

Submission To Victorian Law Reform Committee Inquiry Into The Coroner's Act 1985

By
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Coronial System

Two Views

The Coronial claim –

“We speak for the dead to protect the living.”

The Family perception –

“They defile our dead and mock our grief”

Key Issues

- Deaths Involving Medical Treatment
 - Including Failure to treat
- Under Reporting of Deaths
- Deaths in care
 - Including post discharge
- Medical Records
- Inadequacy of investigations
 - Outsourcing to legal representatives of hospitals and doctors

Key Issues (cont.)

- Powers of investigation
 - Failure to adequately use
- Guidelines for Coroners' Investigations
 - Bogus 'Independent' Experts
 - Failure to rely on published standards
 - Secret protocols with DHS (often a party in inquests)
 - Outsourcing investigation as previously mentioned
 - Absence of investigatory skills and need for training

Key Issues (cont.)

- Death and injury prevention
 - Should be major focus
 - Should receive greater resources than possible crimes
 - Recommendations must be responded to
 - Even if to decide on no action
 - Must always be an explicit decision publicly announced
- Safety in health care system
 - Need a 'corporate memory'
 - Must relate cases to others, past and present to discern patterns and get to 'root cause'
 - Learn from Auditor-General reports

Key Issues (cont.)

- Other assistance with coroners' investigations
 - Need to use sources of relevant expertise
 - Need to locate and apply relevant standards and techniques
 - DHS protocols & guidelines
 - DSM IV (Mental Health cases)
 - AS4360 Risk Management
 - 'Root Cause Analysis'
- Auditor-General seems to have far superior ability to identify underlying issues

Key Issues (cont.)

- Needs of community
 - Transparency
 - Integrity of investigatory process
 - An outcome consistent with the evidence
- Right to legal representation
 - Currently the taxpayer is often funding a cover-up
 - Families often left to fund case serving public interest
 - Perverse and unconscionable

Issues identified by Coroner in Mental Health cases in 1992

- Failure to communicate with next of kin in any meaningful way.
- Inappropriate or non-existent discharge planning.
- A perceived difficulty in ensuring a patient who needs treatment, but is not seen as meeting the criteria in the Mental Health Act to be made an involuntary patient, actually receives treatment

What happened?

- Despite Coroner Wilmoth apparently being led to understand that her comments were referred to a working party for action, no such working party ever existed.
- DHS also deceived Health Services Commissioner into believing such a working party was looking at these issues.
- Coroners continue to make these ineffectual recommendations.

A Recent Example

Recommendations (case no.722/03)

All relevant mental health organisations including the Department of Human Services, the Office of the Chief Psychiatrist and public hospitals should co-operatively consider:

- establishing appropriate procedures to ensure that all patients refused admission after referral by a private consulting psychiatrist not be discharged until after a psychiatric registrar and if necessary the supervising consultant psychiatrist has reviewed the patient and consulted with the private referring psychiatrist;
- a review of the CAT system for assessment and admission procedures for psychiatric patients;
- establishing or strengthening appropriate training programs for those working in the mental health area to provide assistance and support in identifying and managing complex psychiatric emergencies referred from the community.

A Recent Example (cont)

- Such protocols already exist but are ignored.
- There have been numerous calls over the years along these lines. Why should this recommendation have any effect?
- Isn't this what a Mental Health System is all about?

Failure to test treatment against standards

- My son's case illustrates this (1098/93)
- Bogus 'independent' expert witness (colleague of senior Psychiatrists from hospital involved)
- Failure to identify relevant standards and measure treatment against them
- Vilification of family by legal representative of hospital and doctors (not stopped by Coroner)

Coroner found no problems!

Jason Bond - Treatment vs Standards

	Hospital A Emergency Dept / Intensive Care 30/3/93 - 31/3/93	Hospital B Neurology Ward 31/3/93 - 1/4/93	Hospital B Psychiatry Ward 2/4/93 - 5/4/93	Hospital B Psychiatry Ward 6/4/93 - 8/4/93
Consultant Psychiatrist				
Psychiatric Registrar				
Registrar's Experience (as a Psych. Registrar)	3 years	2 years	2 months	2 months
Assessed By Consultant	No	No	No	No
Assessed by Registrar	Yes	Yes	Yes	Yes (re-admission on 6/8/93 - assessment carried out by Nurse G - Dr F present but denied being present)
Next of Kin or significant others interviewed as part of assessment process. FCP p67- 68	No - not applicable as was being transferred for care elsewhere	No - other than Steve Dubsky when he told Dr Stafrace of suicidal statement by Jason.	No	No - despite attempt to portray 'Family Meeting' in this light.
Seen By Consultant	No - not applicable as was being transferred for care elsewhere	Yes - ward round 1/4/93 prior to discharge	Yes - Ward Round 5/4/93	No
Consultant read history	N/A	No	No	No
Transfer letter and history from MMC read by relevant staff.	N/A	No	No	No
Risk Summary Completed as mandated by Chief Psychiatrist letter of 9/3/93.	No - but not a Psych Department patient.	No - but not a Psych Department patient.	No	No
Any documentation of formal assessment of patient risk	Yes	No	No	No
Provisional diagnosis formulated within 24 hours of admission. (DPG p 23.)	Yes - 'Adjustment disorder with background of Dysthymia'	Yes - 'Adjustment Disorder with Dysthymic features. Major Depression could not be ruled out'	Could not locate in Medical History	Could not locate in Medical History

Coroner found no problems! (cont)

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Psychiatric diagnosis and differential diagnosis formulated during admission and confirmed by a psychiatrist prior to the patient's discharge (DPG p23)	N/A	No	No	No
Communication with Neurology Department re treatment of co-morbid factors (FCP p347)	Yes - Transfer arranged to St Vincent's Neurology Dept.	N/A - was admitted to Neurology Ward - also attended by Liaison Psychiatry team	No - other than when Prof B arranged re-admission to Psychiatry Ward.	No
Relatives who were expected to care for Jason consulted prior to discharge / transfer. FCP p68. DPG p15.	Yes	No	No	No
Discharge plan authorised by the 'treating psychiatrist' (DPG p14, p 24)	N/A	Yes, such as it was.	No	No
Carer's specific concerns identified and recorded. (DPG p15)	N/A	Yes (Mr Dubsky's) but ignored. No consultation with next-of-kin.	No	No
Discharge Plan supported by documented policies and procedures and communicated to all relevant parties. (DPG p17)	N/A	No	No	No
Suicidal statements made to visitors and staff advised	N/A	Yes	Yes	Yes
Suicidal Statements made to staff and recorded in history	Unknown	Yes - remarks to Mr D	Yes - recorded By Dr F 2/4/93	Yes - recorded by Nurse G on re-admission 6/4/93. Dr F present despite his denial.

Coroner found no problems! (cont)

Jason Bond - Treatment vs Standards

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Safe environment for patient as provided in ACHS accreditation	N/A	Yes - to the extent that entry/exit under observation from nursing station N.B. Not a Psych Ward.	No - nursing station staff could not observe entry / exit. Whereabouts of patients frequently not known, no restriction on patients leaving or outsiders entering.	No - nursing station staff could not observe entry / exit. Whereabouts of patients frequently not known, no restriction on patients leaving or outsiders entering.
References:				
FCP - Foundations of Clinical Psychiatry, ed. Sidney Bloch & Bruce Singh, Melbourne University Press 1994				
TAAG - The ACHS Accreditation Guide 10th Ed. for Surveys After January 1992, The Australian Council on Healthcare Standards				
DPG - Discharge Planning Guidelines for Psychiatric Services in Victoria, Office of The Chief Psychiatrist, February 1993				

“I am satisfied that appropriate procedures and guidelines were followed on the admission and discharge of Jason Bond on each occasion of his admission and discharge. “ Coroner

In Conclusion

“Lies written in ink
can never disguise
facts written in blood!”

..... Lu Xun