

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 28 November 2005

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Professor J. Ibrahim, research manager;

Ms M. Bohensky, research officer, and

Associate Professor D. Ranson, director, Clinical Liaison Service.

The CHAIR — We welcome back Assoc. Prof. David Ranson, and we also welcome the research manager of the Clinical Liaison Service, Professor Joseph Ibrahim, and its research officer, Megan Bohensky. Thank you very much for coming along to present to us.

Prof. IBRAHIM — I am not sure how much opportunity people have had to go through the submission; it is quite extensive. The basic thing I want to bring across today is that the coroner has an important role in prevention; a very important role in promoting safety and quality in health care. A number of submissions have questioned the role of the coroner in that area, and that is understandable from the point of view of people failing to understand the true role of the coroner in society.

You would have seen from a number of submissions a sense of, I think, misunderstanding about who bears responsibility for educating and training doctors in reporting. Pushing the onus for everything to do with the act and with the coroner onto the coroner is somewhat unfair.

I came to the Clinical Liaison Service about three years ago from a background in research and aged care clinical medicine and had little understanding of the coroner at that time. Over the years it has become very clear to me that the coroner gets a proportion of cases that have had some form of, let us just call it, misadventure within the hospitals; they do not get all of those cases.

The Clinical Liaison Service is able to assist in analysing and investigating the systematic issues that underline that. To me it is important that that continue, and it is important that it continue in both the state of Victoria and nationally in terms of working to improve hospital-based care. We have had a number of evaluations that attest to the value of that across the board through all aspects of the health system.

The major document we have produced outlines 25 separate recommendations. One of the things I wanted to emphasise in that document is the need for a nationally consistent approach because of the change in work practices with doctors as a substantial movement occurs across the jurisdictions. The different acts in each state make it difficult for doctors to know what is going on.

The second point I want to make is that the recommendations highlight areas where the legal system needs to work; where the health system needs to work; and where they both need to work together for it to succeed. Looking at one aspect only is not going to establish the reform that is needed to improve patient care in Victoria. If we do not do that, we lose a huge opportunity to improve patient care.

As a doctor I originally thought that the coroner tended to interfere with the work of our profession. Over time I have come to understand that the community expects an external observer; an external investigation. From the responses we have received during the some of the investigations we have participated in, I would attest to the need to have an external person or authority oversee that. Questions regarding the merits of that case do not address the issue of: if the coroner is not to look into hospital-related deaths, why is the health services commissioner appropriate to take patient complaints and family complaints? Those types of arguments tend to wear thin and are more to do with a misunderstanding by health professionals about the role of the coroner and the act.

The thing I wanted to promote most of all was the need for a system-based approach. The clinical team within the coroners office is able to assist with analysis of cases using a systematic approach. Again, some of the submissions highlighted the 'name and blame' culture which has long gone, but they still have not caught up with what the coroner's role is, or separated that from the media.

Again I do not support the issue to do with the media and suppression of public hearings. It is a question that comes up often. There is a need to have open hearings; the coroner cannot control, nor should they control the media. In terms of how a health service is able to manage issues that are sensitive, they are capable and have media advisers who are able to brief the media prior to any such major event or hearing. Again, I point to the role or partnership that is required from a health service, as well as from the legal side.

I will stop there. I am happy to take questions about virtually anything to do with health and the coroner's work that we have been involved with. Megan has prepared an example of where some of the overlap is in terms of the coroner's investigation. One of the sensitive areas has been the feeling that adverse events in hospitals are over-investigated; there are too many people involved. For example, a case will be looked at by the treating doctor or the treating unit; it may be looked at within the clinical risk unit of a hospital; it may then go to the medico-legal department; it may be reported to the Department of Human Services and have a root cause analysis conducted; it

may also come to the coroner's office and have a separate investigation done there; and it may go to the health services commissioner at some stage. All of these investigations may occur, as well as the opportunity for civil litigation.

The coroner and CLS are not responsible for that multiplicity of structures. Each structure exists for a specific reason; all were designed prior to our understanding of safety and health care prior to the implementation of root-cause analysis into health care. Again, we would need to look at all of those aspects if we were to simplify the multiplicity of investigations.

As I said, I do not support keeping the investigations in-house within the professional groups. If that was working really well, we would not have the situation we currently have.

Mr KOCH — Isn't that a duplication of effort?

Prof. IBRAHIM — There will always be duplication of effort. The question is — and I go back to what is available in terms of the legislation as to the jurisdiction and the sharing of information: the ability to share information between the jurisdictions is quite limited, so there necessarily will be duplication of effort.

I guess I would debate that on the basis that the duplication of effort is warranted to reassure people that they have had an external group or the factors relevant to that party have been considered.

Mr KOCH — By degree.

The CHAIR — You started out your presentation by saying that it was a little unfair to load all of these things onto the coroner's office because some of these things were undertaken by you for the Clinical Liaison Service.

Prof. IBRAHIM — Sorry, I come back to confusing who I am. In terms of research, clinical practice, working with the Clinical Liaison Service, what I meant was that the health service, health professionals, myself as a doctor bear some responsibility for how we interpret and what we do to avail ourselves of information relevant to the act. I did not mean the clinical — —

The CHAIR — But in a sense, you are a creature of the coroner's office; you have been created out of the coroner's office.

Prof. IBRAHIM — That is right.

The CHAIR — You have a role, which is to investigate every death that has occurred within seven days of discharge from hospital or any death that has occurred as a result of a hospital stay. Is that correct?

Prof. IBRAHIM — The criteria for a case review is a death in hospital or a death within seven days of discharge from a hospital.

Assoc. Prof. RANSON — That death being a death that has already been reported to the Coroner. It has to be a case that is reportable to the coroner before the Clinical Liaison Service looks at it. We are not looking at all deaths from within seven days of discharge from hospital.

The CHAIR — You can understand why this is slightly confusing for the public.

Prof. IBRAHIM — Yes.

Assoc. Prof. RANSON — Yes.

The CHAIR — Anyone would assume that a case referred to the coroner has to be investigated by the coroner. Then within the coroner's office there is a group called the Clinical Liaison Service that does investigations into deaths that have occurred within seven days of discharge from hospital, or have occurred within a hospital. But as I understand it you do not generally review psychiatric cases.

Prof. IBRAHIM — That is a resource issue.

The CHAIR — Even if a psychiatric patient were discharged from a hospital within seven days, that would generally not be a case that falls within your clinical liaison service.

Prof. IBRAHIM — That does not fall in because of resourcing.

Ms BOHENSKY — And no-one on the team has psychiatric specialty, so no-one is really qualified to review psychiatric treatment issues.

Assoc. Prof. RANSON — Can I just put that into context: the Clinical Liaison Service was set up because we recognised originally that we did not have, amongst forensic pathologists, coroners and coroner's police officers, sufficient knowledge of clinical practice to properly evaluate clinical management decisions of cases. We operated in the early years on a broad basis.

However, when we had a review in our department — a year ago now — they recognised that one of the significant lacks was that we did not have access to psychiatric advice, which would be prudent and useful to have, given the number of cases that are involved. However, at the moment we may not be continuing as an organised group anyway, because we have not been told that we are going to be funded. As opposed to expansion, we are actually in a situation of trying to manage an increasing caseload from a variety of other work with the team that we have now. That has meant that we have had to rationalise and focus on particular areas where we believe currently we can give value.

The CHAIR — But can you see, from the point of view of the public, it is slightly confusing as to who has the expertise and who is undertaking which form of death investigation?

Prof. IBRAHIM — I would dispute that insofar as we do not direct the investigation; we are there to assist the coroner. We do not hold ourselves up as experts. What we do promote is we understand hospitals and the systems there. We promote our ability to think about errors and adverse events in a systematic way. As I said, we do not direct the investigation, and that is solely the responsibility of the coroner — it remains with the coroner.

Our role is to look at the case, to see if there is anything untoward that we can detect and also to assist the police in directing them to which members of medical staff should questions be directed at. In terms of the complexity of hospital structures, it is not unusual for a patient to be looked at by anywhere from 5 to 20 different doctors, and their seniority will vary from being a first year, third year, trainee, consultant to a senior consultant or head of department. In terms of getting a better understanding of what has happened to a patient, we are unable to direct them to the correct part of the hierarchy for that investigation to continue.

The CHAIR — So do you deal with cases in nursing homes, for example?

Prof. IBRAHIM — If they have been referred to us by the coroner for additional information or assistance by the police.

The CHAIR — And who would deal with psychiatric cases where someone might have been discharged from a psychiatric unit in a hospital?

Prof. IBRAHIM — At the moment, unless the coroner has referred it to us to ask for some assistance, it goes through the normal process — we are not involved in it.

Mr MAUGHAN — So is anyone involved in investigating those psychiatric cases that are inappropriately discharged?

Assoc. Prof. RANSON — Yes, there are. The coroner's investigation will still operate and will still run. Therefore, the coroner's assistants office will write to the various doctors and the hospitals concerned, asking for explanations for particular things that have happened. From time to time they certainly do come back to us and ask us for advice on questions and things like that, but the process is then very much run through the coroner's side rather than having a medical model.

What CLS offers, in a sense, is a medical advice model to the coroner's investigation process. In other words, we assist the coroner by helping to evaluate the information that has come in, to help ask the relevant questions of the right people, but we are not directing the investigation. It is still the coroner's decision as to what is done in terms of the investigation.

The CHAIR — But you are not actually looking, for example, at rural cases?

Prof. IBRAHIM — Again, we will look at cases if they are referred to us.

The CHAIR — But not as a matter of course?

Prof. IBRAHIM — No. I am not sure you have seen the staffing of the Clinical Liaison Service.

Mr KOCH — It is only part-time.

Prof. IBRAHIM — It is nominally part-time.

Mr KOCH — With no funding?

Prof. IBRAHIM — It has a little funding at the moment.

Ms HADDEN — Until 30 June, that is.

Mr KOCH — After 30 June it is very narrow.

Ms HADDEN — It is the first thing I looked at.

Assoc. Prof. RANSON — One of things people saw very early on when they came into the unit was the scope of possibility. I think most of the people who have come to the unit, part-timers, have said after they get there they realise what the potential is, but the framework currently is limited. That is for a variety of reasons; it is not just funding resources that are limited but the way that it interacts at the moment.

Mr HILTON — Would you be surprised if one of the major health groups was not aware of this service?

Assoc. Prof. RANSON — It depends which — —

Mr HILTON — A hospital.

Prof. IBRAHIM — For a public or private hospital, I would be surprised if a public hospital was not aware of it; I would be less surprised if a private hospital was. Our extent has been within the public sector. The informal networks that we have been able to tap into are predominantly in the public sector — both Adam and I work in public hospitals. We do not have very strong connections into the private system. When we started, our job was not to promote the service and educate the hospitals. That is part of what we have become in trying to get information from hospitals.

It is hard to ask people to give you answers to difficult questions if they do not know you or have a sense of trust. So we have had to expand that and the more time we spend out, the less time we have to do the caseload. It is not unusual for the staff to be doing some of that conference-type work and presentations in their own time.

The CHAIR — So who currently does, in setting the death investigation standards, the initial work with hospitals to determine whether a death should be reported, in the first instance, by the coroner and, therefore, you? Who is doing that work with the hospitals, saying the kinds of things to look for? We heard before from David Ranson at VIFM that you were doing some of that work in training medical staff to know what was a reportable death and what their responsibilities were. I am just trying to fit the mosaic together.

Prof. IBRAHIM — I come back to the fact that CLS is there to assist the coroner. We are not there to interpret the legislation for the hospitals. I would see — and CLS would see — that going into the hospitals to tell them what is or is not a reportable death is not our role. I think that would then truly be stepping over the mark of the coroner's jurisdiction. If they want us to assist in how doctors learn, how to recruit doctors to attend, what we think is reportable and what some examples are, we can certainly help with that. However, our job is not to interpret the act for the hospitals on behalf of the coroner.

Ms BOHENSKY — Basically I think junior doctors get training while they are still at university and then each hospital has its own separate procedures and guidelines in terms of what is reportable — so it is not within CLS's current area.

Assoc. Prof. RANSON — CLS has had a number of contact points with hospital and providers. We have nurse risk managers coming in on a regular basis for sessions with us as groups of staff. We go out and give talks at a variety of the public hospitals. I would say we are very clinically focused rather than administratively focused. Early in the year we held a half-day public workshop involving people from interstate presenting a whole range of activities and looking at new and emerging issues in a clinical review of deaths within the coroners system.

Ms BOHENSKY — We put out a newsletter as well that summarises cases that have come across our desks and that we have reviewed, just in de-identified format. I think our current subscription is about 1200 readers, so it goes out fairly widely across Australia for an unfunded, free newsletter.

Assoc. Prof. RANSON — I think most people in the senior unit levels who receive the newsletter often email on to the staff within their unit, so the take-up rate of the newsletter is probably many thousand when you add that extra sending on of the email to people in individual units.

Having said that, I am aware that not everyone has heard of CLS. As I said before, we do make quite a bit of effort in terms of publicity and getting out there. However, you cannot reach everybody all the time, and most public campaigns are like that in a way.

The CHAIR — We are just concerned because I think what was behind Geoff's question was that we had a major teaching hospital in this morning that had not heard of the service.

Assoc. Prof. RANSON — That is very interesting, because I would probably say that almost certainly —

Mr LUPTON — I think the person who was asked the question was not aware of the —

Ms HADDEN — I think you need to clarify that.

Prof. IBRAHIM — Did that person know what a reportable death was? I am being serious. Did they know what a reportable death was? The coroner's work makes up about 3 per cent of any activity in a hospital or within the Department of Human Services. When I went throughout Australia looking at each jurisdiction the coroners courts did not merit much of a mention in the departments because they said it was not part of their major business, and they did not pay that much attention to it. So it is no surprise that when they run into problems they see that as being the responsibility of the coroners rather than their own. They prioritise their workload and prioritise it down quite low. But I would be happy to educate that person.

The CHAIR — Coming back to the question of psychiatric cases or cases under the Mental Health Act, do you have a view about whether it would be appropriate to expand your service to assist the coroner with those cases, and, if so, what sort of expertise would you like to see added to the service?

Prof. IBRAHIM — I guess I would partly defer to David on this. One of the issues is the Office of the Chief Psychiatrist. We spoke earlier about the multiplicity of investigations, and when we come to mental health we are going to add another layer, with the Office of the Chief Psychiatrist, as well as every other body that has been involved. I think the mental health cases need to be looked at.

They require a certain amount of expertise because of their complexity, and one of the issues that we found when we were involved is there is a substantial debate within the professions as to the preventability of deaths in mental health cases, and my understanding, particularly with suicides, is that people fall into believing they are either not preventable at all or they are preventable. The profession has not sorted itself out, and so we have not stepped into that debate.

Ms BOHENSKY — We did review initially psychiatric cases, but I think it became a bit too complicated with the skill set that we had available.

Assoc. Prof. RANSON — Perhaps the one other group to mention in this context within the coroner's area is that the coroner has a mental advisory group largely made up of representatives from the relevant colleges and professional groups. That group meets on a regular basis and reviews the psychiatric deaths that have occurred. Professor Graham Burrows, who is in that group, within its framework of operation and his own work, has also started a process of psychiatric review with the Office of the Chief Psychiatrist. So there is a bit of a research

project under way at the moment looking at coronial investigation of psychiatric deaths and some of the associated issues.

From my attendance at those meetings it certainly comes up regularly and is high up in the minds of the psychiatric profession. As I said before, when we had the CLS unit reviewed, it was specifically recognised as something that we could add value to if we had the relevant technical and medical experts available to us.

Mr LUPTON — If all deaths were made reportable, how would you see the role of the Clinical Liaison Service changing or perhaps being taken over by some other process in the coroner's office, because the coroner's office itself would have to do the job that you are doing — —

Prof. IBRAHIM — When you start looking at certification of death through to looking at cases that potentially have an adverse event and those that are preventable, you have got a pyramid structure, and there is a small proportion of cases that have lessons for preventability, and we think it is about a quarter of the cases we currently see. If you get all cases for certification, then I think you are looking at a different purpose. The Clinical Liaison Service, as it is structured, would not meet that requirement, and if that was to happen, we would look at a different model for the Clinical Liaison Service.

Ms BOHENSKY — I think 48 per cent of deaths in Victoria occur in hospitals, so that is about 15 000 deaths per year that CLS would have to be reviewing, and that would obviously take substantial resourcing.

Mr LUPTON — At the moment you review all deaths that occur in your defined circumstances. If the general reporting process changed so that the coroner's office became the triaging system, if you like, for determining what matters were investigated, there would need to be quite a radical change in the way any internal operation in the coroner's office determined what matters would be investigated, would there not?

Assoc. Prof. RANSON — Yes, I think there would. The issue, instead of being what I call a specialist death investigation unit, which is what CLS is part of now, would have to become very much mainstream, because 50 per cent of the entire work of the coroner's office would effectively be part of the unit and, if you like, the unit would have to be plugged straight into our mainstream death investigation process.

Mr LUPTON — Just picking up on part of the submission you made before the break, David, it seems to me that if we were looking at trying to determine which cases to investigate based on our need to look at preventability and the need for particular medical information, they would be the things that would determine which cases you would investigate. At the moment you are really investigating all cases that fit your criteria, whether they really need investigation or not.

Assoc. Prof. RANSON — Correct; but one of the advantages of the system we have now is although we start off the process of having everything within our framework, very early on we are able to dissect out which are the cases that need more work and which are not. So there is an initial screening process, there is an assessment process and then we are able to say, 'These do not require a detailed assessment. We can carry that out at this level. These now require the next level of work'. These we know are going to be cases where there is a lot of work right up front, and we can then manage that case process because we have effectively triaged or, as Joe said, we have identified the pyramid and we know — —

Mr LUPTON — Are you able to give us an assessment of the proportions that tend to fall into those categories?

Ms BOHENSKY — We review currently about 25 per cent of the overall deaths that are reported to the coroner. In the initial screening we take about 25 per cent of the 4000 — that is, about 1000 deaths. From there, after the assessment period, which involves reviewing the medical record, about 25 per cent to 30 per cent are brought for further discussion at our case review meetings, and from there they proceed down various paths. Probably only 10 per cent go to inquest, but the other ones may require some kind of mention about the medical care.

Mr LUPTON — How does the CLS process fit into the decision-making system within the coroner's office in terms of whether a case is going to go to inquest or not?

Prof. IBRAHIM — It does not. That is entirely the decision of the coroner. We recognise what our role is, and it is not to tell the coroner what to do.

Assoc. Prof. RANSON — Indeed the coroner chairs the case management meetings, so that whilst the team brings to the meeting the cases on the agenda, and there are cases for every meeting where there is a follow-up of a matter that is still under investigation, there are new cases and there are cases where a final decision is being made. The decision is being made by the coroner as to whether that goes to inquest or a chambers finding. That is the coroner's personal decision. None of the other people around the table makes that decision, only the coroner, but they are informed — —

Mr LUPTON — So it is a research and statistical type of role rather than — —

Prof. IBRAHIM — No. What we have done is split the role into, I guess, communication and education; a service role, which is reviewing the medical records and assisting the coroner in interpretation of medical facts or interpretation of the medical record. To give an example, in terms of documentation, anyone with a legal background would be very familiar with the need to document and document thoroughly the most trivial of things.

Mr LUPTON — Even police have to do that, I believe.

Prof. IBRAHIM — I guess in medical practice and clinical practice it is not unusual to make decisions on the run and to talk about what you will do with someone's treatment and a potentially life-threatening disease on the move and document barely one or two lines.

Our experience is being able to read between the lines to identify where issues may have been, to pick up, I guess, notes of dissatisfaction with staff where they have requested the attendance of a doctor or written down about delays. We are able to pick up clues there to assist the coroner as to what direction they might want to take. It is their choice whether they do or do not. That is the service part.

I have talked briefly about communication education through the seminars, the hospital-based visits, the conferences we do, the workshops, the coroners open days we hold, the coroners communiqué, the newsletter. We have also tried to directly target through different organisations, such as the law council. We have attempted on three occasions to get the chairs of the boards of the metropolitan health services, and the attendance has been poor at best. We have had two chairs attend. In trying to get across the message on understanding the coroner and that their role is focused on prevention and not on naming and blaming, we try to convince people that they should be more up front and more honest in presenting information. We think we have partly succeeded with that, but there are hundreds of years of preconceptions to deal with.

Assoc. Prof. RANSON — There is one other thing to add if I can in relation to the decision of those meetings. We provide the medical advice to the coroner on which the decision is made. There are sometimes cases where things have gone wrong or there has been an issue in a hospital and the family have been concerned or whatever, but at the end of the day the medical advice is, 'Even though that happened, it did not affect the outcome, it did not affect the death'. The difficulty for the coroner there is that if all the advice is that this did not affect the death or the cause of death of this person, the coroner really has not got far to go, because that is really what the coroner's jurisdiction is about. Even though there may be unhappiness in the family, there may be significant problems that do crop up, what we have done in the past is, since the coroner cannot act — in the sense that the coroner closes the file — we have been able to communicate that back using our newsletter or perhaps go back to the unit and just say, 'We did notice this did come up in the discussions, but it is not a matter for the coroner and we are not officially bringing it up, we are just letting you know'.

The coroner really has not really got a role in that situation because it did not lead or contribute in any way to the death. That, I think, sometimes is a bit of a misconception, particularly for families in very difficult and trying circumstances. I think psychiatric cases are a good example of this, where there may well have been things that did not go as well as they should have done at the hospital, but if they did not actually cause the death or contribute to the death, the coroner is pretty well locked out of it.

Mr MAUGHAN — Would it be fair to say that right now there is a much higher level of medical scrutiny and investigation in the metropolitan area as compared to country areas in relation to reportable deaths? Following on that, if a magistrate in a country area refers a case to your unit, what sort of time lag is there before that is properly investigated?

Ms BOHENSKY — We had about 70 cases in this past year referred from country magistrates. I think that number is going up a lot because they are learning about our services more and more. Usually when they are referred directly from the coroner in a country case it is towards the end that they will be scheduled for inquest or to have their finding in a short period of time, so we try to prioritise those ahead of some of the other cases that we might just be reviewing on a routine basis. We probably get back to them within a couple of weeks, probably the longest would be a month, from when they send it down to us. A lot of times they will phone as well and have personal communication with us to discuss the case.

Assoc. Prof. RANSON — But that is different from the sort of metropolitan in-house cases where we get involved very much right at the beginning of the investigation, whereas from the rural areas we tend to get involved towards the end of the coroner's investigation.

Ms BOHENSKY — Yes, at the end, when they have reviewed the statements and have identified some issue that the coroner thinks might be medically relevant but they do not have the expertise in house to deal with it.

Assoc. Prof. RANSON — I believe that is the wrong way of doing it. I think the advantage comes when you bring in this medical review process right at the beginning, because it can help shape the investigation and make it more timely.

Mr MAUGHAN — What proportion of investigable deaths are investigated in the metropolitan area versus the country area? Is it higher?

Ms BOHENSKY — For the CLS or the coroner?

Mr MAUGHAN — Yes, for the CLS.

Ms BOHENSKY — It is higher in the metropolitan area.

Mr MAUGHAN — To what degree? Any rough figures?

Ms BOHENSKY — Probably in the past year we have reviewed about 900 cases altogether, and I think 70 to 100 would have been from the country courts.

Mr MAUGHAN — That is a significant difference compared to the rest. That is about 10 per cent, where the population difference would be about 30 per cent.

Mr LUPTON — Is that in terms of deaths within seven days of discharge from hospital or ones that are referred from the coroner?

Ms BOHENSKY — No, they are referred. We do not as a matter of routine review the cases at the country courts, because those magistrates locally are dealing with the cases. It would involve a kind of double-up of efforts if we were to review them in the metropolitan area and they were reviewing them locally as well. It was something that was happening quite often, and we decided not to — given the resourcing issues as well, we decided not to review the country cases because the communication network was not there.

Assoc. Prof. RANSON — But we would take the referrals in cases where they wanted specific advice.

The CHAIR — In previous evidence before the committee we have had families put to us that there have been instances where they have believed that the medical record was woefully inadequate or that in some instances the medical record was subsequently written or rewritten after the death and that the information contained within it could not in any way give you a sense of the verifiable chain of events or the medical interventions that occurred leading up to the death. The families themselves could actually point to things that did happen which they were party to, either by way of information or advice, which were not even recorded on the file. To what extent in your opinion does that happen?

Let us say that you became the specialist group that was investigating every hospital-related death, what sort of powers would you require in order to deal with those problems within the system? It seems to me that on the one hand we have identified that there is a training issue and there is a knowledge issue for young doctors in particular, but on the other hand we also — I am not saying in all or in large numbers of cases — do have instances where

there may be cultural considerations and even attempts to obfuscate what actually went on. Can you say what sort of powers would be required?

Assoc. Prof. IBRAHIM — I guess that is a fairly big issue. Up front, yes, some medical records are woefully inadequate, and yes, people do write notes after the death. The medical record as a source of information has been argued about for many years, and there are many research papers looking at the veracity of the record. There is nothing else available in the sense of how to get information apart from the medical record as documentation. So it remains valuable, although with its flaws.

What we have found in our experience is that when families have written letters, there often is a mismatch in understanding and communication between hospital staff and families. Things that medical staff take for granted such as elective surgery, often in the family's mind is considered to be something non-important — 'important' is the wrong word: families tend to see elective surgery as something not serious. They tend to see pre-operative assessments by a nurse on the day of surgery as meaning surgery cannot be serious, as an example. So when someone dies following elective surgery where they have been seen on the day of surgery, families will often come back and say they did not know this was major surgery. Whereas the medical staff will say, 'Of course it was major surgery, we did not think it needed to be stated'. There is a certain mismatch in understanding there.

Clearly families have a lot to contribute. We do not routinely interview families about the case or directly access information from them if it has not been volunteered. Again we are a new service in an area that has been untested internationally, so we have been very conservative in how far we have been able to push what we do. As I said, our role is to assist the coroner, not take over the investigation and not to direct it.

The CHAIR — I appreciate everything you have said, and that is all very helpful, but that did not really answer the question I was asking, which was: in the face of concerted obfuscation or poor record management which makes it very difficult to undertake the investigation, what powers should either the coroner or you standing in the stead of the coroner, which in some instances you do because you are the medical experts, require in order to satisfy the community and the family that it has been a thorough investigation, the cause of death has been properly established and lessons have been learnt from what happened?

Prof. IBRAHIM — What currently happens is, if questions are being sent out during the investigation and it is clear that the statements coming back are not answering those questions, the coroner will generally go to an inquest. If we are looking into the future, we would need to be able to access the family and to speak with health professionals about what happened. That raises a whole lot of issues regarding whether you interview them alone or with their legal counsel and what is the standing of that. That adds a whole range of complexity to it.

The CHAIR — Right, and you currently do that?

Prof. IBRAHIM — No.

Assoc. Prof. RANSON — It changes the very nature, the process being an advisory service for the coroner directly with respect to medical issues. If we become principal investigators, which is really what you are saying, with powers of investigation, with powers of interview, that really does change the relationship we have with the health professions generally. Currently our role is we are advising the coroner on medical matters, we will look between the lines, we will read between the lines in the notes and we will tell the coroner, 'We do not like these notes, there is something funny about them.'. We will say those sorts of things that will allow the coroner to make to the appropriate inference and go on.

But we also have a direct role with our clinical colleagues — that is, we have a role of going out there, telling them what we find, informing them of the problems that occur in hospitals, educating them about the service. As Joe has actually said, we have laid out these different areas. At the moment we have all three. Maybe a new model would not have all three combined, and there would be a separate area of education which would not be compromised by being a proactive investigator. I think sometimes there is a danger in being both — each can interfere with the other. You can be getting on well with trying to get the message across, but as soon as you come down heavy they do not want to hear from you again when you are getting the message across. It is very important to maintain, if you like, the separation of powers, in a way, to allow those things to operate effectively.

Mr HILTON — What percentage of medical records crossing your desk would you say, first, were deficient, and second, show evidence of retrospective alteration?

Prof. IBRAHIM — The medical records, I would say probably a quarter of them — that is purely a guess — were unhelpful.

Mr HILTON — Is that a euphemism for something else?

Prof. IBRAHIM — It is the double negative, because you often do not know when you are documenting it what you will need to know in three weeks time. If something looks routine on the day, you might not document that or you might put a short note in. When you look back you say, ‘I wish we had all of this information here, because that seems to be the pivotal moment, but that is not there.’. As I said, in terms of culture with health professionals versus legal professionals, health professionals do not come from a strong background of documentation. If we are to talk to the patients, make decisions — the practice is to address a lot of the information to the patient or their family and we do not routinely document the conversations. It will be, ‘Telephone call to family: informed of X’, ‘One-hour family meeting: outcome is ...’, and that is what will go in the notes. Issues where there have been delays in response and we want to know why there was a delay in response, the medical notes do not tell you what the situation was in the ward or the emergency department when something was happening. The medical record does not give you all the information you want. Notes after the fact I think happen infrequently in terms of people trying to change their story.

The time to write notes is after the patient has left the consultation, left the room or after the death. To be writing notes when someone is acutely unwell and you are attending to them is incredibly difficult, so it is not unusual for people to write notes about what they remember of what has happened. I cannot recall a single case where we believed there had been deliberate manipulation of information. We all know that we remember things in a different light after the fact, but I could not say that there has been a single case where there has been deliberate manipulation of information.

Ms BOHENSKY — I do not think the coroners system is designed to find people who are intentionally trying to deceive it, because it is a voluntary reporting system. I mean, it relies on the goodwill of people to report deaths and then be open when the coroner is investigating.

The CHAIR — They have got a legal obligation.

Assoc. Prof. RANSON — Absolutely, but at the same time it is still reliant upon the doctor as the primary gatekeeper. If they want to, if you like, bend the interpretation, which I am sure happens from time to time — clearly the under-reporting rate tells us it does; it may be a misunderstanding or it may just be a misconception of what the terms mean — then they will often look for a particular opportunity for a particular pathway of not reporting, and that clearly happens.

Prof. IBRAHIM — Just on that, if you look to a typical hospital with 100 000 patients being treated each year, there might be 500 to 1000 deaths. In terms of the staff being exposed to a lot of deaths, it is not the case. One in 100 to 1 in 1000 interactions might be a death. The range of medical staff to do the work — as I said before, you might have anywhere between 3 to 5 to 20 doctors involved — does not lend itself to each individual doctor remembering their legal obligation and being able to interpret the act. That is why we have been pushing and advocating that there ought to be a central mechanism for it to be funnelled through within the hospital. Presently, come January next year, first day out of medical school, that doctor could be asked to certify a death and put in their opinion whether it needs to be reported to the coroner or not. That is the system we currently have. Unless that hospital has a mechanism to take that death certificate to a senior, not a third year or a trainee but to a senior head of department to review that, it will continue to happen. Again I come back to this: it is very important but it is a small part of the job.

Assoc. Prof. RANSON — Just very quickly if I may, the other special investigation group we have at the institute is the consultative committee for road traffic fatalities. It has operated in a similar way but with a different level of investigation. It has a much smaller number of cases — only a few hundred each year — and all dealing with trauma road deaths but round the table there are eight senior specialists from every area of road trauma management who not only read the notes but then go out and have an interrogative questionnaire for staff, bring that back in, read between the lines and create clinical summaries. A 2-hour meeting might deal with three cases if you are lucky. It is very, very intensive and picks up a lot of very useful information.

The CHAIR — So the conclusion you draw from that in terms of — —

Assoc. Prof. RANSON — The more you want to put into the system, the more you will get out of the system, I suppose. It is as simple as that. But we all know we have to draw the line in the sand that says where we can get the maximum benefit for a reasonable input. I think we are all very sensitive to that. We are not turning around and saying we want to create the road trauma group model for everything. It is inappropriate for everything, but we believe there is a middle ground which offers the community the best option.

The CHAIR — Thank you very much. That concludes our hearings for today.

Committee adjourned.