

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Mr G. Johnstone, state coroner;
Mr I. West, deputy state coroner; and
Mr R. Roberts, registrar, State Coroner's Office.

The CHAIR — I welcome you all to the second day of hearings of the parliamentary Law Reform Committee's inquiry into coronial services in Victoria. I particularly welcome Graeme Johnston, the state coroner, his deputy Iain West, and the registrar, Rick Roberts. I welcome also some family members who came to our first day of hearings and are in the public gallery. It is good to have you here today. Graeme, we thought we would perhaps give you up to half an hour to talk to your submission and then we open up the inquiry for questions and discussion.

Mr JOHNSTON — I think the starting point is to recognise that all of us can be affected by a coronial inquiry. The real power and import of the work of the coroner is that it has the potential to affect our family, our friends — all of us. If one narrows it down and looks at programs on television such as *Silent Witness* or *CSI*, one sees a focus on suspicious deaths, and many people in this society understand the work of the coroner to be that of investigating suspicious deaths. Even people who work within the medical sphere consider that that is the work of the coroner. But if you think about it and reflect on it, suspicious deaths are only a very small proportion of the deaths that we see in daily work as a coroner. In that sense we see road deaths, we see work deaths, we see recreational deaths, we see drug overdoses. We see deaths associated with the mental health sector and suicide. We see deaths in adverse events and a range of other areas. In that sense each of us, and our families and our friends, has the potential to become affected by a coronial case, because those sorts of areas touch us all and have the potential to touch us all.

Think about the fact that we have a National Coroners Information System, probably the first in the world, that has at the moment around 95 000 deaths listed on it and it has been established since mid-2000 — only about four years, and there are 95 000 deaths. Perhaps 45 000 to 50 000 of those 95 000 are natural-cause deaths, because some are reported to the coroner where a death certificate cannot be written or there is no medical history, but the balance of 45 000 to 50 000 are violent, unnatural, accidental deaths that fit within the sphere of deaths I have just talked about. Of course there is an area of underreporting which I will talk about later. The national database idea was first thought about in 1989. If you think about it, from 1989 to now, if we had had a national database, there would be around 200 000 Australians who died from violent, unnatural, accidental causes and only a very small proportion of those would be suspicious deaths or homicides. The vast majority — many of them — would have been deaths that would have been preventable by changes to systems and practices.

It is all very well to talk about a figure of around 200 000, because we all glaze over, but in your hearings you have seen individual families that have been affected by coronial inquiries. In some ways they have been badly affected by coronial inquiries. They have certainly been troubled by the death of their loved one, and they will remain troubled by the death of their loved one until the day they die. They thought that more could have been done, certainly in relation to comments about the coroner's preventive role and the need to strengthen it.

The vast majority of injury-related incidents are not investigated. There is no investigation into the cause or factors involved in an incident that, let us say, leaves someone with a severe disability, unless it is subject to some compensation claim. There is generally not a systematic way of investigating, and hence the coroner's inquiry is really the area where we need to look to find out factors that are involved in deaths. They are factors where we as a society must all work together. I am talking about working together; I am not talking about working, necessarily, as a legal system, a medical system or some other system, but we have all got to share and work together in relation to this problem, because it is a big problem. It is an extensive problem. It costs our society a lot of money, and more importantly it costs our citizens an enormous amount of emotional pain and suffering. You have seen some of those people here, and we see many more who either do not want to say anything or walk away from it. But in reality they will not walk away from it, because it will be with them for the rest of their lives.

If you look at the theme of the submissions, it is generally a theme that wants to strengthen the coroner's role in prevention, because in a sense for the families that have lost their loved ones, that means a lot. Understanding exactly how the death occurred and what is the real truth of it is important to them, but it is also important to society, because the better we understand how the death occurred, the better we investigate and the better we identify the factors, the more able we will be to intervene and prevent them occurring again. I have given you this simple document called 'The upper limit detection cable'. It is three pages long and, to me, it simply illustrates what the coronial process is about. It is a very simple explanation, but I will get to that in a minute.

You might wonder why we are here. I have just said that. How we got here is another matter, and it will be interesting for you to hear briefly how we got here. How we got here is a result of three conversations. One conversation was between an administrator in the court system and myself in 1988, the year in which I became a

deputy coroner and identified two or three forklift deaths that occurred in Victoria in the early part of 1988 and wondered what could we do to prevent this. If you look at the Coroners Act 1985, the coroner has the power to make recommendations on public health and safety, but there is really nothing in the act about the preventive role of the coroner. We know, if we look at the legislation and the cases, that the power to make recommendations is a secondary role, it is a secondary role to the investigatory role of the coroner. We had a brief conversation about the fact there were three or so deaths associated with forklifts and about the fact that I thought there was a developing trend and would have liked to have known how many more there were. The administrator said to me, 'Really, why do you want to know that?'. I said to the administrator, 'We may be able to prevent them', and the answer I got was, 'That is not your job. Your job is to investigate'. Technically he was right.

We move on to later that year, there were two other conversations, one with a very senior injury prevention specialist in this state, who said to me that he did not see much point in death investigation, because death is a random event. He did not see much point for the prevention of injury and injury-related death because death is a random event. There was another conversation with a senior statutory office-holder who dealt with occupational health and safety. I asked him whether he thought coroners' inquiries were any use to the prevention of work-related death, and he said to me, 'Quite honestly, no'. That was 1988. They were three telling conversations, and those conversations effectively formed a view in my mind that we needed to do something about that. Hence the coronial service in Victoria began the development of a statewide information system. That information system was somewhat limited, and it eventually led to the development of the national coronial information system, which you have heard about and I have just commented about.

We then started to think about how we could get this prevention message through, because it is not an easy one. It is not easy to persuade people that you have actually prevented death and injury in a significant number of areas or you have helped influence the debate, because of course we do not know whose death we have prevented, because they just do not come before us. The thought process was very much that we needed to influence the Australian position, hence the development of the national database. The thought process was also that we needed to also influence the international position. The idea of a national database has its limits, because a lot of our product comes from overseas and a lot of the problems we see are design related. I will get on to these three pages in a second.

We discussed with Queensland the development of the Queensland Coroners Act over a period of two to three years. There were heavy discussions between the senior legal officer who was in charge of it in Queensland and our office. We discussed the idea of prevention in New Zealand in relation to the new New Zealand Coroners Act with the law reform committee over there. Then we had a visit. We saw the position paper or discussion paper for the English system, and it seemed to me it would be wise for us to persuade at least the fundamental review team to come out to Australia and talk to us, and hence that occurred in January 2003. During that three or four days of discussion it became pretty obvious to me that, although we were talking to the English about their system and how prevention really needed to be upgraded and was a really important issue for the coroner's process — because that really was not strong in their discussion paper — our system had significant shortcomings. That really struck me. These have been identified by the families, by the submissions and by the discussion paper. Hence then was the move to review the Victorian Coroners Act in the key areas that you are discussing, and we see the Attorney-General's justice statement that takes up that debate.

Let us get back to another issue — that the coronial process in Victoria has straddled two governments. It started with Labor, it moved through the Liberals, and now it is with Labor again. We see that throughout that process there have been improvements. The developmental funding for the National Coroners Information System came through the Liberals; the finalisation of that story has come through Labor. When you think about it, this debate affects us all. It is effectively a universal and bipartisan thing.

Now we get to the upper limit detection cable. Why do we need to know what happens both interstate or overseas? The answer is quite simple. I refer to two simple stories — one is in today's paper, and it is about the upper limit detection cable. I am getting off the track of my submission, but it is important. It is about a tip truck and the upper limit detection cable. You can see the tipper body in the photograph. This is the second death in Victoria, the two are twelve months apart. If you do not put that bar up, something might happen to you, but you are given no warning. What happens is that if you are cleaning out under your tipper body and it is up, you might accidentally press that unprotected upper limit detection cable, which releases the hydraulics and down comes the tipper body and crushes you.

In 1989 I went on a holiday to America. I visited Washington, and as a detour I went to OHSA, the occupational health and safety organisation in the United States, and I asked them what they knew about coroners. There was some discussion and eventually they got a stack of material out for me called *Fatal Facts*. They posted it back to me. When I arrived back I heard this particular inquest involving the upper limit detection cable and made some recommendations and comments on safety systems and re-design. Then the package arrived from America. Opening up the package of information, you see these fatal facts, the one-pager, and there you have it — the upper limit detection cable. The point I am making is that death and injury knows no boundaries, and yet our systems are very much designed to be boundary driven. We work in silos.

On page 25 of today's *Herald Sun* and on page 6 of the *Age* there is a discussion about Dr Death in Queensland. The editor of the *Medical Journal of Australia* was reported as having said that basically we should be focusing on systems, that Australia still had no national program to comprehensively monitor safety and quality in the nation's health services.

A few weeks ago I made a recommendation in relation to the development of a module in the National Coroners Information System to deal with medical adverse events. We have been pushing the idea that the National Coroners Information System could be used quite usefully across this country with an upgrade of investigation standards, with common investigation standards, with a common methodology for dealing with medical adverse events in this country, not only in this state, and by starting a monitoring system. Hence we see the tensions. Unless we actually exchange information nationally and internationally, we are not going to learn from the isolated small events in this state. Our citizens will be protected if we learn more about what affects death and injury.

Getting on to our submission — the form is only a few pages — it suggests that the inquisitorial investigatory system run by the coroners has a unique potential and that full potential is yet to be realised. Families have effectively said that the coroner's power in relation to investigation, recommendations and comments needs to be listed. Effectively the justice statement is saying that. The brief in relation to this Law Reform Committee says that public safety and prevention ought to be a core role of the coroner, that we should be looking to see whether death is preventable by virtue of systems improvements; because whether you look at the health care sector because of under reporting, which I will discuss in a minute, or whether you look at work, recreation or road, there is a real potential to improve our systems.

If we think about it, our legal system thinks in terms of negligence or criminality. The coroner's system ought to be thinking in terms of human error and of being protective of human error, because we all make errors. I do not know whether any one of us driving here today would not make an error on the roads. If you reflect on it and if you are honest with yourself, you know you do. Hopefully those errors will not result in your death, serious injury or injury, but unfortunately sometimes they do. The system ought to be about helping us avoid getting into those scenarios or alternatively, when we are in one, of being more protective because the nature of human beings, whether they work in the health care sector or in a factory, or whether they are on the roads or operating in a recreational area, is that we will make mistakes. It is very easy for us to say, 'Look, Graeme Johnstone was negligent; he did not keep a proper lookout or take due care and that is why he was injured or killed'. You can put the file away then; you can forget about it and you can move away. But there may be, as with this gentleman, some design or system problem. This happens right across the health care sector and right across all the other sectors, so the power in the coroner's process is not to blame but to find out whether this death was preventable by a system change. To do that we obviously need backup by proper resources and proper research. The data base needs the ability to be properly researched.

As I said on page 10 of this submission, the second main thrust of the submission is the intention to support the public safety and preventative role of the State Coroner's Office. We have recommended to Parliament that it create a coroners court. Really, that is to boost the independence of the office, because if you look at it, the role of coroner is effectively an administrative one, although the public think of it as a court and generally respect it as a court. We think that what we should be doing is looking at boosting the independence of the role and strengthening that process.

The third major thrust is what goes on in the bush, and it is clear to our office that we need to find better ways of delivering service to the country. We need far better training, support — backup — for country coroners. There is already a problem with regional pathology services, as you know. There is a dearth of pathologists in this country and in this state, and there is no sense that that will improve in the foreseeable future, so we are going to have this constant battle of having adequate pathology services to help us as coroners identify cause of death.

Throughout this state deaths are underreported to the coroner. What we have suggested is the methodology to improve that process — and that is a public education campaign. Obviously we think that we should be refining and altering the definitions of ‘reportable death’ to make them easier, more simple and consistent across the country. We think there should be a public professional education campaign about the need to report deaths to the coroner. There is a recommendation for an audit or surveillance system to look at auditing the reporting of deaths to the coroner.

There is also a recommendation for an oversight or audit system within the registry of births, deaths and marriages with some expert medical support in that registry to review the death certificates, an audit system using technology and finally an own-initiative and special investigative power in the coroner to enable the coroner to actually start off some investigations, which cannot be done now.

Then there is the support of the families and others affected by the coronial process, because it is not only families but also witnesses and parties who have been involved in the incident. Many are damaged. We know that police officers involved in shooting incidents do not last in the force more than five years after the incident, and that is telling, because that sort of damage will be done to many witnesses who are involved in many coronial investigations. It will be with them for the rest of their lives. As well as the families who obviously have the far greater emotional and traumatic burden, there are others affected; so the support services should not be limited just to families but should go further afield and should also be statewide.

Let me come to another issue, which is the relationship between the State Coroner’s Office and the Victorian Institute of Forensic Medicine, which does not feature large in this submission but in reality we have gone as far as we can in this state. There is still a way to go, there are still many improvements to undertake. We have gone as far as we have because of the strength and depth of the relationship between the Institute and the State Coroner’s Office, because of the ability of our two offices to work together, because of the fact that the Institute has shared the burden and the responsibility of developing a National Coroners Information System, which has not been easy. You can see that it took 11 years to develop it. Even though it sounds like a good idea, it took a long time with many barriers. There have been many people who have supported it. There have been many governments. There have been many individuals within governments who have supported it. There are many in the injury prevention community who have supported it. But the biggest supporter has been the Institute because it has put the money where its mouth is and is running it for the country’s coroners. The Institute is also supporting the clinical liaison service process, which involves the investigation of medical adverse events, which again this Law Reform Committee seems to be focused on. Admittedly it is a troubling area. Admittedly it is a challenging area, and there is underreporting to a significant degree. But again it is a fraction of the coroner’s work. It is a big fraction, but it is a fraction of the coroner’s work.

If you look at the coroner — the coroner being a legal coroner — basically has the ability to unpick a whole range of facts and factors that surround a death. Often the cause of death is the starting point, not the finishing point. The Institute is supporting us in the newly developed work-related death investigation and resource unit. It is this marriage, and sometimes tension, between the two organisations that is really the gem of Victoria’s coronial system because the professional edges are knocked off both organisations by sharing the work and debating the issues. You can see from their submissions that they have a different focus to what the State Coroner’s Office submission is. Theirs is more a medical focus, but in a sense we are also doing it at the moment with the clinical liaison service and how that is operating. I should say to you — and I want to correct it right at the start — it is said in the submission that the clinical liaison service has ongoing funding. It does not have. The words that I had were that we had ongoing funding. The ongoing funding is funded to 30 June next year so in that sense the submission is inaccurate.

That is about all I want to say except that I think it is important to recognise that we have to spread this coronial service statewide. It is not statewide at the moment. It does not even have an administrative system or technology system that runs statewide. It is essentially Melbourne based and, whilst we have been battling for two or three years to get that up and running, I think there is a limited system about to start.

The CHAIR — Thank you, Graeme, and thank you for the very comprehensive submission which you have sent us which certainly goes into a lot of detail in terms of the main issues you have wanted to raise with us. Could I start with one question? In your submission you refer on page 124 to the increasing frequency of failure to report deaths that began in 2002, which seems to be a worrying trend given that you would have thought that over time particularly bodies that had a statutory duty to report deaths would have become more aware of that with the

increasing professionalism and role of the coroner's office. What do you attribute that to? Why do we have this increasing level of non-reporting of reportable deaths?

Mr JOHNSTONE — I think it is more likely to be a misunderstanding of the coroner's role. I started out talking about the suspicious nature of death. I think it is more likely to be a misunderstanding. The legislation is not easy to read. It is complex in relation to the reporting of medical adverse events, and I think certainly we have taken on the role of looking at falls in the elderly in a far more consistent way, and should I say that many of the falls in the elderly are preventable. The professionals would tell us that many falls in the elderly, with proper management, are preventable deaths, and hence the need to look at those issues, but I think that probably it is not an increasing rate.

There has always been a level of underreporting. The fact is we have started to use systems to monitor whether we have underreporting, and really we did not do that in the past. We did not systemically work with births, deaths and marriages. We did not systemically look at these issues, so I think we are more and more focused on trying to capture the issues of underreporting. Of course we did not have the resources to tackle the issues if they were reported to us and, looking at the medical adverse event area, we needed to develop a system to look at these deaths, and hence about four or five years ago we started work — in fact it is more than five years ago — on trying to develop a system similar to the clinical liaison service with the support of the institute. It took up until three years ago to get that up and running. We really had no capacity to look at increased numbers of deaths, but we started to recognise once we got the professionals on board that there was a significant area of underreporting and it was genuine. It was anecdotal up to then. So we started to monitor and look at it and, of course, there was the Tito report. When was the Tito report?

The CHAIR — It was 1993-94.

Mr JOHNSTONE — Which started to make you think, and it started to be confirmed later that this was in fact the case.

The CHAIR — I am interested in looking at some of the statistics you have provided. We know that the coronial system is stronger in the metropolitan area than in the rural and regional areas, and yet if you look at the frequency of underreported reportable deaths in your table, it is higher in the metropolitan area than in rural and regional areas, and in hospitals and nursing homes where you would expect that doctors would know what their statutory responsibilities are, it is again quite high. How can we address this? One of the issues for us as a committee is, if we are going to have an effective preventive role, we need to capture as many of the deaths that should be reported as possible. There is this ongoing debate anyway, which we will come to, about whether all deaths should be reportable. We will put that aside for the moment, but even within the current legislation there seems to be a significant underreporting.

Mr JOHNSTONE — I think, firstly, we have to clear up the legislation. We have to clarify the areas of difficulty.

The CHAIR — Are you saying that doctors do not understand what is required? They have not had it explained to them in training?

Mr JOHNSTONE — I am sure in many respects they do not. You explain it in training at university level, but that is not adequate. I think we have to go through a process of educating the wider medical professionals through their various colleges, the AMA and in the training at university level and at hospitals. We have to go and present to hospitals to explain the coronial process at the hospital level and at the nursing home level. I think there are probably likely to be more deaths in nursing homes in the metropolitan area than there are in the country.

Mr MAUGHAN — Why has that not been adequately explained? It seems inconceivable that doctors are bombarded with a whole range of other information and various legislation they need to comply with.

Mr JOHNSTONE — I think it is our responsibility. It is the battle between the resourcing issue of how many of us there are and how hard it is to cope with the current workload. To add the education responsibility on top of that would be extremely difficult. Remember, the understanding of the fact that there is a level of underreporting has really only clarified itself in the last three or four years.

Mr LUPTON — You really say the definition is essentially circular, don't you? That is the fundamental problem?

Mr JOHNSTONE — Yes.

The CHAIR — I do not understand why a doctor does not understand 'unexpected, unnatural or violent or to have resulted, directly or indirectly, from accident or injury' just as a starting point. That seems fairly clear. Then there are the anaesthetic-related deaths, but I do not understand why a doctor does not understand that.

Mr JOHNSTONE — It is unexpected by whom, by the family, by the doctor, and at what stage? There is a range of difficulties with that.

Mr MAUGHAN — Is there some concern on the doctor's part that reporting a death might involve them in additional work and having to do a report?

Mr JOHNSTONE — No doubt there is a range of issues from not wishing to upset the family, not wishing to put the family through the post-mortem and coronial process to wishing to finalise the matter. There would be a range of concerns from those to possibly down to something might have gone wrong here and we do not want to get involved in the coronial process. There is a fear of the coronial process, too; it is a genuine fear in the sense the investigation and inquest process brings media attention and whilst in some cases a doctor may well have acted appropriately and the death occurred, the lead-up to the investigation and the investigation take a while for the coroner to find that is the case. There might be media attention that goes the other way for a while, and that is never corrected.

The CHAIR — I suppose one of the reasons that was advanced when we looked at the systems in the UK and Finland for reporting all deaths was to reduce the stigma. It was felt that if there were only certain categories reported, somehow if you were reporting a death it might be regarded as suspicious or a problem; whereas if all deaths are systematically reported, it just becomes a natural part of the process. In Finland all deaths are not only reported but are investigated by police, which I thought was interesting. Can you comment on how we would deal with that situation here? You have indicated that auditing would be the best way to avoid a Shipman-like situation in Australia.

Mr JOHNSTONE — It is a balance of resourcing.

The CHAIR — If there were an auditing system, what level of audit would you propose? Is it something that would be done by your office?

Mr JOHNSTONE — I have left it open. It is a question of policy as to whether it is done by the coroner, the Institute, the Auditor-General, the Ombudsman or some other agency, but I would have thought that an auditing system ought to be random and regular. So there would be an audit system that requires hospitals and nursing homes to answer and present to the auditors what they have done, what deaths they have reported to the coroner and why, and why they have not reported other deaths.

The CHAIR — In Ontario I think they are doing 1 in 10 nursing homes. Would you regard that as a reasonable level of audit?

Mr JOHNSTONE — I suppose you would pick up the trends. What we have said here in relation to the nursing home issue is we need to educate those professionals who are working there in relation to the reporting of deaths, how it needs to be done and when it needs to be done, rather than having all nursing home deaths reported. Once you get them all reported there is the question of whether you investigate each and every one or whether you have a sifting process. In South Australia I do not think you would say that each nursing home death is actually investigated in any depth, and I think that is the expectation, that once it is reported it will be investigated in depth. It is a better process to actually have an educative role, an auditing role, and then have the coroner with an own-initiative or special-purpose investigation. Special-purpose investigation might mean I go into X nursing home for six months and just continually monitor the deaths over a six-months period, starting now for example — starting in advance — or go and look at the deaths six months back.

A special-purpose investigation process, a limited-purpose investigation process, would give you enormous ability to look at things like deaths from occupational disease for example. You would be able to say, 'I want to look at

deaths associated with coal dust or pot room asthma over a two-year period'. You would put the resources together and do it. Then you would find out what you need to find out from the prevention point of view, using a range of experts, a range of agencies, you make your recommendations and then you move on to another sphere of death, another area of death where you think there may need to be some work done on the prevention aspect. Therefore, whilst you are capturing some deaths, you are actually putting your resources in and concentrating on them, and you are not traumatising the families that are affected by that group of deaths for ever. You are actually learning and moving on. You may revisit it in a number of years time and see how the prevention activities have been undertaken, how successful they have been and what might need to be done to change the current methods to improve health and safety in that area.

The CHAIR — If we have a selective system where we say we will investigate certain types of death, what should be the criteria to apply to that investigation to decide that these deaths or this type of death will be investigated or will not? One of the things families have raised with us is the question of not being aware of what the investigation standards were or what they could expect or whether there would be a detailed investigation into the death of their loved one or not. How does that get structured up if we have got those different layers? Some death certificates are signed off, some are subject to an investigation, some are subject to an inquest — how does that work in your mind?

Mr JOHNSTONE — One of the difficulties is actually pinpointing the level of investigation into any particular death. Two deaths that might look the same and come from the same environment might require very different investigations because no death is the same — they are all different. As a coroner I have been doing this work for a number of years, and you will find that you learn something from each death. They are all different and they will all require different levels. To fix an investigation standard, other than a generic standard saying this is what we look for in general terms, I think is flawed, because it may mean that we then focus on the mediocre. We would just say, 'This is all we need to do. We will tick it off, and that is it'. Let us say you were developing a limited-purpose investigation into pot room asthma, for example, deaths associated with that, you would actually work with the experts, you would build up a process of what you were going to look for, and then you would start it. And probably as part of that process you would actually have an investigation standard developed, and then the families would know what you would be looking for once those deaths occurred.

The CHAIR — But the guidelines as to what is investigated and what is not investigated?

Mr JOHNSTONE — In general terms, under the current act every reportable death must be investigated. We have developed limited guidelines in some areas. We have developed guidelines in relation to transport-related deaths associated with the chain of responsibility. We have developed guidelines in relation to radiology-related diagnostic deaths. We have developed guidelines in relation to falls in the elderly and in hospitals — falls in hospitals mainly. Now those have to a certain extent been an experiment in relation to the development of guidelines. In some respects they have worked, in some respects they have not. With the radiology-related standard it is too early to work out whether it has worked, but it has been a standard that is more directed towards the organisations that deliver radiology services or the organisations that manage falls, for example in hospitals. It has had a twofold effect, I think, and it was planned to have a twofold effect. One is to actually say to the hospital, for example, 'This is what we are going to be looking for if we are going to be investigating a fall in your hospital. We are going to be asking you questions about what systems you have got in place to identify falls risk, what systems you have got in place to actually manage falls', and in a sense it is a twofold process. It is both a preventive investigation standard and an investigation standard that tells people what we will be looking for. But that has been developed with experts; all of those standards so far have been developed with the experts in the field.

The CHAIR — With decisions about investigation and then inquest, one of the issues that arose in our first day of hearings was the length of time it often takes to get to an inquest or to get a finding. Can you talk about that? Is this a resource issue or is it the nature of the way in which, when it does go to an inquest, the court operates or is it a combination of things?

Mr JOHNSTONE — There are a number of things. It depends on the complexity of the issues. It depends on the complexity also, as far as I am concerned, of the prevention issues associated with the particular death. I think, firstly, yes, resourcing is an issue. Remember when I started as a coroner with not a thousand less deaths reported probably, there were two of us. That was when I was deputy coroner. When I started as state coroner we started off with two and we came to three. Then we effectively developed to four; then we developed to five; and now we have got five and a part-timer. But there have been health problems and gaps in relation to those coroners

coming on board and there have been training issues with them, so yes, resourcing is an issue. And really one of the other issues is of course chambers findings, and with 4500 deaths reported every year we believe quite strongly that every family is entitled to a finding. That is not so for natural-cause deaths, but any of the violent, unnatural, medical adverse-event type deaths, accidental deaths, we believe the family is entitled to a finding, a record of what happened. That is resource intensive, because you are looking around \$2500 to \$3000 for it to be written. You will find other jurisdictions like New South Wales dispense with findings, they dispense with the inquest. Once they dispense with the inquest, they dispense with any record of what actually happened, so you do not have a coroner's record of what happened. You can find it from the file; by identifying the file you can find the initial police report. So effectively they will deliver findings in inquest cases.

We deliver findings in chambers findings or findings on the papers. We also deliver findings in inquest. We believe this is important for the National Coroners Information System, because it is important to have an explanation of what happened. If you are starting to look back and starting to try to find a trend or a pattern that has not been identified before, at least you have got some words around it. It might not be the full words, but unless you have got some words around it you will not necessarily find all the cases you want to look for. With the increased quality of investigation coming from police — when we started in 1988 the average file would not have been more than probably that thick, perhaps a bit thicker. For the transcript, I am demonstrating probably a quarter of an inch, perhaps up to half an inch. That would be the average coroner's file — from the statements and all the material — and the inquest finding would be one page, less than one page. It would not be a descriptor or summary of what occurred, so you would have to go through the statements to work out what happened.

We have got to a stage where we have increased quality of information from police and others that assist the coroner. We have got to the stage of having files that are as thick as if not many more volumes thicker than the thick file there in front of Iain West. We have to get through that material, and that is time consuming. So we have upped the ante in relation to the investigations and the quality of investigations, and that is not to say they are necessarily looking at everything a coroner needs. It is still police related, it comes from a police culture. Understandably they focus generally on criminality and negligence or blame or regulatory breaches. We believe our work is increasingly more looking at what are the systems behind these events, and that is far more complex. To build that into an investigatory culture is far more complex and difficult — it is gradually happening — but it is building the culture, and that is an important part of the process.

I admit there are consistent and regular delays, and that is one of our problems — it is one of my problems, effectively — but if you want to build a coronial process that does something about preventing death and injury in the future when you have limited resources, you will have delays. If you want to cut the work and not have a finding in relation to the chamber's work and say, 'No, this is not an inquest case; I will put the file away; I will not summarise what happened for the family' then that would free up considerable resources for us, but we would then be inquesting a lot of cases. In some of the chamber's work you can see quite high-quality reporting that deals with a lot of the prevention work and unpicks what occurs in the event.

Mr HILTON — Can I ask a different question, Graeme? When an inquest occurs, sometimes the feeling can be that it is trying to avoid blame rather than get at the truth; some of the parties involved in the inquest are represented by senior lawyers, but some people are not. I am wondering if you have any comment on that?

Mr JOHNSTONE — I agree with you completely, 100 per cent. It comes to another issue that is within the submission, which is an important issue that I have not yet mentioned — that is, the right of a party to refuse to answer on the grounds of self-incrimination. If the coroner's process is getting at truth, as a coroner I am frustrated. The families must be even more frustrated, because they come expecting to find out what happened and they do not hear from the principal players. The real shortcoming in that is not only from the family's point of view, the shortcoming is not really understood by the legal sector, and the shortcoming is we do not get to the truth of the factors. If you really understand what the system problems are, and you get that from the principal players, you can then do something about far more accurate counter measures to prevent these deaths occurring in the future.

The coroner's role is really misunderstood, I think. It is not about blame, it is about finding the truth. 'What are the facts?'. Yes, from time to time coroners might criticise, but principally it is not about negligence, it is not about criminality, it is about finding — unpicking — the truth. Remember, I talked about human error. If you think about it in terms of finding out what the human error is and whether better training systems would have meant that this particular person had followed the right protocols and not acted in a way that caused this death — whether the person was fatigued, overtired and this is really why it happened and there is not a system in place to manage that

fatigue — and until we get to that level of depth, we are not going to be preventing these deaths or the injuries. That is not to say criminal behaviour or negligence or compensation processes do not have a role in the prevention of injury and death — they do — but they are only a tool in the process. The criminal behaviour is a tool for the really abhorrent-type behaviour. The vast majority of things we see are not that. They are humans being human and making errors.

Mr HILTON — What solution would you recommend in relation to that? Should we have everybody entitled to some legal representation or no-one entitled to any legal representation and, as you say, you just speak to the principals to find out exactly what happened?

Mr JOHNSTONE — It is a challenge to educate my own profession in relation to the coroner's role, and I am not suggesting it is not — it is a big challenge. It is a challenge to get the legal profession to come to the coroners court with a less defensive approach. If they come with a less defensive approach, there are lessons for the community. That is not to say that they do not protect their clients' interests. They do and they ought to. Removing the right to silence is a step in that direction. There are some tensions in that and there are strong opposition to that process, but ultimately you have other states and territories having the right of silence not being permitted.

The CHAIR — Is that not, though, a problem with becoming more judicial, which is one of the things you suggest in your submission, that whenever you have a quasi judicial or judicial process, people who could afford lawyers will have lawyers? Finding even that a death was preventable for an institution can have all sorts of connotations about other forms of legal liability.

Mr JOHNSTONE — Of course it can.

The CHAIR — One of the interesting things we observed in Toronto was the coroner saying, 'Let us get the parties around the table — not in a court, in a room — and let us try to find out what went wrong here. If you are going to bring lawyers, I am not going to do that. There are no lawyers there; it is just a process of getting at the truth, finding out what went wrong so that we can produce a finding that the families can feel that the death was not in vain and that becomes a matter of public record'. The recommendations, which everyone signs up to, then become part of a public record so that if it happens again in that hospital, nursing home or whatever the setting, at least there are coroner's recommendations on the record that said, 'We found that this is what happened and this is what should be done to prevent it happening again'. Is that another system that maybe we should look at?

Mr JOHNSTONE — Remember, I had nine years in the Small Claims Tribunal and Residential Tenancies Tribunal, so I am perfectly comfortable with that environment. No doubt it is an alternative that could work in some cases. I am perfectly happy with working with unrepresented parties. It does have its consequences, though — that is, the coroner needs to be an expert in all fields, not just medical. The coroner needs to be basically an injury-prevention specialist running right across all of the areas of hazard identification, risk management, injury prevention, medical, adverse-event management. To do that effectively you need to have that expertise, and it would not be a public process. Behind closed doors it may have its problems, and it may have its detractors. The consequences of another death occurring following a sign-up process may be to turn on the coroner or the coroner's system, because they have not done it properly.

The CHAIR — I am sorry, Graeme, what did you say? I missed it.

Mr JOHNSTON — It may be to turn on the coroner's system. Effectively in a round table process without the expertise and the public process, if it is a binding document, and it may have other consequences. Some of what we recommend may have other detrimental consequences we have not thought of, which needs time for reflection. That is why I am suggesting, effectively, a six-month turnaround for responses. By the way, I am suggesting a mandatory response process in this recommendation by government agencies. Whether that needs to be extended to all community agencies as well as other industry, I do not know.

Mr LUPTON — Why limit it? Is there any reason why any private organisation should not be subject to the same response process?

Mr JOHNSTON — No, I do not think there is. It seems to me to start the process with the government agencies and then perhaps move on a bit later to private agencies. I think it was a question of educating the private sector, that this is what we are doing — gradually bringing them on board in that regard and demonstrating that it is a sensible thing to do. In other words it is a slow process of gradually changing culture.

Getting back to what you are talking about with regard to a round table process, you might start with a halfway house. The halfway house might be an inquest process that is very much a round table: if legal representatives are there — it is recorded; it is run to a certain extent like an inquest, with questions and answers, but it starts to break down the more formal barriers of the thought process. I am not suggesting that what you talked about is out of the question. I think it can be managed in specific cases, but it has its real risks.

Mr LUPTON — What about giving the coroner a more active inquisitorial process? Perhaps the abolition or modification of the right to silence makes sure that questions that need to be asked are asked, rather than leaving it up to the parties.

Mr JOHNSTON — A proactive coroner is an inquisitor. I am in the arena all the time. But it is not the arena effectively, it is my job to ask questions.

Mr LUPTON — There is a flavour from some submissions from the public that family members have felt in particular cases that what they regarded as relevant questions may not have been asked. There may be an argument about whether they were really relevant or not, but there is clearly a feeling in any event that the legal process tends to restrict the flow of information sometimes rather than the other way around.

Mr JOHNSTON — There is no doubt it does in some cases.

Mr LUPTON — How would you see that being alleviated?

Mr JOHNSTON — I think a mix of processes from a more informal process to a formal process is a way to go. It may be that a more round-table discussion process will draw information out, but it also might have its limits in drawing information out.

Mr HILTON — My concern is that the role of lawyers is ipso facto to protect the interests of their clients in this inquest process. Therefore I am not sure that they are necessarily there to elicit information but to, as I said, protect the interests of people who are paying them to be their lawyers. I am just wondering how effective that sort of system is in determining what actually happened and what could be done in the future to stop it happening again.

Mr JOHNSTON — I think in some cases there are lawyers on both sides of the field. There are lawyers of the families, there are lawyers assisting the coroner and lawyer for other parties. And I could certainly say to you that there are cases I have run where I have not been able to get to the bottom of things for a while. I would say to you that generally it is a while. There would be cases where we have not fully got to the bottom of things because of the legal process and the protective role of the legal profession in the process. There are other cases in which we have actually drawn the information out — late in the field — and ascertained what actually happened. But in our society every party, including families, has the right to a lawyer, to be protected. I think you have to run an inquisitorial process with a balance. There still has to be a balance in that process, but you can free up and gradually develop a different culture by actually having a more informal process. I am not saying it will happen quickly. In some sectors if you go down that track it will not be well received. But if you leave it to the coroner and provide the coroner with the resources to do that properly, in some cases it could work.

Mr MAUGHAN — Graeme, you quite rightly talked about establishing the truth or establishing the facts rather than trying apportion blame. There has been quite some criticism of the coroners court with regard to not being able to identify systemic failures, particularly in the mental health system, in terms of not identifying inappropriate nursing practices, not following the accepted guidelines, using medication rather than tender loving care. I think specifically the problem is what is seen as being inappropriate discharge in far too many cases leading to suicide. Would you care to comment on identifying those systemic failures in the system and the number of cases that come before you?

Mr JOHNSTON — I would say to you, Noel, there are number of cases in which findings are made on those very issues, especially in relation to discharge. There are any number of cases that I know of where recommendations and comments have been made on those very issues over a period of years.

Mr MAUGHAN — Is there an argument then for putting all of those together and making a recommendation to the appropriate minister to do something about it?

Mr JOHNSTON — This is where I think there is another potential structure — that is, the process of the coroner reporting to Parliament every year. I am reluctant to say that the state coroner should be the font of all wisdom in relation to making recommendations because I think that is to diminish the role of all the other full-time coroners, or even part-time coroners. They may have a very useful role to contribute to public health and safety. In a report to Parliament the state coroner could draw together the threads and draw together the common recommendations. Even giving the state coroner another power to make an overarching recommendation, in relation to a series of deaths, that goes to Parliament might be a solution to that problem.

In relation to what you are talking about, there are some professional psychiatrists who are doing some research on a range of coroner's findings. They are with the Office of the Chief Psychiatrist doing research on a range of coroner's findings in the mental health sector. That is currently under way. We have been getting out all of those cases for the researchers. They are senior psychiatrists in the private psychiatric field.

Yet if you look at the clinical liaison service process, it is not resourced to look at mental health issues. We have got a suicide researcher position that is now vacant. We are about to readvertise that position. But in reality we need the same triaging, investigatory system for the mental health sector because, from my perspective as a coroner, I see the mental health sector as being an area where significant recommendations can be made. We have already influenced certain standards in the mental health sector in the management of families and listening to families, because families need to be heard in relation to managing their loved one. They know more about their loved one than anyone else does.

Mr MAUGHAN — They certainly do.

Mr JOHNSTONE — It is pretty obvious, and that occurs right across the health sector too. Families can detect that something is wrong with a loved one sometimes a lot earlier than the medical profession can. They have not in the past been really listened to; really heard.

Mr MAUGHAN — That advice is frequently ignored by the health authorities.

Mr JOHNSTONE — Yes, and we have made constant recommendations about those issues. In relation to the recommendation situation there are three principal recommenders in Victoria; three principal coroners who consistently make recommendations. There is certainly enormous potential to improve that with training. We are developing with the Victoria Police an investigation training module, a two-day course in relation to investigation techniques. That will mean police eventually — it will be the Australian Transport Safety Bureau — training on root cause analysis in relation to medical adverse events. We plan to get a spread of investigatory methodologies to train coroners to give them an introduction to investigation methodology and standards and how the different ones could interact in the coronial process. That training process is planned for the middle of next year.

Mr MAUGHAN — Do you think there is a case for formalising that process so that the coroner's office makes recommendations and the government, the minister, the department, whoever, formally responds to that in a given period of time?

Mr JOHNSTONE — That is what I was talking about earlier. That is a necessity. It is essential. It is essential for coroners to learn about how effective their recommendations are, or where they have missed, because just making a recommendation that this should be done safer is no recommendation at all. You have to actually hone it down. Sometimes it may be necessary to make a general recommendation, but as far as I am concerned the more effective the recommendation is the more targeted it is. You may have to run a series of recommendations. In one case you may have a series of recommendations that each builds on the other. That gets into another sphere and that is the need to educate, to train coroners in injury prevention techniques. We need to develop stronger relationships with Monash University Accident Research Centre, the James Goldston Faculty of Engineering and Physical Systems at Central Queensland University in Rockhampton and with Ballarat university. We need to build stronger relationships with those universities to actually introduce coroners to injury prevention, occupational health and safety; all of the techniques in design. That is why I am talking about James Goldston, MUARC and Ballarat — they have those mixed skills.

We really need to get coroners trained in those areas. They need to be introduced to them and trained in them. They need to understand how you can sometimes draw an enormous amount from looking at one death that can actually prevent the next one. To a certain extent we have not done that; at least I have not. I understand how a lot of those systems work because I have worked with the people involved in them for years now; at least from 1988 onwards. I

have seen them develop and grow. I have seen the injury prevention community develop and grow. Real design safety is still in its infancy, and you can see that the Occupational Health and Safety Act has just been amended requiring manufacturers to have responsibility in relation to designing safe workplaces or machinery that is used in workplaces. That is in its infancy.

The CHAIR — You are a full-time coroner?

Mr JOHNSTONE — Yes.

The CHAIR — We have a lot of people out in the country who play the role of part-time coroners. They are principally magistrates and they see this very much as a secondary role.

Mr JOHNSTONE — Yes. When saying ‘yes’, I am agreeing with you completely.

The CHAIR — How do we get beyond that sense that in a way they act as magistrates as coroners? Some of the feedback we have had is that, if anything, it is even more pronounced, that they do not seem to have that full coronial context about how they need to operate with the families and with the various agencies and organisations that they are required to investigate. Beyond training, are there any other ways in which we can lift the standard in country areas?

Mr JOHNSTONE — There are two alternatives. There is to identify six or seven — perhaps a few more; perhaps eight or so — coroners in the country as being the ones to do the principal coronial work; ensure that that is an important part of their job in discussions with the chief magistrate; introduce them to training; give them the relevant support services, the advice and assistance from the centre, including — if we have a research office — the ability for researchers to talk to them about cases they are looking at and what might come from that case; having a computerised administrative system that runs statewide rather than just in Melbourne; and regularly introducing them to training. We have had two training courses, one in May 2003 and one in May this year, at which a number of coroners from the country attended. At least the last one has delivered a really important message to a number of country coroners about the importance of the work. After all, the work is about saving lives and reducing injury, and what could be more important than quality investigation which leads to that? It not only leads to that, but it helps the families in understanding what happened. We also need to bring them back through the coronial service in Melbourne on a regular basis to ensure they are actually up to date. Alternatively you could have those eight or so out in the country and more full-time coroners to visit the country and do the more significant cases.

Mr MAUGHAN — Is there an argument to have full-time coroners who are essential on circuit and go out into the country?

Mr JOHNSTONE — Of course there is, it is a question of resourcing. It is a question of whether people in the country would accept that as being a reasonable management process. It is also important to have the local coroner. Provided the local coroner is committed to coronial work and improving the safety of the community, the local coroner has far more pull and potential than someone coming from the city. Someone who effectively draws together a range of the social public safety issues in the bush is more likely to influence them than me going in, for example.

Mr MAUGHAN — You have identified in your submission the increasing lack, it seems to me, of services in country areas in terms of doing pathology and post-mortems and so on.

Mr JOHNSTONE — And the counselling and support services — there are none.

Mr MAUGHAN — And that is very important, but just looking at the actual technical services, have you any suggestions as to how that might be resolved? You indicate again in your submission that in terms of coronial inquiries, people in country areas are entitled to the same sorts of services as those who live in the metropolitan area, and yet the services are lacking to provide on a timely and effective basis those sorts of investigatory requirements. Any ideas on how that might be improved, other than just providing additional resources?

Mr JOHNSTONE — I think you could bring more bodies of deceased persons into the metropolitan area, but again that is going to be resource intensive and it is going to create a good deal of emotional difficulties for the family. I do not know whether that is a solution. With the decreasing numbers of pathologists — the lack of pathologists nationally — it is a national problem. I cannot see a solution there without resourcing. Stephen

Cordner or David Ranson could probably give you some ideas. There are some ideas about providing studentships and the like for pathologists, encouraging them into forensic pathology, but when you realise that forensic pathologists work in this state for a considerable amount less than what private pathologists might earn, it is a real problem, I think.

The CHAIR — Just following on from that question of expertise, whilst we were away we had an opportunity to look at systems which operate principally on a medical examiner model — in other words, someone who had specific medical expertise was the person who was doing the investigation. That was particularly the case in Finland, obviously. They had medical investigation and they had medico-legal investigation, which was more the role of the police. I notice the Victorian Institute of Forensic Medicine submission suggests that it take responsibility for a number of the initial stages of an investigation, and particularly those cases which you could see as being more about medical investigation, that it should be looking at those and that any that involved legal investigation should be referred to the coroner. Do you have any comments on that proposal?

Mr JOHNSTONE — I see no difficulty in the Institute becoming more involved in the initial sifting process to start with. They have always had that ability if they wanted to.

In relation to the medical adverse event type process, I think the community might be a little more comfortable if you had a legal independent judicial process looking at those, provided it is properly resourced. That can be done with the CLS-type team involvement, which is effectively involving almost a de facto medical examiner but legal control model — legal oversight model — and I think it does work. It does break down some of the barriers within the medical profession to telling us what happened. It does enable us to look at broader system issues, because remember the things we see do not just occur in one hospital. Most of them seem to occur right across hospitals. The fixing might happen in one ward in one hospital, but it does not spread to other wards and it does not spread to other hospitals. We find that what one hospital learns is not transferred to the rest of the hospital sector.

I think there are in-house investigations into medical adverse events at the moment — the root cause analysis central events system. There is obviously the Australian Council for Safety and Quality in Health Care nationally. There are the consultative councils. There is no external public oversight, though. I think the judicial coronial process is the external public oversight but working with the medical side, and I think we already have that marriage. It may be able to be improved, but we have already got that marriage. If you go down the medical examiner system, I think there is a problem. And the problem is it will not be looking at the broader systems. It will not be looking at the design issues associated with this. It will not be looking at broader fire safety issues, for example. I have not talked about fire. Do I have time to talk about fire?

The CHAIR — It is up to you. We have a couple of other areas to cover.

Mr JOHNSTONE — If you look at the fundamental review, and you look at the Luce report and the fundamental review, you see that effectively it is a map of the Victorian system. It has its strong differences because the population is 20 times greater than Victoria, but effectively you can see once you know the Victorian system, you read through the Luce report and you see aspects right through it of the Victorian system and what we are doing in Victoria. There are differences for England. They have not gone down a medical examiner model, although they have added the medical examiner front end because they recognise that problem is so broad and so big with 500 000 deaths, or something like that, across a country with a population of 20 million. It is more than 20 million; what is it?

The CHAIR — Fifty.

Mr JOHNSTONE — Fifty, sorry, and with 500 000 deaths they have a far greater problem. We have the ability to be very small but do it well, and I think if you go down the medical examiner system, you will not be looking at the broad injury issues, you will not be looking at the legal issues as they link into the injury issues. You will not be looking at the equipment design issues, you will not be looking at a range of cooperative work that we already do with other agencies to work on death and injury prevention, and this is what we have not talked about.

The CHAIR — I will just take you back to the issue of hospitals and nursing homes. A number of submissions to the inquiry and a number of witnesses at the last public hearing raised concerns about the Department of Human Services offering lawyers to the police to do the questioning of medical witnesses. Some people were concerned about this practice, particularly given the role of the department and the hospital in funding,

supporting and oversighting the system. In your experience how often does that occur and do you have any comments on it as a practice?

Mr JOHNSTONE — I do not know whether the department offers lawyers, but if that is the case, that would trouble me.

The CHAIR — And hospitals.

Mr JOHNSTONE — There are medical defence systems and hospital lawyers who do deal with the statements of the witnesses.

The CHAIR — They are interviewing medical witnesses and drafting the statements for them?

Mr JOHNSTONE — That is correct.

The CHAIR — Lawyers employed by the hospitals?

Mr JOHNSTONE — That is correct.

The CHAIR — And the police then rely on those statements.

Mr JOHNSTONE — We also look at the medical record. We have the clinical liaison service, which overviews what occurs in the medical record. The statements are not the only thing we look at. I think again it is a resources issue. If one sends police in to do the investigating, there is an issue of the knowledge base from where police come from in relation to interviewing witnesses in a medical setting.

The CHAIR — Who should interview them?

Mr JOHNSTONE — Ideally you would have a separate team of lawyers or specialists who would interview medical witnesses — trained specialists, probably.

Mr LUPTON — Should they be under the coroner's office?

Mr JOHNSTONE — The ones working for the coroner's office, yes, but that will be resource intensive. What are we doing? Are we going down the process of trying to blame the individual hospital or — —

The CHAIR — We are trying to find out what happened.

Mr JOHNSTONE — Or are we looking for system issues? And that is the problem. I think you can often find the system issues by looking at the statements, looking at the medical records, and with expertise sifting that information. You can unpick what goes on and you can ask for more information.

Mr LUPTON — The assumption underlying this query is obviously that the lawyers' involvement sanitises the statement to the point where it becomes ineffectual. From your experience is that the case; how do you deal with it; and how should we deal with it?

Mr JOHNSTONE — My deputy says to me, quite rightly, that if it is sanitised it can be dealt with in the court, in the witness box, if you are running an inquest, and often you will discover that it is sanitised quite easily. It is not a difficult question for an experienced coroner, and that often turns out to be worse for the witness and for the institution.

Mr LUPTON — So you do not see it as big a problem as some may think?

Mr JOHNSTONE — It is concerning, and sometimes we have discovered handwritten statements that are different to the statements that are presented to us. They surface from time to time, but we comment on those issues.

Mr HILTON — You said it is easy for an experienced coroner to determine that something has been sanitised, and yet we have acknowledged that in the country some of the coroners are very much part time and inexperienced. Is there a conflict in what you just said then?

Mr JOHNSTONE — I would agree with that, but again we are talking about how we would get a better service in the country. Obviously if we have better-trained country coroners, that problem will start to diminish, and certainly if we have a full-time service visiting the country it is a different question. But I should say to you that what happens with the clinical liaison service management is that we start with a process of sifting through the medical records and looking at what we need. We then go through a process of saying, ‘Do we need statements here? What statements do we need from what witnesses, and what questions do we need asked?’. This is what we target. We then get the answers back. If they do not satisfy us, we go back again. We might go back three or four times, and by the time we go back that many times we will be saying we need to run an inquest. If they are not answering, that material goes out for an expert opinion or a number of expert opinions in key areas. Whilst on a case-by-case basis, families might be troubled by that, I think the problem starts to diminish as the expertise in the investigation starts to build itself — in other words, the clinical liaison service. I fall back to that all the time. I think it has only been running for about three years, so it is new and has got a way to develop.

The CHAIR — In your submission you indicated that the criteria for mandatory inquests should essentially be amended to only include those where the cause of death in this group of people is unknown or not a natural cause of death, and I am thinking particularly of in-care deaths. I suppose the dilemma there is how would you actually know until you held an inquest — for example, if there are issues of concerns about cover-up?

Mr JOHNSTONE — You still have to have a brief of evidence, and the family will be involved in making a statement for that brief of evidence, if those concerns should be there. Obviously if it is a natural-cause death and there are medical management issues in it, it will go through the clinical liaison service. That would be a normal process. I would envisage what could be done is that perhaps only full-time coroners would do the mandatory inquest process.

The CHAIR — What would be the criteria? Are you basically saying if it is unknown or not a natural-cause death it would be mandatory in care, but otherwise it would be entirely up to the coroner? What would be the criteria?

Mr JOHNSTONE — The criteria would be the normal things that you look for — public health and safety or treatment issues. There would be surrounding treatment issues involved in the management and treatment of that particular person. Remember, we are limited at the moment. What we do has effectively got to relate to the cause of death. We cannot go outside that — for example, if a safety issue comes forward that is not related to the cause of death, the coroner technically is not to go down that track.

The CHAIR — What is your rationale for moving away from mandatory?

Mr JOHNSTONE — Resourcing. As my registrar says, it is still reportable; it is still a coroner’s investigation.

The CHAIR — But not an inquest?

Mr JOHNSTONE — Not necessarily an inquest. It has to be assessed as to whether or not it is an inquest. That is not a question. It is a question of your having to assess it and work out whether it is necessary.

Mr MAUGHAN — I have a quick final question on authorising autopsies. I understand there is a delegated authority for clerical staff in the coroner’s office to be able to order autopsies. There are concerns from other segments of the community that that is the case.

Mr JOHNSTONE — Agreed.

Mr MAUGHAN — You agree? Thank you.

Mr JOHNSTONE — I agree completely. It is in our submission that it is being reviewed, and I do not think it is going to continue. A lot of the work has been done around the institute actually making the assessments or assisting us in making the assessments, so it is not just clerical; it is really a team approach to the process. There is often discussion with full-time coroners on a regular basis. Remember, we are on duty a lot of the time. Most of the time either Iain or I are on duty 24 hours a day, 7 days a week on rotation, and there is a duty coroner at the Coronial Services Centre, so there is often free flow of discussion between the pathologists, the clerks and the registrar about a particular case. But really I think that process can stop now that we have almost six coroners.

The CHAIR — Thanks, Graeme, we are out of time. Thank you also for your very comprehensive submission. There is a lot in it, and we have not necessarily covered all aspects of it, because there was a lot that was self-evident in terms of the submission. We thank you for those thoughts and insights from your experience and role, and we thank Iain and Rick for coming with you.

Witnesses withdrew.