

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Witnesses

Professor S. Cordner;
Associate Professor D. Wells; and
Ms H. McKelvie, Manager, Medico-Legal Policy and Projects, Victorian Institute of Forensic
Medicine.

The CHAIR — I welcome Professor Stephen Cordner from the Victorian Institute of Forensic Medicine and his colleague Professor David Wells.

Prof. CORDNER — And Helen McKelvie, who is a lawyer with a background in law reform and who has been with the institute for eight years or so now. She helps us with all of our medico-legal matters and development of projects. It has been a wonderful thing having a lawyer directly engaged in a forensic medicine institution.

The CHAIR — Terrific. Thanks very much for coming along. Professor Cordner, would you like to take us, along with your colleagues, through your submission? Obviously if you want to talk to it for half an hour, do so, but we have found the useful part is getting into the questions and teasing out some of the issues. But I will leave that to your discretion. The time is yours to use as you wish.

Prof. CORDNER — Perhaps there are really two parts to how we thought we might deal with this. Firstly, I might ask David Wells to speak, after which he may have to leave. David has direct responsibility within the institute for the recent development in the multiple child deaths legislation that you are aware of, where second and subsequent child deaths in families must be reported to the coroner as a reviewable death and the coroner refers that on to the institute. I might ask David to open the batting with that, and when that is finished we can move on to the reportable side of the coroner's jurisdiction insofar as it relates to us.

Assoc. Prof. WELLS — Would I be right in assuming that the committee is aware of that reviewable deaths amendment?

The CHAIR — Yes, we are.

Assoc. Prof. WELLS — I will leave all that out, and I will be very brief. The amendment charged the institute with responsibility for delivering an assessment into the health and wellbeing of any surviving children in those families and into the health of the parents of the deceased children. The amendment, however, did not define when the institute's responsibility towards both the living children and any subsequent children or to the family ceased, so there is no definition of when our responsibility is discharged. We sought legal advice as to how that might be best addressed, and the Crown counsel concluded that the institute had an ongoing role in relation to the family of the deceased child whose death constituted a reviewable death.

Remember that we are only six months into this new legislation, but on our current figures in that six months we have 13 reviewable deaths. We thought this would run in the range of roughly 30 to 40 deaths per year, so that is probably going to be largely on track, although certainly last week there were 5 deaths added to that — in one week. On that basis and on the basis that there are 1.3 surviving children in each family that we have dealt with so far, we will have 86 people each year for whom we will be responsible for ongoing monitoring. In 10 years that will be in excess of 800 people — 300 children. If we are going to have a responsibility in the ongoing management of these children and families and any subsequent children, this will have an enormous financial implication for the institute.

Secondly, it has the potential to be extraordinarily intrusive for the families that we would be charged with monitoring, because how else does one monitor the health and wellbeing of surviving children and the health of a parent without a fairly conscious and careful monitoring of that family? Monitoring these families 7, 8, 10 years down the line on a regular basis to the point that one has to be comfortable about their health and welfare will be an intrusive and I think very distressing phase for many of these families. What we are asking is that we would like to see some form of legislative amendment to define the extent of our responsibilities to these families. That is essentially where we are at the moment, because at the moment the legislation provides no definition, and in many of these cases — and I am particularly referring to hereditary diseases or premature births — we do not see any role in following these families up long term.

Prof. CORDNER — I might just supplement that by saying I do not think it was actually intended that there be ongoing continual monitoring. It was intended that it be a one-off, snapshot view, an opinion formed, a referral perhaps to that part of the Department of Human Services, but in every case a report back to the coroner, and the coroner agrees.

Mr LUPTON — We will take that as adopted.

Assoc. Prof. WELLS — We have some common ground.

The CHAIR — Is that it?

Assoc. Prof. WELLS — I think that is essentially it. In a small number of cases we are identifying high-risk individuals, high-risk families. We are informing the Department of Human Services over those and it provides continuous monitoring, particularly in that acute situation or if future children are born, but in the majority of cases there would be no indication to provide or be part of these families' lives for the next few years, which must be a very distressing process for them.

Mr MAUGHAN — What would be the best guess out of the 30 per annum that you are expecting of those that you think would require ongoing monitoring?

Assoc. Prof. WELLS — It is very early days. As I said, in the first six months there were 13 such cases of which two families — that is, two of the cases that came to us — we referred on to DHS for some concerns there. In the whole scale of it, it related to concerns about parenting skills, some general welfare issues, rather than anything that directly attributed to the child's death.

Mr MAUGHAN — Maybe 20 per cent, something like that?

Assoc. Prof. WELLS — Possibly in that order, but we are drawing a careful extrapolation.

Mr LUPTON — We had some evidence earlier from representatives of the Royal Women's Hospital about peri-natal deaths and how they have been incorporated into the reportable deaths system through this amendment. Are you finding that you are now caught up in that and that those deaths would also be the subject of ongoing monitoring if there were no such amendment as you are suggesting?

Assoc. Prof. WELLS — Yes. The largest contributor to our number is children born with extreme prematurity or birth defects. By definition they become reviewable deaths and by definition, at this stage, we would be responsible for monitoring them into the future.

Mr LUPTON — There is no evidence to suggest that there is any reason for that? For monitoring in this situation?

Assoc. Prof. WELLS — No.

The CHAIR — Can you outline for the committee, just so that we have it absolutely clear, what you understand to be the current legislative requirements in relation to monitoring for the institute, what you believe you are expected to do and how often you are expected to do it?

Assoc. Prof. WELLS — The act does not specify that — it talks about the health and safety of a living sibling of a deceased child, the health of a parent of a deceased child — and makes no end point to that process. I would be happy to provide the committee with the Crown counsel's opinion on our obligations as he saw it.

The CHAIR — We would welcome to have that opinion, but could you summarise what you understand your statutory obligations to be?

Assoc. Prof. WELLS — Perhaps it might help if I read the conclusion from Crown counsel?

The CHAIR — Yes.

Assoc. Prof. WELLS — It states:

For the foregoing reasons, it is my opinion that there is an ongoing role for the VIFM derived from the powers with which that body has been conferred by the amendments to the Coroners Act. Those powers will be exercisable by the VIFM as appropriate where siblings are born after a death which constitutes a reviewable death.

So effectively an ongoing role and also a role with any future children that are born to those families.'

The CHAIR — How are you interpreting that ongoing role? What do you see that constituting from your point of view? What do you understand your obligation to be?

Assoc. Prof. WELLS — I find that a very difficult issue. On one hand, and I am very sympathetic to the role of the Department of Human Services in these high-risk cases of monitoring these children on a day-to-day basis, the only way to guarantee the safety of these children might be to remove them from families, but clearly that is not something that would be approached lightly. I do not think any of us can really understand the dynamics in a household where a child has been lost. There are some groups where you would feel there is cause for concern which might be approachable through educational processes, by greater resources, by some sorts of assistance — respite care or other interventions — and at the other end of the spectrum a much more physical response of supervised care at all times. But I see that latter group as being a tiny number in the total.

Mr MAUGHAN — Has there been any discussion with the department or the minister's office on this issue to see if that is really what was intended or whether it was an unintended consequence of not properly thinking out the legislation?

Prof. CORDNER — There was a little bit of discussion and, generally speaking, there was some sort of sympathy for our point of view.

Ms McKELVIE — I can speak personally from having sat with parliamentary counsel trying to write up the actual legislation, and it definitely was not part of the thinking at that stage. It was definitely an unintended consequence of the amendments.

Mr MAUGHAN — Thank you.

Assoc. Prof. WELLS — I suppose, to get back to your question, we have struggled with this idea of how do we monitor these families in the long term. The thought of making a physical contact — telephoning, presenting on a doorstep or something like that — three months or six months or every year onwards and how does that really give you a good feel of what is going on inside that household, and the answer is it cannot.

Prof. CORDNER — I think it would be reasonably straightforward to say that our responsibility ceases once we have either reported the need for protection and/or reported to the state coroner, who might then ask us to do something else, we are not activated until we are asked by the state coroner to do something else. I think it would be fairly easy to say that that is when it terminates.

The CHAIR — I am trying to get at and understand what your role is vis-a-vis child protection and vis-a-vis the coroner as to whether you are concerned about this area and the potential downstream resource implications. I get some sense that you are also raising questions about your professional expertise in that area and whether it is appropriate for you to have an ongoing role, and what changes you are looking for to the Act in relation to this area.

Prof. CORDNER — I think, as David suggested, a definition of when the responsibility stops, so that it stops if there is a report to child protection and/or when we report back to the state coroner. Since one of our reports might be that there is need for further investigation, it is possible that the state coroner might ask us to do more, but, generally speaking, a report back to the state coroner is, 'Here is the snapshot and we have decided yes or no to report the matter to child protection'. That is it essentially. There are other obligations in section 66A(4), but the action are those two items that I have mentioned.

Mr LUPTON — There would also be a call presumably for some of those deaths, such as were spoken about by the Royal Women's Hospital, to be removed from the process altogether?

Prof. CORDNER — You mean late terminations and things like that?

Mr LUPTON — No, I mean peri-natal deaths through genetic factors or other high-risk factors that that sort of hospital deals with on a regular basis where there is no evidence to suggest there is any kind of child-protection-type issues.

Prof. CORDNER — Yes. That all gets caught up with those cases needing child protection, because it is very difficult. If you are interested in child protection you just cannot draw the line.

Mr LUPTON — It is a difficult definitional issue admittedly, but all the same one worth looking at?

Prof. CORDNER — Yes. It would have to be said the institute is a public body and does what it is asked to do, but this would be a relatively unique responsibility for such an institution in the world. Please do not get me wrong. I am not complaining in the slightest, and we will do it, but it is an interesting additional obligation for an institute of forensic medicine.

The CHAIR — I think we have covered that particular issue. Do you want to now talk about any other aspects of your submission.

Prof. CORDNER — Yes.

The CHAIR — If Professor Wells has to go we will be more than comfortable with that.

Assoc. Prof. WELLS — I will wander off shortly, if I may.

Prof. CORDNER — I do not propose to go through our submission at all. We would much rather be guided by having a conversation with you about any questions you have got. We have tabled a page or two, and perhaps I might just speak to them in a couple of minutes and then be guided by questions. During the course of the conversation we might introduce a couple of things that we would like to make comment about arising from the coroner's submission. If they do not come up during conversation perhaps I could just mention them at the end.

In relation to sort of headlines, if you like, of what we would like the committee to perhaps turn its mind to if it does nothing else in relation to the institute's submission: first and foremost, we are 110 per cent behind the notion that prevention should be part of the aims of the Coroners Act. I think there would be a discussion to be had about the value of a coronial system at all if that is not part of the aims of a Coroners Act. There might be conversation that flows from that, but I think that would be, from our point of view, a must for the development of a new and 21st century kind of system for Victoria.

The second headline, which is summarised on the back page, the very last page of our submission, which sets out our model — it can be summarised, really, at the base of that triangle. The institute believes it could bring to bear some of its health care, medically based values and experience at the front end of the coronial system. It may be that parts of the front end of a coroner's system could be handled with more of a health care, medical orientation rather than as they have been, with the very best of intentions and for historical reasons, by an obviously legally focused enterprise. I am happy to discuss that further if you wish.

It could be summarised in this way: you have been to see some other systems, and you have heard of and seen a medical examiner system. We are not sitting here advocating a medical examiner system. The real weakness of a medical examiner system is exemplified in the United States of America in that there are no public hearings and there is no public accountability in the same way as there is in Victoria and Australia, where there are very strong public accountabilities inherent in the process which just simply are not there in the medical examiner system. That requires a legal framework. It requires magistrates and judicial officers to administer it, which is their background and training. We are not advocating a medical examiner system, but we do believe the system as a whole could be strengthened by introducing some elements of that at the front end.

A small headline, but one that is dear to our hearts: you have heard of the Donor Tissue Bank of Victoria, which is in existence partly because of the tremendous support it has had from the two state coroners since it began — Hal Hallenstein and Graeme Johnstone — but it is only because of coronial dispensation that the Donor Tissue Bank of Victoria has access to the relatives and next of kin. A different state coroner could take a different view. It probably would not happen, because it is hard to imagine that a state coroner would take such a view, but it is a vulnerability for the Donor Tissue Bank of Victoria that there might one day be a state coroner that for some reason does not like tissue transplantation and could make it difficult for the tissue bank to access families.

We would be very keen on some sort of — for want of a better word; I am not a lawyer — *prima-facie* right for the tissue bank to access relatives, which of course in particular cases could be overridden by coronial requirements, but the starting point should be that the tissue bank has a right to approach next of kin. I do not think I need to say any more. We have made our submission and would be delighted to have some conversation.

The CHAIR — Thank you for that, and thank you for your comprehensive submission. This up-front role that you talk about in relation to death investigation which you are seeing as an initial up-front role, when we asked the coroner about that he raised some questions about whether or not medical practitioners would have the skills to

undertake that investigation in the way in which a lawyer does. We were also talking about the other systems such as the Finnish system, where they have a medical examiner system and a medico-legal and a medical stream, so perhaps he was referring more to that. What are the strengths that you think medical practitioners could bring to initial death investigation?

Prof. CORDNER — It should be seen a bit more as a screening function, and in the coroner's own submission there is a distinction between those deaths where there is a public interest in prevention and other aspects of the death and so-called natural deaths. That distinction is drawn in the coroner's submission, and it is within that area of natural death, because we would say that some of those natural deaths have got serious public policy issues and within those deaths are adverse events — for example, adverse health care events. There are still a substantial number of deaths where the death has been reported because it was sudden and, we use the word 'unexpected', with no medical history and no doctor around to sign a death certificate. As I understand it, the coroner takes a view following the autopsy, if it is a coronary artery disease death, for example, that actually that death is now no longer a reportable death and therefore the coroner does not have jurisdiction. I do not think everybody has that analysis, but some of the coroners certainly do. That is where we think the medical and health care-type orientation can be of benefit, because obviously every one of those deaths is a tragedy — there are families, there are things to be learnt from those deaths that can be used for the benefit of families, there can be incidental disease found which has a genetic basis, there can be opportunities for relatives to donate tissue for transplantation or research, there is information of a public health and safety kind that can still be garnered from such deaths. There is still a rich contribution for both involved families and also their community from those deaths. It could be harnessed by a sort of health care approach.

The CHAIR — I am trying to look at the boundary issues here. You get a reportable death out of a hospital. It comes initially to you. You call for the file. In your submission you talk about requiring legal investigation. That it is not necessarily a criminal matter, but there may be issues around negligence or misadventure. Do you deal with that, or does the coroner deal with that? What is the boundary?

Prof. CORDNER — The first thing to be said is that in the framework for this the coroner sits at the top. The framework will be in accordance with the legislation and in accordance with the coroner being satisfied. The other thing to be said is that the coroner is still sitting at the top of the investigation of any particular case; he can still come in over the top of it.

The CHAIR — He would have the oversight of all the investigation?

Prof. CORDNER — Yes, ultimately so. Our policies and procedures all have to be acceptable to the coroner. But the starting point is that the coroner has, to use the word loosely, lost interest in a lot of cases relatively early because they are not deaths which have a high load of public interest or preventability or accountability issues. Clearly with deaths where the screening process throws up issues of accountability or preventability, they proceed along that path, which might end up with an inquest but certainly would include direct coronial involvement. But we are talking about over 1000 deaths a year where at the end of the autopsy essentially the thing stops, because it was coronary artery disease or pulmonary embolism and it is obvious that there is no issue or problem there of a public kind. We are saying that it is a screening test, where the conclusion at the end of the screening is that there are really only private issues and not public issues at stake.

Mr LUPTON — It seems to be implicit in what you are saying that you would be advocating a system that would have more reportable deaths in it, because they would need to get reported in the first place, even though they turn out to be deaths by natural causes.

Prof. CORDNER — I am not advocating any more reportable deaths, I can tell you that.

Mr LUPTON — That is the problem with what I understand you are saying. If we go to the kind of recommendation that the coroner has made, that the definition be changed to bring in a definition of 'natural causes death' —

Prof. CORDNER — That is one of the things that I would have mentioned. I should distinguish between the Institute's submission, which is an Institute document which has gone through the Council of the Institute, and our comments here today, which clearly cannot be regarded as having gone through the Council of the Institute. So this is the executive, if you like, of the Institute talking, not the actual Council of the Institute. That is the first thing to be said.

With regard to definitions of reportable deaths, that is a serious challenge for you because I do not think you will be able to come up with a definition that is really much better than what is already there. I would be very interested to see how you manage that. And with the greatest of respect to the coroner's submission, I do not think it fits the bill either, because its use of trying to turn it around, if you like, to define what is or is not a natural death just does the same thing. For example, it makes reference to a natural death being organ failure and then not due to a lot of things. It basically means that every cigarette-related death and every alcohol-related death is not a natural death and therefore has to be reported, which means we will have 20 000 deaths reported every year in Victoria. That is open to happen now, because with the way the definition is now you could construe tobacco-related deaths or alcohol-related deaths as unnatural deaths or deaths due directly or indirectly to accident or injury. So tobacco deaths are indirectly due to injury. Technically they are all reportable but there is quite a decent understanding that if we reported every carcinoma of the lung or heart disease due to smoking, we would be submerged. I do not think it will be got around with the definition that is in the coroner's submission.

The second thing about the definition in the coroner's submission, and I might be doing it a slight disservice, is a reference in it to a death not being expected following a health procedure being a death that is reportable. I just get the feeling that the person who wrote that might be thinking that that captures adverse events, but it does not capture adverse events because adverse events include failure to diagnose — which is not after a health procedure; it includes drug treatment — and it is probably stretching a point to say that drug treatment is a medical procedure — and failure to treat. So the late arrival of an ambulance is not captured by that. I have no difficulty with that specific thing about reporting deaths that are not expected following a health procedure, but if that is intended to capture adverse events, then it does not do that. People have been thinking for decades how to put firm walls around what deaths will be reported, and nobody has succeeded. So it will be very interesting to see whether you are able to do that.

The CHAIR — How could we do it in such a way that the medical profession understands more clearly their responsibility to report, given that in the coroner's submission we have evidence that since 2002 there has been a decline in the number of reportable deaths, which presumably is not as a result of there being less reportable deaths in hospitals or nursing homes but of just the decline in the responsibility of or the recognition by doctors and others that they should report. How do we encourage more reporting under the current act?

Prof. CORDNER — The figure that is in my mind — and I am very sorry David Ranson is not here to speak about it — is that there are about 1500 deaths in hospitals, either adverse-event deaths or deaths from admission to hospital because of some reportable-event-type injury, for example. But that is forgotten about by the time death occurs and the death is not reported to the coroner. There are those two sorts of categories. There are about 1500 of them in hospitals that are not reported. So even if nothing happens to the law, we have a time bomb waiting for us as the medical profession comes to grips with that, as slowly it surely will because of the sensitivity to adverse events and the increased profile of the coroner's system. So a corollary of how to get the medical profession to better understand is a substantially enlarged coroner's system, which is a serious consequence.

If that is a consequence that Victoria wants, how do you get doctors to better understand their obligation? It is possible — and this is an approach that Magistrate Heffey mentions in her submission — to perhaps engage the medical profession in the principles rather than a prescriptive detailed long list, to say, 'Doctor, turn your mind to the fact that the coroner's system is about prevention and then look at this list'. Of course that has the capacity for abuse and for things slipping through the net. But if you start from the point of view that the medical profession, which is where I would start, is interested in preventing illness and injury and death — and, yes, there are some that are not — then that might engage the profession a bit more intellectually in what this is all about and might mean some more fruitful involvement by them in individual cases. But I do not think anybody has a magic solution. Do you think that adequately represents — —

Ms McKELVIE — Yes.

The CHAIR — Your institute is part of Monash University and they train medical practitioners. In your experience have there been any improvements made to the training of undergraduate medical students that would mean they understand more their responsibility to report deaths?

Prof. CORDNER — It is five years instead of six! I really do believe that medical graduates today have a far better understanding of principles and approaches, where to go to find information and how to solve problems than I ever did. I was a sort of compressed package of facts, but of course that means that I knew which deaths were

reportable to coroners and they do not. Then you are faced with working out how to remedy that and it gets very difficult because the moment they leave university, they are dispersed. While they have been strongly educated in continuing learning and that they should appreciate that having graduated they have embarked upon lifelong learning, I suppose it does depend a bit on interest. The detail of deaths reportable to coroners is probably not at the top of the interests of most doctors. But that does not mean that serious thought cannot be given to ways of doing that, and you could say that the Institute has failed a bit in that regard over the years. It is quite difficult to get to the aggregated medical profession after graduation.

Ms McKELVIE — The fact that there are so many overseas trained doctors practising in Victoria also makes the task even harder — to capture them as a potential audience.

Prof. CORDNER — It is not just overseas but interstate doctors who come into our system. I think well over 20 per cent of doctors employed in the hospital system are not Victorian graduates.

Mr LUPTON — Does it not form part of the registration system at all? Should it; and how would you go about that?

Prof. CORDNER — To be registered now you need to have graduated.

Mr LUPTON — I was thinking more particularly of interstate and overseas practitioners coming to Victoria.

Prof. CORDNER — That is a big issue. I think you could talk to the Medical Practitioners Board of Victoria and perhaps also talk to the Medical Defence Association of Victoria and the Medical Indemnity Protection Society, you would find that they are all actively trying to think of ways of influencing the attitudes and behaviour of all the doctors that come into our system. We are finding — because we are involved with those organisations — to get to them as a group. You can produce materials and you can send out things, but to actually eyeball them and engage with them is impossible the way things are.

Mr LUPTON — Don't they have to turn up somewhere to gain registration?

Prof. CORDNER — They do, but they do not have to pass a test on which deaths are reportable to the coroner.

Mr MAUGHAN — You spoke about the importance of engaging with the medical profession about the importance of reporting deaths. Does not that same principle also apply to the broader community? Out there in the community if there is a better understanding of the importance of the coronial system in preventing death and injury and people accept the validity, the importance of the coronial system, then there is going to be public pressure to report more deaths to the coroner.

Prof. CORDNER — To the extent that members of the public think about it, I think they do understand, because so many people engaging with the coronial system say, 'We want to make sure this does not happen again'. That is the first thing that comes to most people's minds when they are involved with a contentious matter in the coronial system, so it is probably not a big hurdle to get over. Perhaps that also goes to: it should not be a big hurdle to get over with the medical profession itself. Maybe if they could engage more constructively with that, when they read the list it would be clearer to them what sort of deaths they should be reporting.

Mr MAUGHAN — Another one that is dear to my heart — and I am pleased that you included it in your submission — is the decline in the number of pathologists in country Victoria and the difficulty of getting a coronial investigation outside of Melbourne. I think Bendigo is currently the only one where you provide those services. I have read your solutions to the problem. Do you see any alternative other than bringing bodies to Melbourne?

Prof. CORDNER — We do not want that. I would have to say that the institute is vulnerable to criticism over forensic pathology services in northern regional Victoria. We are responsible for those forensic pathology services. The institute has been caught in a difficult position. Philosophically we know and understand that families want their deceased to stay within their locality. We also know that as far as forensic pathology is concerned the full-time practitioners are in Melbourne and that in respect of people in rural and regional Victoria it is a very small part of a much larger function those pathologists perform in regional hospitals. It is also a small function for the

regional hospitals and the mortuary may not be staffed — almost certainly it is not — 24 hours a day, seven days a week, so families are going to have difficulty accessing their loved one at times outside ordinary office hours.

That is only a description of the problem. As to how to fix it, we believe and the Institute wants coronial autopsies to continue to be performed in rural and regional Victoria. There should perhaps be — and it is happening *de facto* — a consolidation of the number of locations, perhaps to four or five locations, so that there is a larger core that might be, if you like, better managed rather than a greater number of smaller collections of deaths, and that work should be overseen to a much greater degree than we are able to do at the moment. We have not been able to apply any rigour, really, with our colleagues in the country because we are very vulnerable to them saying, ‘This is all too much trouble; we do not want to do it’. We would then be left with bodies actually coming to Melbourne.

Doing nothing, the drift is they will end up in Melbourne; in five years time, probably just by the drift that is currently happening. Wangaratta fell over earlier this year, as you mentioned; all those deceased have gone to Bendigo. No more can go to Bendigo because they cannot cope with it; they will end up coming to Melbourne. Geelong some years ago — and there are special issues about Geelong — gave it up. It is a difficult issue. We have been trying to address it. The department has been involved. The department would like to address it, but fundamentally that becomes a resource issue and a matter of priorities.

Mr MAUGHAN — I like the concept of a smaller number of more specialist facilities in much the same way as veterinary facilities: one in the north, one in the east, one in the west and so on. A smaller number of specialist ones would be better than the larger number we have had, most of which have now ceased with the exception of Bendigo.

Prof. CORDNER — There are some very keen pathologists out there. We run a meeting every three months and we invite all of them to come, but there are three or four that come regularly every time. One of them made a submission, Dr van der Hoeven. They should be supported and we should be looking after them better than perhaps we do.

The CHAIR — One of the issues we have to grapple with, that I suppose is linked to underreporting, is the whole question of whether or not there are deaths that — and I suppose I am referring to the Shipman situation — are reportable, should be reported, should be picked up as being deaths other than from natural causes, but are not. I know that you have had a role in testifying before the Shipman inquiry and providing expert advice to it. Can you talk a little bit more about the question of whether or not you should at least check or have a double-check on all death certificates, or an auditing system or a more systematic reporting of all deaths, particularly in the context of what is, I suppose, one of the strengths of the Finnish system where all deaths are reported is that there is no stigma attached to it. Everyone knows that as soon as someone dies that it is going to be reported and there is going to be some level at which it is dealt with. Can you comment on the inevitable tensions in having a selective system which does create stigma and a situation where deaths that should be looked at are missed?

Prof. CORDNER — For us it is an enormous issue and it is very difficult to encapsulate in a few sentences. The way I look at it is that you are really talking about the risk of a Shipman happening in Victoria — if that is what we are trying to prevent happening in Victoria. I think we have not done enough work on understanding whether there are reasons in Australia generally and Victoria in particular that might make it more or less likely that a Shipman is out there. There is an NHS —

The CHAIR — Or a Patel.

Prof. CORDNER — I think that is a little bit different, and we are still waiting for all the facts in Patel so that is a little bit hard. I would love to talk about that in a minute. That is a bit different because that happened well within the system, in hospital, and that bears on adverse events. I would like to see — and it is really social research that might unwrap a little bit what are the differences or similarities between the way our society in Victoria works and the way the society that Shipman was in worked that might mean that we are more or less exposed to that risk. My instincts tell me that we are probably less exposed to the risks, simply because I think we have a more communitarian aspect to the way we live. More people are talking to each other and more people are engaged with each other. These are the sorts of questions that bear on how much effort you would go to prevent Shipman, versus, if you are going to inject more resources, whether there would be better outcomes for prevention by putting those resources somewhere else, because whatever you suggest to cover 40 000 deaths is going to be expensive. That is

about as far as I go, really, because then you start talking about a second pair of eyes and a second mind being brought to bear. That becomes expensive and complicated and seems to me to be a whole inquiry on its own.

The CHAIR — You indicated that you thought more research was needed before you could contemplate such a system. What sort of research would be helpful?

Prof. CORDNER — It would be social science research about having a look at the detail of the sorts of things that went wrong in the, however many, 100 Shipman-type deaths and seeing how likely they would be to happen in various circumstances in Australia in city, suburban, regional and rural settings. I suppose the further out they get the less likely it would be that Shipman would happen in Victoria. I am afraid I cannot tell you whether that is feasible or possible or who would be able to do it. However, I personally do not think the evidence base is there to immediately jump in and go and spend what I would conservatively estimate would be about \$10 million a year having a second pair of medical eyes cast upon 35 000 deaths. Then, and I am sure the coroner has mentioned this, there are instruments of audit and engagement in the registrar's office. Somewhere we would say maybe you could do something with relatively modest resources, some medical input into an audit process in the registrar's office. It would not worry me, for example, if the registrar's office was within the coroner's jurisdiction. That would absolutely tie in any outcomes from that being right within the coroner's jurisdiction.

Ms McKELVIE — I might just mention in David Ranson's absence that I was impressed in his submission by the idea of having an electronically based death certification system. That would allow auditing in a much more efficient way by having a system where the doctors had to answer certain questions and they were led to one conclusion or another about whether a death was reportable. All that information would be captured and would be able to be audited. I am not an expert in how much that kind of system would cost but I think it would be significantly less than having a system that would capture all deaths being reported.

Mr LUPTON — It may be effective in getting the doctors to report more according to the definition as well?

Ms McKELVIE — Exactly.

Mr MAUGHAN — I think you have just put a very powerful argument for decentralising some of those aged care facilities. My experience is that in the smaller rural facilities there is a much greater degree of community involvement and therefore you are less likely to get a Shipman, as opposed to a very large institution in one of the regional cities or in the metropolitan area.

Ms McKELVIE — A few of the submissions mentioned we in Victoria and Australia generally having much more consumer awareness in terms of being health consumers, which I think is a major difference to what is going on in the UK. That ties in with what Professor Cordner is talking about in terms of needing to get a better picture of what socially is happening around health care consumerism.

Prof. CORDNER — David might like to comment on that.

Assoc. Prof. WELLS — Nowadays nearly all general practices, specialist practices and hospital practices have a computer terminal sitting on their desk. Most doctors are now using these computers to write out prescriptions. If we can write out a prescription on a computer terminal, then there is no reason such an important process as recording a death cannot go down exactly the same pathway with prompts and immediate rejection or whatever it may be rather than us getting a rejection days, weeks, months later.

Prof. CORDNER — It is very regrettable that David Ranson is not here to talk about that. It might be something you want to hear from him directly because he is an IT sort of wizard.

The CHAIR — We will see if we can create another opportunity; that would be good. One of the issues we are grappling with is this country-city divide in terms of the quality of service. The coroner has the advantage of having access not only to the considerable resources of your Institute but also the clinical liaison teams and so on. How would you deal with that issue in the country where you often have magistrates in part-time coronial capacities? There is a whole set of issues about their capacity to act as coroners in an inquisitorial system, having overseen an adversarial system. How would you build the medical expertise that they need to properly conduct their role?

Prof. CORDNER — I think that would be difficult. When I meet with the coroners when they come to the Coronial Services Centre, if they do not have a medical background, I usually say to a new coroner — and one has recently been appointed who was a nurse, and I was just saying the other day that it does not apply to her — it is going to take you three years here to really become familiar with the medical dimension of what it is you are dealing with: how hospitals work; what goes on in hospitals; hospitals as four-dimensional institutions, not the two dimensions as it appears in statements; how patients are dealt with and under what conditions; how to read an autopsy report; and all of that. It is actually a very demanding task. Once the coroners have got over that, I have never seen one that is not really good. It is just a matter of getting to that point. So how you do that in the country? I suppose you can — and I think this has been mooted — identify particularly magistrates who are perhaps going to embody coronership in that particular zone for a period and put training resources into that.

That does bear on training coroners more generally. It is interesting if you look at coroners' jurisdiction as being an inquisitorial jurisdiction as opposed to an adversarial one, all coroners come from the adversarial system in one form or another and bring all the attitudes and habits that are bred and developed in that organisation into a system that is really quite different. In the inquisitorial system in Europe all juridical figures are trained specifically for the purpose, so I do not think we have quite made the jump to that particular point. But it just goes to emphasise where it sounds like you are going, that there is a very important role to be played by training and education in this particular area. As to the specifics, you cannot have, or it is very difficult to have, a clinical liaison service in the regions when, as you have already heard, we are struggling with more fundamental things.

The CHAIR — I have a question on autopsies. Your submission refers to the fact that clerical staff have been delegated responsibility to order autopsies. Do you think there are any issues associated with that? Some people have raised questions about whether that should be delegated to clerical staff. We note that it was a recommendation in the Royal Liverpool children's inquiry report that the decision to order an autopsy should not be delegated to clerical staff. I am just wondering what your views are. We asked the coroner similarly about this practice.

Prof. CORDNER — I think that is shifting, even as we speak, so that there is more direct coronial involvement in the decision, and that is the way the law is structured at the moment. That is the right direction, and there are more coroners so there is more ability for them to become engaged in that sort of decision making. Of course in our submission we say that the institute perhaps, as part of that screening process, could perhaps deal with that. I am not going to push that out as a must-do, but that is the gist of our submission.

The way I really see things happening is more and more as part of an engagement with families, with coroners being involved much more as a last resort to make decisions about borderline cases or to reinforce clear-cut cases where the family do not want to accept the inevitability of something. The whole drift of what Victoria has been doing in metropolitan Melbourne has been very much more — and very much more so in the last two or three years — active engagement with families. We are asking, 'What are family preferences in and around autopsy?', and accommodating them to the greatest possible extent, consistent with coronial and public responsibility. I think that is something we can actually be quite proud of — the way that has happened without any shift or change in the law.

Mr MAUGHAN — You argue in your submission that, where the family goes to the Supreme Court to object to an autopsy, the institute or somebody should be put on the other side of that case in the public interest. Would you care to expand on that?

Prof. CORDNER — Yes, we have always been very careful. We do not want to be seen as forcing autopsies down families' throats. We believe strongly in the value of the autopsy, but we also believe people can quite properly have their reasons why they would not like an autopsy. If it is to come to pass that an aim of the coroner's system is to be prevention — and this is a really interesting issue for you — it seems to me that part of its real meaning would be that that value, prevention, would have to be weighed into the balance when deciding whether there will be an autopsy. Possibly, to that extent, private rights might give way. That would be a serious shift in the way things are at the moment, because essentially the private rights in some cases will trump the public benefit. So that is a consequence, and it would be very interesting to hear your discussion about that balance. Some of the submissions from the consultative councils say we do not do enough autopsies. Obviously there would be families who say we do too many. And you are the public representatives who are going to make the decision.

Mr MAUGHAN — It will be an interesting debate.

Prof. CORDNER — Did we cover that question?

Mr MAUGHAN — Yes. Thank you.

The CHAIR — In your submission you talk about VIFM having a role in drafting guidelines, training health professionals and auditing death certificates. Can you talk a little more about that? I assume you are referring to guidelines in relation to the standards for death investigations.

Prof. CORDNER — Sorry, I did not hear the first part of that.

The CHAIR — The drafting guidelines.

Prof. CORDNER — For?

The CHAIR — From your submission it seems that you are talking about death investigation.

Prof. CORDNER — What page is that?

The CHAIR — It is page 38 — guidelines and investigation standards.

Prof. CORDNER — I have not got a page 38 in mine.

The CHAIR — I am referring to David Ranson's submission; his runs back to back with yours.

Prof. CORDNER — This is David's, is it? David Ranson's submission is a couple of times longer.

The CHAIR — Let me rephrase the question: do you think VIFM should have a role in drafting death investigation standards, training health professionals and so on?

Prof. CORDNER — I cannot bring my mind to bear on what David specifically said in his submission about that. I have to pay credit to David Ranson for this particular thing; he is the flag-bearer, if you like, of the dynamic nature of the interaction between the institute and the State Coroner's Office. The general answer is that I would think a state coroner would be well advised to do so, and I know the two state coroners have engaged with the institute on those sorts of things, often informally. That is the beauty of having those two institutions together in the one facility. A lot of other institutions would have to be defined rigorously. It just happens in the nature of the daily interaction of meeting for coffee or whatever.

The CHAIR — Are there any particular points that you would like to highlight that we have not covered?

Prof. CORDNER — I just mention at the beginning that I would make a couple of other points about the kind of submission which unfortunately we were unable to see before it was submitted to the committee and let you know that that was just the exigencies of circumstances. I am not sure that we would wholeheartedly — I think more thought needs to be given to there being a formal declaration that a particular death is preventable. It sounds to me and to those of us at the Institute who have discussed it that that runs the risk of pointing fingers and blame, and to the credit of all of Victoria's coroners, they have announced in public forums that they are not interested in blame, they are interested in prevention systems and in a systems approach to try to work out what went wrong so that we can prevent things in the future. It strikes me that declaring a particular death is preventable might run a little bit counter to an approach that is trying as hard as possible to get away from blame because that is often counterproductive to improvement.

The CHAIR — Just on that, though, families themselves often feel that they need some kind of statement. It is part of the process for them, because no criminal or civil proceedings are going to follow.

Prof. CORDNER — But coroners can pick it up in their finding. They can frame words, and their mastery of words is what judicial figures are there for. They can deliver that in a way that observes the balances that have to be struck, because the other side of the balance is the possibility of frightening those people who need to be engaged for prevention purposes. That is again another balance that sits very squarely in your court. Do you get what I mean about that?

The CHAIR — I understand that perfectly, which is why we have underreporting, but it is a difficult thing, is it not? Because if you are making a finding there are some conclusions that spring from a finding, whether

you use the words or not. There is a natural disposition on behalf of someone — something went wrong. No-one likes having the torch shone on them, do they, whatever the coroner says?

Prof. CORDNER — Yes, but then that goes back to the purposes of the coroner system, and if prevention is there as the headline— look, I do not think I want to say anything, just to mention that as clearly a tension that exists and that came to our minds.

Mr HILTON — Could I just follow that up for a minute. If the role of the coronial process is prevention, in your view as an observer of the process does the adversarial nature of the proceedings assist us; or if not, how could it be done so it does assist?

Prof. CORDNER — I think that is part of the understanding of and training for what the coroner system is properly about, and I do think, understandably, the barristers and representatives who have on the day before been arguing the toss in the County Court or the Supreme Court do not necessarily understand what is at stake in the coroner's court. So the answer to your question is I think it is a little inimical to some of the aims of what the coroners system is trying to do although, if you go down the chair's line — I would not impute it was your line — that families are looking for a bit of direct accountability, then that is what barristers are very good at, so I think it is almost the same discussion.

Mr HILTON — No, because you did say in your summary that very few coroners produce effective recommendations designed to enhance health and safety, and I suppose that is going back to your issue about them not getting adequate training.

Prof. CORDNER — Yes.

Mr HILTON — In fact, they do not get any training at all in how to deduce what you see as the objective, which is prevention.

Prof. CORDNER — Yes. It would be really good if in their training the barristers were imbued with what the purposes are in the same way as magistrates and coroners, as we were discussing, so there is another education lacuna.

Mr HILTON — Yes, but just to take it a step further, the barristers are paid by the people who want representation. Their role is to reflect the interests of their clients.

Prof. CORDNER — Yes. I cannot answer that. That is a point you get to quite a lot when you have the adversarial system and the inquisitorial system meeting. It is just a bit difficult to really meld the two. There are a couple of other things. It was interesting to see in the submission from the State Coroner's Office a recommendation that natural deaths in custody not be subject to an inquest. Personally, that is a direct contradiction to recommendations 11 and 12 of the report of the Royal Commission into Aboriginal Deaths in Custody. I was quite surprised to see it there. For those who die in custody from whatever cause there will be at least one relative who thinks the person was murdered. The ability to eyeball the officers and those involved with the custodial institution to see how they answer questions, to have the opportunity to ask the question themselves, I would have thought was a given in what our coronial system was there for — for families to have that sort of opportunity. Elsewhere, one of the things that came up in the discussion paper was how much more should we be embracing the recommendations of the Royal Commission into Aboriginal Deaths in Custody. Personally, I would not be starting by going backwards.

Assoc. Prof. WELLS — I would like to support that process in that over the last few years I have been developing a program for teaching doctors who are involved in custodial medicine. One would have to say that the service across the country has a considerable way to go to get to the same standard one would be able to access if one were outside the custodial system; so not only in quality of medical services but also in access to medical services and information there is a considerable distance to travel. The concept of having a natural death in custody being exposed to the sort of investigation that we currently have can only benefit in continuing that process much further.

Prof. CORDNER — There is a reference in the Coroners Act, and excuse me if I get it a little bit wrong, but basically it says if there have been proceedings for homicide-related offences — murder, manslaughter, child

destruction and infanticide — then the coroner has a discretion whether or not to hold an inquest. I think that, broadly speaking, covers the situation.

I would like to make a small point about the inclusion of child destruction in that list. To those of us at the Institute who have talked about it, this runs the risk of blurring what otherwise is a very good demarcation of the beginning of the coroner's jurisdiction. The coroner has jurisdiction to inquire into deaths or suspected deaths, which is interesting, but let us just regard them as deaths at the moment. For there to be a death there has to be a life. The common law has defined life to be an existence separate from the mother, broadly speaking. Child destruction is death, if 'death' can be used, prior to an existence separate from the mother. That is an offence that occurs during the course of delivery. It runs the risk of opening up the possibility, I think just the possibility — I would not want to put it higher — that abortion could come to be regarded to be within the coroner's jurisdiction. You might decide that is what you want — that is fine, but my prediction would be that if that came to pass, the coroner's jurisdiction would be severely mired. It is such a complicated zone as to be severely problematic. That possibility could be ameliorated by removing child destruction from that list. I should mention in regard to that — I am happy to table it — that Helen McKelvie and the head of our forensic pathology division wrote a small paper about the coroner and the unborn child which bears on that issue. Apparently you already have it.

Finally, it is quite possible that one outcome of your deliberations will be to make suggestions for legislation about the control of information and documents that result from coronial investigations. Can I make a little plea on behalf of researchers? I know it is in the minds of people, but life for bona fide researchers in relation to information is extremely complicated and difficult. The interests of the community will be served if bona fide researchers in proper circumstances and with projects being approved by ethics committees — and the institute has one — do not have their lives rendered completely unbearable by so many boundaries being put around information that it is impossible to get to. I make that plea on behalf of bona fide researchers.

The CHAIR — Beyond the plea, do you have any specific comments to make on the submissions either from the privacy commissioner or the health services commissioner?

Prof. CORDNER — I have read both of those submissions, but not in the last 24 hours. They would both be sensitive to the needs of researchers. In relation to information in a coronial zone, it is worth remembering that the institute has an ethics committee. The coroner is on that ethics committee, but he also sits outside it and can exercise his judicial powers quite apart from the ethics committee. There are processes there which work well within the health system broadly — about accessing medical records in hospitals, for example. There are analogous mechanisms within the coronial system, and there really is not any need to go beyond those to make it even more difficult for people to get to information.

Ms BEATTIE — Given your plea for researchers, could you expand on donor tissue bank access and the rights of the next of kin?

Prof. CORDNER — If you mean in relation to tissue, there is really nothing but complete respect for the rights of the next of kin by everyone, including the Donor Tissue Bank of Victoria.

What it does is approach relatives of potential tissue donors — because not every deceased is a potential tissue donor — offering those relatives the opportunity to consider donation. It is not approaching them to get consent; it is to offer the opportunity to consider donation. That is, as you can appreciate, a highly problematic interaction to come to a family out of the blue — perhaps, not so much out of the blue because they might have been made aware of it by coroner's staff. In fact they will have been made aware of it by coroner's staff. It is a difficult conversation for our tissue bank staff to have, but they do it. At the end of the conversation there is either a conclusion or they have another conversation in an hour or two, or whatever.

The interaction might also be offering an opportunity to consider tissue donation for research purposes. At any one time there are a number of projects that have been approved by our ethics committee and the coroner as suitable to receive tissue. Relatives are offered the opportunity to donate tissue to those projects. One is constantly reminded of how altruistic so many people in the community are, when we hover between 45 and 65 per cent consent for both those opportunities. We like to think that not only is there a tangible benefit from that donation but it is offering people the opportunity to act altruistically, although it is terrible to think of that as a benefit.

Ms McKELVIE — That is the feedback we have from a lot of those families — that it is an opportunity that gives them some hope arising out of tragic circumstances.

The CHAIR — I do not know whether you have read the Transport Accident Commission's submission. It recommends that the institute develop robust criteria for determining whether autopsies should be conducted. Have you got any views about that?

Prof. CORDNER — I hesitate to say it is difficult because every case is unique and different, but that does not mean we should not have robust guidelines. It has to be said that we do provide in every case a written report to the coroner with our view about how this matter might be dealt with in that particular case. Ultimately it is the coroner's decision about whether or not the family's objection will be accepted.

The first point to be made is that it is not actually our decision, but obviously we are very closely involved and it is an interaction between the Institute and the state coroner. Having said that, I think the Transport Accident Commission — and I know it knows this because I have given it the information subsequent to reading its submission — in the financial year that ended on 30 June there were objections to autopsy in 16 per cent of all deaths reported to coroners with a body admitted to the Coronial Services Centre in Melbourne. There were 3600 such deaths, and in 16 per cent of them a section 29 objection was agreed to. That is up from about 6 per cent two years ago. The graph shows it has more than doubled in two years and is rising. If you look at the TAC cases — that is, deaths arising from the use of a motor vehicle — 27 per cent of section 29 objections to autopsy are accepted. So it is almost double the underlying rate in transport accident deaths and going up.

The CHAIR — Sorry, 16 per cent were objections — —

Prof. CORDNER — Of all deaths.

The CHAIR — Are accepted as objections?

Prof. CORDNER — Sixteen per cent of all deaths were objections accepted.

The CHAIR — What was the percentage of all deaths where objections were lodged?

Prof. CORDNER — Unfortunately the right-hand part of the graph is on the second page, but you might like to see it. You can see there are three years — three double pairs of bars — and the lower of the two is the percentage of all deaths where section 29s were accepted, and the higher of the two is the percentage of TAC-related deaths where a section 29 objection was accepted. So actually the percentage of all deaths where section 29s are accepted is going up directly related to our engagement by our — both the coroner's and the institute's engagement with families, more especially in the last couple of years.

The CHAIR — Just to clarify it, the section 29 requests that are accepted are in themselves a percentage of the number of objections that are lodged under section 29?

Prof. CORDNER — No. Section 29 is the only way you can object.

The CHAIR — Yes, but this is the percentage that is accepted or the percentage that — —

Prof. CORDNER — Yes, but that is the bulk of them. It is a relatively small number because what happens is that most families do not put in an objection where they know the objection is not going to survive. We have an interaction with families. So yes, there are some objections which are refused because families insist upon persisting, and that is absolutely their entitlement, but well over 90 per cent — and Graeme or Iain might have a figure in mind — of all objections are accepted because — —

The CHAIR — What do you attribute the increase in section 29 — —

Prof. CORDNER — It is because families now know they have a right to object because we tell them.

The CHAIR — And how do you think that could be ameliorated? Is it a question of whether or not you could also give more information about the value of autopsies? I think the Royal Liverpool children's inquiry suggested that you should provide a lot more information about the autopsy, what the benefits were and what was involved in autopsies.

Prof. CORDNER — That is built into the sort of engagement we have. I tried to sketch a picture before. I think as time passes we will engage even more with families. More and more what happens at the front end will be

as a result of taking family preferences into account. I really expect that as time passes some families will understand that there are some public benefits, and some families will think, 'Perhaps we should do the right thing'. At the moment we are in a situation where for the first time families are being told that they have a right to object and they are utilising that right.

Mr LUPTON — While the objections in all VIFM cases has gone up from 6 per cent to 16 per cent, the rise in TAC cases is even more noticeable in the graph.

Prof. CORDNER — That is right.

Mr LUPTON — It was not that much higher than the VIFM in 2001–02, but now it is significant; nearly double. Are there any reasons that you can advance that may not be obvious for autopsies in TAC cases to be promoted? I assume that most people object to an autopsy in a TAC case because they believe the cause of death is obvious. What reasons might there be for doing more autopsies in TAC cases?

Prof. CORDNER — This is going to be a very important issue. For example, if prevention is one of the fundamental aims of a Coroners Act, there is in existence at the moment — although its existence is a little threatened — a committee called the Consultative Committee on Road Traffic Fatalities. That committee evaluates the emergency and medical management of everybody who dies after the arrival of the ambulance to see what learnings there can be about the delivery of emergency medical services. People on the consultative committee say, 'Why was there not an autopsy? We do not know whether this person had fractured ribs because the ambulance officers or the emergency department thought they had fractured ribs. Did they have fractured ribs?'. The answer is that we do not know. We did not do an autopsy because there were serious head injuries or something like that. So the autopsy removes any discussion or argument about what was or was not there, and that is very important in evaluating emergency or medical management.

That is going to be an issue in the future, and that is where the tension will lie. A coroner in the future might have to say, 'We know there is a means of evaluating emergency and medical management for people who die in road traffic accidents. Prevention is an aim of the Coroners Act. There were two days of medical treatment here. If we do not do an autopsy, prevention opportunities will be lost'. There will be a balance between that and the objection. It will be an interesting and important decision for the system and for the people involved about where we are going to go with that.

The CHAIR — Do you think the technological advances in non-intrusive autopsy procedures will help overcome that?

Prof. CORDNER — It certainly helps, but it does not help so far as the public imagination would run. In some cases it asks some questions that were previously not questions. It asks, 'What is that?', and unless you go and have a look you do not know. It could be this, it could be that. But certainly in relation to my example of the fractured ribs, the scan and the CAT scan will tell you whether the ribs are fractured, but it may not tell you whether there is a laceration to the liver or to the spleen or the kidney or the sorts of specifics of individual organ damage or the background existence of natural disease of some sort.

That is one aspect of why there might be an autopsy in the face of objection in TAC matters. There is just one other element in answer to your question. There is a common misconception that simply because the cause of death is obvious, it is the beginning and the end of the matter. You have heard many times now that we are about trying to recreate the circumstances within which death occurs. So there will be observations and conclusions which arise from autopsy which bear on the how and not only on the cause of the death. Increasingly we will be able to engage families by saying, 'You need to put yourself in the position that you might wake up in a week's time asking these questions and we will not be able to help you. You need to understand that now when you are objecting to the autopsy. An objection is fine, but there will be questions you have not even thought of that you will wonder about in a month's time. I do not want to push you but'.

The CHAIR — You may not want to comment on this, but is the growth in objections to autopsy arising perhaps because there are newly emerging groups in the community who have that objection for cultural or religious reasons? Is that part of the Victorian community growing where people from particular cultural and linguistic backgrounds have an objection to an autopsy? Are there any trends that you have noted?

Prof. CORDNER — I have not gone into that, and perhaps we should have. There are well-known groups for whom autopsy is a difficulty. We were talking to a man from the Orthodox Jewish undertakers the other day. He is a lovely man, but he is basically an intermediary between the needs, demands and preferences of the coronial system and his community, and he brokers things remarkably well. Generally speaking, we are aware of the cultural and religious differences and there is a very good dialogue about that sort of thing. I do not think there is any particular growth of groups that — —

Ms McKELVIE — Can I just point out that the increase in section 29 applications happened at the same time as the establishment of the Family Contact program, which allowed the information flow to families about their objection rights.

Prof. CORDNER — The one question they had which we could not answer was what percentage of objections are not granted.

Ms McKELVIE — Not granted? Refused. The state coroner's submission does have a graph that shows that on page 54.

Prof. CORDNER — Yes, right, refused.

Ms McKELVIE — Yes. It is quite small.

Prof. CORDNER — Yes, it is tiny. It is as we thought. I think part of the engagement is if people understand that the objection will probably not be successful, but some are, and that is fine.

Ms McKELVIE — Just one other thing that the state coroner has passed on in relation to your question about why you would want to be doing autopsies in Transport Accident Commission cases, if I am right, it is to do with the issues around vehicle design which can be answered by autopsy that otherwise would not be, and that is not something that families would normally be thinking of in that sort of situation.

The CHAIR — I think we have thoroughly examined the issues. Are there any other things that you would like to say or, having reflected on things as we have gone through, that you would like to comment on just briefly?

Prof. CORDNER — I am sure that as soon as I leave I will think of something.

The CHAIR — So will we.

Prof. CORDNER — Not especially. I do not know if Ms McKelvie has anything else.

Ms McKELVIE — No, I think we have exhausted all the things we wanted to discuss.

Assoc. Prof. WELLS — There was a little issue that I think the Chair raised about post-mortems in TAC cases, particularly with an ageing population. Whilst an external examination of the body might reveal the cause of death, it does not then reveal the cause of the accident — for example, what caused a particular person to drive off the road and have this terrible event. In an ageing population we are very keen to get a better understanding of some of these processes. One of the other functions of the Institute is that we act as medical advisers to VicRoads and provide all the advice on people who should or should not hold a drivers licence. Without that information we reach a brick wall in making decisions, and particularly with regard to commercial bus drivers that is going to be crucial information that we need to make informed decisions about rather than engaging in guesswork.

The CHAIR — Thank you very much for your submission. We appreciate the expertise and the special role that the Institute plays in Victoria. I must say that based on knowledge we gained on our travel overseas, we have quite a unique and special body here in the way it is structured and its link both to the university and to the Coroners Court, and that expertise and role are very much appreciated by the committee. We appreciate your evidence here today.

Committee adjourned.