

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Ms H. Trihas, Registrar, Registry of Births, Deaths and Marriages; and

Ms P. Digby, Executive Director, Local Government Victoria and Community Information Division,
Department for Victorian Communities.

The CHAIR — I welcome to this parliamentary Law Reform Committee inquiry into coronial services the Registrar of the registry of births, deaths and marriages, Helen Trihas, and Prue Digby, the executive director of Local Government Victoria and the community information division of the Department for Victorian Communities.

Just so you are aware, this is a public hearing. We take evidence in public hearings under the Parliamentary Committees Act, which means it is subject to parliamentary privilege. As it is a public hearing, there is a presumption that your evidence will be on the public record. However, if you want to provide any evidence in camera, you can nominate that as we go through. After the hearing you will get a proof copy of the report of what you have said and you will have an opportunity to correct any factual errors. After that it goes on our public web site and is available as a public submission to the inquiry. If you would like to talk to us first, Helen, we will then ask some questions.

Ms TRIHAS — Thank you. I did not come prepared to do anything other than answer the questions, so I suppose I should give a little overview of the registry of births, deaths and marriages and its responsibilities.

The CHAIR — That would be helpful.

Ms TRIHAS — And offer an open invitation for the committee to come down and see how the registry operates. I think it is much different to any of the readings you might have done from registries overseas. We probably do have a leading system in its capacity and the technology of our proprietary system, which we call LifeData, is quite unique. I think it would probably fill in the front-end gaps of the information you may have been reading. I hope that once you see the system it will assist in the understanding.

The registry is responsible through the Births, Deaths and Marriages Registration Act 1996 (the Act) to keep registers for recording in perpetuity life events in Victoria. Until recently we looked at those as registering events. We have actually looked at these in a much different way in recent years, we have looked at them as significant life events of Victorians. As a result of that we have probably adjusted some of our operations and our administration of the Act accordingly, with some benefit to the people we actually deal with, because it is very easy to administer an Act in a black-and-white sense until you actually come face to face with the individuals who are responsible for those events.

This is across the board, from our marriage registry, which is just up the road at the Old Treasury building these days, to the death registration process, in which we now offer quite a follow-up with individuals, the next of kin and family members, to provide a facility for them to call and speak to us if necessary — those people are dealing with funeral directors in most instances and the information we receive is usually third hand. Those are a couple of things we have changed in that area recently.

There is also the improved relationship we have with the coroners office these days. In the past — and I have only been Registrar for three and a half years — I do not think there was a great deal of consultation or stakeholder engagement across the different areas of the business. That has been quite beneficial for us, and we have seen quite a number of improvements in the way we administer the Act. In the birth registration area we administer approximately 65 000 births a year. We have approximately 32 000 deaths a year. We have about 25 000 marriages. All in all that amounts to over 300 000 certificates that we issue on an annual basis. That includes those for identity purposes or for the family history component of our business. It is quite a busy operation.

The focus for the registry over the last three years has seen us move more into identity management quite strongly. Where most organisations which are in the identity management framework are requiring cardinal documents of identity, births, deaths and marriages has been recognised as having those documents that people are using for passport purposes or for licences et cetera, so at the moment we are quite inundated with the increased demand as a result of that. It is important to us that we keep the register as accurate as possible and that we provide access as appropriate, which is to the individual that the data relates to. Our business has changed quite considerably in that area, and our access policies are currently being reviewed to accommodate that.

I think that is a quick snapshot of what the registry does at the moment and where its focus is at. Would you like me to address the questions that you put forward?

The CHAIR — Sure. Perhaps just indicate the question you are answering because you may not be answering all of them. It will help us in looking back over the discussion papers if you could indicate the ones you are responding to.

Ms TRIHAS — They were actually questions that you have provided me with.

The CHAIR — I apologise. They are a different set of questions. Please go ahead.

Ms TRIHAS — The death certification process — I think you referred to it as sifting and surveillance in question 1, and that is okay; I think that was a term used by the coroners office in describing what we do. On a daily basis we receive the medical certificates for cause of death, which I will refer to throughout this inquiry as just the medical certificates. They are the first documents that we receive from the doctor. We administer those by checking them to make sure they are readable and complete — some doctors' handwriting can be a bit difficult, as you can appreciate.

The CHAIR — Yes, illegible handwriting seems to be a necessary qualification for the job of doctor, doesn't it?

Ms TRIHAS — Yes — but it does not appear to be reportable. There are certain things like falls, fractures and so forth — agreed terms and descriptions, I guess, that we have discussed with the coroners office — that we will instantly assess as possibly being reportable, depending on where they sit in the cause of death. That is done daily; that is part of the assessment of the medical certificate. Upon its receipt it is entered into our system; it is given a number — usually the registration number — to sit in our system. If it is complete and it is not reportable, it sits there until the registration statement is received, and that will come from the funeral director. The two are married; the information is quality assured to make sure it is accurate. Upon receipt of all the information, if we do not need to go back to the next-of-kin or to the informant, we will issue the certificate to the next-of-kin for administration purposes.

Mr MAUGHAN — Who does that original assessment when the document comes in? Is it a clerk?

Ms TRIHAS — It is a clerk, yes. There are four people in that area, plus a manager, and it is part of their daily duties.

The CHAIR — In terms of the information collected — you mentioned fractures or falls — what other information would be provided to you with a request for a death certificate?

Ms TRIHAS — Have you ever seen a medical certificate?

The CHAIR — No.

Ms TRIHAS — I will hand these up to you. I have also brought a sample of what we would classify. Obviously I cannot leave them with you because they contain identity and cause-of-death details.

The CHAIR — So everyone has to fill out one of these to get a death certificate?

Ms TRIHAS — That is filled in by the doctor. It is then assessed.

Mr MAUGHAN — Does the clerk have the necessary skills to look at a doctor's certificate and say The doctor has written 'heart failure' but there might be some predisposing things that we need to look at. I am not being at all critical of a clerk, but I am just wondering if they have the necessary skills to determine that that is not actually the prime cause of death; it is the end cause but there is something earlier than that perhaps we need to look at.

Ms TRIHAS — Most of the officers who work in the death registration area have a longstanding history with the registry and have worked across all areas of the business. Particularly our most experienced people are in the death registration area. In addition to that, in the last 12 months we have also outfitted them with some specific training in medical terminology, which was a 12-week training program. In addition, we also give information sessions with the coroners office and update them regularly as the information is obtained from the coroners and VIFM, when we hold the information sessions. They are not medical practitioners.

Mr DALLA-RIVA — Sorry, what was that?

The CHAIR — It was a private conversation.

Ms TRIHAS — Prue's question to me was, 'Do they assess the cause of death?'.

Ms DIGBY — I was just asking her to see if that was a relevant piece of information to give you.

Mr DALLA-RIVA — Are you a lawyer?

Ms DIGBY — No, I am responsible for births, deaths and marriages. I am deputy secretary of the Department for Victorian Communities.

Mr DALLA-RIVA — I am sorry; we have had so many people here with their lawyers. It thought you were another one.

Ms TRIHAS — Looking at the ones I that have been filled out, it is usually the disease or condition that directly led to the death. I will not even try to move into the medical terminology, but if, for instance, that suggested there was a stroke, and then in the next category of (b), (c) or (d) it might have said it was a fall, we would rate that as a reportable death, because where there is a fall it is not clear to us whether the fall was the cause of the stroke or the stroke was the cause of the fall. That would usually be the way we would assess these. Where it is not clear we would, in the first instance, move to consult with the coroners office.

The CHAIR — What sort of training do the staff who do the assessments get so that they can pick up cases where the doctor has said, 'I do not believe this is a reportable death within the meaning of the act', but it may well be that it could be?

Ms TRIHAS — If there is any element of doubt, the staff member will either refer it to the manager or we will call the coroners office to eliminate that doubt.

Ms BEATTIE — If a lot of elderly patients had died under the care of one doctor, as with the Shipman case in England, would your system of registering deaths flag it in any particular way?

Ms TRIHAS — The system has the capacity to be developed to make those interrogations. It could be developed to do that.

Ms BEATTIE — But it does not at the moment?

Ms TRIHAS — Not at the moment, no.

The CHAIR — How could it be developed to do that, because one of the questions we are grappling with is this whole question of how you would pick up a Shipman-like situation in Australia? We have had an opportunity to look at the UK inquiry and at Dame Janet Smith's recommendations that every death should be reported to the coroner. That would be comprehensive but expensive. We would be interested in hearing a little more about how your system could play a role in sifting or having flags of concern that might prompt further investigation in this area.

Ms TRIHAS — I think everybody agrees that Shipman could happen and be undetected because the total numbers were not that great, and if you were looking at it on an annual basis he would not have — —

The CHAIR — Been picked up.

Ms TRIHAS — Yes. Nevertheless I think the issues are around the cause of death, and certainly the system is capable of having the smarts developed to identify that certain related causes are unlikely to be the cause of death. I am not a doctor so I cannot go into the explanation of that, but we have had some roundtable discussions with people and identified that probably enough smarts could be built into the system to do it across the board on average on quite a good basis.

The second thing it is capable of is doing an assessment or an audit, a sampling across the causes; so you could check different causes and audit those. That could be done by an agency — whether it be the coroner, VIFM or somebody — so you could sample to see how accurate the medical certificates are processing through the system.

The CHAIR — What do you mean by ‘how accurate’?

Ms TRIHAS — You would have the system smarts built in to be able to assess, for instance, that a broken toe is an unlikely primary cause of death. Therefore, the system would throw that as an exception, so that whoever was administering the certification registration process would need further information on that.

The second part to all of that is that on a quarterly, half-yearly or yearly basis, you could do a random sample across all of the medical certificates or the causes of death within the system — for instance, how many have come up with broken toes as a primary cause — and that might lead to further inquiries across a number of doctors who might be using that as the primary cause of death. So the system, with the information that is held in it, could be interrogated against any one of the available fields that are available in the medical certificate, or the details that are held through the death registration process.

The CHAIR — In Shipman’s case all of the causes of death put on the certificate were medically quite possible and acceptable. In itself that would not have necessarily triggered concern. Would you have the capacity, for example, to be able to check if there were a doctor who had a number of patients of a certain age who were dying and the patients were all dying of similar causes? Under one doctor it would seem somewhat unusual to have a number of patients dying with this certified medical condition attached.

Ms TRIHAS — Yes, you could.

The CHAIR — It could be a bit like a Medicare check, like when they are checking for fraud, and there is a whole lot of bulk-billing claims that have been made that seem to be outside the normal range. Would you have that capacity?

Ms TRIHAS — Yes.

The CHAIR — Is it computerised?

Ms TRIHAS — Yes. It would be helpful if we were sitting in front of it at the moment.

Mr MAUGHAN — Have you done any follow-up work with the coroner? I presume, out of all the causes of death, heart failure or its variances is the main cause of death. Are you aware of work anywhere that has then been followed up with autopsies that either confirms that is the case or suggests otherwise?

Ms TRIHAS — No, we have not. We do not currently have a business analyst on board. Currently we have a recruitment program in place to recruit a business analyst, and part of that work will be to do some system analysis. One of the areas is certainly the death registration area as well.

Mr MAUGHAN — Is it reasonable to suppose that a lot of death certificates that are issued with heart failure as the cause of death have another cause prior to the heart failure?

Ms TRIHAS — Yes, indeed. That is a listed requirement on the cause of death. In most instances we would not accept heart attack as one reason.

The CHAIR — One of the things that Dame Janet Smith suggested in her inquiry in the UK was the idea that in addition to having a two-system check of the certificates, you might actually phone the family and go through a simple set of questions to check whether they had any concerns about the care, the treatment or the certifiable cause of death that was put on the certificate at the very end — families being acutely interested in the welfare of their loved ones and the treatment they are receiving. Is that something that you envisage could occur? What would be the resource implications of that, if it were to occur?

Ms TRIHAS — It is not something that I have turned my mind to or have looked at in great detail.

Ms DIGBY — We could maybe come back on that one and think about what that would mean in terms of resource implications.

Ms TRIHAS — The only care I would exercise on that is that the skill sets, in terms of counselling and grief support which are usually occurring around that time, can be very difficult. Maybe there are other ways of doing that. Maybe the consideration is how it could be done.

The CHAIR — Most of the evidence we have had has been that reporting every death would have significant resource implications. One of the things that we are trying to get our heads around in this inquiry is whether there is a level of reporting, auditing or checking that can be instituted which would be slightly more comprehensive than what exists at the moment, without creating significant resource or workload issues. Maybe that is something you could respond to us more formally about.

In your submission you have indicated that it would be possible to do a bit more of random checking or defined audits. What I am not entirely clear on at the moment is at what level and what would be the resource implications of that? If you can give us any guidance on that, perhaps together with the coroners office or independently, we would be interested to receive that.

Ms TRIHAS — I would be happy to.

Mr DALLA-RIVA — It is the only conduit, is it not?

Ms TRIHAS — There is a definite loss of continuity of information between the death and the registry in terms of the next of kin or informant.

Ms BEATTIE — With regard to the medical certificate, how far away are you from doctors being able enter this information directly from their computer at the surgery or wherever, rather than the cumbersome paper form?

Ms TRIHAS — It is not too far at all. In the last 12 months we have attempted to sample this, and we have done some work with the Department of Human Services in Victoria. As this would affect the national group of registries, we have actually taken it from a local base and put it into the national agenda. It is part of the work for 2006 to see if we can develop a national system so that all doctors, regardless of what state they are in, are completing the same form, and to almost the same level of detail, and that we have the same protocols in terms of the security components that will be necessary for completion of these.

Ms BEATTIE — Approximately for what percentage of medical certificates do you go back and ask the doctor to provide more information?

Ms TRIHAS — I will probably defer an answer in full, if I can. Across the 30 000-odd, there is probably 1 per cent that we actually report to the coroner. So there would probably be only around another 1 or 2 per cent that we might actually do a follow-up on. But I will defer that to an answer in writing, if I can.

The CHAIR — So that would be about three cases?

Ms TRIHAS — Yes. I think there are about 300-odd reported.

The CHAIR — There are 300 reported to the coroner and then 1 per cent of those requires additional information?

Ms TRIHAS — I think there are 300-odd that we refer as reportable to the coroner on an annual basis. There is probably that number again that we question or clarify.

The CHAIR — So it not 1 per cent of 300?

Ms TRIHAS — No, sorry.

Mr MAUGHAN — In your time with the registry have any cases ever been referred to the Medical Practitioners Board because they have been misreported?

Ms TRIHAS — No. I think the form you are looking at now, the medical certificate cause of death, has been revamped. It is a little clearer than it used to be. Certainly somewhere in the submission from the coroner he talked about education, and I support that fully. For instance, some doctors may only register one death a year. I think to become fully aware of all of the changes that might have occurred between one year and the next can be difficult. The education of the requirement, the need for details as they are requested, the timeliness and so forth, I think before any penalties or any of that stronger administration were to take place, we would need to do our job fully and actually provide a full education program to doctors.

Mr DALLA-RIVA — As you have said, a doctor might only complete one medical certificate per annum. However, it has been put to us that perhaps it should be the head of a department who signs these forms to ensure a higher level of accountability. Do you have any views on that?

Ms TRIHAS — I think you would want the person responsible to sign the certificate — for instance how was the deceased identified and did they have a relationship with that individual? If you just relied on the registrar of the hospital to sign them all, that would probably create more confusion than there otherwise would be, unless you actually had the registrar totally responsible for those causes of death.

Mr DALLA-RIVA — That is an important point. It was put to us that to avoid any uncertainty in the certificate, it should be signed off by somebody else.

The CHAIR — A senior in the hospital.

Mr DALLA-RIVA — Yes, but you are saying there is that person far removed who actually has a direct relationship.

Ms TRIHAS — Yes.

The CHAIR — I think the suggestion was that they review it and perhaps add whether it should be reported to the coroner.

Mr DALLA-RIVA — An additional section in the form suggests that it has been certified by the doctor, but then it is checked off. Do you have any views on that, then? And what benefits would you see? Are there any benefits or does it just install another layer of bureaucracy that we do not need?

Ms TRIHAS — Yes, possibly. I had not turned my mind to it. I am happy to take that and discuss it with my staff, as to whether they would see any benefits.

Mr DALLA-RIVA — Yes, that would be good too. Because if they are checking it, it would seem strange that we would want another level of stoppage.

Ms TRIHAS — I guess then you would have to assess as to who has the signatory responsibility for the medical certificate. Is it the doctor who is applying the health care or is it the senior —

The CHAIR — No, it is the doctor. The suggestion is that it is the doctor, but that a senior medical officer within the hospital would review it.

Ms TRIHAS — Perhaps co-sign it.

The CHAIR — Yes, co-sign it. And they would presumably have gone through some procedure to ensure that it was a reportable death.

Ms TRIHAS — Certainly that would probably see some of our work being administered by the senior doctor.

Mr DALLA-RIVA — That is right, because you are currently doing that.

Ms TRIHAS — Yes.

The CHAIR — What sort of training do the staff get to undertake that work that being done within your registry?

Ms TRIHAS — As I advised earlier, each of the staff members who are currently in the death registration area have been with us for more than 15 years, and they have in the last 12 months undertaken a medical terminology training program, which was performed by an accredited provider. In addition to that we have regular information sessions which update them on news or learnings from the coroner or the Victorian Institute of Forensic Medicine, such as the changes that happened I think in the last 12 months in relation to the reporting of asbestosis. Those things are detected and possibly there are doctors out there who are not aware that that is a reportable death, for instance.

The CHAIR — I was just wondering because David Ranson, in his study, suggests that in Victorian hospitals there may be up to 3000 deaths that are as a result of medical treatment errors, and yet clearly not all of those have been reported to the coroner. A lot of people have said to us that there is an under reporting of reportable deaths to the coroner. I am just trying to work out where in the system we can actually lift the reporting rate. Some of that could be by the education of doctors. Some of it could be by having a second check by a senior medical officer in a hospital. I am just trying to work out in my mind what might be the contribution that your registry can make in that, if at all, and do you have any comments on that?

Ms TRIHAS — Yes. I think the system capability around the epidemiology has a significant contribution to make in terms of testing the information that goes into it. That is one component. The second is the random auditing across the causes of death and the medical certificates, to be able to determine whether there are any that are slipping through the system because the smarts are not correct.

The other thing that you can do is actually link it to other databases, such as the Health Insurance Commission. If somebody was recognised as having had cancer for five years, for instance, one would expect that they would have had some treatment and therefore there would have been some claim against the specialist. One would say that John Smith, who died of cancer and who had it for five years, would have a link back into the Health Insurance Commission for claims against a treating doctor for that.

The CHAIR — But your staff who are checking the certificates, are they medically trained at all?

Ms TRIHAS — No, they are not. I am describing a system that does most of the work for you. There is certainly capacity to have experience in, whether it be through a medical practitioner or nursing staff or whatever, some quality assurance work on the death registration process as well, but what I was describing was more the system capability to be enhanced to a level that it can actually do quite a bit of the work for you.

Mr MAUGHAN — How would you respond to the proposition that the closer that checking is to the death, the better, and if it is by another medically trained person — a registrar or whatever — actually in the hospital or close to where the death is, that that would be preferable to a clerk or a public servant remote from the death? Would you think that the former, where you had a medical practitioner within the hospital checking on the first assessment, would be perhaps a more accurate way of doing it? How would you respond to that proposition?

Ms TRIHAS — I do not know what I can actually offer to that proposition. I do not necessarily have an opinion on that. As I said earlier, it would depend on who was responsible for the certification of that death.

Ms DIGBY — As opposed to the registration of the death.

Mr MAUGHAN — Yes.

Ms TRIHAS — So if you had Dr John Smith certifying a death, having been the treating doctor, and you had Dr Brown as the more senior, I guess the question you would ask yourself would be: who would certify that death? And if Dr Brown was concerned with the level of care provided by Dr Smith, is there a possibility that that medical certificate could be reworked so that it did not look quite as bad, for instance? I do not know.

Mr MAUGHAN — Or the other way around.

The CHAIR — How could you check that at the moment?

Ms TRIHAS — We would not. But what I am suggesting is that there is the need for the medical history to be provided as it currently stands. The second doctor may be an enhancement. What do you do, though, where there is not a hospital setting? There was a process within the Crematoria Act that required a second medical practitioner signing off on the disposal of remains. I am not sure how that worked or whether that is still the case.

Mr DALLA RIVA — Is all the information on the certificate entered into the computer?

Ms TRIHAS — Yes, it is.

The CHAIR — At what point do you think you will have made the appropriate enhancements, in cooperation with the coroner, that would make the system not absolutely foolproof, but would lead to a higher level of safeguards in the system? When do you anticipate that that will have occurred?

Ms TRIHAS — It would require some policy formulation, and it would probably require some funding, not extensive funding, but it would also require some state/commonwealth consideration and agreement as well.

The CHAIR — So it is not something that is currently happening?

Ms TRIHAS — No, we are at the point where we have a system-to-system development project for the medical practitioners board database, which will allow the automatic comparison of the data that is coming in from medical practitioners, which is what you see at the rear of the form, matching the medical practitioners database on an as-it-happens basis. That will check on a daily basis as you register a medical certificate.

We had looked at other ways of doing it, but we felt that with suspensions and different treatment environments it was too hard to update on a quarterly or half-yearly or yearly basis. This way it is an online system-to-system comparison.

The CHAIR — Have you done any work on what it would cost to upgrade your systems, together with the coroners office, to make them more Shipman-proof, if I can use that terminology — in other words, based on what you have identified as needing to be done, have you actually costed what it is and are you able to provide us with any information as to the nature of the changes that would be necessary?

Ms TRIHAS — No, I have not costed it. We have done some analysis, we have assessed some of the risks, and we have done some relatively low-level analysis. But as I described earlier, we have not had the resources to do some meaningful data interrogation to actually be able to properly assess what our needs will be.

The CHAIR — Do you think you are in a position to do any of that work whilst this inquiry is running, and can you provide us with any indicative costings or suggestions as to what might be needed to upgrade the system to that level of capability.

Ms TRIHAS — When does this inquiry conclude?

Mr DALLA-RIVA — Tomorrow.

Ms TRIHAS — I am good, but not that good!

The CHAIR — We will certainly be running well into next year. I would anticipate we will not be reporting until August, but obviously we would need that information as early as possible.

Ms TRIHAS — As I said, the coroner and I spent some time about a year or so ago looking at what the issues might be in terms of Shipman — what would be the things we could do at a local level, given the fact that the UK model looked at a number of registries, whereas in Victoria we only have one. We looked at it from a slightly different perspective to the way the report is considering this. As a result of that and what we knew at the time we developed a framework of what we thought were the key issues, but we have not been able to take it any further than that, given other priorities.

The CHAIR — If there is any work that you and the coroner have done or could do that would assist us, we would really appreciate it, because we are grappling with these system change questions.

Ms DIGBY — We have a list of initiatives and actions that we believe we should take and we can provide you with those with some costings, in broad terms.

The CHAIR — That would be great. That would be useful.

Ms DIGBY — That work was also done with Victoria Police.

The CHAIR — Excellent. We have roamed far and wide and took over your answers to our questions by asking new questions. Looking down the list, are there particular questions that we have not asked or you have not provided answers to that you would like to return to?

While you are ruminating over the list, one of the questions we asked was whether or not the registry contacted doctors where it has been established that the death has been incorrectly reported, or misreported, to the registrar instead of the coroner.

Ms TRIHAS — That is question 13. I will just read you the response as I have it: the registry does not contact the doctor if the cause of death is clearly reportable. If it is clearly reportable, we make the call and refer the medical certificate directly to the coroner. Where there is any doubt as to whether something may or may not be reportable, we in the first instance may contact the coroner and discuss the items that are listed as the cause of death. We may then identify a series of questions or we agree on a series of questions that we might direct to the doctor in the first instance.

At the conclusion of that we may be satisfied or not satisfied. If we are not satisfied, we would obviously advise the doctor that we will be referring it to the coroner. If we are satisfied, then we close it off as not being a reportable death.

The CHAIR — Do you provide information to doctors as to why the death should have been reported?

Ms TRIHAS — Yes indeed.

The CHAIR — What about the question relating to prosecutions for breaches of the Births, Deaths and Marriages Registration Act? Have there been any under section 37(4) or section 53?

Ms TRIHAS — I will answer the first. To the best of my knowledge there have not been any prosecutions under section 37(4). I do not actually have any prosecution rights as such; I would have to pass that on to somebody else. Whilst the penalty applies, I do not have any way of progressing the penalty. I go back to what I suggested earlier, which is an education program and a way of actually identifying the number of errors that a doctor may have made, so if you had a repeat offender who did not, for instance, provide certain details, you would either refer them back to the medical practitioners board or you would have an agreed position through the AMA or whatever. Then you would have an agreed position where you know what action you will take as a result of that, which may very well lead to referrals through to the OPP, for instance.

Mr DALLA-RIVA — I do not understand; who would you refer it to?

Ms TRIHAS — I would have to pass it on to the police.

Mr DALLA-RIVA — To the police. I noticed on the form that the offences are pretty light on in terms of penalty. For doctors to get 10 penalty units — that is just a weekend drive for them. I am not asking for a comment, I am just putting it on the transcript, but if we are serious about reportable death and about trying to establish some accountability, there needs to be a bit of a carrot-and-stick approach. I was surprised when I saw the certificate by just how light the penalties were. I am not asking for your comment, I am just putting it on the record.

The CHAIR — Finally, have you referred a misreporting incident to the medical practitioners board?

Ms TRIHAS — No, we have not.

The CHAIR — Because?

Ms TRIHAS — It links back to the issue about the one death that a doctor is going to report in a year. I really believe we need an education program that hits not only new but longer serving medical practitioners — we have a regular communication channel. Currently there is a bit of a difference, because you cannot target all doctors through one channel, so you have to go to different communication channels to capture all.

But we have started, and recently we did two communication bulletins through medical practitioner journals. I think a more coordinated approach to communication, providing them with follow-up where they actually do get a referral that says, ‘This is the second time you have done it in the last six months’ or whatever it might be and what the action resulting from that might be, is a far more positive way of creating change than simply exercising a penalty of 10 or 12 penalty units for an incomplete form.

The CHAIR — Do you ever run seminars?

Ms TRIHAS — No, but that is certainly part of our work plan.

Mr DALLA-RIVA — If we made it two years jail, they would then conform, and that is what I am getting at. It seems to me that we have heard from other people — and this is again a comment for the transcript — that they are not satisfied with the process undertaken by doctors. It is too easy for them.

Ms TRIHAS — I believe passports have a 10-year jail term.

Mr DALLA-RIVA — Pardon?

Ms TRIHAS — Passports have a 10-year jail term for incorrect information.

Mr DALLA-RIVA — And there is no sort of let-off if you drive down the street at 2 kilometres an hour over the speed limit. It is about priority. It would seem that they do not take reporting of a reportable death as seriously as driving down the street at 2 kilometres an hour over the limit.

The CHAIR — I think you could take that as a comment on the question. There are no other questions. Thank you very much for coming in and giving us the benefit of your expertise today.

Ms BEATTIE — We would love to go and have a visit.

The CHAIR — I think a visit is a good idea.

Ms TRIHAS — Yes, please do take the opportunity to come and visit us if you can. I think it will be worthwhile.

Committee adjourned.