitals, it would not be sufficient, in my view, to require that deaths be co-certified by the medical superintendent. The evidence before this Commission is that most of these persons are no longer practicing clinicians. Moreover, in the case where a patient has been under the care of a specialist consultant, the Medical Superintendent usually will not have sufficient specialist skill or knowledge to act adequately as a safeguard against a rogue specialist.

Preferred option for reform

- 7.37 An elective procedure in a public hospital by its definition and nature is surgery from which a death is not an expected outcome. As I have stated, by definition, the scope of procedures that constitute elective surgery is surgery which can be delayed for a period of at least 24 hours. I see no reason why, in the provision of any other health service, any other health procedure which could be delayed for a period of 24 hours, also would not by its nature be a procedure from which death would be a reasonably expected outcome.
- 7.38 In my view, the intent of the s8(3)(d) would be better achieved and the mischief to which I have referred overcome simply by including within the meaning of a reportable death, an additional category being a death that happens within a certain time of an elective procedure. The requirement that all deaths happening within a certain period of time following an elective health procedure are reportable, removes the dependence presently placed upon a single doctor to decide whether a death was reasonably expected. At the same time, it should not overburden the State Coroner's office with the responsibility of investigating all deaths arising from a medical procedure. Trauma deaths would remain subject to the existing provisions.

- 7.39 Dr Woodruff described a 30 day period, the perioperative period, as an accepted yardstick of surgical performance⁵⁸ and, perhaps, this could be a reasonable period to adopt. Alternatively, a shorter period may also be appropriate. Further medical input may need to be sought about the length of such a time period.
- 7.40 The Australian Capital Territory has a special category of reportable deaths being where a person dies during or within 72 hours after or as a result of an operation of a medical, surgical, dental or like nature or an invasive medical or diagnostic procedure other than an operation or procedure that is specified in the regulation to be an operation or procedure to which the requirement does not apply.⁵⁹
- 7.41 For present purposes, I will adopt the period referred to by Dr Woodruff and recommend amendment to s8 by adding a new subparagraph, after subparagraph (d) to read:
- ‘The death happened within 30 days of an elective health procedure’.
- And by adding a new definition in Schedule 2, to read:
- ‘Elective Health Procedure’ means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome.
- 7.42 The health practitioner responsible for the care of the patient should still be obliged to provide a medical opinion on the cause of death, if possible. However, the final certification of the patient’s death would be determined by a coroner thereby removing the risk of concealment of medical error or neglect or misconduct by a doctor in certifying the cause of death. Obviously, there would be a need to ensure that the Office of the State Coroner and other coroners is adequately equipped and resourced to discharge the responsibility of investigating and determining the cause of such deaths. However, the burden will be not as great as it would be if all deaths were referred to a coroner.

Need for expert support

- 7.43 I am informed that a need already exists for the State Coroner and other coroners to have a dedicated medical officer to review medical charts and to assist in determining whether a cause of death certificate should be issued without further investigation of the death.⁶⁰ In my view, such a position should be provided.

⁵⁸ T4273 line 10

⁵⁹ *Coroner’s Act* 1997 (ACT), ss13(1)(e), 77(1)

⁶⁰ para 24 Submission Michael Barnes State Coroner 14 October 2005: (Final Submissions Volume 1, No 2)

- 7.44 Additionally, in my view, a need will exist for a coroner to have more specialised assistance available. The investigation of deaths in a medical setting, as I have said, involves particularly complex and challenging issues. I am informed that when a death occurs in other unusual settings, coroners already have available to them persons from specialised investigative bodies: for example, inspectors from the Department of Natural Resources and Mines in relation to mining deaths; officers from Maritime Safety Queensland in relation to boating accidents; and officers from the Australian Transport Safety Bureau in relation to aircraft accidents.⁶¹ By contrast, I am informed that most coronial investigations in the medical setting are undertaken by police officers, who have a reasonable level of expertise in investigating matters such as suicides, motor vehicle accidents, homicides and many other matters that frequently come before a coroner, but who do not have medical expertise.⁶² I am further informed that hospitals frequently fail to co-operate with police investigators. The State Coroner receives complaints from police and local coroners that doctors and nurses will not provide statements despite repeated requests, and on occasions, police have to resort to search warrants to obtain medical files.⁶³
- 7.45 The State Coroner informs me⁶⁴ that currently he has arrangements in place with the Chief Health Officer, whereby coroners who need access to independent expert medical opinions can approach the Chief Health Officer to have him nominate an expert. However, those experts can only be provided with medical reports and the self serving statements clinicians may have provided. There is no system in place, I am told,⁶⁵ for experts to take a more proactive role such as for example interviewing witnesses. On occasions, the State Coroner has received reports of investigations undertaken by senior clinicians appointed to act as investigators under the *Health Services Act 1991* and these have been very useful.
- 7.46 In my view, the State Coroner should, in addition to current arrangements, and those which I have already proposed, have access to a specialised panel of trained persons in various health service disciplines, appointed from either the public or private sector, who would be prepared to consult and provide assistance on an hourly or part time basis in relation to what deaths resulting from an elective health procedure might requiring investigation, what investigative steps might be appropriate and what, if any further independent experts might needed to provide an opinion in the matter. Members of the panel should be given the powers necessary to enable effective investigation,

⁶¹ para 26 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶² para 26 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶³ para 27 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁴ para 31 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁵ para 31 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

including, for example, if considered necessary, the power to require prospective witnesses to answer questions or attend for interview.

7.47 I am informed⁶⁶ that the Victorian State Coroner has such system in place. Under the Victorian system all deaths are initially reviewed by a multi-disciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that the advice of this clinical liaison team is that a particular death should be investigated, the team then advises what investigative steps are appropriate, and what independent experts might need to provide an opinion in the matter. This information is then used by those persons involved in the investigation, including police officers.

7.48 The State Coroner has drawn my attention⁶⁷ to a recommendation which he has made at the conclusion of a recent inquest, that the Chief Health Officer develop, with the State Coroner's assistance, a policy and process for the independent expert investigation of all deaths that are not reasonably expected to be an outcome of a health procedure. He also recommended that the reports of such investigations should be made available to the coroner, and the family of the patient, as soon as possible. Given the recommendations I propose, an independent investigation and report in respect of deaths resulting from elective health procedure deaths and occurring within 30 days should not be essential. Such a report, however, would be most helpful to a coroner and to the auditing processes of a hospital. Other reportable deaths also may still arise within a hospital, including under the current category of a reasonably unexpected death. In those cases the recommendation of the State Coroner remains apt.

Certification by junior doctors

7.49 The anomalous practice highlighted by the evidence of Dr Patel getting the most junior doctor in the operating theatre to sign a death certificate should be addressed. Sensibly, in my view, the person responsible for the care of the patient or in charge of the relevant health procedure should be responsible for signing a death certificate and certifying to the appropriate authority, that the circumstances of the death do not require further investigation.

Recommendations

7.50 I make the following recommendations:

- (a) The *Coroners Act* 2003 be amended by:

⁶⁶ para 33 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

⁶⁷ para 32 Submission Michael Barnes State Coroner 14 October 2005 (Final Submissions Volume 1, No 2)

- (i) adding a new subparagraph to s8(3) after subparagraph (d) to read:
'The death happened within 30 days of an elective health procedure'.
- (ii) adding a new definition in Schedule 2, to read:
'Elective Health Procedure' means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome.'

The 30 day time period specified in my proposed amendment may need to be the subject of further medical input.

- (b) The *Births Deaths and Marriages Registration Act 2003* be amended to ensure that:
 - (i) in the event of a death happening within 30 days of an elective health procedure, the health practitioner in charge of the procedure is obliged to provide to the coroner his opinion on the cause of death;
 - (ii) all deaths otherwise occurring in public hospitals are certified by the health practitioner responsible for the care of the deceased person;
- (c) A dedicated medical officer be appointed to the State Coroner's office to assist in determining whether deaths happening within the stipulated period of an elective health procedure are required to be further investigated and to assist in the conduct of that investigation;
- (d) A panel of specialised persons trained in the various health service disciplines be appointed, and given such powers as are considered necessary, to enable coroners to consult with and receive assistance from such persons, on an hourly or part time basis, for the purposes of determining whether deaths happening within the stipulated period of an elective health procedure should be investigated and for the purposes of conducting that investigation;
- (e) A process of auditing compliance with the reporting obligation be undertaken at all public hospitals;
- (f) Queensland Health put in place a policy to ensure investigation is undertaken in relation to each death that occurs in a facility operated by them, and that a report of that investigation be provided to the coroner and the family of the deceased;
- (g) Continuing training be provided to all doctors to ensure that they remain aware of their obligations to report.