

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 20 September 2005

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Ms B. Wilson, Health Services Commissioner.

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The CHAIR — I welcome the Health Services Commissioner, Beth Wilson. Thank you for taking the time to appear before us; we appreciate that. This is a public hearing. It will be recorded by Hansard, and you will have an opportunity to correct the transcript. It will then be put on our web site. Would you like to present to us first for 20 to 25 minutes and then we will ask some questions.

Ms WILSON — Hopefully I will be more brief than that, and thank you very much for the opportunity of appearing before this important review. I have learned a great deal from reading some of the submissions that you have received. While I do not like to start with an apology, I have changed my mind about one or two things from reading the submissions, so I hope to clarify that during this submission. Obviously as the person whose role it is to administer the Health Records Act, which is the health privacy legislation in Victoria which was supported by all houses of Parliament, my primary focus will be on the tensions that exist between trying to learn from deaths to prevent deaths, and at the same time taking account of the sensitivity of health information and privacy issues.

I am sure you have already been told many times about the release of information to Julian McGauran. That was an unfortunate incident and I think it indicates we need to do a lot more work with the state coroner. I would like to be involved in consultations with the coroner, and in drawing up some kind of protocols or guidelines about when you do and do not release health information. I believe the coroner needs to have quite strong discretion in these difficult issues, and I do not want to see that fettered. But I think the privacy commissioner, Paul Chadwick, and I, as well as other relevant stakeholders, could be very helpful in advising in that process. We are not trying to stick our nose into what the coroner does, so much as offer assistance.

My own view is that no-one should be given access to medical records that are in the care of the coroner unless they are determined to have a special interest — and, of course, you can define that in different ways. I do not think there should be an automatic right of access to health information for anyone; it should be determined on a case-by-case basis. I have certainly had complaints to my office where there may, for example, have been a dispute between neighbours. One of the neighbours had a mental illness in the family. The mentally ill person subsequently committed suicide and the information was given to the coroner, as it should be, but the neighbours with whom the dispute was happening simply waltzed down to the coroner's office and got access to this person's health records. I would like to see better consideration given to the giving out of that kind of information. It obviously caused considerable distress to the family. Often the coroner's information is not just about people who are deceased; it is about their relatives as well. Unlike the Privacy Act, the Health Records Act applies to deceased persons for 30 years after they have died.

Having had a look at some of the submissions, in particular Jacinta Heffey's which I found most impressive and informative, I would agree with her that the definitions of reportable deaths in the current legislation are unsatisfactory and need tightening up. I take her point that if you are going to attach penalties for non-reporting, then people need to know precisely what it is they are supposed to report including concepts like accidental death and unnatural death. Unnatural death is something I really do not understand. I can remember being asked to write an essay when I was a university student on what does 'natural' mean in John Keats's poetry? I am still trying to work that out 35 years later. I think it is a very unhelpful definition and we need to look at that much more closely. I think Jacinta Heffey's notion of notifiable deaths would be better.

I have no doubt that deaths are under-reported from our hospitals. Sometimes it is because responsibilities are not very clear. Sometimes it is very clear what is a reportable death, but it gets much trickier when you have causation and remoteness problems. Something may have happened in a hospital or a nursing home some time ago that sets up a chain of events which may or may not have contributed to a death further down the line. It is often unclear to people who have a duty to report, which ones they need to report and which ones they do not. I think we need to give people better guidance in that regard, particularly if we are going to have penalties for failing to do so. In a medical context a better approach would be to adopt definitions that include deaths which would not have occurred had the medical treatment or management been different. In my view the coroner should be able to investigate all deaths relating to persons in custody because these people are not able to make their own choices about medical care. That should be extended to people on parole, or people who have recently been released from prison. At my office it has often been brought to our attention that people who have a life-threatening illness may be discharged from prison, but then when they die the coroner may or may not investigate or hold an inquest into that death.

I have also had families come to me whose family member has died because they have not sought health treatment while they were in prison for a life-threatening illness. Sometimes they die after release, or sometimes during. The reason they have not had the health service is that they do not like being transported from a low-security prison

back to Port Phillip Prison for treatment. Prisoners who are in that situation lose all of their privileges. They lose their cell and their job and it can be very distressing. So some people choose not to have treatment, with very unfortunate results.

I have given death certificates more consideration than I did in my hastily written submission. It seems quite apparent that doctors who write death certificates should view the body. In fact I thought that was already the case, but apparently it is not. It has also been brought to my attention that too often the certification of deaths, particularly in hospitals, is left to junior doctors who have insufficient training. Death certificates are very important and senior assistance and involvement should be available to junior doctors if they are being asked to do this.

I am also interested in the situation in which our international medical graduates find themselves. We currently give them far too little support and training on their requirements under the law here in Australia. I was talking to about 12 international medical graduates working in the psychiatric area. One of them said, 'I have to write a report for the coroner. Can you please tell me what a coroner is because we do not have one in our country'. If we are going to use people like that in very difficult areas such as psychiatric services, we have to give them much more training about their responsibilities.

I made a mistake in my submission. I was a bit too soft on the privilege against self-incrimination. Thinking about the New South Wales model sounded all right, but not really having any experience of it, on reflection I think the privilege against self-incrimination is a fundamental human right enshrined in our law, and I think it should continue to be applicable in coronial proceedings. From my point of view, in administering the Health Records Act I need to know more clearly if the coroner is "quasi-judicial". We have judicial precedent to say that the coroner is not a court, but is the coroner exercising quasi-judicial functions, or are they administrative, as Jacinta Heffey suggests? I need to know that because the Health Records Act would not apply to the coroner where the coroner is exercising quasi-judicial functions, or where there is something in the coroner's legislation that is inconsistent with the Health Records Act, because quite clearly as a principle of statutory interpretation the specific always overrides the general. I think also the coroner should continue to have jurisdiction only in cases where a child has been born and has actually breathed, although I know this causes some interesting discrepancies for families. I had two cases: one in which the child drew breath and died; and another in which the child died during the process of birth. In one case the parents were able to avail themselves of a coronial investigation and inquest, which was important for them. In the other case they were not. There will always be some anomalies there, and it is a very difficult area. But on balance I think the coroner should look at the deaths of people. That is all I will say as an opener.

The CHAIR — Just picking up on this question of death certification and the reporting of deaths, in your submission you indicate two things. Firstly, that it is really not possible for doctors to accurately certify a cause of death without examining the body of the person who has died. You indicated support for the Luce proposal which was, as I understand it, that certified deaths should be audited by some sort of statutory medical assessor. Is that what you are proposing?

Ms WILSON — Yes, that is my position. The Shipman case of course causes particular difficulties in this area. On the one hand you are dealing with a person who is a psychopath, a criminal, but for people in statutory offices like mine, when I get up and read in the newspaper that patients have been murdered, I think, 'What is the use of offices like mine or the coroner's? Could it happen here?' I think it could happen here. Whilst we can say he is a criminal and a one-off, nonetheless we need to learn lessons from that and not just say he is a bad guy, too bad.

The CHAIR — Just a rotten apple in the barrel?

Ms WILSON — If you cannot pick up something as extreme as that, then there is something flawed in the system.

The CHAIR — There are two elements here. You are saying the doctor who signs the death certificate should have to say, 'I went and I viewed the body', and for whatever reason that person died, natural or unnatural, sudden, violent or accidental? In signing any death certificate they should actually view the body. You are suggesting then that there be a statutory medical assessor in the coroner's office who would audit all those death certificates?

Ms WILSON — Yes.

The CHAIR — Would they do that on a selective basis or a 1-in-10 basis or all death certificates?

Ms WILSON — An audit would have to be selective. We have to be practical after all. What you would be trying to find out is what the trends are there; is the system working properly; are we missing out on things? I was thinking of that kind of audit rather than all. If it was all, I would call it a survey or a census. An audit would be something like a project where you try to learn from what is happening.

Mr LUPTON — If the intention is to try to prevent a Shipman, though, that sort of thing would not be adequate, would it?

Ms WILSON — It is after the event, I agree.

Mr LUPTON — The question is whether it is really appropriate, practical and necessary to set up a system that is intended to prevent the Shipman matter or to do some other useful exercise.

Ms WILSON — I think it is an ‘other useful exercise’ after the event and you can learn from that. All of the recommendations in the report are resource intensive. It would be fantastic if we could review every single death that was in any way a little bit suspicious, but we have to be realistic about how much work the coroner can take on. Similarly, I get a little concerned about the coroner being seen as someone who can also be like the Australian Safety and Quality Council, because the coroner’s core function should be to investigate deaths and learn from that. If you expect the coroner to make a hospital safe, it could not happen. Neither could my office do that.

Mr DALLA-RIVA — I am thankful for your submission and in particular question 2. It alarms me that you mention the Shipman case could occur here. You also say in your submission that the Health Services Commissioner agrees there is underreporting of deaths involving medical treatment. We have heard evidence from a variety of people before you who have expressed a significant concern with the lack of reporting to the coroner on medical-related deaths. As a committee we have some work to do. I am thankful you have given us some guidance in terms of the Queensland act, but I am concerned that you said that even with all the processes and resources we have, we still may not be able to prevent a Shipman-type event occurring again. Given that we are going through this review process, is there some way we can actually ensure we are capturing those medical negligence practices that are occurring? We know they are occurring because we have had evidence of that. I am thankful that you are providing at least some supportive backup to the statements that have been given by other members.

Ms WILSON — There are two things. One is Shipman, which is probably separate. The problem with general practitioners is very often they work alone and in isolation, as he did. Increasingly, general practitioners are working in larger practices where there may well be more scrutiny and that is better. I was doing a hypothetical for the Australian Medical Association which was “Could a Dr Shipman happen here?” One of the members of the audience said, ‘How do you know I am not involved in murdering my patients? Who would know?’. First of all, he did not have a nice grey beard and a friendly face and glasses, but more importantly he was there with his peers — so peer review. There are other kinds of processes you might want to tackle that with and not have doctors work in isolation rather than a coronial process. When you are talking about medical negligence practices, are you talking about it primarily in hospitals?

Mr DALLA-RIVA — Yes.

Ms WILSON — We have to have very high professional standards in place and risk management practices. From my experience of being in this office now since 1997, I have learned that I have to accept when human beings work with human beings there will be mistakes made in a high-risk endeavour like health care and in very complex organisations like hospitals. I do not mean to minimise that or say we should not be trying everything we can to improve that, but there is no such thing as a risk-free society. From my point of view a lot of the work I do is accepting that mistakes are made and trying to get resolution for individuals who have suffered as a result, hoping to learn so we can implement quality changes. People who come to my office want to know what went wrong and why, and want to make sure it does not happen to someone else. That is far more important to people than monetary compensation — in other words, people who lodge complaints are usually seeking quality change. In individual conciliation proceedings one of the things that is often sought in order to get a conciliation closed is what you are going to do to make sure this does not happen to someone else. The hospital will have to come to the table with an explanation of how things have been changed.

Mr DALLA-RIVA — That is right. However, the evidence we have got, and I would like your views on it, is that where hospitals have been directly involved in a death that would require presentation at a coronial

inquest. Witnesses have said there have been a wall of lawyers who are defending the hospital to the nth degree, and they have left the process bitter and twisted and feeling there has not been an outcome. If there has been an outcome, any recommendations made or suggested in terms of ensuring there is not a repeat have not been followed up. How do you respond to that?

Ms WILSON — My personal view is my profession, law, has been very unhelpful in dealing with patients. The adversarial system of law, negligence cases, is risky, costly and not therapeutic. It does not help people get better; it prolongs it. That is why I prefer to work in an area where there is conciliation. Particularly where there have been deaths, we want hospitals to be able to communicate well with the families. That is one time when it is so important for people to have good communication. If the lawyers come in and say, ‘Do not admit anything’, then the lines of communication close and we have big problems. The open disclosure project is happening at the commonwealth level. We have developed with a lot of stakeholders an Australian standard for how hospitals can go about honestly telling people what has happened after an adverse event. It is now being piloted here in Victoria. I have great hopes that will improve things. The lawyers do tell hospitals not to own up, not to admit anything, and at an individual level that is quite traumatising. I have had people who have been involved in a birth process and things have gone wrong and the baby dies just after birth. The families say, ‘The nursing staff were lovely until it went wrong, and then we felt like they were blaming us’. It may be that they are frightened and that is why their attitude towards the family changes. But 100 per cent of the complaints I receive, if you dig down into them, are about communication failures. We have got to be much more creative in finding ways that our services can be much more open with people, not for punitive purposes but for quality improvement.

The CHAIR — On that it does seem that there are some overlaps between the kind of role you perform and the coroner.

Ms WILSON — Yes.

The CHAIR — I am particularly interested in this whole question of what are the non-adversarial alternatives that would allow families to feel what had actually happened and gone wrong was brought out into the open, and there was some resolution arising out of that where practices changed or we learnt from the experience. Could you talk a little bit about your conciliation process, and have you got any suggestions about how those elements could also be incorporated into the coronial process?

Ms WILSON — One of the things people tell us about the coronial process is that although it has certainly improved and it tries to help people, families often feel left out because they are treated like witnesses; they do not know what is going on; it takes too long. Conciliation is a process which facilitates resolution. It allows the parties to get together to talk to each other in a privileged, confidential setting. As I mentioned, often the outcome is improved quality changes. It can take all kinds of forms. My conciliators work in different ways. Some of them go to people’s homes and visit them, others prefer to work by mail or over the phone. They are flexible about that. It depends what the aspirations of the parties are. We have a high level of cooperation from the insurers and the hospitals, and organisations like the Australian Medical Association, which in the early days opposed the existence of the office of the Health Services Commissioner but now in fact supports us very strongly because we are seen as a better alternative to going to court. The medical indemnity people would rather see \$55 000 go into the pockets of people who have been injured than into the pockets of lawyers, for example, so they give us a high level of cooperation.

We use expert opinion, meetings — meetings can be very therapeutic, where people in a confidential setting can say, ‘I am so sorry that happened’. That little word ‘sorry’ is incredibly important to people, to have their pain acknowledged. It is amazing how forgiving most patients are who have been involved in an adverse event, and I am not just talking about deaths here obviously because my office deals with all kinds of adverse events, not just where the outcome has been death. I would argue that conciliation is far less costly, takes much less time, is less risky and much more therapeutic for the people involved. That can work for both sides too.

I was talking about this to a group of anaesthetists. One of them told me that when she was just starting off in her profession she had been working very long hours, she was tired, had the flu and probably should not have been working at all, someone gave her Sudafed which reacted very badly with her. In the morning the patient was numb all down the right side of his body. He was an elderly man and they thought he had had a stroke. The family were furious. The son was a lawyer threatening to sue. A confidential privileged meeting was arranged at which the parties could speak to each other. The anaesthetist was completely honest with the parties, told them exactly what

had happened and apologised. After the meeting the very angry daughter gave the anaesthetist a hug and the anaesthetist burst into tears. She said to me, 'It was so important for me to be involved in a process where I could tell the truth and I could be forgiven as a professional, but also just as a human being'. We have got to see these things from the sides of all parties. Most health service workers in my experience are thoroughly decent people who go into the job because they like people and they want to help them. When things go wrong they are just as distressed as anybody else usually.

The CHAIR — In a sense what you have just said, as you described it, in that confidential setting, where you are mediating and trying to get an outcome, that in fact people do abrogate the privilege against self-incrimination and they say, 'This is a confidential process; it is going to have no consequences in terms of other proceedings; therefore I will speak up even though it might implicate me. I might be subject to civil or other proceedings.' Why can we not do that in the coronial system? Is it because it is a court? Is it because it is open and people then bring in lawyers? That may be appropriate in some cases but why can we not have something else that might sit with it?

Ms WILSON — Although our proceedings are confidential and privileged, anything you say may be used in a different kind of way. If the parties decide to withdraw from conciliation and go to court, the material could be re-discovered in a different way. It is not seal proof.

The CHAIR — The pressure is on you to get a result.

Ms WILSON — Yes, that is right. We have very few people who do withdraw from conciliation. There has been about 2 per cent, and they have followed up and called us back and they did much worse than they would have done if they had stayed in, as it happened. But you are saying why could conciliation proceedings not occur at the coroner's court or office?

The CHAIR — Or more informal processes about what was the cause of death; why did this person die; what can we learn from it, so the families feel like what actually happened comes out, and it comes out in a way that is not lengthy, expensive, intimidating or incomprehensible to them?

Ms WILSON — The problem with conciliation is that it is not open to the public. This is a criticism that is made of it quite a lot. It is confidential, so how do you learn from it? That is a fair enough criticism. The reason we have open hearings at the coroner's office or court is because the public needs to know that these things are being aired — but the coroner should have discretion to suppress names, for example. I would support the continuation of that. The way in which you do your inquests does not have to be adversarial, but the role of conciliation or mediation I see as being separate. I can also take on cases where the coroner may have made a finding. It could then come back to my office because there are outstanding issues to do with compensation or grieving. I cannot repeat what the coroner has done, but I can still deal with the grief and problems facing the families. For me it is two separate kinds of things, and I do not really think it is appropriate for the coroner to be examining deaths in secret. I do not think the public would accept that.

The CHAIR — He could issue, as the Toronto coroner does, a finding, such as: I have conducted this round table; these are the recommendations I am making arising out of that particular in-camera round table. These are the recommendations I am making to the hospital; these are the recommendations I am making to the college of surgeons; these are the recommendations I am making to the manufacturer of these particular goods.

Ms WILSON — It sounds excellent in theory, but I do not have enough knowledge of how that is working in practice to be able to make comment.

Mr LUPTON — Just to take up on the question that the Chair asked before, it seems to me that what he was asking was that in your conciliations, the fact that evidence that comes out at those conciliations cannot be used in subsequent proceedings, by agreement, is probably an important reason why things come out in the way they do. Possibly the search for the truth is more successful sometimes and people often feel that the process has been the better for it. Is it not a sensible idea perhaps to extend that process into the coroner's inquests to the extent that we might remove the privilege against self-incrimination so long as nothing that was said could be used in subsequent proceedings?

Ms WILSON — It sounds very attractive. Obviously from someone who has been working with conciliation for so long I see it getting really good outcomes for people and for the institutions in which they work

all the time. I suppose I have always thought about deaths a little bit differently and have not really considered the closed-shop approach to the investigation of deaths, but I would certainly be interested in reading further on that issue. I do not really feel qualified to comment on what is happening elsewhere. It is a great theory.

The CHAIR — On the complaints, do you have any comments about the complaints mechanism that is available through the coroner's service and from your vantage point, I suppose, of being a professional complaints and mediation service, whether there are ways in which it can be improved? Are there complaints you have received from families who have been through the coronial system where they said, 'I was not happy with this or that', or 'I did not feel I had enough information'?. Are there things that you can suggest as improvements based on your own professional expertise and role?

Ms WILSON — The kinds of things that people tell us is, 'We felt closed out; we did not know what was happening; we did not get enough information; we are the family, we should have been treated better than that'. The other complaint is where private information, health information, has been given to members of the public, which has been very hurtful to the family in question, particularly where that involves living siblings. Length of time is a big problem for people, because they tell us that when the coronial inquest finally comes around it can be re-traumatising for them. But remember, you have only asked me to tell you the negative things.

Mr LUPTON — On that point about timeliness I would assume, but I would like your view, how soon after an event is it sensible to have a conciliation process and how much difference does that make to the potential outcome?

Ms WILSON — The complaints that I receive are like wounds — if you leave them sitting around and do not tend to them they get infected and they get worse. If people feel they are in a vacuum — they do not know what is happening, their concerns are not being addressed — it can really exacerbate their suffering. Some processes need to start early. Quite often people will ring me prior to the coroner deciding whether there will be an inquest. We play a supportive role, giving people information — sometimes giving them someone to talk to about how they feel — but once the coroner starts dealing with it we will then withdraw. That is kind of happening anyway. Whether more could be done at the coroner's office I guess is the issue. But for people who have suffered the trauma of a death to feel that they are closed out, to not know what is happening, to have a long delay and then the insult of information being given against their will to other people that they think do not have a sufficient interest, that is the sort of thing that I hear complaints about.

The CHAIR — Or worse, they are blamed.

Ms WILSON — Yes.

The CHAIR — We have had quite a few families — I am thinking particularly of the mental illness cases — where someone has been released into the community, sometimes against their wishes, that person subsequently commits suicide, and in defending their position the professionals seek to say that somehow the family did not properly exercise its duty of care as the carer. It is adding insult to injury. They felt they should not have been released in the first instance. They think the fact that they went from being an involuntary patient to a voluntary patient heightened the risk, or was something they were opposed to; and then when they get to an inquest they are often pushed back the other way — say, it was an appropriate professional decision, but what went wrong was what went wrong in the community. I am interested in why that does not happen in your process, or tell me if it does. In terms of dealing with the professionals, because you have families and professionals around a table and you are trying to get at what went wrong, are the dynamics of the process such that you just do not get the professionals to do that because it is not adversarial in that sense?

Ms WILSON — I have the privilege of having to be impartial. I am not an advocate for one side or the other, so I have to hear all sides of the story. I think I would be a dreadful advocate, because most of my career I have been hearing both sides of the story. We are about facilitating good communication between parties, helping them to communicate with each other. We try to operate on therapeutic jurisprudence principles, so that we do not make things any worse. Good communication skills are absolutely vital. Families do often feel as though they are being blamed, much less so I hope now than in the 1970s when R. D. Laing's theories were so popular — that mothers caused schizophrenia. You can go back through nursing notes and see, 'Keep mother away from Johnny; do not let her near him even on his birthday'. You can see those fashions changing when you read through the files. I hope those ideas have been discredited now and people are working better with families.

Some services are better than others. Some use the privacy legislation as an excuse to tell people nothing whatsoever, so privacy has a danger of becoming secrecy. They say, 'Cannot tell you anything because of the privacy act'. We had a situation where a person was in a mental service in one area and the staff said, 'I cannot tell your family anything; I cannot tell a thing'. But then the person absconded — to use the quaint word that we use in mental health services — to another service where the staff were just so much better skilled at talking to the patient and the family and helping them through a situation where they could talk to each other and work together. Because when the person is discharged back into the community, it is the parents who will be doing the caring. There are some concessions that have been made to the role of primary carers being now able, under our Mental Health Act, to have information that would otherwise have been confidential, which I hope is helping, but it all goes back to good communication skills or poor communication skills.

Mr LUPTON — The last question I asked went to the issue of the privilege against self-incrimination and the function of the conciliation process where you do not have an opportunity to use any of the material that is disclosed in conciliation. That is one of the chief factors, in my view, in why conciliations can be so successful — the fact that people are prepared to open up because they know that there should not be any adverse consequences.

Ms WILSON — When I said the privilege against self-incrimination should be kept I was talking about open, public hearings rather than in a confidential setting.

Mr LUPTON — I think you misunderstood, perhaps, my question.

Ms WILSON — I probably did.

Mr LUPTON — I was not talking about maybe changing the coronial inquest process into a more closed one, but rather that if the point about successful conciliation is largely around the ability that people have to open up and tell their full story, is it not a sensible thing to try to encourage that even in an open inquest environment as long as you remove the possible legal consequences against somebody of telling the truth, such as by making sure they could not be prosecuted? That is the point I was trying to get at: to try to use some of those things that conciliation has going for it and adopt them in the open inquest process.

Ms WILSON — Certainly we can learn from that, but you cannot use conciliation to cover up crime, for example. Although my proceedings are confidential, there is an exemption so that I am not in a position of having to cover up criminal acts. I can give evidence in a court case in a criminal proceeding, but that is in my mediation function rather than my conciliation function. We have to try to strike a balance between facilitating that kind of communication — finding out what went wrong, learning from it, improving the system — but we cannot cover up criminal acts either.

The CHAIR — In your submission you referred to the need for proper scrutiny and accountability of the role of the state coroner. I wondered whether you wanted to expand on that in terms of any suggestions you had as to how that could be achieved and who would be responsible for that?

Ms WILSON — People like myself and Paul Chadwick, if I may speak on his behalf, are available to work with the coroner, but are rarely asked to do so. We would like to have an opportunity to provide our expertise, and there are many other stakeholders as well who would like to do that. One of the problems I have is with the recommendations that coroners sometimes make, which may be inconsistent or impractical from the point of the view of the services — for example, saying that the police should have access to all mental health information that is held by the Department of Human Services. I would be horrified if that was the case. So there might need to be ways for the coroner to ensure there is more consistency in recommendations that are made and perhaps more consultation with the people who have the expertise to know whether that is going to work or not.

The CHAIR — So it is perhaps more about some protocols for how you talk to the relevant agencies before you make recommendations.

Ms WILSON — That is right, and that is just good practice anyway, because then you do not make a fool of yourself.

The CHAIR — The privacy commissioner in his submission made the suggestion that your office could play a role in reviewing who gains access to information on coronial records. Do you want to talk further about that? I know you are involved in drafting these protocols, so that is one aspect of it, but do you think —

Ms WILSON — Which protocols am I involved in drafting?

The CHAIR — I thought you described them as court guidelines or —

Ms WILSON — No, I say that should happen, but I am not involved. I would like to be.

The CHAIR — You would like to be. Also, in your submission you seem to be suggesting an approach to categorising reportable deaths which includes listing specific diseases, and I suppose I have a question in my mind about whether we go down the track of having a long list of reportable diseases in the act. Why would one disease be a reportable death and not another one? To this point we have been dealing with unnatural, violent, accidental and so on.

Ms WILSON — I think I would modify my position. It sounded like a good idea at the time I put it in, but subsequently, and having had the advantage of reading other submissions to your inquiry or your review, I feel I am better informed too, and I do see precisely that problem where you start listing more and more.

The CHAIR — Categorisation?

Ms WILSON — But more so I think that we have to keep the focus on what is the coroner there for and what should they be doing. Is that better dealt with as a public health issue by the public health authorities or the Department of Human Services than the coroner? Because I think the coroner is strapped for resources, and if we give the coroner all sorts of impossible tasks to do, then we may be setting them up for failure for their core function.

The CHAIR — Finally, one of the critical issues we are dealing with is the underreporting of reportable deaths, obviously particularly in hospital and medical settings. You did clarify the definition of what is a reportable death, but do you have any other suggestions as to how we could improve the level of reporting of reportable deaths?

Ms WILSON — Education is really important in —

The CHAIR — But when and how?

Ms WILSON — Education is a total, lifelong, continuing process. Bureaucracies will roll out new legislation and say, ‘Right. Education takes place from January to March’. It does not, because —

The CHAIR — But how do you deal with the medical professionals out there who are qualified, who have got their practising certificates and to whom you say, ‘Come along and find out what your responsibilities are under the Coroners Act’, and they go —

Ms WILSON — Drug companies put on nice lunches; that helps. I am a very popular speaker because I am funny and I play the harmonica. I use humour and story all the time. I do not go around bashing heads in, but I can turn potentially hostile audiences around and get them working with me.

The CHAIR — It is indifference not hostility in many instances, or fear?

Ms WILSON — It is fear, apprehension, not understanding. I was out at the Austin Hospital doing what they call a grand round, which is just a hospital name for a seminar, on how they handle situations where there has been a death in the hospital. There were over 400 people there of all ages and different levels of seniority, and I was doing my thing: ‘You can say sorry. You can tell the truth’, and a senior consultant got up and said, ‘What are you saying to people, Beth Wilson? You are going to get us into all sorts of trouble with the lawyers’. So I said to the medical director, ‘Can you please tell your people what is this hospital’s policy where there has been a death’, and he stood up and said — music to my ears — ‘Anyone at any time, anywhere in this service can say sorry’. So clear policies from the top and then support and training throughout the organisation. The Austin Hospital has about 4500 staff; they change. That kind of education has to be continual in our medical courses, every opportunity that arises, and it is not just a one-off thing. But if you have got good, clear policies at the management level, then that is going to be a lot easier to achieve, because everybody knows where they stand. It is where policies are inconsistent or out of date or nobody knows how to find them, that is when your problems happen.

The CHAIR — Thank you very much for taking the time to speak to us. We know you are an incredibly busy person, and we appreciate your lending us your expertise today.

Ms WILSON — Thank you for the opportunity.

Witness withdrew.