

**LAW REFORM COMMITTEE**

**Inquiry into Coroners Act 1985**

Melbourne — 28 November 2005

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Witnesses

Mr W. O'Shea, corporate counsel, Bayside Health; and

Professor C. McLean, Director of Anatomical Pathology, the Alfred.

**The CHAIR** — I welcome everyone to this third day of public hearings in relation to the Coroners Act and the review of coronial services in Victoria. I welcome Bill O'Shea and Associate Professor Catriona McLean from Bayside Health, and I more particularly welcome Professor McLean as the director of anatomical pathology at the Alfred.

This is a public hearing. It is governed by the Parliamentary Committees Act. The evidence you give today will form part of the public record. If there is anything you want to tell us in confidence, we are happy to have a closed hearing. In due course you will have an opportunity to correct the transcript, and then it will be put up on our web site as one of the submissions we have received in these hearings.

Perhaps if I could hand over to you, Bill, for you to make your submission to us. We will then ask questions. We have half an hour or so, and we look forward to hearing what you have to say.

**Mr O'SHEA** — Thank you very much, Mr Chairman. I am very pleased that Professor McLean has been able to come here with me this morning. Professor McLean is responsible for anatomical pathology at the Alfred, which involves all the work in relation to post-mortems. She has particular expertise in the field of brain pathology. She is a pathologist by training and therefore has a great interest in that area, as do a number of staff in our public hospitals. I think that is an issue we want to touch on later — that is, that the level of expertise available in the public hospital system with people such as Professor McLean is something that the coroner's office might well take cognisance of in terms of the way the public hospitals can assist the coroner in post-mortems, particularly in relation to the cause of disease, as opposed perhaps to the cause of death which is sometimes a different issue.

I would like to work through the answers in our submissions, if that is okay. I assume members have copies of our submission. I might start by saying that in 2004 there were 608 deaths at the Alfred. Of those, 157 were referred to the coroner, which means 26 per cent of all deaths at the Alfred in 2004 were reported.

That might seem like a high number, but of course a lot of those deaths are due to road trauma, and they are always reported. Nevertheless, we are a major user, if you like, of, or we certainly have a major involvement with, the coronial services. We are probably one of the major users in the state.

The first question our submission deals with is the classification of unexpected and accidental deaths. Bayside Health operates not just the Alfred but also Caulfield General Medical Centre and the Sandringham and District Memorial Hospital. Caulfield in particular has a number of aged care patients and is a major facility for aged care and psychogeriatric care. There are a number of deaths which will occur in a hospital such as Caulfield which are not necessarily unexpected, as they have been a long time coming and the patients have been on a steady progression. Those deaths tend to be very much borderline in terms of what is a reportable death.

The staff we have consulted in aged care would like some stronger or clearer classification of unexpected and accidental deaths to help them to decide when a death should be reported. It is clear on some occasions that you can predict it, but whether it is still unexpected — unexpected by itself is not always enough. There are cases where our staff would believe it would be preferable to report it but there is no mandatory requirement that it be done. I do not know whether that has been submitted in other areas, but particularly younger doctors are not always clear on what is a mandatory requirement and what is not. This sort of touches on question 2, where we talk about deaths involving medical treatment. I think, particularly for younger medical practitioners, it would help if those criteria were clearer.

I might add also that in our view there is a need for greater education of young doctors in the area of coronial services and post-mortems generally. I think our view would be that young doctors find it very difficult to talk to relatives after a death and to encourage the relatives to agree to a post-mortem. In a sense I guess it is our responsibility, but across the whole health system a number of post-mortems are not being consented to because the families are either not spoken to at all, which is often the case, or when they are spoken to the doctors who are involved are often young and do not quite know how to put it to the families in order to get consent to an autopsy. Our view is that there is a serious under-representation of autopsies. We do not believe there are enough, and maybe clinical education is an area where we might improve the number of autopsies which are consented to.

That is our first point: if there is some ability to make clearer the categories of reportable deaths, we would find that helpful. Did you want to discuss anything about that or do you want me to keep going?

**The CHAIR** — Keep going.

**Mr O'SHEA** — Catriona will join in when she feels I am straying off the point or if there is anything she wants to add.

**The CHAIR** — Perhaps make sure we have some time at the end for some questions.

**Mr O'SHEA** — The second issue is deaths involving medical treatment. The act stipulates unexpected, unnatural, violent or accidental. We have a view that all deaths in our hospital are investigated, whether they are coronial deaths or not. If it is a death which is unexpected but goes to the coroner, we will still investigate it. We will normally undertake a root cause analysis. We believe the area of reportable deaths due to medical treatment needs to be brought up to date. We will deal with this in question 3 under 'anaesthesia', but we are attracted to the reportable category of medical procedure as set out in the Queensland act. We believe if we had equivalent wording in Victoria to the Queensland act, that would make the Victorian act more objective and more readily able to be implemented.

In our view the category of medical treatment should be clarified. Our view would be that it should be clarified in such a way that we get more autopsies, not less. We have no problem with deaths through medical treatment cases being reported to the coroner — in fact the more the better. Of course the difficulty is that, if more cases are reported to the coroner, then it becomes a resources issue, and again we will deal with that later in our submission. We are concerned that the coroner's resources are not sufficient now to meet the number of cases referred to that office. A lot of cases going to the coroner's office at the moment are visual inspections and not internal surgical autopsies. For us, that is generally unsatisfactory. Our medical staff are keen to know the cause of death and are often disappointed when, due to numbers or the pressure on the coronial services, there is no internal surgical autopsy. There will be a resourcing issue if there are going to be a greater number of referrals to the coroner.

Just coming back to the issue of what we do. As I said, we investigate every death that occurs in Bayside Health — as I would imagine do all health services. We have a problem with qualified privilege, particularly in relation to root cause analyses (RCA). The reason we do a root cause analysis is probably a different reason than the one that the coroner might see for such an analysis. We do an RCA as a quality assurance activity to help understand why the person died, or why a particular serious adverse event occurred — it might not always be a death. At the moment, a root cause analysis is not the subject of qualified privilege, notwithstanding section 139 of the Health Services Act, which enables the activities of a safety committee to be privileged. A root cause analysis is developed by doctors involved in a death and might not be done through or on behalf of the safety committee. So in general, the coroner — in theory — can ask for an RCA at any time.

In April this year we had a case before the coroner of a young person who died, and the root cause analysis was sought by the coroner. The difficulty for us is not that we want to keep it secret, but we want full and frank disclosure from the medical staff involved — in fact all staff involved in the death, because of it being a quality assurance issue. If the medical staff involved believe the root cause analysis can be made available to the coroner, or could automatically be made available, even on FOI, they might as well say it is going to be available on the front page of the *Herald Sun* — whatever they say in an RCA. That will inhibit full and frank disclosure by medical staff in a root cause analysis. It is because we are at cross-purposes. Our purpose is to improve the quality of what we do, and therefore we depend entirely on everyone involved in a serious adverse event being open and frank, even if that might mean some admission of liability — so be it. That is not why it is done. It is done to ensure that a similar adverse event does not occur in the future. So there is a tension between the two.

**The CHAIR** — Is that not what the coroner is doing as well?

**Mr O'SHEA** — The coroner is trying to find the cause of death, not necessarily —

**The CHAIR** — And prevent deaths happening.

**Mr O'SHEA** — Sure. Well, it is a side effect. Essentially the coroner is there to find the cause of death. What we are there to do is not so much to find the cause of death but to find what systems and procedures we have that could be improved that would not cause a death in similar circumstances in the future, which is slightly different.

**The CHAIR** — From our point of view that is one of the central things that we are primarily concerned about: how the death certification process and the cause of death can be utilised in order to ensure that deaths that

may have occurred as a result of systems failure do not occur in the future. The whole preventive role of the coroner is something that we are intensely interested in.

**Prof. McLEAN** — I think that is really sensible, and it is a good attitude to have. The problem is that at the moment it is a bit of a dichotomy between the coroner saying, ‘I am here to find the cause of death’ and the hospital referring cases. I think the referral process is not working correctly to identify all those issues that would improve general health care because of what Bill is talking about here. I think there is a slight problem here in reportable issues and looking at the broader picture of what is happening in the hospital that should lead to further quality assurance issues and involve improvement in health in a general sense.

We have a problem here because a lot of cases should be investigated further, and we have a mechanism for that, just as a general review of treatment procedures. New X-ray procedures and a lot of things are happening within the public hospital system and they are not followed through because they do not currently come in under the Coroners Act in the strictest sense, and therefore can go without autopsy. This is what we are trying to aim at in part, trying to explain this issue to you as a team.

**The CHAIR** — I know, but I am just focusing on this question of whether or not the root cause analysis material should be available to the coroner. We have two elements here. Firstly, obviously the family wants to know what happened, and if in fact there were things that went wrong, what went wrong and what is going to be done to correct the problems that led to the unexpected death. Secondly, the community wants to be assured through some sort of transparent and open process that we have identified the problems and that steps have been taken to fix them. I am not sure if it is an issue of concern about the liability in relation to further civil or criminal proceedings. That is something the committee is turning its mind to and asking what sort of protection should be given to that information in order to make sure that we have a forensic analysis of the truth. I want to flag that one of our primary concerns is how you get at what happened and what can be done to make sure it does not happen in the future.

**Prof. McLEAN** — It is a little more complex, in that when the root cause analysis is being performed currently, and I think it is being done fairly diligently by the hospital, there is no autopsy in most cases. So in fact you are doing the root cause analysis without an autopsy. In my view it is very unbalanced, and yet currently in the system there is no way to get an autopsy as part of that general procedure. So we are really not getting a very good idea in a global sense of what is happening within the hospitals with different treatments and things, because they are not being picked up and investigated as they should be.

**Mr O’SHEA** — There are two issues here. There is the issue of why we need more autopsies. Often there will be a death and there is no autopsy, and we have an RCA and away it goes. Then there is the case where there is an autopsy and we do an RCA, and then you have the issue — if it is a coroner’s case — of what privilege is attached to that RCA. We would not object to an RCA being available to the coroner or to the family if it had qualified privilege. At the moment section 139 of the Health Services Act is almost unworkable. If you talk to legal counsel at most of the hospitals, they have virtually given up trying to bring their safety committees under that section, because there are so many exemptions there, so that more often than not a report will not have qualified privilege because of the way in which it has been prepared.

So what happens is that the quality meetings degenerate into verbal meetings, because doctors are all worried about even writing down minutes. They are worried about what will happen to the minutes if they become a document and on the public record. It is not in the interests of the safety and welfare of future patients if they are labouring under that sort of fear of some form of liability. They already have an exclusion under the tort law reforms for apologies; the Coroners Act already extends to that, and indeed so does the Wrongs Act, so an apology is not admissible. But it seems to us that a broader qualified privilege for all sorts of safety documents that are prepared, including RCAs, would be a worthwhile thing, and then they could be made available. We would certainly support that.

The next issue is compliance with the Health Records Act. We are obviously concerned about the current case before the courts in relation to Senator McGauran. We urge that the Health Records Act and indeed the Health Services Act be followed in relation to the access to medical records by individuals or groups who are not party to coronial proceedings.

I will deal later with the issue of the conduct of police in relation to inquests. There are two other points which are minor but are worth making: hospitals should be notified of the results without having to request the notification of coronial inquests. Some of the hospitals have raised the fact that they do not always get told. In addition, when a patient is referred to the coroner we usually send an original of the medical record to the coroner and that then makes it difficult to conduct an RCA without the files, so we would like to see a better system between the coroner's office and the public hospitals as to how they deal with medical records; but that is more of a procedural thing which probably can be worked out with the coroner's office.

The third issue in our submission deals with deaths following anaesthesia. We support the recommendation of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity as quoted in the discussion paper. We are particularly concerned about the definition of an operation. A death under anaesthesia these days — the way anaesthesia has developed, it is not simply a case of dying on the table; people can die months after anaesthesia and the question then arises: is that a reportable death?

We had a case recently in a hospital with a heart-lung transplant patient. Clearly the operation was done under anaesthesia, but the patient has never fully recovered from that operation and has had an adverse outcome through a bleed or whatever else might have happened. Recently we had a young patient die following an operation of that kind, and the question is: is that a reportable death? Clearly it is a death following a transplant operation, but it originated from anaesthesia and the death did not occur until some months afterwards. We would like to see some clarification of deaths under anaesthesia. I guess that is dealt with quite adequately in the discussion paper.

The fourth issue we deal with is deaths in care and custody. Again, I touched on this in the beginning, and that is: to what extent do we have to report deaths, particularly of aged patients, in care? If that were to be increased we would see more resources being needed by the coroner's office to deal with that issue; but on the other hand they are the most vulnerable, and if we do not have some balance between reporting and no reporting we could end up with the Shipman scenario where the most vulnerable people die and those deaths are never properly investigated.

The fifth question we deal with is certification. We believe there is a contradiction at the moment between the Births, Deaths and Marriages Registration Act and the Coroners Act in relation to how a doctor can certify a death. We would like the certification process changed to remove the conflict between those two Acts. Three options for death certification are given in the paper. We support option (c), which is the model for certification by a medical practitioner and one medical assessor from the coroner's office. We would certainly support that out of the three options that are in the paper. I do not know whether you wish to have any further discussion about that issue?

In terms of certainty and the cause of death, our junior medical staff sometimes have difficulty dealing with death certificates. We would like to see more specific guidelines relating to the cause of death. The result of their not being certain is that they do not sign the death certificate, which means that you end up with an unnecessary coronial referral. So if there is some ability to improve the guidelines for completion of a death certificate, we would welcome that improvement.

I will move on to police assistance with coroners investigations, which is question 14. We have difficulty with the extent to which police behave, sometimes in an intrusive way, in relation to not just deaths but generally, in the hospital. The Alfred is a hospital which often has cases involving an element of breaches of the law — the patient might have been involved in drink-driving or in criminal activity prior to admission to the hospital or indeed might be a victim of crime. While we understand the need for the police to get information as quickly as possible, we would prefer there to be an enforceable code of conduct with the police as to how they react and how they behave at the hospital.

For example, our mortuary has regular requests by the police for medical files to be handed over by mortuary assistants. That distracts them from what they should be doing. They are not sure whether they should or should not hand over these medical files. There is a privacy issue because the medical file of a deceased person is still governed by the Health Records Act and by the Health Services Act, and the senior available next of kin has responsibility to give consent. However, often the staff who are approached by the police do not understand what the rules are and can inadvertently breach the privacy of the patient. Therefore we think an enforceable code of conduct with the police would be of great assistance in that regard.

We now have a code of conduct in the emergency department with the seizure of clothing from patients who are admitted to emergency, which has been a problem in the past for DNA analysis. There has been difficulty with the

police up until now causing interference in the emergency department when the staff are engaged in trying to save someone's life. We now have a protocol which has been agreed with the police — not enforceable but nevertheless agreed — and followed by the police. We would like a similar protocol in relation to deaths.

In terms of the safety, question 30, I think we have already canvassed the extent to which can we work more closely with the coroner's office on safety issues. A major area for us would be to have the ability to conduct post-mortems that the coroner feels unable, due to time or resources, to conduct. We see that as a major opportunity for the hospitals to do more post-mortem work and to relieve the strain on the coronial services.

A simple telephone call from the coroner authorising the hospital to undertake a post-mortem would be sufficient for us to then do that work. It could not be done if there were some potential for a conflict of interest: if, for example, there might be some element of risk of involvement of the hospital in a death, the coroner might well decide that is not an appropriate case where the hospital could undertake a post-mortem. That is really a matter for the coroner to decide, but we would very much like the opportunity to do more post-mortems at the hospital, the reason being that a lot of deaths that occur are in technical areas where the skills needed to do those post-mortems does not reside with forensics services at the coroner's office.

We are talking about heart-lung transplant patients, HIV patients, and where there is bone marrow research and where there is neuro-trauma. For example, Dr McLean's area is neuro-trauma; it is dealing with neuro-pathology. There is no-one at forensic services who specialises in the pathology of the brain. There are similar experts in our other public hospitals who deal in other areas of specialisation who are not available to the coroner, and we believe if there was a contracting back, if you like, of coronial services we would have better outcomes in medical research and understanding the causes of death in these new and emerging areas.

We urge the committee to take that on board. It is one of our major submissions in this report: we believe there is a serious lack and a serious understatement of autopsies in Victoria, particularly in these emerging health areas. I am conscious of the time, and I am happy to take any further questions.

**The CHAIR** — Thanks, Bill, and thank you very much for your submission, of which we have a copy. On a couple of issues around death certification, you talked about the difficulties with junior medical staff and interns signing death certificates and being able to determine the cause of death. You also indicate in your submission that there are instances of doctors being able to physically examine a body. Can you give us examples of where a doctor may not be able to do that? There are some concerns for us in that if they are unable to do that, how are they able to certify the cause of death?

**Prof. McLEAN** — It is very difficult for the young interns to actually certify people. They find it difficult to work out what the cause is. Often, especially in circumstances during the middle of the night and things like that, this is just a difficult area and I think it is not performed well; they do not understand it well. The best thing would be if we could try to overcome this by having this link with VIFM where the certification could be discussed with someone who has a much broader interest, so that the death certificate or the certification itself becomes a clearer thing. It is very unclear to the doctors what to put as a cause of death and how to certify a patient. It is just poorly done.

**The CHAIR** — I guess I was just more interested in the fact that you were indicating in your submission that at times doctors are unable to undertake a physical examination. I just wondered how they could actually determine whether it was a reportable death if they did not actually do a physical examination of the body.

**Mr O'SHEA** — The act does not require it. That is the problem with the two pieces of legislation. The Births, Deaths and Marriages Registration Act does not necessarily require a physical examination, whereas with the Coroners Act you would expect it would. We just want some uniformity in that area. We would have no objection to there being a mandatory requirement for an examination of a deceased person before there could be a certification of death, but at the moment it is just unclear.

Deaths often occur at difficult times. The consultant might not be available, and if the young intern is unclear as to what the cause of death is they just do not write anything rather than perhaps writing something that might not be strictly correct. Clearly if a person had been on the decline for a long time and the consultant had been treating that person for a long time they are able under current legislation to sign a death certificate saying that the death was caused by the illness for which they were being treated over a long period of time without a physical examination. That might not be regarded by the committee as being satisfactory, but it can happen under the present legislation.

**The CHAIR** — Could you just elaborate on why Bayside Health believes each change to the law limiting a person's common-law right to claim the privilege against self-incrimination is not justified? We talked before about how you actually get at the nature of the truth in coronial proceedings. If in fact some protection was extended against that information being used in other civil or criminal proceedings, why would Bayside Health be concerned about an abrogation of that privilege against self-incrimination? We actually want to find out what happened, why it happened, and what could be done to prevent it in the future.

**Mr O'SHEA** — I think we had this conversation before, but in the context of a different submission. The difficulty is this: let us say immunity was given against prosecution for evidence given in a coronial hearing. As I understand it that does not preclude a federal offence being admitted and prosecuted by federal authorities. I am not sure that a state-based coroner giving immunity would be effective in a federal court jurisdiction. That is one issue that needs to be borne in mind.

**The CHAIR** — What sorts of federal offences?

**Mr O'SHEA** — In aged care, for example. There could well be offences under the aged care legislation that are federal offences. That is one difficulty with immunity. The other is that we believe that if the reports that are prepared, such as the root cause analysis, were given qualified privilege, the need to deal with that issue would largely have disappeared because you would have full and frank disclosure in the RCAs and any other reports that were written, and a person could then be cross-examined in the box, I guess, on their report. And if the report is privileged, the extent to which self-incrimination arises will be much less.

I think the problem is that at the moment fear of civil liability, not to mention criminal liability — for example, a breach of the Health Services Act or the Mental Health Act could involve criminal liability — is a big inhibitor to medical staff giving full and frank disclosures in RCAs. It is a major issue. The doctors do not say it all the time because it has not arisen too often.

It is not often that a coroner has asked for a root cause analysis to be produced. Earlier this year we almost ended up in the Supreme Court arguing that point on one particular coronial. In the end we decided to release it rather than stop the coronial and go off to the Supreme Court and argue the case. It does need to be clarified. If a case like that was argued and the result was that an RCA was deemed to be available for public disclosure, there would be a huge backlash among the medical profession in terms of their willingness to cooperate. It is a major issue for them.

It does not matter that you tell them that it is not admissible or in terms of apologies that apologies are not admissible. If they believe that what they say can be used against them, they just will not cooperate. Their insurers, if no-one else, will tell them not to cooperate. The MDAV, the VMIA and whoever else insures them will tell them, 'If this is going to expose us to liability because of what you have to say, you should not cooperate. Do not participate in that RCA if it is going to become public'.

**The CHAIR** — What is the hospital's policy on that?

**Mr O'SHEA** — The hospital wants as much participation as possible because we are all about patient safety and trying to understand the causes of death. Maybe Prof. McLean can speak about that.

**The CHAIR** — I know some hospitals have developed policies around full and frank disclosure and said, 'That is what we should be doing and that is how it should work'.

**Mr O'SHEA** — That is our policy. We have an open disclosure trial running at Bayside Health at the moment which deals with giving full and frank disclosure to patients and their families following an adverse event. That is a new area of interrelations with patients and families, and Bayside Health is one of the sites where that is currently being trialled. We believe in open disclosure and we practise it. But there is a conflict.

Open disclosure involves telling families and patients facts, not opinions. If the medical practitioner strays from facts and wanders into opinions, the liability on that practitioner increases dramatically. So they are very wary about what they can and cannot say. They want to be full and frank and open to the families by giving factual information but the reports that they produce sometimes go beyond that.

An RCA is more than just facts: it is really getting to the root cause of why that person died. It might be, for example, that there are not enough nurses on duty on weekends in a psych ward; or it might be that one registrar in

a psych ward on a Sunday is not enough. Arguably that is an admission of liability by the hospital — that is, failure of a duty of care. That exposes it. It is more than just factual; it goes to cause and it goes to opinions, and that is where you have this conflict between open disclosure which deals with facts and straying from that into opinions. So it can inhibit open disclosure for the fear that you will go too far.

**The CHAIR** — Do you have any comments on the Clinical Liaison Service? How does that work in relationship to Bayside Health and the coroner's office?

**Mr O'SHEA** — I am not sure what you mean by the Clinical Liaison Service. Do you mean the link with the Victorian Institute of Forensic Mental Health?

**The CHAIR** — No, the service that has been set up to try to work with various health networks around the issue of reportable deaths in hospitals, what the procedures are and what happens when there is a death in a hospital.

**Mr O'SHEA** — I am not aware very much of that being done with Bayside Health. I know we have had involvement with the coroner through the coroner's communiqué and through the sort of interaction we have there, but I am not sure to what extent that has happened with our director of medical services on that.

**The CHAIR** — And what about the investigation guidelines and all that kind of work?

**Mr O'SHEA** — No, I cannot really speak to that, I am sorry. I can take that on notice if it is an issue and send it in writing from the director of medical services.

**Mr MAUGHAN** — I would like to ask a question of Prof. McLean. Mr O'Shea has made two comments, firstly, that doctors are disappointed that there are insufficient autopsies and, secondly, that doctors, and particularly young doctors, find it difficult to talk to families of the people that have died and perhaps should be referred to the coroner and refuse to give consent. Leaving aside the question of resources, would you favour every death being reported to the coroner and more autopsies being done than is currently the case?

**Prof. McLEAN** — I would definitely favour more autopsies. I think the autopsy rate in our hospital is well below satisfactory. It is equivalent to what is happening Australia wide, but as such it is unsatisfactory in allowing us to get a good understanding of the very broad issues of quality assurance right through to cause of death.

Dealing with the two questions, one specifically related to individuals who are not autopsied. This particularly refers to areas which are very important to the Alfred, such as lung transplant work. A lot of resources go into these lung transplant operations, and also heart transplant and bone marrow transplant operations. When those patients die not all of them are autopsied, and it is my belief that all these patients who have all these new techniques applied to them should be autopsied so that there is some sort of understanding of the effects of this therapy and of broader concepts of what should be done in the future with regard to the management of these individuals and how they actually died.

I think some areas, like the lung transplant team, are very keen to have autopsies performed, but it is not always possible. Approaching the families is not always easy.

**Mr MAUGHAN** — So if every death was referred to the coroner, would that reduce the stigma and allow for more autopsies to be carried out?

**Prof. McLEAN** — We would have to trial it, I suppose, but to my mind it would be easier if we referred them to the coroner and had this discussion and allowed the potential for more autopsies, as long as we then had the reciprocal right, in a way, to have the autopsy performed within the hospital so that the expertise was there as well. With all these new techniques that we are still coming to grips with understanding, I think it is important to go to that extreme of having an autopsy and understanding the full extent of why they died.

**Mr O'SHEA** — It is the same with HIV. HIV deaths are now much less frequent because of retroviral treatment. We run Fairfield House, which is the former Fairfield hospital now located at the Alfred, and the medical staff say that people do not die of HIV any more. Because of the drugs they are on they now can live for quite lengthy periods. If they do die, there is a lot of interest in why the drug therapy has not worked. Clearly they have died of HIV, but it is not enough for a coronial officer to say, 'That is an HIV patient, we do not need to do an

autopsy'. It is such a complex area that we need to understand the drug pharmacology that caused that death when perhaps it has not caused death in others. Different patients react differently to the drugs they are given when they are HIV-positive.

**Prof. McLEAN** — The problem is that even if they are referred to the coroner, the coroner will often choose not to do an autopsy. That has been quite disappointing for the specialists and infectious diseases consultants at the hospital, because they have realised that the case was unusual and for medical reasons would have liked to find out why. So there are problems happening where autopsies are not being performed or the deaths are being referred to the coroner and autopsies are again not being performed and there is just a visual inspection. That is just not satisfactory.

**Mr O'SHEA** — They are the ones we think we could do, contracted back, because they are perhaps more for medical research and for the welfare of the community generally than necessarily strictly on the cause of death that the coroner might be concerned about.

**Mr HILTON** — Would you advocate taking the family out of the decision-making process on as to whether an autopsy is performed?

**Mr O'SHEA** — We have discussed this. It is a tricky question.

**Prof. McLEAN** — As a pathologist, it would make it easier if the family was taken out of the equation, but I do not think that is necessarily something that would be perceived as the correct thing to do. If I could remain reasonably focused here, I am interested in the medical welfare of the community at large, and an individual to me represents an individual from a much bigger pool that we may be able to improve management of in the future. Unfortunately, when you look at it like that, it is easy to say, 'This person has received this therapy. We do not really understand it; let us do an autopsy on them'. It is very different at a one-to-one level because the perspective changes so much when you say, 'This is an individual who has died, this is the family'. Do you know what I mean? It is the broader perspective that you can find quite hard when addressing an individual family when you say, 'We would like to do an autopsy on your family member who received this therapy and died because we would like to know what has happened with this therapy'.

Some of the very junior doctors see this as a kind of admission of something that is not correct, and then they do not want to proceed with the discussion. But the broader concept is: what is happening to our patients in this hospital? Do we need to look into this a bit more — and we do look into it further.

**Mr O'SHEA** — Maybe having the coroner involved might be more persuasive to families than having a young doctor who was on the ward at the time of the death. This might bring some more gravitas to the issue and make the family think.

**Mr HILTON** — I think what prompted the question, Bill, was your comment that maybe young doctors do not have the skills to communicate effectively with the family. If that is the case, we are maybe losing a lot of useful information which could have been used in the future.

**Mr O'SHEA** — We are, yes.

**Prof. McLEAN** — That is absolutely correct.

**Mr HILTON** — Taking the family out of that is one way of ensuring that we do at least do some work which could lead to the public good.

**Prof. McLEAN** — What you are saying is absolutely correct. At present when someone from the Coroners Court requests the use of tissue for organ transplantation, for instance, from deceased individuals, they are extremely experienced in talking to individuals and requesting autopsies. It is known from studies that if it is correctly asked for by someone who is experienced and gives the broader picture, the rate of acceptance of an autopsy can be as high as 60 per cent. That is the documented rate, given experienced people. But that is a very different scenario from an autopsy being asked for late at night by an intern who just wants to go home and who has not had experience.

**Mr O'SHEA** — They might be stressed out about the death and do not know how to deal with the family.

**Prof. McLEAN** — And says — we do not want to continue down that path.

**The CHAIR** — Thank you very much. Thank you for your submission and for talking to us today; we appreciate it.

**Witnesses withdrew.**