

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 22 August 2005

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Mrs C. Storm

The CHAIR — First of all, by way of explanation, we have protective services staff here today, not because we are anticipating any trouble, but because we are not in the usual place for parliamentary committees and the building manager has requested this as part of their ordinary security for the building, so I hope you do not feel unduly alarmed. I am sure they are a very friendly and helpful part of the proceedings.

Mrs Storm, welcome and thank you very much for taking the time to come and speak to us today about your experiences with the coronial system. If you could spend 5 or 10 minutes going over the key issues, then we will ask questions.

Mrs STORM — I would like to say how very much I appreciate the fact that you are having personal experiences told to you today. I had not expected this when you asked for personal submissions and it is very good that you are giving up your time to hear us. I would like to read this first part to you simply because it might relax me a bit.

The CHAIR — Use your strongest voice Mrs Storm, so that people behind you can hear and the reporters can hear you.

Mrs STORM — I will try to.

The CHAIR — I should also point out that we have some representatives from the media here so that people are aware of that. It is perfectly fine because this is a public open hearing, but I mention it so that the people presenting are aware of that.

Mrs STORM — Yes. I am the mother of Anne Cameron. She died on 16 March 2002. She was one of the serious mentally ill — that is actually a medical category which is capitalised: SMI, and it is usually seen in reports. She had schizophrenia and she had possibly had it for 20 years but we had not been aware of it until 10 years after that. She got through her 20s fairly well but when she was 30 she became very ill and she lived only 10 years after that.

She twice attempted suicide before her final admission to the Alfred hospital. This meant that she was a person of very high risk. She was sent on leave overnight on 15 March, despite my filed letter asking for more leave with her, despite a medical note recording that she had asked for more leave with me before she went out alone and despite the fact that she was still an involuntary patient. Thirty hours later she killed herself by train.

It is three and a half years since she died. It is a year this week since Mr West's finding was given and there has been a lot of time for reflection. We parents of the dead remember and wonder every day about what we see as the political and systemic failures of the mental health and coronial systems. My submission makes it clear that my major concern is to do with the very relaxed attitude of the coroner towards what was a dismaying lack of medical documentation, communication with me and breaches of duty of care. Indeed the coroner's severest criticism in his nine-page finding of a complex five-and-a-half-day inquest was 'this excuse is not good enough'. I think that is the kind of thing you might hear in the principal's office rather than perhaps about the death of a daughter.

It is obvious that if staff know their documentation will be regularly reviewed at a unit or hospital level, then not only will the lack of documentation decrease but the orders of practices of procedures (PP) manuals are more likely to be followed. I think this is a part of something that I wrote to the Human Rights Consultation Committee and I would like to read it to you now. It comes down to a matter of how patients are seen, how hospitals work. "From 1994 to 2002 the human rights of Anne and those of so many other clients we were with in clinics and hospitals were routinely disregarded. So many professionals simply do not act or speak as if they see their clients or the carers of their clients as their equals. It is impossible to describe the number of ways in which this disrespect is expressed, not by all professionals in the mental health system of course, but from my experience I can say, by a majority. How must this affect clients visit after visit, year after year?"

This was a constant fact of our time in the mental health system, and I believe it has to do with the fact that in psychiatric hospitals more than any other, it seems to me that medical documentation is not kept strictly. You have the record of the director, a year and a half after Anne's death, saying to the coroner that it is burdensome to expect psychiatrists to sign that people should go on leave, when, as I showed you, this is directly against his practices and procedures manuals.

For example, a consultant psychiatrist wrote a short medical assessment of Anne on 28 February, including his final risk assessment. He next writes of my daughter, an involuntary patient until her death, on 17 March to say that he is sorry that she died. That was 17 days without any documentation for a seriously ill patient.

As another example, Dr Doherty gave evidence that it would be impractical and an administrative burden to expect documentation of authority for leave. His PP manuals, signed off by him, state that many things must happen, which the coroner accepted did not happen. The coroner chose to accept that undocumented assessments and procedures did happen, he chose not to question Dr Doherty about, or note in his findings, the grave contradiction between what the doctor says and what he expects to be done and states must be done in his PP manuals. If, as I had hoped, the coroner accepted that if it is not documented, it did not happen, the finding regarding Anne's death would have been different, I believe.

In his submission to your committee, the chief coroner offers a request for improvement. He wants coroners to be able to present a finding of 'a preventable death'. I believe totally that this must be allowed to happen and I can see it as a very great improvement on what is happening today when blame cannot be attributed, when breaches of care cannot be noted because a breach of a duty of care is a definition of negligence, and negligence cannot be noted. Perhaps to do this the act must also be changed to accept another of his recommendations, that the coroner's office must become a court. Chairman, I am not sure what is meant by that. If it became a court, would that mean that common-law evidence would have to be part of a court, as it is in other courts? I know that you have not had time to discuss this.

The CHAIR — We have not yet had an opportunity to talk to the coroner about what he precisely means by all of that. We have not had an opportunity to think about the implications of what he is proposing but presumably he is suggesting they become more judicial in nature.

Mrs STORM — Thank you very much.

The CHAIR — Obviously, to that extent, that would become slightly more formalised around things like rules of evidence and findings and so on, but we have not had an opportunity to talk to him about what he precisely means.

Mrs STORM — I can understand that. As the chief coroner states, many people believe it is. I must say that I believed it was when I was attending my daughter's inquest. I certainly felt as if I was in court during the adversarial cross-examination I endured for 3 hours. As I said to you, the theme of those questions to me was, Towards the end, "if you knew she was so ill, why didn't you save her?". That was in what was supposed to be a non-adversarial situation and where there are no requirements of evidence, especially medical documentation, to be produced. I believe it is something that perhaps needs your consideration, because it is very bad. Thank you for listening to that. I do not know if I covered what you would like to know about my submission or other things.

The CHAIR — Thank you very much for that presentation. There are a lot of things that come out of your submission that we would like to follow up. You have raised the issue of compliance with procedures and documentation. In your daughter's case, the consulting psychiatrist said in his evidence that this procedure was an impractical administrative burden.

Mrs STORM — That is the director of Alfred's psychiatry, Dr Doherty, not the consultant psychiatrist.

The CHAIR — Yes, would you like to comment on that a bit further?

Mrs STORM — Yes, I certainly would. I believe it goes back to what I mentioned before regarding attitudes of many professionals in the mental health system and, eventually, to attitudes of personal and professional ethics and integrity. It seems incredible to me that the director of what has been described as the mental health flagship of Victoria can write practices and procedures manuals as he believes they should be set out — possibly with guidance from the Department of Human Services, possibly with guidance from the chief psychiatrist's office — and then not see that they are followed in his psychiatric unit.

Dr Aizenstros, the consultant psychiatrist, actually became a fellow of the college of psychiatry five days after Anne's admission. He had of course had psychiatric experience in his training, but one would think that a very new psychiatrist who is looking after a very seriously mentally ill patient at high risk of attempting suicide again would be somehow helped or supervised by the senior doctors of that unit. As far as I am aware, that was never done.

I was with Anne for 6 hours a day for most of her admission. I know very well how often Dr Aizenstros, the consultant psychiatrist, saw her, even though the coroner accepts that he saw her more than is documented. I know very well that no senior doctor from that unit saw me, saw her or was even seen on the floor for those 37 days of her admission. I do not know the legal terms but I would describe such an attitude as malpractice. I do not see how else it can be defined — that the director of this unit can even say to the coroner, ‘It is a burdensome thing. It would be an administrative burden’, that it is impractical that an involuntary patient who is at high risk of suicide does not need to have medical authority for her to be sent out.

Just in passing I would say that I intend to try to go to the Nurses Board, not to speak of particular nurses but about the fact that this means nurses sent her out on leave without medical authority, and that should not be allowed. I do not understand such an attitude by Dr Doherty. The coroner was listening to his evidence and after he said that, on the next page of the transcript, our barrister questions him and says, ‘But what you stated would appear to be contrary to your practices and procedures manuals’. Dr Doherty went on to something else and the coroner ignored that minor discussion. The thing is he also ignored such a paradox, such a medical contradiction, in the findings he made.

I know that my daughter was very ill. While she was alive I never believed anything but the fact that she was going to remain alive — I think that is the attitude of all parents while their children are alive. I realise now that her death was very likely going to be by suicide. The crux of this matter, of this particular inquest, is that she should not have been sent out as she was then before the anti-psychotic medication, which was being slowly titrated up, had had its full effect. She should not have been alone in her flat with the company — sound asleep in another bedroom — of a person who also had schizophrenia. She should not have been in a position where she could kill herself. The coroner’s finding was different. I know that nothing can be done about that but I must speak to you about these matters, which should, I think, have been the concern of the coroner.

The CHAIR — You seem to be indicating in terms of the lack of documentation and procedures that you felt that the coroner did not comment on those adequately?

Mrs STORM — I do feel that. You are right.

The CHAIR — Do you want to say some more about that?

Mrs STORM — I think you are about to see an example of what was accepted by the coroner as legitimate medical documentation. It is a so-called discharge plan, by which my daughter was sent out on 15 March — she killed herself 30 hours later. As you see, it is on unlined paper, it is unsigned, it is undated, it has scratching out, it has interpolations. There is no sign that any doctor saw it. The doctor said he knew about it and that he had approved it. I would like to say that that is a great miscarriage of appropriate care for my daughter — that she was sent out on a paper like this, which the case manager who wrote it said many times through the inquest was only a brainstorming exercise. You would expect something more official than this to take a dog out of a pound.

I think I would prefer to reply to your specific questions rather than continue with this matter any longer. I have a lot I want to say and I do not want to become upset.

The CHAIR — This is very illustrative of the point you are making. It does not seem like an acceptable discharge plan to me.

Mrs STORM — It was accepted by the coroner as a legitimate medical document. He spoke of ‘the discharge plan’ in his findings, which I am sorry I did not think to send you. Would you like me to give Michelle the coroner’s findings at another time?

The CHAIR — I think all the coroner’s actual findings, as distinct from the details in the case notes and so on, are public documents.

Mrs STORM — Yes, they are, of course. I am sorry.

The CHAIR — That is okay. Just on that, in your submission you indicated that you felt that a lot of the coroner’s statements were motherhood statement sentiments which the coroner knew would never be implemented, and that you felt they were not specific enough. Do you want to talk a little bit further about that.

Mrs STORM — Yes. I am sorry, I cannot remember what I wrote in my submission but I did not mean the coroner's statements, I meant his recommendations at the end of the finding. I thought they were useless. I saw they had no point. He was only repeating what was already in the practices and procedures manuals of the hospital and what should have been done. The documentation should have been made. The consultant psychiatrist should have taken care to get from me all the valuable information I had about my daughter. He did not do that.

I made you aware of the fact that he spoke to me for only 15 minutes through the whole 37 days, and that was with my daughter present when I could not be entirely frank with him, as I wanted to be without Anne present. To say that they must remain vigilant really has no clear meaning in medical terms. I think if the coroner is going to make recommendations, they should be things which can be followed through. Dr Doherty knew that these recommendations were in his practices and procedures manuals already, although he also agreed that at least some of them could be ignored by his staff.

Surely it is an encouragement for his staff to ignore practices and procedures manuals for him to state it in sworn evidence to the coroner. I meant that they look good at the end of the finding. They seem to give a reason for the coroner's finding, that he has made recommendations but in fact I do not believe they have any value whatsoever.

The CHAIR — You are pointing out that a lot of his recommendations related to the fact that the hospital's own procedures and documentation require them to do certain things, which the coroner obviously was commenting on, had not been followed and needed to be followed. What more can the system do to make sure that recommendations are followed up or procedures are followed when they should be?

Mrs STORM — There must be, as you have questioned in your terms of reference, a mandatory order for coroner's recommendations to be followed up. The chief coroner himself has suggested in his submission to you that although the Department of Human Services is supposed to take note of the coroner's recommendations, there is no time limit for it to do so.

There is no broadcasting of whatever recommendations they want made to hospitals or hospital services. There must be a particular person, as you suggest, who is supposed to see that recommendations of the coroner are made serious matters which need to be followed — for example, I said that I have not been able to find that anybody is supposed to see that the coroner's recommendations are followed. To me that did not matter very much because his recommendations were repetitions of what is in the PP manuals.

As regards the police spokesperson who said that they will not stop high speed chases of people, I do not know what is to be done about that, but these matters should all be part of your consideration because, as you are aware, you have them in your questions.

Mr MAUGHAN — Do you therefore believe that there should be some mandating of a response to a coroner's inquiry from the relative government departments within a time limit? Is that the sort of thing you are proposing?

Mrs STORM — Yes, I do believe that, and I do believe that there should be some response from the hospitals that they are doing this, and that such responses should be sent to the senior carer of the person whose death has elicited these responses.

Mr DALLA-RIVA — I am conscious of your statement that you are not wanting to be questioned too much.

Mrs STORM — I am happy to answer questions. I just could not continue on with the documentation.

Mr DALLA-RIVA — I may have misread what you said in the context of evidence being given in the Coroners Court, or the hearsay as opposed to evidence given in the Coroners Court, which may be more rigorously adjudicated at a level such as the County Court or Supreme Court. Do you have a view about the way that evidence is presented at the Coroners Court, evidence which you would like to see perhaps not given or you would like to see given, or you would like to see more scrutiny of the process? I am interested in the process at the Coroners Court. I am fascinated with this document. This is just atrocious — —

Mrs STORM — Thank you for that word.

Mr DALLA-RIVA — It is atrocious that you could rely on this being a document that would be accepted by the Coroners Court without rigorous scrutiny, cross-examination and the like. I am just curious: are you saying the reason there was not that rigorous examination perhaps — I am assuming — of this document was because the level of evidence given in the Coroners Court is perhaps not as rigorous as it is in perhaps another court of law, as in the County or Supreme courts?

Mrs STORM — I am not really qualified to answer that question, but I would have expected a much more rigorous approach to much of the evidence which was given at that five-and-a-half day inquest. There was a lot of contradiction. I would have assumed it was the coroner's place to remain on top of that and perhaps question it, and if he chose not to at the inquest, to note something like that in his findings. The person who wrote that was also Anne's case manager. She herself said it was a brainstorming exercise and yet she put it in the hospital file. People allowed it to stay in the hospital file; a nurse-manager allowed it to stay there and the coroner did not question that, nor her assertion that on the day before Anne died she and I spoke on the telephone, and I told her at length and with some anger that Anne should not be sent out because she was in the same state as she had been each time she had tried to kill herself previously.

The case manager's evidence was, and what she noted in the Waiora case manager file regarding this telephone conversation, was that she, 'Allowed mother to vent'. Her evidence was to the coroner that I did not say that to her and that she did not know that I believed Anne was in this crucial stage. In the coroner's finding it can be seen that he accepted her evidence that she had not been told these vital facts. He rejected my evidence, which was that I had told her this — and I need to ask the question in my mind: what else would a mother say about a daughter she believes might be sent out to die?

Ms BRAND — I just want — —

The CHAIR — I am sorry we cannot take questions from the gallery.

Ms BRAND — I just want to repeat, that I know someone else who was discharged under very similar circumstances and he died as well — almost identical.

Mrs STORM — I think I have told you in the submission that I see Anne's case as one of very, very many in the mental health system. There is a systemic problem. It will not be solved except by senior clinicians, for example, working according to the act, and you have had a very clear expression in Dr Katz' evidence of the fact that the senior expert witness at the Alfred hospital, who was a mental health director himself in Melbourne, stated in answer to Dr Freckleton's question, 'Are you saying that you discharge patients who are posing a risk to themselves or other people?'; 'Yes, that is correct, it is practice.'

I think if the public knew that there would be an outcry to get the necessary funding for the mental health system to be serviced in the way in which it should be so that we are not in this dreadful revolving door policy for acute beds in that my daughter is sent out on leave a week before Easter when I had been told they had to have empty beds for Easter, and another equally sick patient — perhaps sicker, perhaps not as sick — is admitted. It would have to be someone who was very, very ill when Anne killed herself 30 hours after she was sent on leave and was supposed to have been held in care.

I can see and accept the fact of no blame, no attribution, no coroner saying that that doctor's action killed my daughter. I do not want that. But I would feel satisfied with a change in the act if the coroner was able to say "this was a preventable death", and that is what he is asking for. I would feel as if something was being said about the system and that perhaps people who are still to come into it will not die in such numbers. I think that is a crucial matter of the chief psychiatrist's submission. The minimum we should be able to hear is that this was a preventable death.

The CHAIR — Mrs Storm, can I just ask a little bit more about the whole process of the court, to follow Richard's question, because you referred to the lack of procedural rules and you felt that there should have been more rigorous questioning of some of the witnesses. You also refer in your submission to your own ordeal; I think you were cross-examined for 3 hours. There is a difficulty here because the Coroners Court is trying to be a little more informal and accessible. On the other hand there is this difficulty of do we actually get to the truth of the matter through the process? Is the coroner and the process being rigorous enough in its treatment of witnesses who come before the court? How do you think we could resolve that dilemma so that it meets the needs of families and gets to the concerns that you are raising?

Mrs STORM — The ancillary people of the coroner's office are excellent persons in their jobs. I was greatly helped by the counsellors, the chief clerk in particular who is one of the most humane men I have ever had to deal with in the mental or coronial system — even the woman on the telephone, Jeanette, who is still there. The Coroners Court is very, very well staffed, but I think that what you are talking about as regards the actual case itself, having the Coroners Court as a court, which he is asking, would not affect families because the effect on families is exactly the same as if we were in an ordinary court. I have only been in a family law court; I was very closely questioned there. Unfortunately it had to end in a case — a trial — and I was very closely questioned. I did not feel any worse there than I felt in the Coroners Court. If you were able to be more rigorous about the collection of evidence, then obviously that would be a help for everybody.

Mr HILTON — You obviously felt uncomfortable with the adversarial nature of the court and the fact that you were cross-examined for 3 hours by a barrister. I presume you would not have been able to afford your own representation. Is there a possibility that we do not have legal representation in these courts, that it is more a presentation of evidence and that people are not finding themselves being questioned as to the evidence that they have given by barristers?

Mrs STORM — Questioned then by whom?

The CHAIR — By barristers.

Mr HILTON — It may be the coroner who asks the questions; he is not associated with a particular witness who is trying to present the case in the most favourable light.

Mrs STORM — First of all I do not believe that the health services would ever let you get away with that; it is going to put such pressure on you. Already in your submissions you have Bayside Health saying that they do not want to have the root cause analysis documents made public. I did not realise that there might be a problem about that. Obviously the health services are trying to close documentation down to families, to coroners — I do not know — to anyone you might name; to the public or to the media. I thought root cause analysis would remain a public document. It may not if they get their way, although it is of course up to your committee. I do not know how this could be done. All I know is that when I was in the family law court and on the witness stand for a long time there, I felt no worse than I did in the Coroners Court. I know I would have felt much better at and after the inquest if I had known that evidence was being brought up at the Coroners Court as it was at the other court, especially documentary evidence.

Mr MAUGHAN — I get the impression from your submission and from the evidence that you have given that you think it is a very unfair contest between the hospitals and the doctors with their barristers, on the one hand, and the family of deceased persons on the other. Is that a fair assessment or the gist of what you are saying?

Mrs STORM — Not quite, because we had Dr Freckleton who is a barrister. I imagine that his questioning of the psychiatrists was, you could say, as rigorous, but I do not know that it was as personal as the hospital barrister's questioning of me, especially the fact that she was eventually saying I could have done this; I could have done that; I should have got my son to see her; I should have done that. It came down to the fact, 'Why didn't you see her?'

The CHAIR — Do you think that some of those questions should not have been allowed?

Mrs STORM — I would have thought so. I was surprised that my barrister did not object and I was surprised that the coroner did not object.

Mr DALLA-RIVA — You spent an inordinate amount of money yourself on legal fees?

Mrs STORM — My ex-husband did — Anne's father.

Mr DALLA-RIVA — Tens of thousands of dollars.

Mrs STORM — We wanted to have as full an inquest as possible. It was our choice and today I would still say I am pleased that we had it. I had to have it examined as closely as I could.

Mr HILTON — I suppose by extension, if you had not been able to afford \$20 000 there would have been no opportunity for you to state your case in terms of your views of the circumstances of your daughter's death?

Mrs STORM — I believe there would have been. The senior next of kin is allowed to speak at the coroners office, but of course many of my friends who have lost children to suicide in the system have not even been told that they have the possibility of an inquest. I found out by accident because of the fact that the head grief counsellor at the coroners office at the time Anne died happened to live in Daylesford and stopped by to see me and my daughter, and told me some of the matters which would happen. I know that a person I met for the first time three weeks ago is most upset that he was not allowed to have anything — there was only a chamber hearing — and he did not even know about that.

The CHAIR — Mrs Storm, is there anything else you would like to say to us before we conclude your reference.

Mrs STORM — The reason I spoke about the frail aged is because I believe they are extremely vulnerable, as much as small children, and there should be someone to sign their death certificate after they have seen the naked body to say there are no signs of abuse, of a fall, of poor hygiene or of pressure ulcers, which are reportable causes of death. I would like to state the fact that I tried to have a psychological autopsy done for Anne; I was told by the police that was not allowed — by the coroner's assistant. I still do not know whether the coroner knew about that. I think it would have helped greatly, and my ex-husband had offered to pay for it.

In reference to documentation, I would like to read you something from the Auditor-General's report 2005:

"The Department of Human Services has maintained the absence of documentation of a particular action does not preclude the possibility that the action occurred."

I agree but add that the opposite equally applies, and of course it does in the Coroners Court as well.

In the Coroners Court the coroner seems to — I think I used the word 'benignly' in my submission — accept that procedures had been done, visits to my daughter had been made, assessments had been made when there was no documentation. He did not take the fact that the opposite equally applies.

"Documentation does not guarantee quality outcomes. However, I encourage all agencies to work towards effectively documenting their actions because such documentation can provide evidence that the planned activities which contribute to the effective outcomes took place, information from which to learn from past experiences and assurance to individuals accessing services of the wider community that appropriate actions are being taken. Our judgment was that on balance key service delivery processes may not have been undertaken adequately in a timely fashion."

He is speaking of more than the coroner's service here of course — the hospital services — but I think it can be applied to what you are looking into. I think the sentinel events committee of New South Wales was correct in saying of such appalling psychiatric documentation, if it is not documented, it did not happen. That is the basis on which it made its report.

I would appreciate your looking into a grave and increasingly serious part of the coroner's work which is in the *Age* report I gave you with Ruth Vine's figures given to the reporter. The working out of those figures, which clearly can be shown, shows the increase in suicides of clients of the system from 1995 to 2002 is 81 per cent. The death figures of this jointly authored report were known in 2004; in fact they were known before the last two budgets were put out — and the death figures should be made known. The death figures are the benchmark of any health system. If you know that triple bypass death rates have gone up 81 per cent, there is going to be an uproar. If you know that child leukaemia deaths have increased 81 per cent in eight years, there is going to be another uproar. Someone should know this because the government might be shamed into putting the huge amounts of money which are needed into the mental health system — \$180 million for four years which means \$45 million a year; \$45 million this coming year is covered by a new Bunjil ward and the beds at Maroondah.

I thank you very much for listening to what I have had to say.

Witness withdrew.