LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Ms E. Kennedy, corporate counsel; and

Ms H. Kane, coordinator, reproductive loss services, Royal Women's Hospital.

The CHAIR — Thank you for taking the time to come and talk to us today. Our work is governed by the Parliamentary Committees Act. Obviously this will form part of the record. We have Hansard recording your evidence today and that will be in public. There will be an opportunity to correct any factual errors if you wish to after viewing the transcript but otherwise it will be on the public record and on our web site. If you would like to talk to your submission for 10 or 15 minutes, we will then ask questions.

Ms KENNEDY — For the record I would like to clarify that I appear today for the Royal Women's Hospital only. As members of the committee would be aware, the Royal Women's and the Royal Children's were separated as of July 2004 to form two separate hospitals. While they made a joint submission to the committee, I appear today only for the Women's hospital because on 29 August the Royal Children's appointed its own corporate counsel — in between the lodging of this submission and today's hearing. I am now only the corporate counsel for the Women's. Legally I can only appear to represent the Women's; I ask the committee to make that note. It does not in any way affect our written submission, but the oral arguments will be advanced for the Women's hospital.

The CHAIR — I assume they did not want to appear.

Ms KENNEDY — No, because they have just basically left it in that situation. We would like to address the committee on only two aspects of the current review of the Coroners Act. The first is in relation to access to medical records actually held in the coroners office, and, the second is in relation to the somewhat new amendment in the definition of the category of deaths known as reviewable deaths. In relation to that second issue, as you have heard, I have asked Ms Helen Kane, who is the coordinator of our reproductive loss service at the Royal Women's, to expand on issues of concern, as we set out in the written submission.

The discussion paper asks at question 35 whether there are any issues or concerns regarding the requirement in the Coroners Act that a coroner may make available any statements which the coroner intends to consider at an inquest to any person with a sufficient interest. I want to make the point that the Act provides for the release of statements to a person demonstrating sufficient interest. In his submission the Coroner has quite rightly drawn to the attention of this committee the provisions in the regulations made under the Act. If you examine the regulations, you will see that they have been drafted far more broadly and give the coroner a discretion to make available the coroner's file before the completion of an investigation and the coroner's record and file after completion of an investigation.

It is interesting that the regulations speak about the Coroner's record and file, whereas section 45 of the Act, which is the committee's focus of review, speaks only of statements that the coroner intends to consider in any investigation or inquest. I would submit that the regulations may be ultra vires — that is, going beyond the provisions of the Act. The Act has a very narrow ability of the coroner to release information, whereas the regulations allow the coroner a very wide discretion. They are somewhat curiously drafted, because whereas the Act refers to 'any person with a sufficient interest', the access to records before completion of investigation is to 'such class of people as the coroner directs', so it is a class of people and persons falling within a class, and after completion of an investigation the coroner's record and file is then open to public access unless the coroner orders otherwise. I guess my submission is that, in focusing on a review of the Act, attention needs to be paid not only to the provisions of the Act but also to the regulations.

With respect, the approach does not address the status of a hospital file produced to the coroner at the time of a reportable or reviewable death. It is clear that only parts of a hospital file may be relevant on the evidence to be adduced before the coroner. I would draw the committee's attention to the submission made to it by Ms Jacinta Heffey, a former coroner herself, who points out, for example, that in a maternal death the hospital file which contains entries relating to a whole obstetric and gynaecological history may be totally unconnected to the death under review. Ms Heffey's suggestion is that offending entries should be removed prior to examination of that record. The problem is that with an in-hospital death the full medical history must go with the body to the Coroner's or to the Institute to be available to the pathologist conducting any post-mortem. I do not have any objection to that current practice of hospitals releasing the entire medical history. The problem is that that entire medical history is then in the custody of the coroners court should an investigation or inquest be under way.

The Royal Women's Hospital is most concerned, as I have stated in our written submission, that the State Coroner freely admits to having authorised his staff to give Senator Julian McGauran the complete medical file from the Royal Women's Hospital in the so-called late termination case before he sealed the file on 9 April 2002. To the best of my knowledge, and I was not here to hear the Coroner's submission this morning, the Coroner has not publicly

made available his reasons for releasing this highly sensitive and confidential material to a politician. With due respect, I believe the issue is not addressed in the Coroner's written submission to this inquiry. In fact, section 45 I believe is not mentioned in the Coroner's submission and, as I have stated, the Coroner has focused on his very wide powers under the regulations.

The Royal Women's wishes to express publicly concern over the release of the medical file in this case, but the reason we are here today is obviously to cure the defect in the current legislation. It is my submission that there was clear legislative intent that only statements should be given out to any person with a sufficient interest, and the hospital medical file is a completely different category of document. It is therefore our submission that, whether or not the hospital records form part of a coroner's file or the coroner's record, the hospital records must be kept quite separate when in the custody of the coroners court and only made accessible to parties or their legal representatives without consent unless they are connected in some way to the matter under investigation. So when the committee asks in its discussion paper whether family members should be able to access statements and other information, the answer is clearly yes, because they are interested parties. But then it states:

> Should the Act place any restriction on the right to access certain sensitive documents such as medical files? Who, in your opinion should not have access to this information?

I will leave it to the committee to determine perhaps who should not have access but, on any view, it is the hospital's submission that Senator McGauran was not a person demonstrating sufficient interest and should not have been given access to this information without consent. Consent is the magic wand over which all release of health information can be waved, and then there is no legal objection.

The coroner would also have you believe privacy laws are something of a recent phenomenon. He talks in his submission about the "recent privacy legislation" and publicly expressed concern over the release of the medical records from a coroner's file. I would like to point out to the committee, though, that the legislature has, since at least 1982 in the Freedom of Information Act, tried to protect personal privacy from unwarranted scrutiny. For example, the documents under the Freedom of Information Act are exempt even if the person has died. So there is clear legislative intent in the Freedom of Information Act to protect the confidentiality of medical records when someone has died and a requirement that the agency or Minister in deciding whether disclosure would involve the unreasonable disclosure of information relating to the personal affairs of any person must take into account, in addition to any other matters, whether disclosure would be reasonably likely to endanger the life or physical safety of any person.

The Health Records Act also defines personal information to include information about an individual who has been dead for more than 30 years. So the most recent enactment of our Parliament to protect personal health information clearly extends the rights to deceased persons. The Act applies in relation to a deceased individual who has been dead for 30 years so far as it is reasonably capable of doing so in the same way as it applies to an individual who is not deceased. That is section 95 of the Health Records Act.

In the case that has attracted public scrutiny, the patient was not deceased and the records related to a patient who was very much alive and who expressly, I believe, would have objected to the release of the sensitive information to a politician who then went on to use the file under parliamentary privilege to make a complaint to the Medical Practitioners Board and to send copies of all or part of the record to various journalists.

We would ask the committee to therefore tighten up the provisions in the current Act which allow the coroner to give out information in the coroners court. We submit that in its review the committee should limit rights of access to statements on the coroner's file or record and not to medical files delivered to the coroner by hospitals. We would suggest that the medical records be kept physically apart and secure and accessed only by the parties and/or their legal representatives unless the express permission of the hospital is given. The hospital, of course, would need to communicate with the senior next of kin for permission to grant that access.

Finally, it is our submission that there should be penalties for the coroner's staff if confidentiality is breached, just as there are penalties in Acts like the Health Services Act for hospitals and their staff who breach patient confidentiality unless the matter comes within a clear exception. For example, there is fine of $5000 for breach of section 141 of the Health Services Act, which is designed to protect identifying information being given out in respect of health services.

I will now ask Helen to briefly address the committee on the issue of reviewable deaths in response to question 7 of the discussion paper.

Ms KANE — Firstly, when a death occurs at the Royal Women's Hospital, post-mortem is always discussed and families complete a consent form, including the giving of non-consent to autopsies. That is a routine part of our procedure. They then have a six-week follow-up interview with a senior consultant. That interview includes discussion of cause of death; it is around why the death occurred and, in particular, the results of any post-mortem and any other tests that have been carried out. The death is sometimes unexplained, but generally it is explained and the cause of death is identified in the documents which are sent to the consultative council on peri-natal mortality and morbidity. The Royal Women's Hospital has a high incidence of peri-natal death because of the nature of our high-risk pregnancy group. We are a tertiary level maternity hospital and, yes, we actually have more deaths than most hospitals.

We understand that the introduction of the new category of reviewable death was designed to protect babies who had died — for example, non-accidentally inflicted injuries — but we wanted to point out that in fact there were no protective issues with the babies that generally die within our hospital. They die as a result of extreme prematurity, chromosomal abnormalities, family medical conditions et cetera. Where there are concerns and questions about the cause of death, we normally would report that to the coroner. Our particular concern is the large number of babies who may well come under the umbrella of reviewable deaths simply because they are the second or third child within a family to have died. Within our system, perhaps for reasons that we are aware of from the family medical history, we would like the committee to factor into its deliberations when considering the effectiveness of this new category of reviewable death the pain for the bereaved family that has lost a baby and obviously fits within this category because it is the second or the third time that they have had a child die.

I will go back a little: the main issue for us with the introduction of reviewable death was that in fact we knew nothing about it. Obstetric hospitals have not been involved in discussions around the changes, which I understand were made to the legislation back in December and implemented on 1 February. The first that we and the Children's Hospital were aware of the changes was an announcement at a regular meeting about the Victorian bereavement support network. We realised that this would impact upon us, going back to the basic fact that we have high-risk pregnancies, women with high risks in the families, and we do have women who lose a number of babies within our hospital. We were initially advised that referral to the coroner as a reviewable death would be happening from the registry of births, deaths and marriages with the registration of the death, so we moved fairly quickly to try to inform our staff that this was happening and included the information in our patient information. Obviously we would not always know when previous deaths had occurred within particular families.

We have had really positive, fruitful discussions with Natalie Morgan from the Victorian Institute of Forensic Medicine, who is the person setting up the system to deal with the reviewable deaths, and we have been very happy with that. We have discussed a way of dealing with the reviewable deaths, which forms part of our recommendations to this committee. Our understanding of the way it was designed to work was that the family would be contacted by the coroner and advised that a report had been made. We have now included that information in our patient information, so the families will not be surprised to receive the call. Natalie has discussed with us and with the Royal Children's Hospital how we might go about very quickly moving to manage the review of the situation and to look at the file and use the professionals involved with the family to review very quickly and decide whether or not it needs to go further and become a fully investigated death or whether it could be regarded as reviewed, an explanation given and family informed. That is what we have reached and what we have been able to do in some instances already. I guess that is our recommendation to you.

It should be at the discretion of the investigating officer to halt any investigation process when two or more children in the one family have died in circumstances where it is clear that the children have suffered from a medically certified, life-threatening condition and this has a recognised recurrence rate within families. In other words, we would ask the committee to accept that there are many families who suffer multiple deaths of babies and that there should be a list of criteria which might allow the investigating officer to exercise discretion so as to exclude cases from further investigation and causing the families additional grief at their recent loss — for example, extreme prematurity, babies born after 20 to 24 weeks gestation, those born with congenital heart disease et cetera.

What has been happening is that since the implementation of this we have been moving, with the full involvement of the institute of forensic studies and the children's hospital, to find a way of working efficiently and quickly. Our original concern had been about the way in which the contacts would be made with the family when in fact we had

only just started the post-mortem process within the hospital. We have been able to work on that with Natalie as well. In terms of the general population most people probably do not know that this category even exists. We have had to move very quickly to inform our medical staff and have only just today received the form that the doctors are supposed to use to certify the death. It has been a system running very much on the hop, but it would be a good idea to inform the general population. There is a stigma attached to referral to the coroner. It would be really good if families were aware that this is a new process designed to care for families, so that if you are contacted this is what it means. At the moment anybody whose baby dies with us will at least have had something in their written patient information that advises them about this process. For a family whose baby dies in a country area with not such a sophisticated information system, the first they may know is the call from the coroner.

The CHAIR — We have two main areas to deal with. In relation to the release of files, do you have a view about whether or not the coroner is bound by the Information Privacy Act in these circumstances? It seems to me, whilst you refer to the regulations, the regulations only draw their power from the act, presumably in this area under section 45, but in terms of the coroner acting in this role are you asking for some reform to the way the Information Privacy Act works?

Ms KENNEDY — No. I can tell you without checking that the coroner most certainly is not bound by the Information Privacy Act, which only binds, as I understand it, public sector agencies. If anything, I think the act that we would be looking at would be the Victorian Health Records Act with its health privacy principles, but the coroner may regard himself as a law enforcement agency and be subject to exemptions even there under the act. I have no quibble with the coroner having full and complete access to hospital medical records, but as I have said, it is then about who has access to those records. I have no problem with the coroner having access for the purposes of his statutory duties. It is a question of what the coroner can then do with those records in relation to third parties, who in my submission are totally unconnected with those statutory duties.

The CHAIR — The privacy commissioner seems to indicate that the act applies to the office of the state coroner as a body 'established or appointed for a public purpose by or under an act, except perhaps when he is carrying out coronial inquests and inquiries. Is that your understanding of the position?

Ms KENNEDY — That is precisely what he is doing at the time that he is looking at this confidential health information, yes. Confidentiality is not an absolute, and clearly there are exceptions to patient confidentiality. As I said, I have no quibble with the traditional approach of hospitals to send in the hospital record immediately a patient dies. For example, in hospitals the file follows the body, and that is how the file is usually delivered into the custody of the coroners court. Otherwise the coroner simply writes and asks for it, and it is invariably delivered into the custody of the coroners court for the coroner's statutory functions. But our concern is what happens once the file is in the physical custody of the coroners court and who might access that file. It seems to me wrong that the coroner would give out that confidential health information without reference back to the hospital, the owner of the record, and indeed the patient, if the patient were alive, simply because someone asked to see it.

The CHAIR — The privacy commissioner in his submission indicates that maybe a way to deal with this is to insert a section 6 similar to what is in the New South Wales Privacy and Personal Information Protection Act. Have you got any comments on that?

Ms KENNEDY — I do not know what is in the New South Wales act. I would have thought there was sufficient protection of privacy for health information in our existing legislation and I believe the committee is to hear from our own health services commissioner, Beth Wilson. Under the Health Records Act her jurisdiction is to look at the privacy of health records, whereas the privacy commissioner is looking at the privacy of information that is, by definition, confidential. So we have a more specialised, if you like, piece of legislation that deals with health records, and I do not believe the coroner in exercising his statutory functions is bound by that legislation. He has his own act and that is the focus of your inquiry. Our submission is that we should look at that provision in the context of other legislation, and that is why I pointed the committee to the Health Records Act and to things like the Freedom of Information Act. If Senator Julian McGauran had made an application to the hospital for access to that record under FOI, section 33(1) would have denied him access as being an unreasonable intrusion into the personal affairs of a deceased person, if the person was deceased, or personal privacy if the patient was alive and well. I want the committee to realise that there are other pieces of legislation designed to protect sensitive health information from unwarranted access by third parties who have no interest in the material.

The CHAIR — But to clarify the situation in relation to the Coroners Act, what do you recommend?

Ms KENNEDY — To clarify it we have suggested that hospital records should be regarded as not part of the public record, but retained as separate and secure from public access and only given out to those parties with sufficient interest in the proceedings.

Mr LUPTON — That may be brought about through the current legal proceedings, may it not?

Ms KENNEDY — I do not believe the current legal proceedings will have any influence on the way in which the Coroners Act operates. Are you talking about the Supreme Court proceedings? That is purely a fight in respect of a search warrant served on the hospital by the Medical Practitioners Board for delivery up of the medical record. Appearing before you is very interesting because whilst I would hope that this committee would effect some reform of the Coroners Act so that that case would never happen again, and the hospital record would never, ever be given out again to a politician, it will not save the hospital record in that case from being given up to the Medical Practitioners Board without a court order to prevent it.

Mr HILTON — You said the record should go with the body. Does it physically go with the body or is there a time — —

Ms KENNEDY — No. In my experience, if the patient dies in hospital and the matter is reported to the coroner, the hospital record usually accompanies the body, unless there is a reason. For example, if it is not there physically with someone coming into an emergency department full of bullet holes, then there may be a record from prior treatments and prior episodes of care that needs to be sent in within 24 hours. But invariably hospitals have nothing to hide. I know previous witnesses have suggested that the hospital record was well and truly doctored before it went in to the coroner's jurisdiction. In my experience that is not correct.

Mr HILTON — In terms of the hospital appearing at an inquest, what is your role as counsel to the hospital in relation to talking to people who may want to give evidence at an inquest?

Ms KENNEDY — Yes, it is true. I heard the other witness this morning. It is my role as corporate counsel to assist members of staff with the statements they make to the coroner. It may well be the role of external lawyers to also provide assistance, and indeed barristers if that were required. However, I see my role as being a bit of a bridge between medicine and the other health professions and the law. I ask you to accept that many health care professionals who are asked by a policeman to provide him with a statement find that task somewhat daunting, and they have the right to seek legal advice and assistance in the preparation of that statement.

Mr HILTON — But in terms of protecting the interests of the hospital, how do you see your role as counsel?

Ms KENNEDY — I do not appear for the hospital usually in coronial inquests, but that is certainly my role. It is my client; I act for it. At the same time, as I said before, it is not my role to cover up. In hospitals we have now a policy of open disclosure of medical errors, and near misses in that case. Certainly in my experience it is not true that we would try to cover up or pretend that something did not happen when we know that the coroner is going to investigate. I heard the previous witness say that often times were missing from statements, for example. That is why the hospital record is so vital to scrutiny, and that is why I do not have any quibble with that. It is meant to be the contemporaneous record of someone's episode of care. So the statement must fit the accurate record. Yes, it is my job to represent the hospital and to arrange for legal representation in any inquest, but that is our system of justice.

The CHAIR — When a policeman takes a statement, people say, 'I have to tell the truth here'. People understand that it can be used in a court of law. What warnings do you give staff about the statements they are giving to you in preparation for a coronial inquest? Is there any sort of procedure the hospital goes through in terms of what it says to staff prior to making the statement?

Ms KENNEDY — In terms of warning?

The CHAIR — Just about the significance of the statement and that it forms part of the record that is going into the coroner's court. Do you have a set of things you go through?

Ms KENNEDY — No. Invariably what usually happens is that the medico-legal office in a hospital gets a letter requesting that statement be forwarded from the coroner's office. That is then sent to the named health care professionals, be they doctors or nurses or others, for compilation of a statement. Those health care professionals then need to read the file to see what notes they made about the care, because remember there is usually some time lag. It is just accepted that it is part and parcel of an investigation into the death of a patient that there will be a coronial inquiry. It is well recognised and the hospital staff know the minute the patient has died, if the matter is reported to the coroner, as it may need to be, that the coroner then has jurisdiction over that body and the investigation into the cause of death.

Mr LUPTON — Just on that procedure, how does the medical professional get access to the hospital's files and records if the body has gone to the coroner?

Ms KENNEDY — Sometimes the file can be accessed again and sent back. Maybe the patient has not died in the hospital in which the statements are required — for example, in the children's hospital the care may have been at a rural hospital and with the staff at that hospital, whereas the child might have died at the children's hospital where the death has been reported and the file has gone in. Once the file has gone into the coroner you can access it and obtain copies. Copies should be made, but originals are usually produced to the coroner.

The CHAIR — Do you follow a particular procedure in taking a statement — for example, have you always read the file before you take the statement?

Ms KENNEDY — No, I leave that for the health care professional. I do not usually read the file. I read their statement. Being a lawyer I know what the cross-examination is going to ask about. Doctors are very good at saying, 'I did something' but they do not say why or when or who told them to. It is things like that I would try to improve in the evidence that is being put before the coroner.

The CHAIR — You would draw that out of them. You would try to get them to — —

Ms KENNEDY — Try to make it a better statement.

Mr LUPTON — Just to clarify that, the chair asked when you take the statement which assumes that you sit down and ask questions and get someone to write down the statement. Could you elaborate on your own procedure?

Ms KENNEDY — At the women's hospital?

Mr LUPTON — Yes.

Ms KENNEDY — The statement is prepared usually in draft form by the health care professional himself, and would perhaps be sent to me for settling in consultation, if that health care professional wished to have the assistance provided. A copy would then be sent by me or our medico-legal office often to the hospital's insurers and the insurers might elect to send it to their external lawyers for further scrutiny before it is sent in to the coroner's court.

Mr HILTON — All of that seems to imply that you are looking to protect the hospital from some consequences of the coronial process. Is that compatible with trying to determine what the truth of the situation might be?

Ms KENNEDY — I ask the committee to consider that alongside the coronial process are hospital processes where we are often sitting down with the relatives, at the bedside if the patient has died in hospital, trying to explain and answer questions from the relatives, because as I said we have this policy of open disclosure. So no, it is not an effort to put the best possible light on the hospital and protect the hospital. I would ask you to consider that alongside the coronial process is a hospital process going on with the family to try to explain to the family what has happened to their loved one. The hospital shares with its families its own investigations. We do not wait for two years for a coronial inquest to be held before we try to learn the lessons to be learned and make our own system improvements to see if there are things that could be done better so that it does not happen again. Then hopefully that will also stand us in good stead when we go before the coroner if we can demonstrate that we have considered a death as an avoidable death and we have put steps in place to make sure that that hopefully does not happen again.

Mr MAUGHAN — That is all very commendable. Have you any reason to believe that the sorts of standards you apply at the Royal Women's are applied across hospitals generally?

Ms KENNEDY — I believe, as I think it was Lorraine Long who said, that our coronial system in Victoria is the best in the country. I am a Victorian and I do not practice anywhere else, but I believe it is the best in the country. Whilst I would concede that there are many deaths in hospitals that are preventable and there are medical errors that occur, I believe that hospitals in Victoria, because of the initiatives of the coroner himself and the Department of Human Services, do pay heed to recommendations made in not just inquests involving their own hospital but any other hospital. That is the purpose of having, I guess, a corporate counsel in every metropolitan hospital whose job it is to review coroner's recommendations to see how they might apply to that hospital, to see if the system of care can be improved.

Mr LUPTON — Could you elaborate on what effect the potential of future civil litigation has in the investigation and open disclosure process, and possibly looking at reforms to practices?

Ms KENNEDY — Again, I might take a hypothetical example. In parallel to a coronial process, which as I said is not going to occur within weeks of the death because of the time lag between a report and maybe the need to gather evidence, the hospital would begin its own internal review of a death with a view to sharing with the patient's family what it was that occurred. With open disclosure that means sharing with the family when errors have occurred which have resulted, obviously, in harm or a less than desirable outcome in the case of death, where they have resulted, perhaps, or contributed to the death. There are patient safety committees, or quality committees, in the hospital which would examine that as soon as all the relevant material was known with a view to sharing the investigation of that patient's death with the family. That is how it now works.

Mr LUPTON — It may be argued that there is an inherent conflict between, in this situation, a hospital going through that open disclosure process in the setting of a legal system that allows action to be taken against a hospital if there has been negligence or other forms of behaviour that give rise to legal proceedings. How do you see that sort of conflict in practice, and are there any suggestions that you might make about how to deal with those issues?

Ms KENNEDY — I guess I can answer it this way. The insurers that are arranged for all public hospitals have supported the open disclosure policy in all hospitals and are very much aware of it. You might find that strange, because open disclosure may, on one view, be precluding the insurers from taking a certain defence in answer to legal proceedings, but the insurers have been active proponents of open disclosure and they do support it. It may seem, at first glance, to be an inherent conflict of interest. I do not act, obviously, for the hospital in a medical negligence claim in the civil courts; that is entirely handled by our insurers and external lawyers. But the trend these days is to disclose in an open and transparent way with families when things go wrong.

The CHAIR — Can you explain the purpose of sending a statement to the insurers? Why is that done?

Ms KENNEDY — I guess because they have a vested interest for the reason that Mr Lupton has just alluded to — that there may well be potential for civil litigation. It is only fair under our policy of insurance that they be on notice as to precisely what the facts of the case are. It is not with a view to changing the facts of the case; it is purely as part of their being able to put a figure on a claim, I guess, at the end of the day.

The CHAIR — That is prior to the statement being finalised.

Ms KENNEDY — Correct.

The CHAIR — Has an insurer ever requested a statement be changed?

Ms KENNEDY — An insurer has requested that the statement might go to its external lawyers for further scrutiny.

Mr MAUGHAN — Do you modify it on that advice?

Ms KENNEDY — Yes. It would be choice of language. Just in defence of my own profession, lawyers are very careful about words. It is not changing in any way, shape or form the facts of the case; it is the way in which the statement is expressed. So it would be purely choice of words rather than changing any factual outcome.

The CHAIR — Helen, you indicated in the submission, and you talked about this, that many of the practitioners are not aware of the new categories of reviewable deaths. I am somewhat surprised by that, partly because there was so much publicity around it. I think the Premier made an announcement about it and it was on the front page of the newspapers.

Ms KANE — The health industry did not notice.

The CHAIR — What more needs to be done to make them aware of these things?

Ms KANE — It was a very specific gap. Everybody was aware of the circumstances that were behind it, of the issue of the woman where there was a series of deaths and the thought that there had to be a better way of picking up such deaths — fairly self-evident — but it was seen as an issue affecting the protective area. The gap in the consultation was obstetric hospitals, because we literally did not know that that affected us. It was thought to be a protective matter. The babies who die with us are not protective matters. They are everything else — the grief and loss et cetera — but there is no reason to think that there is anything untoward behind those deaths.

The gap in the consultation was with maternity hospitals. We, literally at the last minute, discovered that this applied to us, so we pedalled very quickly to try to find out more about it. Fortunately for us we then found that the system was not ready. But in fact the new medical certificate for the under-28-day babies, which are obviously our clientele, was not ready. The registry of births, deaths and marriages did not have the form prepared, so we found a way of complying with the legislation and making do and, again, trying to very quickly educate our doctors and nursing staff. The form itself has just arrived today. We can now do a medical certificate for a peri-natal death. It is a vast improvement on the old way of doing it.

The issue for us is that the largest number of these deaths, if you like, is going to be in places like ours. My concern was that the families that are going to come under this umbrella are already part of our system and have just had the discussion with a doctor around post mortem, have just consented, are waiting for the next step in the whole process, and it is rolling along, the information is being gathered and the family is being involved. Alluding to Elizabeth's comment, we have a meeting within weeks of the death of the child looking at what were the avoidable obstetric issues.

In fact from the very beginning within our system we are looking at why has death happened and how is it possible to not have it happen and how is it possible to not have it happen next time. We have high-risk groups, we have one-of-a-type genetic counselling programs in the state, we actually have a whole program that deals with non-genetic medical reason problems in pregnancy, which is why we have so many deaths, because they come to the Royal Women's Hospital from all over the state.

We have a system that actually recognises the issues, and it has actually kicked in as we are learning about this new system that nobody has actually told us about. Our concern was to inform the patient families, which in fact we have done, and the next thing is to inform our doctors, and now we have got the new medical form we can educate our doctors with what they have to do now instead of the old way.

As I alluded to earlier, we have actually had a really good working relationship with the Victorian Institute of Forensic Medicine. It too has been doing this on the run, and we have been coming up with ideas of ways of actually managing this that reduces the stress for the families and enables everybody to do their job. The question at the beginning was: with the degree of stress involved in this, is it worth it? All the families that we will be dealing with at the Royal Women's Hospital are there because of diagnosable medical reasons. The baby has never left hospital, because they do not. They are born in our hospital and they die in our hospital. There is no reason to suspect that anything untoward has happened. When something untoward does happen, we report to the coroner.

The CHAIR — Thank you. I thank Elizabeth and Helen for coming and speaking to us today. It has been very illuminating. And thank you for your submission.

Witnesses withdrew.