

LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 28 November 2005

Members

Ms D. A. Beard	Mr R. J. Hudson
Ms E. J. Beattie	Mr D. Koch
Mr R. Dalla-Riva	Mr A. G. Lupton
Ms D. G. Hadden	Mr N. J. Maughan
Mr J. G. Hilton	

Chair: Mr R. J. Hudson

Deputy Chair: Mr N. J. Maughan

Staff

Executive Officer: Ms M. Mason

Research Officer: Ms M. McDonnell

Witnesses

Associate Professor. D. Ranson, deputy director;

Dr N. Woodford, forensic pathologist; and

Ms. H. McKelvie, manager, medico-legal policy, Victorian Institute of Forensic Medicine.

The CHAIR — I welcome representatives from the Victorian Institute of Forensic Medicine to the Law Reform Committee's inquiry into the Coroners Act. Our work is governed by the Parliamentary Committees Act. It is a public hearing and your evidence will be on the record; it will be subject to parliamentary privilege. You will get an opportunity to correct the record and then it will be available to the community, who will be able to see your submission unless you specifically ask for any of it to be in camera. I will hand over to you, David, and we look forward to hearing your submission.

Assoc. Prof. RANSON — Thank you very much. I must apologise for being unavailable on the previous occasion when I was rather unwell. What I have done on this occasion is to summarise some of the materials that I think are relevant and important with regard to your reference, to look at the underlying principles that cause some of the difficulties with the current systems and to look at some opportunities for improvement and change. There are lots of opportunities here. There are lots of opportunities that one can see around the world for the way in which coroner systems operate and the way forensic pathologists operate. However, I think it is important to consider that in the broader picture of the overall death investigation process, because you really cannot separate them.

Setting out some initial, I believe, reasonably structured facts, there are about 100 deaths a day in Victoria and about 10 per cent of those are reported to the coroner. We know from our experiences that the Registrar of Births, Deaths and Marriages, who receives the death certificates that are written by medical practitioners, has to report about 500 of those a year to coroners because of features on the death certificate which indicate that the death should be or is a reportable death.

Most of the studies still show that many death certificates are wrong. It does not seem to matter very much whether you go back 100 years, 50 years, 20 years or 10 years. Despite medical advances, the rate of error of death certificates still seems to hover, depending on the study, at somewhere between a third and a half. That is certainly very interesting but it is not a change.

The next fact is that we have recently completed a study of two major public hospitals, looking at reportable deaths and deaths that have occurred. We think from that study there may be an under-reporting rate of up to 60 per cent. That is a very substantial figure, and it relates to public hospitals. A paper for that has been submitted to the Medical Journal of Australia.

We have to ask ourselves some hard questions about those facts. I think the three main questions are: firstly, does this matter? Secondly, why does it happen? And thirdly, because we have been focusing somewhat about hospital related deaths, what about the community deaths? The first thing in relation to the question of whether it matters is that, interestingly, statistically it probably does not matter. It probably does not matter that we do not have a lot of deaths reported to the coroner, and it does not matter that a large proportion of death certificates are wrong — that is, when you are thinking about health care planning and so on.

That was looked at in the UK some years ago when they looked at error rates in death certificates and tried to work out whether this would be significant for health care planning. But the reduction in the number of cases that could be investigated by a coroner means that the prevention possibilities that might come out of a death investigation are limited — the scope of them is limited. However, one has to say that if one were to be investigating more cases — that is, if more cases went to the coroner — and let us say that we were to correct our 60 per cent underreporting from hospitals, we might be looking at dealing with 8000 to 10 000 cases a year, not 4000. That is a real, potential issue.

The other issue is family concerns that may or may not be raised initially but come to light later on may not be addressed well if the case is not subjected to some external review process. Families take a great deal of cognisance of the work of the coroner and, I believe, have a great deal of faith in the coroner as an independent, external investigator.

The other point under the question of 'Does this matter?' is that even if our reporting rates to the coroner were to double or go higher, we probably still would not prevent, say, a shift instantly occurring. This is largely to do with the comments of Janet Smith, who said that the system is reliant totally upon the medical practitioner who signs the death certificate — I will come back to that.

I think it is true to say on the question of 'Does this matter?' that although we have talked about 10 per cent of deaths reported to the coroner and problems with underreporting, I would make what could be a somewhat controversial comment.

The coroner and the Victorian Institute of Forensic Medicine are snowed under with deaths that may well be valueless with respect to their investigation and prevention. That is, there is a very large proportion of cases dealt with by the coroner that never go to inquest and that will never need or be perceived as needing a very detailed medico-legal investigation. They have a medical investigation — and I am sure the right results come out of that — but they may not influence or support the community in a safety or prevention-of-injury model. That is an interesting challenge for us. I hesitate to use the words ‘valueless death investigation’, because I believe that all death investigations are valuable; but it depends on the scope and the purpose of that value.

The next question I put to myself was: why does this happen? Why do we get unreporting of cases and why is there an issue? I think it is true to say, and I said in my submission, that there is a misunderstanding about what is the purpose behind a coroner’s investigation. There is a misunderstanding by the doctors and a misunderstanding by police and I think by others in the community. I think that has come out of some of the submissions that you have received, where perhaps incorrect advice has been given to people — by the police and others, who might be expected to understand the coroner’s process but actually do not. I think that is a real challenge.

In part I think that is because we do not have a clearly stated purpose in the coroner’s legislation as to why the coroner is investigating. It tells us what the coroner has to investigate, but not why the coroner is receiving and investigating those cases.

I suppose the experience, perhaps, of doctors in the inquest process is that they do not see their time in the witness box, let us say, as being focused around prevention. It seems to them, I think in most cases, to be focused around blame. Even though the coroner rightly says that that is the focus of the inquest, it is something that is a perception, and that perception carries through to medical practice.

I think there is a lack of experience in coroner staffing in relation to medical matters, as there is amongst doctors, such as pathologists, with respect to clinical matters. I think there is a lack of clarity in the reportable death criteria of what is, after all, an unexpected death — unexpected by whom? This lack of clarity makes it very difficult for the hospital or medical staff and others who are duty bound to report a case to the coroner to know what to report. There is also, I think, a fair disconnection of the family from the whole process of certification of death and so on. I think that separation of the family means that that lack of knowledge extends through.

Doctors’ skills with death certificates are poor, as we recognise by having 500 certificates come back to us from the Registrar of Births, Deaths and Marriages with it saying there is a problem. And when the doctors do get feedback it is probably too late for them to really learn from it. There is very little in the way of an integrated system of certification. In fact, each doctor tends to operate a little bit individually, and there is very little support. Indeed, quite often in a hospital setting it is the junior doctor who writes the death certificate, whereas the more experienced doctor, who would perhaps have a better view of it, is not tasked with that job.

We do not know the reason why doctors fail to report reportable deaths in detail. Professor Cordner referred to some of the sociological research that is needed to get a better idea of what is going on here. I think one of the areas of sociological research would be to really understand why it is that doctors do not report reportable deaths. Is it a lack of knowledge of legislation, a lack of the ability to interpret legislation or a lack of clarity in the legislation itself? There is often an opportunity for counter-reporting instructions — that is, you are a junior doctor and your boss says, ‘Don’t report this case; we don’t need to’, when you believe it is reportable. Within that hierarchy it may be quite difficult for a junior doctor to act independently.

There is very little audit review or feedback of the decisions made about reporting or not reporting, and often I think there are some family pressures, which come out in the medical records I see, where the families say things like, ‘We don’t want an autopsy’ where the doctor feels they probably ought not report to the coroner. The link between coroner and autopsy is very close. I think this is one of the areas that my colleague Dr Woodford will comment on, which is alternative means of investigating deaths.

I think the community death issue is much more difficult to get a handle on. The experience of death certificate writing by community practitioners is much lower, of course, because they will have relatively fewer deaths amongst their population in any given year, where the experience in a hospital setting is likely to be larger.

Before I come to some ideas for what I think we could do to resolve some of these issues, I would like to set out a couple of underlying premises that we have been operating on, or I was thinking about when I made my submission and when the institute made its submission. We do believe that there is significant under-reporting of

deaths to the coroner. However, we also believe that the coroner and the Victorian Institute of Forensic Medicine could not cope if all the reportable deaths were reported. Indeed, probably our overall ability to provide the service at all would actually go down rather than get better. That is a challenge.

If the most important aspect of involving the coroner in a death investigation is the identification of preventable factors, then the relative absence of large numbers of coroners' recommendations could be an indication that the coroners themselves are largely investigating deaths they do not need to investigate — so the proportion of cases that need recommendations is quite small, or that the coroner's resources to carry out the detailed specialist investigation may be insufficient. If we need to have expert psychiatric appraisal of deaths in a psychiatric hospital, for example, where does this come from?

The clinical liaison service we have has no psychiatric support or expertise available to it directly, and when the Department of Justice undertook a review of the clinical liaison service it determined that in fact this would be one of the things that would really enhance the service — to be able to include psychiatric matters.

I think we still have an issue where the ability to detect those cases and to operate a case investigation using route cause analysis is something that coroners simply do not have. They do not have that structural base available to them without buying it in, if you like. Indeed, it would be true to say that as pathologists we suffer because we are unable to bring to bear clinical root cause analysis because our specialty is in the pathology side rather than in the myriad of changes that are going on in the clinical practice.

There clearly is a need to police the death investigation system for evidence of criminality, yet 90 per cent of the deaths that occur have no such external review. In order for us to maximise the positive learning we need to focus on those deaths which will give us the most value. One of the other premises, which I know Professor Stephen Cordner is very keen on, is the fact that the relative absence these days within the hospital-based death investigation system of the hospital autopsy, the absence of pathologists being very much engaged in the death review process and the limited review or assessment of death certificate means that it is not a very robust system at present.

On the last page are some suggestions for what we might do. I will be a little bit controversial here, because I think there is no point in just hearing the same words from multiple numbers of people. The first thing I will say is that although I and other people have talked about having all deaths reportable to a coroner, there is an opposing view. The opposing view is to actually reduce substantially the numbers and classes of death that are reportable to a coroner.

In part my reason for saying that is that if that were done, the coroner would be allowed to focus on those cases that are most likely to have important outputs for public health and safety. Just as most deaths are investigated by a local doctor writing the death certificates, the majority of coroner's cases are investigated by a pathologist doing a report and the coroner's clerk making the statutory finding and closing the file with really little more done to it.

In a sense that may be a wasted opportunity in some respects, but it recognises the fact that the vast majority of cases do not need a very detailed and deep root cause analysis based, inquest based investigation system, but there are some that do.

For those that need that real depth, we need to put more resources into getting that real depth of investigation right and adequate. If these two ideas were combined — reducing the overall number of cases but focusing in more depth on the ones that probably really matter for the community — we might well have a cost-neutral solution because we would be able to offset the savings in one area by focusing on areas where we would gain the maximum community benefit.

The CHAIR — How would you reduce it? I understand the — —

Assoc. Prof. RANSON — Logic.

The CHAIR — The logic behind your premise but in dealing with a piece of legislation — —

Assoc. Prof. RANSON — It is difficult.

The CHAIR — What would you in categorical terms say are deaths we are currently looking at that are legally required under the act which you would remove?

Assoc. Prof. RANSON — I think you would have to turn back to what you do when a death occurs and turn back to look at the process of death registration and certification. That underpins the process — everybody goes through that process. Currently it is just the treating doctor on their own who deals with that, and a very junior doctor in some cases. Medicine is no longer practised in that way.

Our death certification system says, 'You are the treating doctor, you sign the death certificate', but most care these days is team-based care involving groups of people. If you involve groups of people in certifying a death, the opportunity among that group to identify cases where a detailed investigation might reveal matters of important health and safety for the community and medical practice is much more enhanced. Similarly, if we just take the hospital model for the moment and say, 'Who is responsible for the medical staff in the hospital?', it is in fact the medical director's office. If the medical director was the person charged with dealing with death certification in that setting, then you would have a situation where that medical director could have an instruction for reporting to the coroner which was based far more centrally on, 'Does this case reveal issues of criminality? Does this case reveal issues in relation to preventable factors?' — —

The CHAIR — Sorry, medical director?

Assoc. Prof. RANSON — Of the hospital — in charge of that hospital. That is easy for the hospital setting because you could then link that medical director in charge of the senior staff in those units and those senior staff are responsible for their junior staff. It may well be possible to have a different set of criteria in relation to reporting that is more focused on prevention and cases that are likely to lead to real benefit for the community than the one that just says, 'Everybody who comes into hospital having fractured their neck of femur and dies two weeks later from pneumonia because of their multi-organ failure and their age needs a full coroner's investigation'.

I think in most cases of that type they probably do not. However, there will be some where it would be appropriate to identify the fact that this person fell over because of a preventable factor in a hospital or nursing home. This would charge and medicalise a little bit of that front end of the reporting process, making it perhaps a little bit better focused to achieve what we might want to achieve.

The CHAIR — Except that the medical director of a hospital is not independent.

Assoc. Prof. RANSON — No, and that will be the major risk of that process.

The CHAIR — The medical director of a hospital is concerned with the reputation of the hospital, as are practising surgeons or doctors.

Assoc. Prof. RANSON — The only way of removing that particular problem is to add two more elements to the process I am suggesting. The first of those is involvement of the family in the process of certification. I know this has been a successful option in some areas of Scandinavia where the family is intimately involved in that process. The other is an ability for a proper death certificate audit process to be able to be undertaken, perhaps by the coroner but perhaps by another person.

Underpinning a lot of what I have just said is the way we deal with death certificates at the moment is very much a paper record — filling in a paper form — and it goes off and some weeks later it gets here and some days later it gets there. The opportunity, which I think I mentioned earlier, for electronic reporting of deaths and electronic death registration and certification offers some advantages which may also deal with this issue that you have raised about external review.

If a doctor is required to fill in, if you like, or answer questions in an online way electronically, there is the capacity for the answer to a particular question to be a filter that says, 'You have answered this question this way, this raises immediate concerns', or asks for more information. As you are obliged to provide that information, it may trigger activities that say, 'Thank you very much. We are no longer proceeding with this death investigation, this case has been automatically referred to the coroner'.

There may be a number of safeguards you could build into a system like this to use electronic-type reporting. I raise that because that is something which is increasingly happening in terms of kiosk activities for government processes. I believe that today our systems are probably secure and robust enough to deal with that in a safe fashion. Clearly that would be a major project.

The CHAIR — When you say ‘auditing’ are you suggesting that every certificate would be audited or are you suggesting that there would be a process of random selection or 1 in every 10? What are you proposing there?

Assoc. Prof. RANSON — I do not think I know the answer to that yet. I am trying to give an idea of what processes might be in place. I always feel a little uncomfortable with random audits because we are dealing with something that is so intensely personal to a family and of individual value to the community. What I am suggesting is that the audit process that the coroner could exert may well be a random process but that the medical death audit process should be compulsory — that is, if a medical director of a hospital, through their staff or whatever, seeks to write a death certificate or register a death, then that should be subject to an external review by a second medical practitioner.

That could also be managed electronically very easily these days, both in hospital settings and in a general practice setting. For example, currently the only deaths that are subject to that sort of process are deaths where the person is to be cremated — there is a cremation form which has other doctors involved and other certification that takes place. Arguably that is perhaps not necessary if you have a thorough, proper review process that affects all death certificates that are written and that review process is medical.

The depth of it is always difficult and the devil is in the detail when you get to what depth can an external reviewer go. For example, in general practice you could have a system where if a practice doctor issues a death certificate, there is a mirrored practice or a reference practice which is linked to that practice and the doctors there have to do the second review. In a hospital it could be a death occurs in a cardiac surgical unit in one hospital and the cardiac surgical unit from the other hospital does the review of that death certificate. There could be a direct linkage process.

That was where I was going to be with my radical view, and I am sure you think it is somewhat radical. There is a lot of potential detail that could be teased out of some of those issues. The alternative view, which was put forward in other submissions, is for all deaths to be reported to the coroner. That certainly has some significant advantages because it removes all of the problems we have currently with reporting.

The difficulty is how do we adequately investigate those cases. I think Dame Janet Smith in the Shipman inquiry was really confronted by that as well. The scope of that investigative process of all deaths is a real challenge. When you look at, for example, what the Home Office came up with and what Dame Janet Smith’s inquiry came up with, it was very intensive in the use of other medical practitioners to run that front end. This is where we fall back on the submission from the institute where we talked about medicalising that front end but with appropriate external review safeguards that are outside the medical profession.

The CHAIR — Is that not the same thing in a sense? You are saying that you narrow the scope of the deaths which are subject to a coronial investigation but you have an external medical audit process for all death certification, except I assume you are saying outside the jurisdiction of the coroner.

Assoc. Prof. RANSON — That is right. The difference is where you place the jurisdictional limit of the coroner.

The CHAIR — But you still have the same resource implications involved because you are still talking about a double-checking process?

Assoc. Prof. RANSON — Yes, you do have a significant resource. It is just in terms of the resource that is applied to the coroner, currently resources are being placed into the coroner’s office to deal with a large number of cases which arguably perhaps do not deliver the most community benefit. If those resources were plugged back into in-depth investigations, you would gain there.

However, if you then say, ‘We are going to move to a process where a second doctor is involved somewhere in the process, whether it is linked to the coroner or linked to the registry of births, deaths and marriages or linked to the hospital or a care group’, that will have cost implications. There is no doubt about that. But so will having all deaths reported to the coroner and having a potentially inadequate investigation in more cases that go to the coroner.

I suppose what I am really saying is that we need a triaged filter set or triaged set of deaths as to where they best lie and where they are best investigated. Within that triage system the jurisdictional limit to the coroner will have a line

drawn somewhere. Perhaps it is not for me to say where that line should be drawn. I am simply saying there are a number of places where you could draw that line.

Mr LUPTON — Isn't one of the issues here the purpose of the investigation?

Assoc. Prof. RANSON — Yes.

Mr LUPTON — If you are trying to prevent a Shipman, that is a very intensive and costly process.

Assoc. Prof. RANSON — Absolutely.

Mr LUPTON — If what you are trying to do is, if all deaths are reported, allow the coroner under the appropriate legislation to sift through the cases that the coroner and the experts in the coroner's office regard as being those that are most likely to result in useful preventive or medical information coming to light, then it need not necessarily be as intensive but you are more likely to get at the cases that you really need to get at.

Assoc. Prof. RANSON — Yes, in part that is what I meant when I was talking about the triage system. I think you are quite right. We do apply filters even now. We apply filters with respect to cases that come in. The pathologists in many ways provide those filters by looking at the notes, looking at the records and saying, 'Is there a problem here? Is this a case that needs to go to this level or depth of investigation?'. So we currently are starting to do a lot more work in that area. The clinical liaison service itself applies filter sets to say, 'Do we think there is a value in a much more detailed medical investigation?'.

What I am saying I suppose is that is all really rather ad hoc and external to the legislation. It is how it is put into place in practice. Should we in fact be being more defined about what we say the legislation is really saying about how the coroner's office should operate? Part of my reason for saying that is, if you like, we have got a little bit of a cult of personality here — that is, we have some very dedicated coroners who are dedicated to the prevention arm and prevention approach.

However, the legislation does not really mandate that or does not necessarily send a coroner down that track. If the coroners who are at the office were to change, then we might have an approach which was entirely different, and many of the prevention advances that Graham Johnson for example has really done tremendous work on might be lost because another corner might say, 'I am not interested in that. I am more interested in this aspect'. If we do not have that put in, that we run the risk of losing some of the gains we have made in the last 10 to 15 years.

The CHAIR — I am struggling with this whole question. Let us say that one of the primary purposes is for the broad community benefit around preventing these kinds of deaths happening in the future. However we do have an important subset here which is that when there is an unnatural, unexpected or violent death, families want to know what has happened.

Assoc. Prof. RANSON — Absolutely.

The CHAIR — The process at the moment at least sets up a system whereby those deaths go to an independent investigative arm through the coroner's office. To go back to your definition it sounds — —

Assoc. Prof. RANSON — The devil is in the detail of the definitions.

The CHAIR — It is, because yes you can have a system of dual medical certification but of which ones? And which ones go to the coroner's office? That is still the outstanding question.

Assoc. Prof. RANSON — That is right, and that is what the legislation would have to determine. The legislation would have to work in an administrative structure that allowed that to work. For example, with your suggestion in relation to injury and violent deaths and families wanting an explanation, there would arguably be a difference between somebody crossing the road and being hit by a tram and somebody being hit on a building site by a falling lift or a bucket system. They involve trauma which a family may want a detailed explanation of, and rightly so.

However, the nature of the advantage in public health and safety that comes out of that might be different. We might say that one is best investigated through one model and line and one is best investigated through another.

Finding the right term and words that actually help and clarify the issue of reporting deaths to the coroner is going to be difficult. I do not have the instant answer to that.

The CHAIR — You have no new paradigm?

Assoc. Prof. RANSON — The paradigm should express the intent of the system — that is, if the intent is to prevent the deaths that are avoidable, then I believe that should be the underlying paradigm of the reportability of a death to the coroner. That would clearly send the message, but I do admit that defining that legislatively would be awkward and difficult, and it will be very reliant upon the administrative framework amongst doctors, hospitals and other care groups to actually allow that to work effectively and have some proper oversight process built in.

The CHAIR — We have obviously got more questions, but do you want to do the other side of your presentation?

Dr WOODFORD — I can talk to you a little bit about the CT scan. Helen McKelvie has invited me here today to talk about that, but I am not quite sure — —

Assoc. Prof. RANSON — Perhaps I can just pre-set it. When I talked a little bit before about the issues saying that we are already taking steps to provide a triage process in terms of how we deal with cases, one of the processes is that when a death occurs and is reported to the coroner it is looked at by the coroner's staff, but is also looked at by the medical staff, the pathologists, who make a decision as to whether they will advise the coroner an autopsy is strictly necessary or whether the case may be held to be investigated another way. Introducing the CT scanner as part of that process, it increases the opportunity to gain more information to look at a case in a different way to pick up different information and to perhaps stratify the way in which we investigate. I hope that leads into — —

The CHAIR — Let us cover this briefly then we will come back to some of the broader questions.

Dr WOODFORD — There has been an increasing interest here and overseas, particularly in England and Switzerland, in the use of CT scanning and whether or not it might obviate the need for autopsy in certain circumstances — in fact there is a word, 'virtopsy' which has been patented by a group in Switzerland, which suggests a virtual autopsy — if there is a need to do away with it.

We also we have had a CT scanner functional at the VIFM for several months. It is true to say that we are still finding our way with it and working out where it fits in the diagnostic algorithm in terms of providing information for a pathologist to come to a reasonable cause of death.

There are lots of advantages in the CT scanner. We are incorporating it as part of the admissions process, where all bodies get scanned at the time of their admission to the VIFM. It is a quick procedure; it is done in the body bag. It provides a wealth of information which sits on the computer. Imaging at autopsy is not a new thing — it has been done since the late 1800s — but CT scanning is performed in very few places around the world. We find that it is going to be of most use perhaps in validating so-called death certificate inspections, where a body arrives at the VIFM but for one reason or another is not accompanied by a death certificate, although one might subsequently be written.

We are using the CT scanning in a way, if you like, to validate cause of death as given on a death certificate although that is a work in progress. We are also using it in circumstances where the families or next of kin raise objections to autopsy under section 29. There is one example that comes to mind, of a baby with a presumed diagnosis of sudden infant death syndrome where the CT scanner revealed unexpected blood within the head. It would not have been seen any other way, and that changed the complexion of the case entirely.

The CT scan is not going to provide all the answers. It does not diagnose common natural disease such as ischaemic heart disease or pulmonary embolism. It does not diagnose toxicologic causes of death or microbiologic ones. And perhaps most importantly it may not provide information of significance to next of kin in terms of heritable disease such as malignancy and metabolic disease processes. It also does not provide a histologic cause of death, which is often what we rely on to come to a diagnosis when the macroscopic or naked-eye appearance does not help. So it an exciting time ahead. It is going to provide lots of information, but the bottom line is we are not exactly sure how it fits into the diagnostic algorithm yet.

The CHAIR — So do you think it is something that will eventually replace autopsies or is it something that will be an additional tool?

Dr WOODFORD — I see it as an additional tool. For all the reasons I have outlined, it does not provide all the answers. One other issue I did not raise is providing images for courts that are more aesthetically pleasing. It does not provide all the answers, but it gives us more ancillary information than we have had in the past.

The CHAIR — If I could I go back to Professor Ranson. You indicated that coroners do not look at root cause analysis; they do not have the capacity to do so. That was something you indicated in your earlier submission.

Assoc. Prof. RANSON — Yes.

The CHAIR — I suppose most people would think, and I would have thought, that that was exactly what the coroner was meant to be doing, that the coroner was meant to be looking at what was the actual cause of death — the how, what, when, where and why — and then be able to record it so that the community and the family would know the exact circumstances in which the person died, and hopefully, if the coroner is able to make recommendations, to make recommendations as to how that could be prevented in the future. Are you saying that that is not happening?

Assoc. Prof. RANSON — I am saying that where it is identified that that sort of analysis is appropriate in a very big and complex case, the coroner brings in those people and engages those people and the hospital specialists come in. That sort of process certainly occurs, usually focused around an inquest or using the root cause analysis that has been provided by hospital staff or from the department. What I am saying, however, is that that does not underpin the process of all coroners investigations. The vast majority of coroners investigations do not go to inquest. I think there are around 300 or so inquests a year, and yet there are 4500 reports to the coroner. So the vast majority do not necessarily get that level of root cause analysis, and in part that is what I was saying when I said that, if resources were focused on those cases where that sort of process could reveal positive information of value to the community, then we would perhaps be able to have more cases receiving that level of detailed investigation.

The other thing is that the legal process of investigation is subtly different from the medical process of investigation. It focuses and gives weight to different facts in the legal system than would be the case, say, in a medical or scientific system. Root cause analysis is, if you like, another model of that medical investigation or scientific investigation process. The coroners system per se does not have many people within it that have that service/scientific/medical approach. It has the institute as a separate organisation in the same building, and we are able to offer certain of those services, but we do not have a specialist root cause analysis unit, although we are developing one in the sense of the Clinical Liaison Service and the specialist death investigation units, including the workplace death investigation unit that is now in place. So we are developing it, but it is a relatively new development. And it is suffering at the moment — in fact, we do not even know if the funding will be continued for it. We have been told that we only have funding until the middle of next year for the Clinical Liaison Service.

So there are real issues about how that is integrated, if you like, into the investigation process that the coroner has. That is partly why I say that if we change the paradigm we may be able to more substantially integrate that type of root cause analysis system into death investigation.

The CHAIR — The guidelines you have developed as an institute for hospitals and others to assist them with understanding what are reportable deaths — these are guidelines you have developed, rather than the coroner — do you believe they have led to an improvement at all in the system of reporting, given there is still chronic under-reporting?

Assoc. Prof. RANSON — That is very difficult. I suspect the answer is that they help a little bit in some cases with some people. So the answer is that they do not really help, because the reality is that the people who report most of the deaths are the junior staff. And the junior staff change over. Every year I have to give the same lecture to the junior staff at the couple of hospitals I cover, and my colleagues give lectures to other junior staff. Every time the changeover occurs, they ask us to come in and talk to the staff, and we do. We give out the handbooks and the information. We provide it as part of our undergraduate teaching to the medical students. But, interestingly, sometimes when you talk to your colleagues in the university system, they often complain that as soon as a doctor leaves the university and goes to a hospital they get re-educated in the way the hospitals do things

as opposed to what they tried to teach them at university. There may be some good reasons to re-educate them, of course, but there might also be some reasons to say that creates a problem.

Mr DALLA-RIVA — Just in respect of the root cause analyses that are undertaken, I have some concerns because it appears on balance that we seem to have an oversight by the legal fraternity in the process — or indeed the insurers, as it were — who perhaps give some level of guidance in terms of the analysis to the extent that it becomes quite clear that the only way we could find out what truly happened to a deceased person is through a proper process. We have heard evidence from a variety of other witnesses, specifically family members, who raised major concerns about process. Some of the medical records we have seen — my 8-year-old could do better with a crayon. I am being flippant about it, but the reality is that some of the evidence we have seen is less than satisfactory in the process of detailing the death of a loved one. What is your view about specific mandatory reporting in certain locations? I heard what you said before, but I am concerned about how you get there when we know that we have significant blocks prior to the reporting of a death. Would you entertain the thought of specific organisations — hospitals or the like — having to report on a mandatory basis as opposed to generally?

Assoc. Prof. RANSON — Yes, I suppose in one sense that is a subset of saying, ‘All deaths go to the coroner’, although I realise that is not what you are saying. But the extension for those areas that you might designate would effectively be that. I think in South Australia they have designated nursing homes, for example, and nursing home deaths are reportable — again to try to focus on particular issues that have emerged. That may well be something that could be done legislatively in terms of delegated legislation or something like that which could vary from time to time according to perceived community desires. I would agree with you that I have also seen appalling medical records and I have heard appalling stories from time to time. I am sure you with your constituents would have exactly the same thing. However, that does not necessarily tell you that there is a general problem in that area or in that region or in that institution. It may simply be a reflection of a particular person or a reflection of a particular night on call or something like that. That does not mean to say that some of those cases do not need detailed investigation, but I am not sure whether that would necessarily be the evidence for geographically or temporally linking them.

I have a problem with arbitrary or randomness in allocating. You could say, ‘Let us have the north of the state compulsory this month and the west of the state compulsory next month’ and so on, or structure it in some other way. The difficulty is that deaths are happening across the board, and any area might have a problem or an issue, and if you do random selections then you run the risk of missing the one really important case that would have had a good message. It would have been better to have selected the case on the basis of an underlying principle that detected that there was a real issue there rather than on a geographic or temporal basis.

The CHAIR — Obviously the issues Mr Dalla-Riva is raising are issues around culture and the propensity for medical institutions to want to limit their risk, whether it is civil or criminal, and that is something we have to grapple with. In any system, whatever the legal definitions, if that is part of the culture, then you have a problem. But you are pointing to another problem, which is that a lot of the death certification is done by very junior medical staff. Regarding interns, registered medical officers and so on, do you have any recommendations about how that aspect of the system could be improved so that you do get better reporting?

Assoc. Prof. RANSON — This is where the concept of electronic reporting and reporting within a hospital framework for interns, for example, is potentially very important. Once you leave the writing of the death certificate just to the intern or the resident, you run the risk of their inexperience creating either administrative problems for the families later on or problems of poor recognition of matters that need further investigation.

If you place the burden on the medical director of that hospital, who is responsible for that staff, to both review and to ensure that the death certificate statutorily, if you like, meets the required standards from the institution, you are putting in place an audit and control system within that organisation that allows for continuing education and allows for a reflection of what really happens in medical practice — that is, it is team-based service delivery these days, not an individual doctor on the ward.

Mr HILTON — The Chair asked you that question previously, and I think you mentioned that the family could have some involvement in determining what course of action is taken after a death.

Assoc. Prof. RANSON — Yes.

Mr HILTON — I am interested in what role you see the family playing and whether you see them at that time emotionally capable of having any input that is of any value at all.

Assoc. Prof. RANSON — That is a very challenging question, if I might say so. But I think it picks up on a very important issue. At a time of bereavement it is difficult for families to take decisions that have long-term implications because they are often thinking very much in the short term. With the right support, with the right family support — and I see it from the coroners' side — but the right support from the hospital side or the general practice side as well, I believe families can be put in a position where they can make sensible decisions in their own best interests, but it is a process that requires intensive support.

I have been very impressed with how I have seen coroners staff and coroners counsellors really help families through this difficult period and allow them to really make positive decisions that they have later come to appreciate having made at that time. Therefore, although you are right that it is very difficult at that time to make really quite discriminating decisions, whether it is donation of an organ or whether it is transplantation, all those sorts of issues, or whether it is an issue about whether they accept the death certificate written by the doctor or whatever, I think with the right family support framework it can be done, and I have seen it work well.

The CHAIR — You were referring to the possibility of online death certificate audits and a second medical practitioner. The committee is grappling with the various areas of expertise that are being brought to it. Professor Cordner in his submission referred to the idea of the Victorian Institute of Forensic Medicine having an up-front role in the auditing of death certificates and referred to VIFM as being the medical death investigator that would review all reported cases and decide in consultation with families whether an autopsy is required and also would recommend which cases required further death investigation. Is that a model that you are also supporting?

Assoc. Prof. RANSON — From the VIFM point of view, yes. The medicalisation at the front end goes a little bit along the way of what I have been talking about when I have been saying that not all cases need to have the depth of the full coroners investigative process applied to it and that with sensible medical external review you can achieve a level of selection, if you like, of the best cases. What I was going on to say from my own perspective was that —

The CHAIR — That is somewhat external, though, to the medical director of a hospital or even another medical practitioner.

Assoc. Prof. RANSON — That's right, yes. The reason I say that, and as I think Professor Cordner also said, is that the cost of that process would still be fairly high to have that review. At 100 or 140 cases per working day, that will be quite a challenge, even for us. As I think was recognised in the UK reviews we need to consider on what basis that decision is being made by those people, who are very separate from the care that has been provided in a death and health care setting — in other words, we have the notes to go on perhaps, or the general practitioner's notes or the circumstances from the family, but not much else.

In a hospital setting they have a much richer information source from their own experience of what went on, even though that may be fallible. Therefore it may well be that there is a level at which some of those cases which would have been reportable to a coroner may well be adequately investigated on a peer basis, if you like, between the treating institution and another paired external medical institution. I am just offering that model in addition to the institute one, because for the institute to do it — and we could — would have a major resource implication for us.

The CHAIR — Are you suggesting that we might just ask the hospitals to do these peer reviews?

Assoc. Prof. RANSON — No. I can see the hospitals being very thrilled about this as well! But they actually do have that infrastructure in place. We are not asking them to employ new staff; we are asking them to apply procedures which they really ought to have internally — and many of them do have internally — but now applying them in the greater public area rather than just in their private area. I do appreciate the conflict that that may set up in respect of insurers and so on.

Mr DALLA-RIVA — I was going to ask you that question. It is always interesting to work on the Law Reform Committee because you often have lawyers coming in and saying the police should never investigate the police because there is always a vested interest. As a former detective I always find it fascinating that when you go to talk about lawyers investigating lawyers, that is appropriate, and we have medical staff investigating medical staff, and that is appropriate, so I do have grave concerns.

The model that you are proposing is that you would have the director of the hospital review the medical certificates. In the ideal world that would be good, but that becomes difficult when the lawyers are breathing down your neck saying, 'Crikey, don't go down there, otherwise we will be at enormous risk and we should be fighting this tooth and nail'. Perhaps we should not be limiting the RCA or indeed any examination. I just have grave concerns regarding that area. In the ideal world where everything is perfect the model would be great, but I am a realist, and I just think the evidence the committee has received is perhaps not as clear as one would like it to be. I am not having a go at my legal friends on both sides.

Assoc. Prof. RANSON — Having been involved with many police investigations done by police, and having been happy with very many of them, I might add, I think the model can work. It depends on the point that the Chair made before about the culture. The medical director is not the CEO of the hospital. The CEO of the hospital may have a legal responsibility and carry those financial burdens, but the medical director has responsibility for medical services. If that person and/or their equivalent in the community has a legislated responsibility that goes with that title or that role, then one would expect a professional to exercise that statutory responsibility in a responsible way, remembering that they also have the Medical Practitioners Board looking at them in respect of their professional medical practice.

I would probably say the same thing in relation to the police: if you look at an investigation that is undertaken by the relevant person, then I think you do see that responsibility is carried on down the line. That is not to say there should not be some process of audit and review externally. I maintain the view that at the end of the day the coroner should be the end stop of that death investigation process, and if things go wrong or go awry or are unsatisfactory or a complaint is raised, then I believe the coroner is a very important judicial figure to be the end stop of a death investigation.

The CHAIR — Perhaps we could go to the NCIS database. In your submission you indicate that it could be enhanced by the development of expert systems which would assist the coroner in developing death investigation standards and so on. Could you expand on that for us?

Assoc. Prof. RANSON — Yes. The national coroner's information system is a national system of which Victoria is a very full and active member. We hold the database and were responsible for establishing it. In its current form the database holds something like more than 100 000 records of coronial deaths. That is information that is contained in both field data and text data of reports and so on. It is searchable. Currently a coroner with a question can come along and ask, 'How many cases have we had of five-year-olds who have fallen off a brick wall?' or whatever, and they can get that information. They can look at how serious or significant that case is.

At the moment if a death comes in and is put on the database we do not have a database that says, 'You have just put in this range of data; in fact I can tell you automatically there has been X, Y and Z; there have been four coroner's findings; those coroners recommended the following things', and right from day 1 of that reported case that information forms part of the coroner's file. The coroner is therefore able to use the expertise of the database in an intelligent way and say, 'Here is the case I have been presented with; do I need to deal with this case as an in-depth investigation because there are a lot of legs on it, or is it one which we do not have to investigate as much because the system tells us there is not a major problem here?'. It may be a judgment call that the coroner can make based on information that has come out of an expert system review linked to each case that is reported. That is the sort of thing I am envisaging that the long-term direction of NCIS and the individual states and databases could achieve.

The CHAIR — Could you give the committee your views on what level of information should be given to families about autopsies — for example, if you look at the Royal Liverpool Children's Hospital inquiry, it recommends that an extensive amount of information should be provided. They are talking there about the nature of the exam and whether there was a need to open up the body and to remove, examine and weigh organs and so on. Do you have a view about the appropriate level of information that should be provided to families about autopsies?

Assoc. Prof. RANSON — I do not believe you can prescribe that sort of level. The difficulty is that information has different value for different people. The most successful way in which you can inform families is by sitting down with them and understanding what their needs are. It may sound a bit paternalistic but it is not meant to be; it is meant to be responsive to what they believe, what they are understanding is what they know, so that you can couch the information in the right way. It is rather like saying a consent form must contain these

50 questions with this explosion of consent forms that took place in medical procedures. That would put people off most of the surgery that they would ever undertake. On the other hand, failure to give them enough information to let them make an informed decision has significant legal and social problems.

I do not believe you can prescribe it. It is something that relies upon really good counselling and support services being available at that time, and that to some extent is a mirror of the question you asked me in relation to families at this difficult time. It only works when there is this very close personal consultative and counselling relationship with the family. That is a very medical social thing rather than a legal thing.

Mr MAUGHAN — Following up on that, what is the value of a coroner's report giving the weight of organs and describing all the technical matters when it might well be that there has been a suicide because of an inappropriate discharge from a psychiatric institution?

Assoc. Prof. RANSON — In terms of the coroner's finding, not very much at all in most cases, but the coroner does not usually include those in the finding. The issue for a pathologist when carrying out an autopsy is you are being asked to carry out an investigation, the extent and end of which you do not know until you have come to a point where you are satisfied that you have collected all the relevant information.

Many times in a lot of investigations you collect things in the early stages which turn out to have no value, but if you failed to collect them and it turned out that they were very important, you would not survive long in the witness box, which is arguably where we are tested at the end of the day.

Therefore, a thorough investigation process means that you carry out some things in a pro-forma way, but other things in a way that is directed by the nature of the investigation. Remember, the autopsy is not there in just to provide the cause of death; it is to help reconstruct the circumstances surrounding the death; so maybe even an organ weight might have value, for example, in the suicide of a person who is discharged from hospital too early, because it underpins the natural disease process they had which may be linked in some way to their behaviour or their taking of a drug or not taking a drug. Unfortunately, you do not really know until you get to the end of the investigation, so a prudent investigator carries out a number of things that are pro-forma or structured and a number that are in fact variable, depending upon the direction the investigation is heading.

Mr DALLA-RIVA — Noel, I have a question in relation to your role. A previous witness talked about continuous suicides. When particular cases are continually coming in front of you — for example, railway suicides — do you find that a lot of recommendations are made but there is no reporting or follow up at some level? That is one of the things we have been finding out. If you were to see a pattern emerge, do you have the capacity to report that to the coroner, or is it external to you?

Dr WOODFORD — In some ways it is external to me, but we have good if not commonly informal lines of communication with the coroner. If circumstances suggested there was a particular pattern or mode of death emerging we work in a collegiate atmosphere so I would know from my colleagues if they had been seeing similar cases. If I was concerned because of the number or frequency, I would talk to the coroners about that. I do not know if there is necessarily a formal mechanism for us to report those, but part of the formal mechanism, if it existed, might be the way we phrase the cause of death in the autopsy reports so that that information is recoverable later. For instance, in the example you brought up about the train-related deaths, if the word 'train' was included in the cause of death statement — multiple injuries sustained during impact by a train, for instance — that is information that is easily recoverable from the system, including the NCIS.

Mr DALLA-RIVA — But it would require somebody external to you or your office then examining that information to decide whether they had a particular problem. As you said, it is very informal. It is not a formalised process, it is just through general discussion.

Assoc. Prof. RANSON — Yes.

Mr DALLA-RIVA — I do not want to put you into a position. You can take legal advice if you wish —

Assoc. Prof. RANSON — No, not at all!

Mr DALLA-RIVA — I am being serious, because we did have evidence from people about the fact that that these same examples are constantly coming up. They may involve a train or they may be issues connected with hospitals and the way they might treat patients, but it is only by accident or by some external event that we can then go back and say, ‘We have just found we have had 100 such cases over the last five years’.

Assoc. Prof. RANSON — In part, that is what I said before where the NCIS and those sorts of databases can help to detect those things and plug them straight into the coroner’s process, so that every time there is another case all those previous cases should automatically be available in the system. You are absolutely right, we have informal conversations with coroners all the time — most systems would not work on just the rigid hierarchies — and that is very useful and leads to coroners following up cases on an active basis if we identify something that we think is a real issue. There is a good strong history of that having happened in Victoria.

Mr DALLA-RIVA — Have you any examples, Noel?

Dr WOODFORD — I could use another example, of psychiatric-related deaths and deaths in psychiatric institutions. At one level perhaps certain cases tend to be channelled towards pathologists with an interest in that area, so an individual pathologist might accumulate a lot of experience and see most of those sorts of cases coming through our institution.

I have an interest in psychiatric deaths, so there have been many occasions that I have ended up talking to coroners and raising my concerns about issues of management or why these so-called natural deaths and medication-related deaths are occurring, but that tends to be, at least in my experience, the level of referral that occurs.

Mr MAUGHAN — Does that then carry through in the report to comments on a systemic problem within the health system, for example, in terms of psychiatric deaths with inappropriate discharges?

Assoc. Prof. RANSON — We tend not to put those big comments in an individual case. We will raise them with the coroner largely because in the autopsy report or, if you like, a summation of the investigation on that particular matter we may well say, ‘Please see coroner’s database where there have been X previous cases’. We will tend not to comment on the public institution side of that because we feel — very properly, I think — that that is the role of the coroner to do so, having been given the facts and having given those agencies and organisations a right of reply, and in the open process of the coroner’s investigation.

But if we see something — for example, like some years ago with the methadone deaths where we had a spate of people dying in the early stages of being treated on the methadone program, we were able through the toxicology department to detect that there was a spate of these and that they all seemed to have just started on the program. We were able to go straight back to the health department and let them know about the problem. They were able to take immediate action, and although subsequently the coroner held an inquest and dealt with the issue, the matter was resolved long before that, so there are avenues for doing it and there are occasions when we will.

The CHAIR — But in your new model, which approximates I think what Professor Cordner was recommending or suggesting to us, VIFM would have a greater role in that initial death investigation in terms of looking at the medical causes. Taking the example that we have been talking about — such cases have been put to the committee by family members — where someone dies of a drug overdose or commits suicide, what expertise would your office have to look behind that to say, ‘That was the result of a premature or an inappropriate discharge from a psychiatric unit in a hospital’, or, ‘It was as a result of the fact that there was inadequate supervision as to the administration or prescription of medication’, or whatever it is, or, ‘A failure to properly assess the psychological or psychiatric condition of the patient’? This is where it becomes an interesting challenge in how you draw together the very strands of skill and expertise that might be needed to do this work so that we can get at the real reasons behind it — not the presenting reason — and in your model, how would that happen?

Assoc. Prof. RANSON — The only way that would happen in our model is if we had those clinical experts available to us. We have some of them, but by no means all of the ones that we would need to do that job. I suppose it is very similar in some ways to what happens now. We are still looking every day at cases to see if we can think of a problem or on the face of the case it looks like this, but could it be something else, and if it is, then we raise those issues with the coroner, even today. The cases you have raised, are the ones that will go on to the coroner and go on to inquest because they contain those very elements.

The CHAIR — But how would you know? If someone has just died of a drug overdose, how would you know whether there were significant causative factors that had contributed to that that might need investigation?

Assoc. Prof. RANSON — My argument would be, how do we know now because we are already applying these same sort of procedures now? The reason many cases go to the coroner and go to inquest is because of family pressure, because of the concerns that various people have, and rightly so. I believe it is a very important opening or avenue for families who have a concern to have that concern fully heard, and I do appreciate that. It is just the institution saying, ‘Do not worry about it, it is okay’, that may not meet all family concerns.

But it might meet many of them, and in the settings where I have met with families following an autopsy, where there is active discussion about whether there should be an inquest or not, I sit down with the family and I go to the findings and I try to act as the interpreter of the medical staff clinically in a communication with the family. In many cases the family says, ‘Now I understand. For the first time I understand’, and that defuses a great deal. Now, will we find cases where there is some hidden thing in the background? If it is just the institute looking at it at a particular level, I am sure we will miss many. But will it be any worse than we have now? No, I think it will probably be a bit better than we have now because we will have a more medical focus looking at those things, whereas for the most part unless there is a letter of concern on a coroner’s file or a clerk of courts thinks there might be a problem here, it might not go any further.

Mr MAUGHAN — You mentioned earlier families consenting or otherwise to an autopsy, and you commented that you had struck some terrific people who were able to do that. What sort of skills are required? I presume this is only available in the metro area and we have not quite got the same skills in country Victoria. Firstly, what sort of skills are required and, secondly, how can you extend that to country Victoria?

Assoc. Prof. RANSON — Just to preface that, it is not a consent procedure at the moment for a coroner’s process. There is no consent issue here. The issue is that the family has a right to object to an autopsy and they need to have that right clearly explained to them so they understand it and understand the social, medical and legal implications of it. I think people need to have those three skill types. They need to understand the legal framework they are working in; they need to understand some of the health care implications for the decision — genetic testing, issues of detecting inheritable diseases, issues of advice on a future pregnancy in the death of a child; and they need to have some medical framework.

That does not mean to say they have to be a medical practitioner, but they need a proper medical framework and they need counselling skills and experience that means they can sit down with a person and really engage with them. We have that, in my belief, amongst, for example, our tissue transplant coordinators in our donor tissue bank; we have that amongst the counsellors in the coroner’s staff. But you are right, it is a very metro-centric service. It would be fantastic to have that or an offshoot of that available where required elsewhere in Victoria.

The CHAIR — At the beginning you mentioned there are 100 deaths a day in Victoria or thereabouts and you said that a third to a half of the death certificates that are written have the wrong cause of death.

Assoc. Prof. RANSON — That is what the studies would tend to suggest around the world, somewhere around about a quarter and a half.

The CHAIR — Which seems to me to strike at the very heart of the fundamentals of the system we are talking about.

Assoc. Prof. RANSON — It does.

The CHAIR — How can we improve the accurate certification of death on death certificates so that we get it down to something way beyond a third to a half?

Assoc. Prof. RANSON — I suppose the first thing to say is that no-one else in the world has managed it as far as I am aware. That does not stop us having a go, but it is a very difficult task, in part because clinical medicine is a difficult and skills-based task. It is as much about experience, knowledge and art as it is about core science. At the end of the day it is the judgment of a professional whom you are placing your trust in, in one sense. You could say even in the legal profession half the legal advice might be wrong in the sense that someone is going to win and someone is going to lose.

The CHAIR — Are you saying a subsequent study has shown that to be wrong?

Assoc. Prof. RANSON — Yes.

The CHAIR — A peer review?

Assoc. Prof. RANSON — That is right. That is usually when you have applied the autopsy process to the clinical assessment of death certificates. We know that adding all of the wonderful new technology to the clinical resource of assessing a patient does not improve that figure. What might improve it, I suppose, would be the sense in which a cause of death that is reasonable or appropriate in the circumstances is understood by the reporting doctor — that is, there is not an essential need to give a cause of death that is overly dogmatic. I am being perhaps a bit vague here. Let me just give you an example of what I mean. Somebody dies in bed. The doctor says they have probably had a heart attack, and everyone on the committee would say that is pretty reasonable. They have had angina; they have had a problem; they have died in bed and so on.

We do the CT scan and we discover they actually died of something completely different — they had a stroke. In one sense the statisticians tell us that does not really matter. Of course, if someone is going to make a complaint about the treatment of heart disease, that matters a great deal because they have now died of a heart disease and not of something else. Perhaps if we were to be more realistic about what a cause of death really is, then, unless prescriptive into defined categories, we may find ambiguity might be a more reasonable thing to say.

The CHAIR — Or is it because not enough doctors are properly examining the bodies or they are not requesting autopsies when they should be requesting autopsies before signing death certificates?

Assoc. Prof. RANSON — No, in fact if they do not know the cause of death they really cannot ask for an autopsy. Basically you need to know the cause of death before you can ask for a hospital autopsy from the family. The hospital autopsy is only to determine really the extent of disease, the effect of treatment and so on. If you do not know the cause of death, it is reportable to a coroner.

Mr MAUGHAN — Are you saying the figures are no better in jurisdictions where every death is reported to the coroner?

Assoc. Prof. RANSON — I do not know there are many jurisdictions where every death is reported to the coroner. There are jurisdictions where they have a more formalised process of death review through different mechanisms, but where an autopsy is performed, because it is considered to be the golden standard in terms of what the cause of death is, in those situations where a death certificate has been written and an autopsy has been subsequently performed, then there are high levels of discrepancy between the death certificate and the autopsy findings.

Mr LUPTON — So it is really the higher rates of autopsies that are going to give you the best result?

Assoc. Prof. RANSON — Yes, that is right. That is something Professor Cordner says very strongly in his review of the whole process of death certification. He is really saying that because over the years we have reduced the number of hospital autopsies, we have reduced the information we are gaining not only for training and education and community support, but we may well be increasing our error rates and not detecting where the underlying problems lie. Having said that, and whilst that is certainly true in respect of what has happened in hospital practice, the high level statisticians at a national level say this does not actually cause us a big problem for health care planning. I am always amazed by that, but that is what the statisticians tell us. I am not a statistician.

Mr LUPTON — It is hard to imagine how they know. Would the reporting of all deaths in your opinion be more likely to lead to the doctors filling out death certificates being less dogmatic?

Assoc. Prof. RANSON — If they reported all deaths, there would not be any death certificates for the doctors to write, so that problem would go away.

Mr LUPTON — They would still have to provide some form of information.

Assoc. Prof. RANSON — They provide information to the coroner or the investigator as to what the background is.

Mr LUPTON — They would not have to be as dogmatic about coming to a conclusion; they would be able to provide perhaps some more useful information about the background.

Assoc. Prof. RANSON — I suppose so, although they usually do come to some sort of conclusion when they provide us with a lot of information, even in a reportable case. Sometimes they are right and sometimes they are not.

Mr KOCH — Noel and I represent all those small indigenous communities within our provinces, as Dianne does to a lesser degree in Ballarat Province. From your perspective, has there been any difficulty with the acceptance of conclusions reached in some of the autopsies involving our indigenous communities?

Dr WOODFORD — No, not really. There are cultural imperatives operative a lot of the time in terms of rapidity of burial and returning of the body to the relatives. We have that very much in mind when we are dealing with these cases. Perhaps there is a higher incidence, although I do not have figures available, of formal objection to autopsy.

Mr KOCH — I was going to ask if objections were a significant issue.

Dr WOODFORD — In some circumstances — let us say, in overt criminal acts and homicides — relatives may object. I guess the likelihood of the coroner allowing that objection would be lessened if there is a legal imperative in a case. But where the pathologist reviews the case and the death is likely to be natural causes, and feels there might not be much more to be gained by doing an autopsy, then we would advise the coroner — it is the coroner's decision finally — that perhaps an autopsy is not necessary.

Assoc. Prof. RANSON — Certainly we have seen a very significant rise in the number of objections to autopsy, and in part that rise has come from cultural parts of the community.

Mr KOCH — I do receive some personally in my own electorate.

Assoc. Prof. RANSON — That is a reflection of many changes in social structures, ideas and belief sets that are not necessarily related to any single cultural group.

The CHAIR — As there are no more questions, I thank you very much for coming along and giving us your opinions and considerable expertise today; we appreciate it. Thanks very much.

Witnesses withdrew.