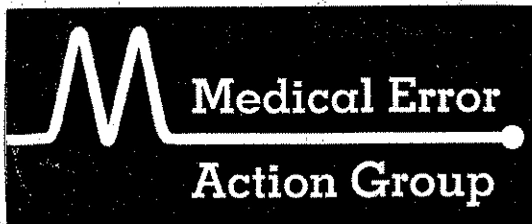

• Awareness
• Compassion
• Action

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Victorian Law Reform
22 JUN 2005
Committee

5 May 2005

SUBMISSION TO VICTORIAN PARLIAMENT LAW REFORM COMMITTEE

Coroners Act 1985
Discussion Paper

To
The Executive Officer
Victorian Parliament Law Reform Committee
Level 8, 35 Spring Street
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"Truth is the summit of being; justice is the application of it to affairs"

...Ralph Waldo Emerson, *Essays: Character*, 1840s, page 49

1. FEEDBACK FROM BEREAVED FAMILIES

Medical Error Action Group (MEAG) has been in a unique position to listen to bereaved families involved in the coronial process.

Valuable feedback has been gathered and stored over the years from those bereaved families; ones involved in the coronial process, and ones who did not get that opportunity but had traumatic experiences to share.

MEAG has produced substantial reports on the plight of bereaved families and direct patients affected by medical error when hospitals and medical professionals failed them.

By May 2002, we had listened to thousands of affected families over a 6 year period during their search for answers and the realisation they were up against a formidable force when accountability, health and legal systems failed them.

The one point the bereaved families identified as THE priority is the role of the coroner because of the "prevention" focus.

Families of the deceased whose death has been reported, or should have been reported, MUST be included in the process.

2. POWER OF CORONERS' FINDINGS

To illustrate little has happened and how powerful Coroner's recommendations are, 10 years ago Coroners heralded the problems. How many deaths have to occur before someone listens and acts? The medical profession has just got on to it and is now working on the problem.

2.1 Coroner's Case No: 608/92 Heard: 23 November 1992

In 1992 a doctor gave orders for a Jelco cannula in the patient's hand to be flushed with saline (sodium chloride) at 4 intervals per day.

The patient indicated that the IV site was painful and the RN decided to flush the site as a therapeutic measure. The RN took Potassium Chloride from the drug cupboard, instead of Sodium Chloride. Each is contained in an identical plastic ampoule, but Sodium Chloride is marked in green lettering, and potassium chloride in red lettering. The latter is also marked Dilute Before Use. The RN did not have the drug checked by a second nurse when she obtained it from the drug cupboard as hospital procedures required her to do. The RN then began to administer the drug to the patient, without having another nurse check the drug at the bedside.

Very soon after the patient stopped breathing and resuscitation was commenced. The patient revived then ceased breathing again and resuscitation attempts were abandoned. Patient died 1 March 1992.

2.2 Coroner's Case No: 1815/93 Heard: 2 February 1995

The patient had a Cooks Catheter in place and it was required to be flushed three times per week.

The RN informed the Charge Nurse that she was going to flush the patient's catheter and was looking for sterile gloves. The Charge Nurse observed the vials in a kidney dish and believed the RN would have checked the drugs with another RN who was working with students. At no stage did the RN ask the Charge Nurse to check the drugs.

The RN had apparently injected 2 vials of Potassium Chloride with the intention of flushing out the patient's catheter with heparinised saline. She did not refer the vials to another RN for checking before injecting the drug into the catheter tube. Before the process was completed she handed the empty vial to a student nurse stating 'have a look at this'. The student was not aware of the significance of Potassium Chloride in this case. Apparently 6ml of the solution was injected into the patient.

After the Potassium Chloride was administered the student nurse observed that the patient 'clutched her chest and rolled her eyes'. The RN then told the student that something had gone wrong. Patient died 9 June 1993.

2. POWER OF CORONERS' FINDINGS (cont)

2.2 Coroner's Case No: 1815/93 (cont)

Coroner's General Comments - 2 February 1995

"The Coroner's process is but one method of providing public warning and recommendation to avoid repetition of unnecessary tragedy.

There are many government agencies with warning and safety responsibilities in particular areas...

It is a matter of good sense and judgement as to how warning is given prior to completion of a Coroner's investigation.

It would be embarrassing and contrary to public responsibility if further tragedy occurred during the course of and prior to completion of a Coroner's investigation simply because warning had not been given prior to the completion of the Coroner's work." [1]

Coroner's Recommendation 3

That the Australian Pharmaceutical Manufacturers Association re-examine the packaging for Potassium Chloride in the light of the facts in this case and the above comments on packaging.

Distinctly different (and uniform) packaging for potentially dangerous drugs such as Potassium Chloride might be appropriate. Apparently there is no National Standard for packaging of Potassium Chloride.

2.3 Another Unnecessary Case for the Coroner

It is clear from the previous two cases cited that no one observed the Coroners' findings because it happened again. The case is under investigation so cannot be elaborated on further but it raised such concern that the State Coroner of Victoria was prompted to issue a warning nationally:

"Warning on deadly saline mix-ups", *The Australian*, 26 September 2003

"Warning on chemical", *The Weekend Australian*, 18 October 2003

Potassium Chloride when given in excessive amounts or when given quickly, undiluted can cause cardiac arrest leading to cardio respiratory failure. It causes sudden imbalance in the electrolyte concentration in the heart causing arrest.

The Coroner warning the public illustrates the power of coronial findings to save lives.

Coroners see the problems early but tragically no one took heed of the Coroners' findings and recommendations of 10 years ago.

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[1] Coroner's Case No: 3863/86

3. "CONTRIBUTION" FACTOR IN THE ACT

Bereaved families are not happy at the amendment to the Coroners Act 1985 in 1999 for any death occurring after 1 July 1999, a Coroner is no longer required to find the identity of any person who contributed to the cause of death.

Families seek findings of "contribution" against hospitals, doctors and nurses.

Families want the Coroner to state that the medical practitioners had departed from a reasonable standard of care with respect to the deceased.

It may be the families' only way of informing hospitals, doctors and nurses that what they did is not acceptable to them and the community.

4. SNAPSHOT OF WHAT'S NEEDED

- The role of the Coroner in bringing attention to the problems is paramount.
- Families need greater level of explanation and need more, not less.
- Involving the families in the investigation by way of listening to them, their concerns and observations.
- Families need someone to contact them to inform them what their rights are.
- Family contact program (in metropolitan Melbourne) needs to be expanded State-wide.
- Every hospital death must be reported to hospital CEO to see if reportable; not left up to individual doctor to decide.
- Process needed where the Coroner can go into hospital.
- Medical records must be seized immediately to prevent tampering.
- The Coroner's Office needs team with medical experience, e.g. reading and comprehending medical records and medical jargon, and to have a grasp of how hospitals are run.
- Hospitals must report death tally annually independent of doctor involved in management.
- More autopsies, encourage them. Good for families' peace of mind, diagnosis families can live with, and trainee doctors' knowledge. Exhumation is not an experience to recommend.
- Death certificates must be signed off by two (2) doctors.

5. REPORTS PRODUCED

MEAG's report to the State Coroner of Victoria and the Attorney-General Victoria, **"Medical Adverse Events and the Coronial Experience of Families"**, written 1/6/00 and revised for this submission, is attached herewith.

It covers everything from families expectations of the coronial process, observations, suggestions and recommendations.

I would be happy to expand on the coronial experience, both personal and from the families' viewpoint, during public hearings.

Lorraine Long
Founder
Medical Error Action Group

Sydney
5 May 2005

6. ATTACHMENTS TO SUBMISSION

6.1 "National Forum on Coronial Information"

State Coroner's Office, Southbank
27/11/02

- *Opening Address*

6.2 "Medical Adverse Events and Families"

Report for Australian Council for Safety and Quality in Health Care
third edition 16/1/02 (first edition 20/12/00)
selected pages:

- *Coronial Investigations*
- *Health Complaints Commissions*
- *Problems and Suggested Solutions (coronial)*
- *Development of a Specialist "Medicals Module" for the NCIS*

6.3 "A Rescue Package for Patients and Doctors, Hospitals and Government to Avoid Litigation"

Report to the Prime Minister, All Ministers for Health and the AMA
revised edition 20/5/02 (first edition 28/2/02)
selected pages:

- *Solving the Crisis and Problem*
- *Public Safety The Coroner's Priority*
- *Role of Governments*

6.4 "Australian Hospitals - Monitoring Their Performance"

first edition 6/3/03
selected pages:

- *Death Certificate Discrepancies*

6.5 "Medical Adverse Events and the Coronial Experience of Families"

Report to the State Coroner of Victoria
revised edition 5/5/05 (first edition 1/6/00)
full report

National Forum on Coronial Information

STATE CORONER'S OFFICE
SOUTHBANK
WEDNESDAY 27 NOVEMBER 2002

Opening Address

I am one of the unnecessary coronial families touched each year by unnecessary grief.

My mother, June Long, died in June 1994 unexpectedly in a large Melbourne public hospital. My family was saddened and traumatised by her death. It took a while to get to the bottom of it - it was quite harrowing.

There was a Coroner's Inquest, and it was a relief to find out what happened, but on the other hand, it was awful to hear how Mum died. The Coroner's finding highlighted system failures and problems in a number of areas and recommendations were made that could prevent similar hospital deaths, like the importance of hospitals swapping information.

Cases like my mother's occur across the country daily. Learning from one family tragedy could prevent another family suffering the same ordeal.

I speak for all coronial families in that we do not want to see tragic events happen twice - because that is unforgivable. Families are owed more than just having the death classed as another statistic.

A natural way to do this is to go back through Coroners' findings and see what has been found before in each State and Territory. But who has time to sit down and read several hundred Findings constantly to find out what trends are apparent in deaths?

For example, what happened in one State with playground design may not be known in another State and the similar cause of deaths continue unnoticed. If coronial data was linked nationally, that playground design would be immediately apparent and trigger change.

Linking coronial data nationally is a far more efficient and cost effective method than waiting some years for a trend or pattern to be discovered, probably by chance. Accessing coronial data at one point may prevent coroners needlessly duplicating work across the country.

If a Coroner wanted to know how many schoolboys had died a certain way, cross-checking data in other States could expedite the investigation and reveal a trend not observed before.

Coroners matching their results of investigations and findings can observe trends. Patterns emerge. But these trends and patterns need to be pooled quickly for analysis to be effective to prevent further unnecessary death and injury.

Coronial data linked up and shared is good for all families in Australia, not just medical adverse event death families, but for *all* unexpected deaths --- child deaths, suicide, infant deaths, road deaths, work-related deaths and recreational deaths.

Pooling coroners' data has the potential to save lives and consequently relieve the devastating and unnecessary trauma on families like mine.

Lorraine Long

Sydney
27 November 2002

11. Coronial Investigations

We have addressed the problems of families of deceased medical error patients in the coronial jurisdiction to State Coroners and Attorneys-General and made recommendations.

There are 5 important issues to the coronial process involving medical deaths

- Serious under-reporting of medical adverse event deaths to Coroners
- Serious under-funding of all Coroners' Offices nationally
- Coronial investigations taking years to inquest or disposal
- Inadequate medical reportable death investigations due to lack of resources and lack of coronial police officers with medical and nursing expertise to steer medical investigations
- Coroners allowing hospital lawyers to collect and control evidence and prepare witness statements.

A growing trend of concern, is that some Coroners in New South Wales are referring medical reportable deaths to the *NSW Health Care Complaints Commission* (HCCC) for action instead of investigating the death themselves. It is a Coroner's job solely to investigate the death, regardless of funding, not a health complaints commission. The NSW HCCC does not have the investigatory powers of a Coroner. New South Wales Coroners must not pass their task and responsibility on to the NSW HCCC for action. This trend should be resisted at the highest level.

All Coroners' Offices around the country should be looking at more medical deaths. Coroners nation-wide are currently seeing approximately 7,500 violent, unnatural deaths across the country[12].

What does the above figure say for

- Current reporting of medical adverse event deaths?
- The 18,000 the *Taskforce on Quality in Australian Health Care* said died in one year?
- Learning from past mistakes and improving hospital systems?
- The 18,000 dead who have slipped through the system *each* year?

It is imperative, and Medical Error Action Group cannot stress it strongly enough, that all medical adverse events resulting in death *must* be reported to the Coroner. There *must* be mandatory reporting for systems to change and less people to die.

[12] *"Coroners' Death-Defying Decisions"*, *The Law Report*, ABC Radio National, 10 October 2000

12. Health Complaints Commissions

The complaints about health commissions, and medical boards, no matter what state or territory, run along the same lines. We approached all health complaints commissions to highlight the problems we are hearing about across Australia.

The only venues for appeal for those dissatisfied with their health care by hospitals and medical professionals - short of going to court - are themselves generating severe criticism by patients. The system patients rely on to investigate complaints about their medical care is ineffective and rarely punishes doctors or hospitals when they provide poor care. Consequently it is not seen, and 18,000 deaths pa confirm, to be effective. Patients and families go to lawyers in an attempt to resolve their complaint when commissions and medical boards fail them.

Basically the system simply isn't working the way it's supposed to work. Commissions are paper tigers. They have been set up to fail with their restrictive legislative framework. Some serious attention and work, including reviewing the respective state and territory legislation, is warranted along with Medical Practice Act of each state.

All commissions should have powers to recommend and award compensation from Treasury so the complaint is finalised once and for all. Compensation decision-making must include the public. **Medical Error Action Group** should be consulted due to the wealth of patient experiences it has received nationally and written about.

For the half million affected by medical adverse events per year, resulting in some 50,000 permanently injured and some 18,000 dead (that we know of), medical error is a leading cause of death and injury in Australia. When complaints are rising to record levels, the number being investigated do not correspond. Patients do not end up dead and injured for no reason.

There are 6 important issues

- Their ineffectiveness generally across the country
- Their lack of recognition of public safety factors
- Their failure to act in a timely manner on public safety issues
- Their complaint handling is adversarial and takes far too long, going into years
- The complainant is forced to be the instigator to progress their complaint
- Their failure to resolve complaints results in patients having to take their complaints to lawyers and court.

Problems with health complaints commissions and medical boards

- Being selective with what they will, if at all, investigate
- Lack of equality of access for the patient is apparent in the self-regulatory process
- Professional standards committees are capable of hiding and suppressing low-grade opinions posing as standards for there are no medical standards, only unchecked opinions
- Medical boards' legislative architecture is re-active and the discretionary processes are hidden; no benchmarking, no public access, e.g. the Medical Practice Act [NSW] dominates the Health Care Complaints Commission Act

12. Health Complaints Commissions (cont)

Problems with health complaints commissions and medical boards (cont)

- All accountability processes come back to relying on individual medical opinions
- Medical boards undermine commissions from doing their job appropriately because the two Acts are tied in and the Medical Practice Act dominates (classic example of losing ownership of complaint - commissions become the nominal complainant or third party) and decisions are made by professional standards committees, not health complaints commissions.
- The commissions may take the more serious position in evaluation but the Medical Practice Act in professional standards committees control the end decision process in the absence of the public
- Medical boards and professional standards committees comprise medical professionals and have no public mechanism to check public safety on any issue
- Medical boards comprise medical professionals and sit in judgment on their own profession; an utterly contemptible situation considering the results.

14. Problems and Suggested Solutions

Problem #1: Accountability

- Serious problems with responsibility and accountability by hospitals and clinicians
- Alarming pattern of inadequate medical treatment levels
- Families not being given correct information on cause of death or injury
- Clear streak of similarities in each and every case
- Routinely incomplete hospital medical records
- Death Certificates knowingly completed inaccurately and falsely
- Serious under-reporting of medical adverse event deaths to the Coroner
- Hospitals' appalling lack of error-prevention programs; hospitals not being improved to safe enough levels; collecting lots of data and identifying problems but failing to implement changes; indicative of organisational and committee culture problems.

Solutions

✓ *Hospitals to make clinicians responsible and accountable for their mistakes and introduce mandatory re-education programs for erring clinicians*
✓ *Hospitals to provide full disclosure, be up front and honest about what exactly happened in detail*
✓ *Hospitals to become accountable for adverse events to their Minister for Health*
✓ *Clinicians must comply with relevant Acts by completing Death Certificates accurately; reporting adverse event deaths to the Coroner; not tampering with medical records; not making false and misleading statements for the Coroner and other jurisdictions*
✓ *Hospitals should consider including their most vehement complainant on their error-prevention program and hear **their** solutions; team work produces results*
✓ *Hospital accreditation to include adequately kept medical records and Coroners' recommended system change implementation **before** accreditation endorsement*
✓ *Hospitals to **earn** accreditation; no warning of impending visit.*

Problem #2: Coronial

- Hospital lawyers controlling coronial inquests and evidence
- Hospitals not implementing Coroners' recommendations and more people die
- NSW Coroners referring medical reportable deaths to the HCCC for investigation
- Inadequate funding of all Coroners' Offices Australia-wide.

Solutions

✓ *More in-depth medical deaths investigations by coronial police with medical and nursing experts employed by Coroners' Offices to steer investigations; not allow hospital lawyers to collect and control evidence and prepare witness statements*
✓ *Hospitals to shake up their divisions responsible for system change implementation; system improvements should be well documented, forward-dated to assess progress, and reported back to Coroners*
✓ *All medical reportable deaths must be investigated fully by the Coroner's Office; it is a Coroner's job solely to investigate a reported death*
✓ *Due to Coroners' death-prevention focus, in a beyond blame atmosphere, **the Council** to recommend to Ministers for Health, who in turn to recommend to Attorneys-General, to have funding boosted for all coronial jurisdictions Australia-wide.*

19. Development of a Specialist "Medicals Module" for the National Coroners Information System (NCIS)

We note from the NCIS information pamphlet that there is no mention of a medical adverse event deaths "Medicals Module" being contemplated. Considering, conservatively, there would be more medical adverse event deaths per annum than road accidents, homicides, suicides, work-related accidents, firearm deaths and fire deaths put together, we have taken some steps to see this position is changed. **Medical Error Action Group** has already written to every Attorney-General in Australia (including the federal Attorney) and made submissions to SCAG, and urged them to pressure the federal government, to not only provide more funding for their own coronial jurisdictions, but also to adequately fund the NCIS operation.

We note that death associated with adverse reaction to drugs is not one which has been widely flagged as of interest to "Drugs Module" stakeholders. It is interesting to note that as *"the problem of adverse drug reactions is widespread, serious and costly"*[32] why hasn't the medical profession demonstrated any interest in getting a "Medicals Module" up and running? There needs to be an awareness that this project is not just about medical deaths as such but that it covers a wide range of health issues, e.g., making better health-care decisions and system improvements, which affect us all. We note that should the NCIS be relying on information from the Australian Bureau of Statistics (ABS) for "medical deaths" then there may be no urgency to implement a Medicals Module due to the unbelievably low number of "such deaths" recorded by the ABS.

Stakeholders who are not directly involved in producing the relevant data could also assist the development of the Medicals Module by becoming involved in a process of educating potential supporters of the project and the community about the benefits for public health and death and injury prevention of having access to timely, and nationally consistent information about deaths involving medical mishaps.

To develop a "Medicals Module" would take a lead-in period of about 3 years. It would need a budget of $300,000 for its specialist module development. What was proposed for the Drugs Module development can be drawn on for a Medicals Module development. Coroners would need to get together first to discuss standards of investigation and the issue of defining terms then conduct workshops with the appropriate stakeholders.

As a Medicals Module is, astonishingly, not yet on the drawing board big opportunities to reduce the death toll are being missed.

The potential for medical disasters is growing.

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[32] *"NCIS Drugs Module Stakeholder Analysis"*, Dr Graham Scott, Monash University Accident Research Centre, December 1998, for *Developing a Drugs Module for the National Coroners Information System*, Feasibility Report, May 1999

2. Solving The Crisis And Problem

KEY IDENTIFIERS

1. **Public Safety**
   Is and must be paramount.

2. **Hospitals**
   Must take ownership of "their" negligence. This is about doing the right thing when things go wrong. Their reputations as institutions of care will be restored immeasurably.

3. **Coroners**
   Are pivotal to death and injury prevention. Their valuable role, in a beyond blame environment, is immeasurable in driving system changes which save lives. Families need the death investigated to find out what went wrong. Their overwhelming desire to "tidy it all up" is human nature. It releases their grip on the tragedy and allows them to move forward.

4. **Compensation**
   An equitable and fair system of compensation for people with legitimate claims as a result of iatrogenic death or injury must be developed. It alleviates the discrimination against patients and leaves the legal system and court process out of it. The failure of the available accountability processes is a solid reason for such a scheme.

5. **Commonsense Working Solution**
   Government must implement a trial system of complaint resolution, e.g. based on the Medical Error Action Group solution package exampled by the USA Veterans' Affairs Medical Center Lexington, Kentucky.

6. **Convincing the Medical Defence Industry**
   Medicos, insurers, indemnity providers will need to be convinced that if patients take the scheme option it *will* finalise the complaint swiftly, so the scheme has to be realistic to work.

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3. Public Safety The Coroner's Priority

Coroners and their supporting investigators are in a unique position of having access to a wide body of information relating to such deaths and the means to make public the issues and factors that have contributed to the death. There are many coroners, clinicians and pathologists who see this educational and preventative role of the Coroner's service as one of its most important aims.

Coroners' records are seen as the key data source containing in most cases a rich collection of reports and investigations about causes and circumstances of deaths. It is of no benefit to the living or justice for the dead if that valuable information remains buried in coronial files. Existing information should not be allowed to go to waste. That information - the clues to prevent unnecessary reoccurrence - already there, just needs tapping into and utilising. [2] [3]

The sum of all coroners' findings represents a wealth of information on the incidence and causes of death. The need to get the findings of all Coroners' Courts from the eight coronial jurisdictions out on a national basis in order to reveal any significant trends to prevent more unnecessary deaths is of utmost importance to all Australians and society at large. Public safety is paramount.

The wider the dissemination of coronial recommendations and the broader use of medical protocols, the better public health and safety would be enhanced. Currently there are a lack of mechanisms for uniform implementation of Coroners' findings and their monitoring within public hospitals. A quality Australian health system would be one in which adverse events and near misses are detected, openly investigated and lessons learnt are applied promptly. [4] [5] [6]

If the results of coronial investigations are not informing public health and safety strategies then big opportunities are being missed to reduce the death toll. [7] **The potential for medical disasters is growing.**

[2] *An Avenue for Death and Injury Prevention*, Graeme Johnstone, State Coroner of Victoria, in *The Aftermath of Death,* 1992
[3] *Coroner's Inquiries and Recommendations*, Graeme Johnstone, State Coroner of Victoria, in *The Inquest Handbook*, 1998
[4] *Final Report to Health Ministers from the National Expert Advisory Group on Safety and Quality in Australian Health Care*, July 1999
[5] Victoria Coroner's Case No 1835/94, Finding 16 August 1996; Case No 2160/95, Finding 19 November 1997
[6] *Measurement and Review of In-hospital Mortality as a Quality Improvement Initiative*, July 1998
[7] *Developing and Managing the National Coroners Information System*, 1997 and 1999

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7. Role Of Governments

1. Fulfil public safety management transparently
2. Address the catastrophic medical error problem - it won't go away by ignoring it
3. Resource patient safety and death and injury prevention initiatives which save lives, such as the National Coroners Information System [NCIS]
4. Acknowledge iatrogenesis is a leading cause of death and injury in Australia
5. Stop wasting public money on medical defence lawyers to fight patients and bereaved families and further harm them

KEY POINTS

- No other industry or profession makes the same number and types of reckless mistakes repeatedly and remains unaccountable as does the medical profession.

- The magnitude of the medical malpractice problem in Australia is hidden by the meagre numbers who make it to court.

- The National Coroners Information System will be the number one instrument to turn the tide on the colossal number of unnecessary deaths. It is the key for change. It is one worthwhile development because it has the most potential with its "death prevention" focus. It must be enhanced and supported by all governments to reduce the unnecessary death toll.

- In the USA the legal and political system has been reflecting the medical malpractice problem. In Australia it has been hiding it.

- Governments' record in seeing justice is served to injured and dead patients caused by health care management, not their illness or disease or both, is abundantly lacking. A compensation scheme would go some way to redress this.

- Give medical error patients and families options - currently they have none. By implementing a compensation scheme governments would be meeting their humanitarian obligations inherent in the social contract.

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9. Death Certificate Discrepancies

Medical Error Action Group has been observing discrepancies in death certificates [22] [23] for some years and there are 2 glaring inconsistencies:

1. The Taskforce on Quality in Australian Health Care found in 1995 that <u>18,000 people</u> died from medical adverse events in <u>one year</u>.[24] [25] [26]
2. Australian Bureau of Statistics states for the period 1990-1995 only <u>346 people</u> died from medical adverse events in <u>five years</u>.[27]

These indications reveal, conservatively, that 90,000 doctors have not told the truth when completing death certificates in a 5 year period. It also reveals some 90,000 adverse event deaths have occurred that ABS doesn't know about. This gap may well indicate that there are thousands of death certificates being completed in a misleading manner each year whether through ignorance at best, wilful omission or intentional error. Be there other more palatable explanations - none are currently apparent.

These figures are shocking. They tell us about 89,654 people have gone to their graves, not only unnecessarily, but the truth on how they died was buried with them and their families are unaware. This is betrayal of the worst kind.

Death certification is such an horrific subject, and can be complex, that no one, including government, wants to know about it.

It should be realised that the truthful completion of the death certificate by the clinician in certain cases where adverse events are concerned would involve an acknowledgement of contribution; one that the clinician may be very reluctant to make.

Dr Harold Shipman, of Manchester, England, got away with his murdering ways because no one monitored death certificates he signed off on. As he lied in his death certification, he went unnoticed because 'natural cause' deaths are not reported to the Coroner. It is obvious no one in Britain was monitoring death certificate trends. Checks and balances appear non-existent.

It was an alert daughter of a deceased patient of Shipman's who raised the alarm. A local undertaker and doctor, asked to co-sign cremation certificates, expressed concern at the number of deaths to police, who concluded there wasn't enough evidence to pursue charges. Police were thwarted by the UK General Medical Council which refused to pass on information about Shipman to them during their enquiries into the doctor's past.

Even when the Shipman case suggested serious flaws in the self-regulatory powers of the medical profession, the General Medical Council, the Royal College of Medical Practitioners and the British Medical Association responded with less than lightning speed to right the wrongs committed by one of their own.

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[22] *Medical Adverse Events and Death Certificates: They Don't Add Up* by Medical Error Action Group, June 2000
[23] *Medical Adverse Event Deaths: The Data by Medical Error Action Group, August 2001*
[24] *Quality in Australian Health Care Study*, June 1995
[25] *Taskforce on QAHC*, Sept 1995 (Final Report, June 1996)
[26] *The Medical Journal of Australia*, Nov 1995 [Vol.163, p.458-471]
[27] *Measuring Adverse Events: Problems and Potential* by Jenny Hargreaves and Richard Madden, Oct 1997

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9. Death Certificate Discrepancies (cont)

Audit of death in Australia is done by Coroners. If deaths are not reported, then there is no audit. If ABS is not checking death certificates and observing trends, then who is? This is totally irresponsible of government to treat the public in such a dangerous manner. All death certificates should be signed off by two (2) doctors as a check and balance.

Evident areas of discrepancies when comparing

- Medical records
- Death certificates 'cause of death'
- Australian Bureau of Statistics 'causes of death'
- Adverse Event Morbidity/Mortality figures

Death certificates 'cause of death'

- A clinician can dictate/decide the 'cause of death' entry
- Preliminary death certificates go to the Registry of Births, Deaths & Marriages for registering and issuing
- 'C' (complication) codes in medical records relate to the **nature of the condition** of the injury or poisoning
- 'E' codes relate to the external cause of the injury or poisoning (for the classification of the **underlying cause of death)**
- Both C and E codes should be taken into account.

The E code in patient medical records and the ensuing morbidity data must relate to the principal underlying cause of death on the Death Certificate part 'I' and the ensuing Mortality Data where the death was the result of an adverse event.

Just as the Death Certificate part 'I *(a)*', the principal underlying cause of death must relate to the Disease or Condition directly leading to death - not the mode of dying, e.g. heart failure - but the disease, injury or complication which cause death.[28] Other significant conditions contributing to the death should be listed as part 'II' of the Death Certificate.

There are cases where the encoded adverse events contributing to the cause of death in the medical record is not represented on the death certificate 'cause of death'. Death certificates have not been filled out correctly in accordance with the above ICD-9 Rules. Hence numerous disparities may have occurred.

Death certificates need to be scrutinised and where found to be misleading, corrections be made and the certifying clinician penalised.

[28] ICD-9 Medical Certification and Rules for Classification, pages 699 - 701, page 712 - *Rule 12. Errors and accidents in medical care.* Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death, WHO (1977)

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9. Death Certificate Discrepancies (cont)

Australian Bureau of Statistics 'causes of death'
The low number of deaths related to adverse events as recorded in death registration data is well noted.[29] [30] [31] ABS (Brisbane) citing less than 100 deaths annually Australia-wide due to adverse events is incomparable given the information available from all other sources. This disparity is highly alarming. Given the varying approaches to mortality data presentation; current ABS figures seem to present a narrow and somewhat different scope of data.

ABS receives the actual death certificates and compiles its figures into *Causes of Death* according to ICD categories. ABS data is based on the principal underlying cause of death - not other underlying causes of death - hence it appears that contributory factors/events leading to a death are not included where adverse events are concerned.

Why the ABS does not publish the specific adverse event data in *Causes of Death*, considering it requires this information to facilitate its core activities, such as identifying adverse event death numbers, is a mystery. It appears to ABS that there are "so few" medical adverse event deaths that it's not worth defining the exercise.

Policymakers misled
If policymakers, health industry and medical researchers rely on ABS for planning then this could be a contributing factor why medical adverse event deaths are not being addressed or have not, according to ABS, sufficiently high enough numbers to warrant tackling the massive problem that it actually is.

Illustrating a credibility gap
If the **State Coroner's Office of Victoria** alone receives some 300[32] medical treatment related deaths per year, and another 2,700 are not reported, it is perplexing why ABS has not queried its own figures as to why there is a glaring gap in its data to that of, in this instance, the Victorian State Coroner's Office.

To further complicate, Australian Bureau of Statistics 'causes of death' is **calendar year** based whereas State and Australian Institute of Health & Welfare data are **financial year** based - a direct comparison of the years involved may show an even greater disparity.

Hence we would suggest that the disparity in adverse event morbidity/mortality data between ABS and AIHW requires significant investigation.

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[29] National Summit on Quality & Efficiency in Medicine *Measuring Adverse Events: Problems and Potential* by Hargreaves & Madden, AIHW, Oct 1997
ABS for 1990-1995 has 338 deaths reported as due to "Misadventures" and "Complications" and 8 being caused by "Drug adverse effects", totalling 346 for the 5 year period, page 15-18, Oct 1997

[30] ABS figures for several years constitute approximately 1/10th of AIHW conservative figures for one year only. While compared to more inclusive AIHW figures for one year only, ABS figures for several years constitute approximately 1/20th.

[31] AIHW National Hospital Morbidity Database 1997-98
'Number of separations in 1997-98 where *any* reported external cause code was between E870-E879 and between E930-E949, by mode of separation' were 7,102 deaths
'Number of separations in 1997-98 where the *first* reported external cause code was between E870-E879 and between E930-E949, by mode of separation' were 3,564 deaths

[32] "The Coroner's Concerns: Adverse events doubts raised", Insight: Fatal Care series, *The Age*, 21 November 1999

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