LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 5 December 2005

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Dr S. Robertson.

The CHAIR — I welcome Dr Shelley Robertson who is here today in a personal capacity. We have about half an hour, so if you could talk to the main aspects of your submission and then we would like the opportunity to ask some questions on it if we could.

Dr ROBERTSON — Thank you for giving me the opportunity to address this committee. I am a forensic pathologist. I have been employed by the Victorian Institute of Forensic Medicine since its inception in 1988, but I am here today based on my experiences and my views are not necessarily those of the institute. As I said, I have worked at the Victorian Institute of Forensic Medicine for nearly 18 years now, and in that time I have had extensive experience of our coronial system. In my opinion the greatest flaw in it is that the coroner is legally qualified only and has no medical expertise of his or her own, and I think that has led to serious deficiencies in the office over the years. Yes, the coroner does take medical advice provided predominantly from the Victorian Institute of Forensic Medicine, but also from other parties. However, the extent to which they take that advice, and certainly to which they take that advice on board, is very much a personal and an individually driven thing.

The CHAIR — I should have said to you that this will be a public submission on the public record unless you ask for it to be in camera.

Dr ROBERTSON — That is okay; I do not have a problem with that. Most people who work with me have heard this before anyway.

I think that this has led to inconsistencies in the way the coroners office operates, and this proposed law reform is a wonderful opportunity to institute a medically trained coroner, and preferably, I would think, a forensic pathologist. I have visited other jurisdictions where a medical practitioner has been appointed as coroner, with or without legal training. I have not personally experienced those systems, but my understanding is that there are problems there too, but when you have available the actual investigators who are doing the leg work, if you like, I think they are the logical persons to be appointed as coroners.

The opposition to this, which is particularly expressed by my boss, Stephen Cordner, is that a medically trained coroner is seen as losing some of the legal powers but, as I pointed out in my submission, the institute has duly qualified medical and legal personnel amongst its pathologists. Three of us have full law degrees and two others have postgraduate legal qualifications, so that aspect could certainly be overcome. Certainly that could also be overcome with the training of future forensic pathologists within a medical examiner system. The universities are offering combined medical and legal courses these days, and there are quite a number of medical practitioners with dual qualifications.

That is really the basis of my submission. A lot of the other things within the submission are related to legal points, and it is perhaps not my place to make any attempt to right those, but I think the main thing is the appointment of a medical coroner.

The CHAIR — Just picking up that central point and then we will come back to other points in your submission, obviously there are people who are medically and legally trained but they may not necessarily have been a magistrate, and currently the system is built around the idea of a Coroners Court with someone having had experience in exercising a judicial function. Do you think it would be possible to have a system whereby people with the appropriate medical qualifications that you are talking about assisted the coroner, or do you think it is absolutely essential that the person who is the coroner is both medically and legally trained?

Dr ROBERTSON — Firstly, one of the present incumbent coroners has not gone through the magistrates system and was appointed outside that system, so that person has no prior experience with judicial-type inquiries. Secondly, I think an appropriately qualified medical practitioner can certainly be trained like anyone else. The fact that three of us went back to university to do law so we understood how the law works to enable to us carry out our roles as forensic pathologists adequately, I think demonstrates that we have a willingness to learn and a willingness to undertake ongoing education, and I am sure we could pick it up, if you like, if we were given the appropriate instruction on the role of a magistrate and how the Magistrates Court operates — those sorts of areas. I still think it is of paramount importance that the coroner be medically trained because the coroner is the person making the decision, and unless he or she has a very clear understanding of the medical issues involved and the pathological issues and all the other medically related issues, their job must be extraordinarily difficult.

Mr DALLA-RIVA — There has been a suggestion that rather than go the other way that we put a County Court judge at the helm — in other words, somebody who has gone through the system and understands the legal

framework that is required in a court. What do you think about that? On the other hand, elevating it to a higher judicial level.

Dr ROBERTSON — I do not think that is addressing what I see as the fundamental issue, which is the lack of medical knowledge.

Mr DALLA-RIVA — The second point is that during this inquiry we have also got evidence from a variety of witnesses, and I think we had the best today when it was indicated by a couple of witnesses that during one inquiry there were nine QCs across the chamber in the Coroners Court. I am just wondering how somebody who is medically qualified could combat the gamesmanship that is played when you have nine QCs, each with their vested interest, each testing every point of law in an environment where it is not often, from what we have gathered from the evidence we have received, about gathering the full facts of the case but rather about protecting certain individuals or indeed hospitals and the like. How do you think a medically qualified person with some legal training would be able to combat the deluge from nine QCs with all the barristers and their instructing solicitors? I am just curious as to how that fits into your submission.

Dr ROBERTSON — I think that is probably the least of our problems, if you like. As forensic pathologists we are constantly giving evidence in all courts at various levels in this state, and in interstate ones too from time to time, predominantly in homicide related matters. We are all experienced expert witnesses and we have learnt techniques, if you like, and strategies to deal with a bench full of QCs. For most of us that works pretty well. If it does not work well, you probably do not continue on as a forensic pathologist because that is such a large part of our work, so I do not really see that as a big problem.

The CHAIR — I think Richard was referring to the conduct of the inquiry as distinct from how someone might answer questions directed to them individually — how you make sure the inquiry is not swamped with objections and so on, on technicalities, and attempts to exclude evidence or claim privilege, or all sorts of things that can derail inquiries.

Dr ROBERTSON — Once again that is a procedural thing and one would hope whoever is sitting on the bench has learnt the appropriate procedure and is comfortable applying it. The other suggestion I might make in that situation is that perhaps if we do have a medical-appointed coroner whose primary focus is medicine rather than the law, why not use consultant lawyers like those QCs who occasionally assist the coroner now? Use that same process and instead of having a medical person advising the coroner, you have a legal person advising the medical examiner.

The CHAIR — It could work either way, I suppose. Perhaps to go around another way, could you point out to us what, from your experience, you see as the major deficiencies and problems in having a legally trained but not medically qualified coroner. What have been the major problems you have identified?

Dr ROBERTSON — Inconsistency is a big one; even for things like the wording of findings or the causes of death. One coroner, for example, favoured the main cause of death as cardiorespiratory arrest. He virtually gave that at the beginning or ending of every finding — cause of death, 1(a) cardiorespiratory arrest. That means your heart and lungs stop. Everyone's heart and lungs stop when they die. That is not contributing anything. I always thought that lacked an understanding of what we were really aiming towards, which is putting a cause of death which has potential benefits for statistical and epidemiological purposes, even for the family's closure, for possible future generations and all those things. Putting down something like cardiorespiratory arrest is not helpful.

The CHAIR — That inconsistency you referred to, is that something that is most evident, say, between the Melbourne-based and the country coroners? Or is it a variation you have perceived even amongst the Melbourne-based coroners?

Dr ROBERTSON — It is even amongst the Melbourne-based coroners but it is probably enhanced as soon as you get out of the central Coroners Court.

Mr MAUGHAN — Have you seen the Toronto system which has a medical model?

Dr ROBERTSON — Yes, I visited the Toronto system some years ago now. At that time they had a medical but not necessarily a forensic pathologist as the equivalent of the coroner. I think it is probably too long ago to comment on how it was working, but it did seem to work well at that time.

Mr MAUGHAN — Do you favour every death being referred to the coroner for investigation?

Dr ROBERTSON — In an ideal world, yes. The logistics of doing that would require major resource allocation, and that is way out of my area. I do not see how we could possibly cope with a system like that at present, but it would be nice. I think with the Shipman-type incident — and I presume that is underlying a lot of why we are here today, to avoid that type of occurrence in the future — there are probably simpler ways of looking at that too. For example, in Harold Shipman's practice an extraordinary number of people all around the same age were dying over a reasonably short period of time. Surely that is just an information technology matter, something like what is used in Medicare billing. You look at a doctor's profile of deaths in his practice. If he has had three in the last two months, surely that should raise a little flag. Then you would have to go to the doctor and say 'How come all these people are dying in your practice?' He would then have to justify why his practice attracts that high death rate. But that is just information technology. I do not think that really needs or warrants an overhaul of the coronial system because, as was shown in the UK, it was a long time before it was picked up.

Mr MAUGHAN — One of the obvious benefits is that it removes that stigma of being referred to the coroner which tends to put some people off providing information that is needed. It would seem if they were all referred to the coroner, the coroner could then decide which ones he or she wanted to investigate further.

Dr ROBERTSON — Yes, again with appropriate medical input, and that is another stumbling block. Yes, that would be fine in an ideal situation.

Mr MAUGHAN — I have a final question regarding autopsies. We have had it put to the committee that the number of autopsies should be increased in order to gain the maximum amount of knowledge around the use of pharmaceuticals and various procedures in hospitals — not an autopsy for autopsy's sake, but it would helpful if we had more autopsies to increase our medical knowledge, to improve the chances of success of various procedures done in hospitals. What would be your response to that?

Dr ROBERTSON — This is in the same ideal world, I presume, because it is obviously a resource-dependent investigation. However, I think the biggest problem with that is that a big cultural shift has taken place in society over the last perhaps 10 or 20 years, certainly since I was a medical student when autopsies were almost routinely carried out on anyone who died in hospital and the onus was on the families to object before we had actually carried it out, if they were going to object. That has changed dramatically, and even the way in which we carry out autopsies at the institute is very much culturally driven these days to the point where it is, I feel, impinging on our scientific accuracy.

The best example of this is we no longer are able to retain brains in a routine manner. To dissect an unfixed brain, a brain that has not been subject to preservation in formalin, is pretty well a waste of space. If you are going to get proper pathological and medical information from dissecting the brain, you really need to have fixed the brain in formalin for two weeks before you actually section it. It is just too soft an organ to handle it otherwise. We do not do that routinely any more. We do it when absolutely necessary as dictated by the circumstances — for example, in a homicide case where we think there may be ramifications down the track in the criminal and legal system. We are constrained now by these cultural things that the families say that of course they do not want you to keep the brain — the, 'I want my nearest and dearest back in one piece', sort of thing and this is the way it will be done. That has already compromised the way in which we do autopsies.

To get even more information from autopsies and do even more, some of this cultural shift has to be taken in the other direction again. We have to encourage the public by saying that it is a scientific examination. It is not something we just do because we are nasty, mean pathologists. We are really trying to find scientific answers. I think that perhaps is not the picture the public is getting at the moment.

The CHAIR — What do you think you currently miss out on in that area, or what is the potential to find out by not regularly and routinely being able to examine the brain?

Dr ROBERTSON — It is just a large section of the body's systems that we are not examining properly. We are presumably missing significant pathology as it relates to that area.

Ms BEATTIE — You seem to be critical of the fact that there are mandatory inquests. Could you expand on the reasons why you do not believe there should be mandatory inquests in any circumstances?

Dr ROBERTSON — I think an inquest has turned into being currently a fairly long, time-consuming, expense-consuming exercise, and one needs to justify why it is being held. I think looking at the cases on a case-by-case basis rather than there being a mandatory rule is a much better way of allocating resources and making sure that those cases from which the community could actually benefit from an inquest go to inquest and that those other ones, where there is very little benefit to be got, do not.

The CHAIR — You raised some questions about the NCIS in your submission and said it is not an effective tool for investigating similar deaths due to the poor data collection record. Can you expand on that and indicate ways in which you think it might be able to be improved?

Dr ROBERTSON — A lot of the other states were very reluctant to contribute to it, for a start. I think that is the main thing. It has not been a universally embraced system until very recently. I think its usefulness is limited, as with any data collection, by the data that goes into it. Some states, I believe, are abbreviating what they put into it. It is not a receptacle of forensic pathology reports, if you like, which would perhaps be, certainly from the point of view of epidemiology and those sorts of areas, a lot more useful than a coroners finding.

The CHAIR — Back on the question my colleague Liz Beattie asked about mandatory inquests, are you saying if someone dies in care or there is a suspected homicide that you do not believe it is necessary to say there should be a mandatory inquest?

Dr ROBERTSON — If there is a suspected homicide, presumably the brief will be handed up to the office of the public prosecutor if an offender is charged or apprehended, so that is sort out of the jurisdiction of the coroner anyway. If no offender surfaces, I do not know that it really contributes much. Two very high-profile cases spring to mind, which presumably were homicides but an offender was not charged or convicted. I think a lot of duplication of the original criminal proceedings — in the second case, anyway — took place, and with the first case nothing much more was achieved than the original coronial findings. I do not think much is achieved in that sort of circumstance. When there is a suspicious death, yes, treat it as a suspicious death and let the appropriate prosecutor deal with it.

The CHAIR — But with a death in care, whether or not it is suspicious may not be readily apparent at first glance.

Dr ROBERTSON — Again it would depend on the circumstances, but I do not see why, for example, where someone who is in care but has a documented history of heart disease and one day clutches his chest and falls to the floor should attract an inquest, when it is fairly obvious that the cause of death is ischaemic heart disease, unless there are other circumstances which would necessitate an inquest.

Mr DALLA-RIVA — In your submission you talked about question 45, which asks, 'Should accommodating the needs of families be a specific function of the act?', and said you did not see that that should be a function, as it may result in the loss of ability to investigate matters in a scientific and impartial way. Obviously this is a very emotional issue for many family members.

Dr ROBERTSON — Yes.

Mr DALLA-RIVA — We have had a lot of evidence given by family members. I understand what you are getting at, but how do you in your own mind work that logic, when we are trying to help people grieve? That is especially so in the context of what we have heard — and you would have heard it all over your 18 years — about the suggestion that hospitals and individuals are trying to cover up situations and people have gone to the Coroners Court to get assistance but there really has not been much assistance and they are feeling very aggrieved, not only by the death of their loved one but by the process of trying to get closure, which is a word we may use. How do you come up with that statement without making it sound as though you are cold to the process?

Dr ROBERTSON — I know it does sound like I am cold and heartless, but in fact that is not the case. But I do see the need for maintaining impartiality. I have been involved in so many homicide investigations over the years, and I think that to the community we have a very important role in ensuring that continuity of evidence and all those sorts of things are maintained. However, with respect to the majority of deaths reported to the coroner — whilst keeping that tucked at the back of one's mind — yes, the needs of families do have to be addressed, but I think with the issues you have mentioned, especially angst about hospitals covering up and all these sorts of things, a lot of it is based on ignorance, most of it is based on poor communication and a lot more of it is based on lack of

appropriate grief supports. I think that if appropriately trained counsellors were available at a very early stage, a lot of that could be avoided.

I think doctors have a lot to answer for too, in hospitals. Most of them are not prepared to deal with aggrieved relatives — in the early stages, at least, anyway. But I think the medical courses at the universities are addressing this. They are placing a lot more emphasis on doctor–patient interactions and how doctors should deal with relatives and talk to them and impart information, getting away from the sort of paternalistic role that doctors traditionally had. I think it is a matter of education combined with appropriate grief counselling support. I think at the present Coroners Court there is a grief counselling system, but I do not think it is anywhere near adequate, and I think that is an area which needs very marked improvement.

Mr DALLA-RIVA — There is the liaison service that operates out of the Coroners Court.

The CHAIR — Clinical or family?

Mr DALLA-RIVA — The clinical liaison service. How do you see that operating?

Dr ROBERTSON — Personally I see it as making the life of a pathologist extraordinary difficult. It has introduced an extra factor in getting the timely release of bodies from the institute. We used to have what was called the 48-hour rule, which meant that a deceased person was released to the relatives within a 48-hour period of arriving. That has totally gone by the board now, because so much time is spent trying to contact relatives. There is so much toing-and-froing. Someone will have their phone turned off and will get back to me hours later, and then I will have gone off duty. I do not think that is a system that is working well. I think that even before we had that system our timely turnaround of bodies was probably much better for the community than this present one. But that is my opinion.

The CHAIR — How would you overcome that? Are you suggesting that we should get rid of the clinical liaison service, or do you think there are ways in which it can be improved?

Dr ROBERTSON — I think there are ways it could be improved. At the moment the first port of call when a death is reported to the coroner is the coroners clerk. These people have absolutely no medical or much of any other sort of training whatsoever. They do not ask the appropriate questions — which may lead to a more timely release of bodies.

How can I put this? They do not have medical terminology skills. Were they to ask someone if their relative had a significant medical history that might assist the coroner or the pathologist, first, they do not, and second, if they did they would not be able to spell it or pronounce it, and we would have no idea what they meant anyway. They do not ask about things like medications or things that are risk factors in various disease processes. I think all that could be improved if we had the type of investigator taking that first call that I have seen operating in various jurisdictions in the United States, again as part of the medical examiner system — that is, the initial investigators, the ones who take the primary calls, belong to the medical system, not the legal system. I think that would be an enormous improvement in our system and would obviate the need for the clinical notes of people, because that could all be carried out at that very early stage. They could be told about the ramifications of an autopsy, the ability to object, all those things could be dealt with with that first call. But that is not what currently happens.

The CHAIR — Thank you very much. We appreciate your coming in and giving us your time and your thoughts today. Thank you for appearing here.

Witness withdrew.