

**LAW REFORM COMMITTEE**

**Inquiry into Coroners Act 1985**

Melbourne — 28 November 2005

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Ms M. Way, director of strategy, risk and clinical governance;

Dr A. Kattula, medical leader, clinical governance; and

Mr S. Rosalie, mortuary scientist, Austin Health.

**The CHAIR** — I welcome Austin Health to this public hearing of the parliamentary Law Reform Committee. I particularly welcome Margaret Way, Dr Andrea Kattula and Simon Rosalie from the Austin. As you know, this is a public hearing. What you have to say to us today will form part of the public record. After you have had a chance to correct it, it will be put up on our web site and be available for the community to look at. We thank you for coming along to speak with us. It is over to you to present to us and we will then ask a series of questions.

**Ms WAY** — Thank you. I will probably start. My name is Margaret Way. I am the director of strategy, risk and clinical governance at Austin Health. Just to introduce Simon and Andrea to you today, Simon is our mortuary scientist at Austin Health and Dr Andrea Kattula is one of the senior clinicians who works with us in the safety and quality area. At Austin Health when we received the discussion paper we were very interested to make a submission, so we convened a small working party to go through all the questions in the discussion paper. We had senior medical and nursing staff who wanted to contribute to that and our director of anatomical pathology. Our medical staff included staff from the emergency department and staff from general medicine, and we had our corporate counsel as well. That is the process we went through. People used the discussion paper as an opportunity to have a look at how we were going with coronial death reporting at Austin Health. I might hand over to Simon to talk a bit more about the background to what we put in our response.

**Mr ROSALIE** — My name is Simon Rosalie; I am the mortuary scientist for Austin Health. Just to frame our response today to this inquiry, we thought it was important to give some background to the systems we have introduced over the past three years. This has been a collaborative effort between the Department of Anatomical Pathology and the Clinical Governance Unit. We have implemented an extensive education program for all clinical staff. We have standardised procedures and protocols for deceased patient management across the health service but with a major focus on providing support structures for identifying and reporting coronial deaths. As a result of this work, and in conjunction with this review, we think we have identified two major issues which we would like to address and which may warrant reform. These are the need to review and clarify the definitions of a reportable death, this will be addressed by Dr Kattula; and the need for death certification system reform, which I will address. I would like to now hand over to Dr Kattula to continue.

**Dr KATTULA** — I am going to address the issues we have identified in relation to the definition of a reportable death. This has really come out of our experience in liaising with our junior and senior medical staff and anatomical pathology at Austin Health. From our experience we realised that doctors are actually highly aware of their obligation to report reportable deaths. They strongly wish to comply, but we found some common situations where they tend to seek advice and quite frequently seek advice about their reporting obligations. These have seemed to come up as patterns over the last few years.

One of the things we have noted is that difficulties often arise in the interaction between the coronial system and the clinical system, which we think are related to the different languages being used by each of the systems. There is some opportunity there to make some change to the Coroners Act in terms of the language used to make it more understandable to the clinicians in terms of their reporting obligations. The following terms are the ones which seem to come up on a regular basis.

The first one is about the term ‘indirect’ in the Coroners Act. That is particularly in relation to accident or injury, particularly when the accident, injury or incident which triggered the reportable death is quite remote from the time of death. That often requires a judgment by the medical staff about the degree that original incident contributed to the death. That can be quite difficult for the medical staff. It is really the term ‘indirect’ that they find confusing.

Another area is where there are some contradictions in the interpretation of the Coroners Act. The one that we find coming up regularly is medical staff are aware that they need to report asbestos-related deaths, but they are unclear as to why that does not mean they also need to report tobacco-related deaths or alcohol-related deaths. For them it is not that intuitive why asbestos-related deaths would be reportable.

Another term they find difficult is ‘unnatural or unexpected’, particularly in relation to clinical conditions. It is interesting. Doctors tend to approach that from a clinical perspective so they think of the term ‘unnatural or unexpected’ in the sense of the natural progression of that disease or that clinical problem. They find it quite difficult to view it from a legal perspective in terms of whether it was unnatural or unexpected in terms of the patient’s background.

The other one that comes up is deaths that occur intra-operatively and post-operatively. The medical staff seem very aware that a death on an operating table under an anaesthetic constitutes a reportable death, but they are unclear when it comes to post-operative deaths about when a death in the post-operative period would be unexpected or not due to natural causes. We find that comes up particularly in relation to emergency surgery. There also seems to be a common misconception in the medical community that deaths within 24 hours of surgery are still reportable, and some believe up to 48 hours after surgery — they are not clear on what constitutes a post-operative death that would be reportable.

Another situation which is arising more frequently is deaths in association with regional anaesthesia. There is often concern with, for example, epidural anaesthetics or epidural analgesia used on the wards post-operatively. They are unclear when it becomes anaesthesia versus analgesia and when it will constitute a reportable death, particularly as local anaesthetics are often used in those techniques post-operatively on the wards. It is also coming up more frequently because we have a lot more procedures which are undertaken outside of a theatre setting — for example in radiology departments and in cardiac catheterisation laboratories, that involve the use of local anaesthetic and involve the use of sedation but not necessarily the involvement of an anaesthetist.

Another area where we find frequent questions is where do complications and drug reactions fall in relation to the act. This is a category where doctors feel particularly unsure and they often seek advice from our department of anatomical pathology or clinical governance. It can be very difficult for medical staff to make a judgment as to whether that drug reaction or that complication actually related or contributed to the death. When they are asked to make a judgment the doctors are sometimes unsure about how they make that judgment — on what basis.

This is particularly so when the treatment involved was standard treatment for that particular condition or disease but when there are known risks associated with it. I have some examples of situations which we were thinking about before coming to the inquiry — for example, there are some drugs which are associated with pulmonary toxicity, and that is a known fact, but when would that become a reportable complication? The patient who presents in heart or renal failure but also has digoxin toxicity, patients who are receiving chemotherapy but develop febrile neutropenia, and another one that comes up would be bleeding complications in association with anticoagulation therapy, particularly when the anticoagulation therapy was within standard treatment.

Determining when that reasonable therapy becomes an unexpected or unnatural complication can be very difficult, particularly if the patient has a lot of complex medical problems. In the current environment we are treating a lot more complex patients, and there is a reasonable expectation that some of those patients will have complications even if their treatment is optimal. It is trying to define when does a complication become unnatural or unexpected.

The other thing we found is that these judgments overall are becoming very difficult to make in the setting of a teaching hospital because we have multiple medical staff across all levels — junior and senior — involved in one patient's care, but we also often find patients are transferred between different treating units, so there might be a different group of staff involved in their care at the end of their care versus the group that was involved at the start of their care. Making those judgments about the relative contribution of an incident or event to their cause of death can be quite difficult.

The suggestions we have to be considered by this inquiry for the reform of the Coroners Act are that it would be very helpful to review and clarify the definitions of a reportable death, specifically addressing all of those areas that we just outlined. We believe this would not only help the medical staff with their obligation to report and complying with that obligation, but we think it would also help the relationship between the coronial system and the medical community. What we think would be very helpful would be the development of some guidelines that are designed specifically for clinical staff. In my mind I think of this as the clinical equivalent of plain language guidelines for medical staff. That would help them interpret the legal wording of the act, particularly in regard to the definition of reportable deaths.

The third thing we would find very helpful would be having a clinically trained liaison officer at the coroners office when the medical staff actually make their initial reporting phone call. One of the patterns we have identified is often when they call up they talk to a coroner's clerk, and when the doctor is calling and they are not sure if the death is reportable or not, they ask the question, 'Should I report the death?'. Sometimes they are asked, 'Could you write a death certificate?'. The difference in the language that the coroner's clerk and the medical staff are using sometimes creates another level of confusion, because the doctor is thinking, 'I can write a death certificate but what I am really seeking advice on is whether I should write a death certificate.'. They are often asking clinical

questions of the coroner's clerk and having a clinically trained person for them to report to would make a difference and take away some of that confusion at that level.

**The CHAIR** — The Victorian Institute of Forensic Medicine has developed some guidelines as to what it believes should constitute a reportable death. They are not issued by the coroner's office but by the institute of forensic medicine. Are they being used by the Austin at all?

**Dr KATTULA** — I was not aware of the existence of those guidelines. I do not know if Simon is.

**Mr ROSALIE** — We certainly utilise them when we are talking to medical staff before they write certificates. But we still find that they like to have things fairly well prescribed so that they can make a judgment very easily on what the guidelines say, whereas the current guidelines still refer to those terms of being indirectly due to an accident injury whether a death is unnatural or unexpected, and it is the broad range that those terms can encompass that often causes the problem.

**The CHAIR** — So you are saying that the institute's guidelines have not adequately dealt with the issue from your point of view?

**Mr ROSALIE** — In my experience they probably need to be a bit more prescriptive to help, particularly for the junior medical staff.

**Ms WAY** — What we tend to find is, say with those guidelines, that what the doctors want to do is talk about their particular case, so they then want to say what has happened in this case. As Dr Kattula said, the event of their death was some time ago, and then they are wanting to clarify that with that person. Those guidelines give you guidelines but they do not actually give you assistance on that particular case.

**Dr KATTULA** — One thing we have found with our education of the junior medical staff that has been particularly helpful was — I cannot remember the exact year, but a few years ago — the medical board bulletin had a lovely summary of what constitutes a reportable death, and the language used in that bulletin was terrific in terms of communicating to the medical staff, and was very well understood by our junior medical staff. We still use that as part of our teaching. It provided some of the examples which frequently come up, but it also did it in very clinical language which they found really helpful.

**Mr DALLA-RIVA** — Do have a copy of that?

**Dr KATTULA** — We do at the Austin. I do not have it with me today.

**Mr DALLA-RIVA** — Could you provide a copy to the committee, because it would be beneficial.

**Mr MAUGHAN** — You talked about ringing the Coroners Court and getting a clerk rather than a clinical person who can give detailed advice to doctors. Is that common, or if you really need that advice, can you get onto a clinician who can give that advice doctor to doctor?

**Dr KATTULA** — Simon might be the best person to answer that question. My understanding, though, is that the medical staff can request to talk to a clinical person, but that is not widely known amongst clinical staff. We are introducing that concept in our hospital to make sure the staff are aware of that, but we think that sometimes it would help if the initial point of contact was actually a clinically trained person.

**Mr ROSALIE** — From my experience, when a doctor rings up and speaks to a coroners clerk, they would like to get a simple one-point response. Perhaps it is just the hierarchy of moving through the Coroners Court that can cause some of the confusion, and having to relate a story on a number of occasions. Certainly there have been instances where a request has been made to speak to one of the coroners or to a forensic pathologist in a particularly difficult case, but generally they would like to be able to get a fairly simple answer straightaway from whoever they contact — is this reportable or is it not?

**Mr HILTON** — But if all deaths were made reportable there would not be any confusion.

**Mr ROSALIE** — That is true.

**Ms WAY** — Obviously a large number of deaths occur out of hours so, as I said, it often then requires calling someone on call, that kind of thing. Obviously with the doctors, they are also out of hours so you add some complexity to it, particularly when it is out of hours. If it was simpler to say, ‘We could put you through to one of our clinical people on call’, that would probably assist them after hours, just as with our own after-hours services we try to make that easier for them.

**The CHAIR** — What training do you provide to interns, for example?

**Dr KATTULA** — We have actually done a lot of work in the last three years around this area. Through clinical governance and the department of anatomical pathology we do joint sessions with all our interns and our resident medical officers, and we run them roughly twice a year. We started with about four times a year, but they found that a bit overwhelming so we went back to twice a year. We try to do a whole range of things with them, so not only their legal obligations, particularly around what is a reportable death, and we provide some case examples for them as in hypothetical cases for them to review and consider whether that would be reportable or not. Our director of anatomical pathology also attends those sessions so they can ask questions directly. That also helps establish a relationship for them with the department of anatomical pathology, so that when they have questions they know who they are talking to; they have met the director of anatomical pathology and Simon during these sessions.

We also make them aware of where the resources are when they are unsure. We make it clear to them that it really needs to be a unit responsibility, that their senior members of the unit should be involved in those sorts of decision making and in completing the paperwork when a patient dies. The resources are quite important, about them knowing in hours and after hours where they can seek advice and where they can seek help, and in understanding their obligations in terms of calling the coroner’s office if they are unsure and providing that information for them.

**Mr HILTON** — But the point I made with Simon was that if all deaths were reportable, there would not be any necessity for all this confusion.

**Dr KATTULA** — That is true.

**Mr HILTON** — Would Austin Health have any difficulty with that scenario, that all deaths were reportable?

**Mr ROSALIE** — I will address that in ‘death certificate reform’, if I may. Of the options that were outlined in the discussion paper, we had a couple of major concerns with the three of them that were outlined. All of them were physically removed from the institution in which the death occurred, and that makes accessing medical records either difficult or time consuming. Instigation of any audit processes around death certificates in a major teaching hospital would be likely to result in delay in funerals or non-coronial autopsies, and therefore we believe they would be unlikely to get widespread community support on those grounds.

We would like to make some suggestions in regard to that. We believe ideally any audit of death certificates should occur prior to the lodgment of the death certificate with the registry of births, deaths and marriages, prior to the funeral, and without causing any unnecessary delays. This would be difficult to achieve centrally because of the difference in location. It may require a local audit rather than a central audit by someone independent from the actual treating unit — that is, doctors that are not linked with those doctors. It is our position that an audit process should allow easy communication with the signing medical officer in a timely manner so that any identified issues can be dealt with quickly and that any audit system should incorporate a defined process for escalation, so whether the auditor reports directly to the coroner or whether they talk to the medical unit, it needs to have some defined process surrounding it. I hope that answers your question in some way.

**Dr KATTULA** — There is one area where I think a more prescriptive approach would be very helpful, and that is in the setting of post-operative deaths. I have noted that some other states have time frames — for example, 48 hours after a death makes it reportable when it is post-operative. I think that would be far more helpful to medical staff than trying to make a judgment about whether a complication may or may not have contributed to the death, and I wonder if that would be a potential place for introducing some more prescriptive reporting.

**Mr ROSALIE** — We have not made any further suggestions, but one thing we do find with death certification is that some of the issues often relate to very simple things like the spelling of names, differences in

dates and that sort of thing. That could be addressed far more easily at a local level than at a central level, and can also involve discussions with the family, which is often an important thing.

**Ms WAY** — Just adding to that, one of the principles of good clinical practice is that whoever is the treating clinician, whether it is the doctor in the hospital or the GP, should know what the outcomes of their care are, so that is part of the process that we encourage in the education of the junior medical staff. One of our initiatives was to make sure the general practitioner was aware that a patient had died and also to make them aware if the patient also was the subject of a coronial referral, because the GPs are often the ones dealing with the families, and if they have a family member come to them and they are unaware of the processes, that can obviously cause some concern where people do not understand what it is about.

In terms of reporting all deaths, we are taking the approach at Austin Health to encourage all of our medical staff — the consultants who are responsible for the care of the patients — to review the outcome of all of the care, so they should review all of the deaths as part of their normal standard practice. That is something we encourage them to do. We encourage them to make sure they have completed all the paperwork. Some of the work we have done at Austin Health that has helped our doctors and a number of other doctors in other hospitals is to put all the paperwork together, because you often find there is a lot of paperwork at the time of death and that can cause delays, whether it is a coronial process or whether it is just all other paperwork you need to do.

Some of the work we have done has been trying to take some of that mystery out of it, trying to take out some of the bureaucracy, if you like, so the doctors then know this is all the paperwork you need to do for a routine death, if there is such a thing, and this is the help you can get if the patient is going to be referred to the coroner. We have found that has been a really important thing as well and it gives you opportunities to also get them to go through the care of their patient because that is obviously what our concern is.

**The CHAIR** — What sort of disclosure policies do you have in relation to a death in terms of information, say, to the family? Do you have a policy written on this area?

**Ms WAY** — Again, that has been part of routine clinical practice. We expect that our clinicians will discuss the death of a patient with the family members. We put as part of our education that they should contact the family as soon as possible, even if it is the covering doctor, and then arrangements should be made for the usual treating doctor to talk to the family after that death. We find that the common thing is families want to know what has happened, and what happened in the last hours, particularly if it happens after hours — what actually happened in the time up to that.

Obviously we encourage, and certainly our nursing staff have a big role in this, communicating with families if they need to come in before a patient dies. Our principles have always been based around good clinical practice, which is that our doctors would talk to the families, talk to them about what is happening, talk to them about what their treatment has been and talk to them about the outcomes.

**Mr MAUGHAN** — Do you as a routine get a report back from the coroner on any deaths that the coroner investigates?

**Dr KATTULA** — We have put a system in place to ensure we express interest in all deaths that are reported to the coroner so that we can follow through. That also involves communication back with the treating units as well, which is a very important part of the coronial process as well.

**Mr MAUGHAN** — And do you send the original paperwork to the coroner or do you send copies or keep copies?

**Ms WAY** — In terms of the medical records, we send the original medical records to the coroner. What we have put in place is that we often take a copy of the most recent admission, because we have found sometimes that the notes stay a fair time with the coroner and it is very difficult then for the clinical staff to either have discussions with the family or to actually review it. Again, it is part of standard practice that all of the units review all of their cases — all the patients that are discharged, whether they die or whether they go home. They need to review that so they need access to the notes. We send the original documents to the coroner and any other material that is requested.

**Dr KATTULA** — One of the changes we have put in place for our junior medical staff was also to develop an approach for them when a patient has died, so we have a check list that guides them through the steps. What we have really made a big difference on in the last few years is making sure they think of that question, ‘Is a death reportable?’ as their no. 1 step, so after they have pronounced a patient deceased; that they actually run through the common causes or common reasons a patient’s death would be reportable as a matter of course for any death in the hospital so that they make no assumptions and they always look at it with open eyes about whether there could have been a remote injury that may have contributed or have been an indirect cause. That has been quite helpful to the staff because it gives them an approach to each patient’s death so they know what they are looking for and what they are following through on.

**Mr DALLA-RIVA** — Firstly, the root cause analysis, do you undertake that within the hospital — an RCA?

**Ms WAY** — We do. We comply with the Department of Human Services. It has a sentinel event reporting program, so anything that is called a sentinel event, which is something that has been agreed nationally and internationally, things that are unexpected that they expect us to report, and then we would do a root cause analysis, which basically means undertaking quite a detailed review as to what happened.

**Mr DALLA-RIVA** — You explained earlier that you did not quite get clarification as to what an unexpected death is, but you undertake an RCA under the notion of an unexpected death, so how do you work out that one is an unexpected death that you do not examine, yet you undertake an RCA for an unexpected death? You have just explained why you find it difficult, yet you undertake an RCA based on an unexpected death. How do you clarify that?

**Ms WAY** — Under the sentinel event program there are certain prescribed things, and I am going through them in my head. Not all of them result in death. The discharge of an infant to the wrong family does not result in death. There are a number.

**Mr DALLA-RIVA** — Is that a publicly available — —

**Ms WAY** — Certainly. The sentinel events report is put out by the Department of Human Services clinical risk management group on an annual basis. There is usually a report in various of the media about how many sentinel events have been reported through Victoria. With those sentinel events, whether it results in an unexpected death or an unexpected outcome, we regard them all as learning opportunities. There is something that I need to explain. The first one on the list is the wrong procedure on the patient. It does not necessarily result in a death, but that is something that you would not expect to have happen, so we do two parts of it. One is we look in our own institution and say, ‘Could that happen here?’, and we have a good look at that for something that has not happened to us yet. We might have something we call a near miss where the staff has actually picked up that that could have happened, and that could be because of confusion with patients of the same name. That kind of thing can happen. Where an actual event has happened, we would look at that. Certainly they do not all result in death, and there is not really a clear definition in any of the guidelines from state or commonwealth about an unexpected death at this stage.

**Mr DALLA-RIVA** — One of the other parts of evidence we have received has been the fact that these RCAs, or root cause analyses, that are undertaken are perhaps not as open, honest and transparent in respect of information provided for fear of litigation. What are your thoughts on that aspect?

**Ms WAY** — I will check with Andy, but I’m sure about this, with all our root cause analyses that we have undertaken we have an open disclosure process, and I can say that in all of the root cause analyses we have undertaken the patients and family have been informed, and we have been in discussion with them. That is the standard we have set and we think that is an important principle. Often the family members themselves have information to contribute to the root cause analysis of what actually happened in relation to that event.

**Mr DALLA-RIVA** — Is it not true that some legal advice or indeed some of the insurers may intervene in some of the processes that are undertaken in terms of the RCA or indeed any matters that may be referred to the Coroners Court for investigation?

**Ms WAY** — It has not been our experience at Austin Health. We have found that we have worked very closely with our insurers who have been very supportive of the process and that is based both on work in Australia

and overseas, that if you do work around talking to patients and their families earlier on, they are much less likely to take it further. What they want to know is what has happened and what can be done to prevent it. They want someone to say they are sorry. Our experience has been if we take advice and follow that through, we have been able to have a reasonably good outcome.

**The CHAIR** — Could I ask then why in your submission you were not in favour of abrogating the principle against self-incrimination in the Coroners Court where the trade off presumably would be that that evidence could not be used in other civil or criminal proceedings? If the intent is to get at what happened, what caused the death, how the death can be prevented in the future, why do you maintain a position against abrogating the principle against self-incrimination?

**Ms WAY** — I will speak on behalf of the people in the working party. As we would all understand we are in a system where there is more likelihood of people being sued. A lot of the work that has been done around statutory immunity and qualified privilege has really been around encouraging our medical staff to raise issues early, to talk to people in the system about what has actually happened. I think some of that wording there was really just trying to take the worry out of it in terms of encouraging them to be part of the process without worrying themselves.

**The CHAIR** — I do not think you actually answered my question which was about Austin Health's position, which is that the privilege against self-incrimination should not be abrogated even if that evidence cannot be used in any other civil or criminal proceedings.

**Ms WAY** — I might just have to refer back for the answer to that question.

**The CHAIR** — You could get back to us. We are trying to understand the tensions between full disclosure, finding out why someone died, what the cause was, how the root cause analysis might contribute to that and then preventing that death in the future, and saying that there were certain questions that would not be answered in a court.

**Ms WAY** — We were quite happy to take that back and then provide you with the response.

**Mr DALLA-RIVA** — I have one final question in respect of your submission for which I thank you and I thank you for attending — was it reviewed by your legal counsel and altered before it was submitted to this inquiry?

**Ms WAY** — Our corporate counsel was part of the review group and there was consensus on what was put forward by the members of the working party.

**Ms HADDEN** — Could I ask — and perhaps you could add it to the answers you are going to provide us in relation to privilege against self-incrimination — whether your answer is part of the whole insurance package. Is that a requirement that your insurers would have or impose on you in relation to deaths? I am thinking that it might well be possibly something that is part of your insurance requirements.

**Ms WAY** — I would like to get back to you.

**Ms HADDEN** — There are reasons why, as you are aware.

**The CHAIR** — One final question in relation to the clinical liaison service: what is your experience of it? Have you found it to be useful when dealing with this whole question of reportable deaths?

**Ms WAY** — We have attended a number of education sessions that they have conducted. We went to one in the Coroners Court, we had a number of staff attend that. We think the newsletter they put out has been very helpful, but I think we have only seen two, where they give good case examples which have been particularly helpful. We have liaised with them on a number of cases, for example there have been a number of cases that have looked into nasogastric tubes, but it has been very difficult to get any searching of the database to find out the recommendations and any actions that have been put in place by the health services. That has been quite difficult. To access the international database requires quite a substantial fee, as we understand it, so we found the clinical liaison service themselves to be helpful but fairly limited in what they have been able to provide to health services.

**The CHAIR** — How would you improve it or expand it in any way?



**Ms WAY** — Certainly its ability to look at sharing the learning and some of the recommendations and actions that have been put in place would be very helpful — obviously looking at some of the other cases and how they could help hospitals to look into those. I think the education sessions would be very helpful. We can do our own education services in-house, but having people from outside, like from the Coroners Court, does carry more weight. I think it would be helpful.

**Dr KATTULA** — There is a huge opportunity with the clinical liaison service to do things at a state level. Particularly a number of the issues that we find that arise will be occurring across health services, they will not be unique to Austin Health or one particular service, they will be issues related to drugs or how we do procedures across health services nationally or at a state level. In fact there is an opportunity there when people find system changes that are actually useful and effective, that is the potential way to share that learning and also provide resources at a central point that will help people and people can communicate.

I think it is an enormous opportunity to actually put in the system changes that we were just talking about before in terms of outcomes and root cause analyses, those sorts of things, and to actually develop them at a much higher level.

**Mr HILTON** — One quick question about these RCA's which you prepare: to what extent does corporate counsel have an input?

**Ms WAY** — Our corporate counsel and insurers are involved in helping us with language and they obviously look at that but it is our job to establish the facts and to look at the actual information. I do not believe it is in anyone's interest not to get to the facts because we need to take that further.

**Mr HILTON** — When you say, in terms of language, you are not talking about grammar or semantics, what are you talking about?

**Ms WAY** — Sometimes you can use words which are more negative — for example, 'a lack of policy' when in actual fact what you mean is that the policy has not been documented but people know what it is. That helps you to get the actions correct. We also find in doing the root cause analyses it is not just from a legal point of view, you also need to have the clinicians trust the process. If they start to see information that says lack of this and lack of that, it is not really conducive to them participating. When I say 'language' I mean they get us to be more precise with our language.

**Mr HILTON** — The RCA is unprepared from a medical perspective if that is the right term, and then it goes to a court or a counsel and they have a look at it, finetune it in terms of — —

**Ms WAY** — Often what we do with our corporate counsel is that they will look at it with fresh eyes because you find that a lot of clinical staff may have a lot of detail and you say, 'What was the main thing that happened?' or, 'I cannot understand this, what happened here?'. It is really about filling the gaps rather than changing it. It is about filling the gaps and saying, 'I can't understand what happened here, can you explain it to me?' or, 'What was going on there?'. That is in their role, to assist us, and that has been very valuable.

**The CHAIR** — Thank you very much. Thank you for coming along, for your written submission and for speaking to us today.

**Witnesses withdrew.**