LAW REFORM COMMITTEE

Inquiry into Coroners Act 1985

Melbourne — 19 September 2005

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Ms L. Long, founder, Medical Error Action Group.
The CHAIR — I welcome Lorraine Long, who is the founder of the Medical Error Action Group. Lorraine, it is great to have you here and I thank you for taking the time to come down from Sydney to talk to us. As a parliamentary committee we are governed by the Parliamentary Committees Act. Evidence, as you know, is being recorded by Hansard and it is subject to the privileges of Parliament and your evidence will be on the public record. You will find it on our website. You will have an opportunity to correct any factual errors or other things in your evidence should you need to do that, but otherwise it will be available publicly. If you would like to speak to your submission for maybe 5 or 10 minutes and then we will ask questions.

Ms LONG — I think what came across through the group was that medical adverse events were not being looked into deep enough or hard enough. It seemed to be the view of the families that whatever medical professionals said, that became the spoken word and if anyone else said anything that was dismissed. That was the feedback that came from the families. They wanted it to be shown that neither the medical profession was involved or steering the investigation nor their lawyers.

Talking to the people who had input into the report that the group wrote for the state coroner a few years ago, they wanted the coroner’s process to be enhanced and they wanted the investigation process to be speeded up and that was the result of the report, with suggestions in every subject of the coronial investigation as we saw it. Whether that is how the coroner’s office conducts the investigation, we do not know. We can only speak from the experience we have had ourselves.

The overwhelming comment that came from people was that their trauma was dismissed. Someone will always die in your family and you should always be able to cope with it, but it is the circumstances and not finding out the truth that does the damage and causes the trauma for the families. Enhancing the coronial investigation and getting to the truth is what will help the families in the long run. Of the families who had input into the report, none of them had legal minds or medical minds, they are just families. So our viewpoint should be taken in that context and not as experts in any field or with any agencies that the coroner’s office deals with. We are just families of deceased people who have had matters reported to the coroner.

A couple of aspects came up that we have thought about more and have not really put it into the submission, and it was about the auditing of death certificates. That needs to be done by an independent agency and not the births, deaths and marriages. One of the things that concerns the families most of all is that if anything went wrong during the medical care, automatically the doctors would do the right thing and that would mean telling the coroner something had gone wrong. Families still have blind faith that honesty plays a part in all of the caring for patients, when in fact they find out that is not always the case. That is why they want to see things changed and why I think the feedback from the families is so important.

One other aspect was that families did not necessarily expect an inquest, but they did not want the investigation closed with a letter saying, ‘Your investigation is now closed’, because they were not given reasons. They would be happy with an in-chambers finding, but they wanted reasons, they wanted it spelt out to them in detail what happened and they wanted some sort of report and with that report they wanted to see that the mistake does not happen again. We think that could come with an in-chambers finding, where the recommendations by the coroner then could be implemented, whereas in just closing an investigation, whether something has gone wrong or not, there is no leeway for recommendations to be made to make sure that protocol failure at the hospital does not occur again.

The CHAIR — Thank you very much.

Ms BEARD — Could you share with us a little bit of information about how the coroner’s investigation worked in relation to your mother’s inquest?

Ms LONG — It was unknown territory — —

I have made another submission today from a personal viewpoint and that tells you how the coroner got involved and why. It became apparent on the day of my mother’s funeral that something was wrong, but it was just a series of circumstances that had happened. My mother’s body was lost. The hospital said they did an autopsy, the cause of death differed between my father and myself and no doctor would come near us. The way my father was told that my mother had died was quite brutal. They just rang him up and said, ‘Your wife is dead’. All along she had been dying for hours and there was no attempt for the hospital to get my father in there and also to notify my brother and me.
When we reported it to the coroner the response was very efficient and good. What happened then for the next nine months was we did not know what was going on from one day to the next. There was a change of state coroner later that year and there had been a lot of changes in the police officers looking into it. At one stage we felt we had a police officer so young that he did not have life experiences to really comprehend what was going on. They were just our viewpoints, but as it rolled on, getting up to nearly two years, we still did not know what was going on and there were a lot of legal antics going on with the hospital, particularly the hospital lawyers who we felt were trying to stop any further investigation and also to definitely stop it going to inquest. Also, any time any publicity came up in the media there were denials issued by the hospital that it was untrue, whereas in fact it was making it very difficult toward us. The more it would not give us the medical records, the more we started to suspect something was wrong, but we still really did not think anything had gone drastically wrong. We did believe them, but without the coroner getting involved in the case we would never have gotten to the bottom of it.

That was the crucial thing. At the inquest it unfolded in a chronological order from the witness box, and if we had relied on just reading the statements — the evidence then that came out of the witness box was what opened it all up. It was quite not devastating but mind-blowing to think that the evidence we had been given completely contradicted what was coming out in the witness box. We found that quite bewildering, and so did my father — he could not believe he was lied to so convincingly and also that he had believed it. The good thing about the inquest or the finding — I will go back to the inquest — listening to all the evidence and one particular clinician just talked and kept talking and let it all come out and that was the best thing to hear.

Counsel for the hospital told him to stop. They were trying to stop him talking, but he was not really answering any questions. He just talked. Supposedly you could say he just spilled the truth, and the coroner encouraged him to keep talking — and that was the best thing we heard. Then when the finding came out and the coroner had made recommendations that other hospitals should be alerted about asthma protocols and what had happened — although my mother did not die from asthma; she had gone into hospital with asthma but she did not die from asthma.

One of the things that came out of it also was the importance of note taking. In my mother’s case the doctor had gone to see her but did not make notes, and at other times a doctor made notes who had not been to see her. So it was like later on catching up with writing notes. Notes were being entered, but they were not seeing the patient. Those sorts of things were commented on by the coroner. One of the things that came up years later from the hospital was that the hospital wrote to me and told me that they had changed protocols in that they did not have young doctors running the hospitals overnight; they had at least five years experience and not months of experience; and no junior doctor was left without another senior doctor on in emergency. I look at that 11 years later and there have been some great changes, although to the outsider they may just look like small changes. For a hospital then to come out and say, ‘We have changed our ways and we have done this’, I think that was well done.
The CHAIR — You also indicate that you think the coroner should have the power to go into the hospital and seize medical records at an early stage to prevent tampering?

Ms LONG — Yes.

The CHAIR — And that the hospital should be required to sign a declaration that all medical files have been handed over. Have you got cases where they have been tampered with or you believe all medical records were not handed over?

Ms LONG — Yes, there is a great degree of tampering with medical records, and medical record pages get pulled. They just disappear. When you look at medical notes, they do not run in date and time order. There are gaps, and sometimes a fresh page will be inserted. I can understand that if a doctor is just writing something in a corner. He has not got the medical records there, so it gets inserted, but I think when the hospital knows the coroner is involved, records start disappearing, and I do have proof of it. It is wide ranging in all hospitals. It is not just an isolated incident. There is a concerted effort to smother and to make sure that while that family will be a nuisance for a while, if we just ignore them they will eventually go away. A good deal of families do, but they have to get the answers first. Medical record tampering is a real problem. I think once the death has been reported, the coroner’s office should get those records within hours — and not photocopies, the originals. They have got to scoop them up and take them, and I think they should stay with the coroner’s office until the matter is dispensed with.

Mr MAUGHAN — Are you suggesting this problem is not just confined to Victoria but is Australia-wide?

Ms LONG — Australia-wide. Some hospitals are worse than others, but I think it just gets down to who is running the hospital. If you have a good chief executive in there, he will have his finger on the pulse and he will not stand for that sort of nonsense. You can see some really well-run hospitals where everything in the hospital is efficient, and they have efficient staff to deal with it. It is easier to be truthful and it is easier to run things properly than doing it the other way, you would think. It is just easier being efficient. It is easier making sure there is a check and a balance on everything, but I would like to see the coroner’s office scoop up the records with the body. You take the body, you take the records.

Mr MAUGHAN — Do you think it is largely about efficiency or largely about protecting their backs?

Ms LONG — Protecting their backs. Also, after a patient dies, and even after a patient is discharged, there is still medical record documentation in various departments — pathology, radiology — until that gets into the file. If the file goes straightaway, you would hope that the hospital will forward on the documentation that comes back to be filed, and most hospitals then start a temporary file, and the documents in that temporary file should then go into the main medical record.

The CHAIR — You also say — and this was something we were asking the coroner about — coroners should not allow hospital lawyers to collect and control evidence and prepare witness statements. Do you want to elaborate on that point?

Ms LONG — It becomes then that the lawyers are controlling the evidence, and they are controlling what is in the statements. Statements that I have seen lack time detail. They are sort of a glossed-over view of what happened, especially when the time statements are taken or provided is sometimes a couple of years after the death, and they say, ‘I don’t remember anything remarkable about this case’. But I think it is unfair that a family has to provide sworn statements very quickly after the death. Most families do not have a lawyer on tap. In fact I would probably say that hardly any family has a lawyer on tap to be able to provide a statement for them, and families then just put into the statement what they believe has gone on, but the doctors or the clinicians do not have to provide statements right up until nearly the brief is being prepared. That should be captured early and should not be done by the hospital lawyers. Mr Johnstone was talking about the fact that you need experts to go and gather the statements from everyone, but they have to be attached to the coroner’s office — they cannot be independent — so it does not look like there is any bias.

The CHAIR — Do you have a view on the question of who signs the death certificates? Should the treating doctor be signing the death certificate or do you think it should be an independent doctor?
Ms LONG — There are a couple of aspects to that. All death certificates should be signed off by two doctors as a check and a balance. It should not just be one doctor. In my mother’s case the doctor who signed the death certificate did not treat her and he answered questions in the medical certificate inaccurately. If he had answered them truthfully, we would have known something had gone wrong straightaway. But there needs to be a check and balance with all death certificates. All death certificates should be audited. Sometimes they are not signed and they go to the coroner’s office for the coroner to sign, from my understanding, but just because that is signed off in the death certificate does not mean to say that is necessarily the cause of death or even the underlying cause of death. But there must be two clinicians signing off — absolutely. That change should come.

The CHAIR — What do you think Victoria can learn from the other jurisdictions in relation to improving coronial services given your national role and your observation of other systems?

Ms LONG — The State Coroner’s Office of Victoria is the best in the country. It is the most efficient, it has the right approach, it has the clinical liaison service. It has a mentality of prevention and goes about its work along those lines of, ‘This has happened; how can we stop this happening again?’ The National Coroners Information System is based in Victoria, and that should be boosted with resources to get that going everywhere. All coroners’ offices should be online and able to tap into information in other jurisdictions. The State Coroner’s Office of Victoria should be the example for the country, because it is outstanding. There is certainly the dealing with other states and territories: they do not even want to look at medical treatment-related deaths; they are not interested. They are not interested in seeing how things could be improved in hospitals, and that is the pity of it. Too many magistrates sit as coroners, and they have not got a clue. I read transcripts and I am amazed. They will just listen to what the doctor says in the witness box and that is it — inquest closed — ‘natural causes’ is determined and nothing is gained from it.

The CHAIR — You were suggesting also, in terms of independent medical witnesses, that there has to be some sort of process for determining they do not have a conflict of interest. Do you want to expand on that?

Ms LONG — A lot of times medical experts are called in to give an opinion, and they do not disclose they have a conflict of interest. Sometimes I see the opinions. They say, ‘The doctor did not vary from the accepted standard of care. He is a fine doctor, and we play golf together every week’. Those sorts of comments are put in statements. But the independence of an opinion — you could even go interstate to get the opinion — has to be completely separated and it has to be someone who has not got a conflict of interest. They have to be an expert in a field, not just someone who can read medical records. If there is a calamity in the emergency department, you want someone who knows what goes on in an emergency department, not necessarily a specialist sitting up there in Collins Street. You want someone who is an expert in running a hospital as well. There has to be complete independence. The coroner’s office in Melbourne has a team of medical experts, like a doctor or a nurse, and they can steer the investigation. They would probably know the right people to get onto to provide the opinion, but opinions could certainly be sought outside of the state.

Mr HILTON — You made a statement, Lorraine, that some coroners or people who act as coroners have not a clue. That is a pretty broad statement to make.

Ms LONG — I have seen some shocking transcripts.

Mr HILTON — Do you feel that there should be some sort of system of accreditation that before a person acts in a coroner’s capacity he or she has to meet certain standards of knowledge or training?

Ms LONG — Yes, I do. The only experience I have with the legal system is via my group, but the coronial jurisdiction is completely different. You are not sitting there with a magistrate finding out a criminal act or something. With the coroner it is an investigation — it is to get to the truth — and they need to be experts. They have to know how to handle families, they have to understand the importance of the family’s role, they have to be able to have someone interpret medical records. Can a magistrate interpret jargon in a medical record? Do they know what has gone on? Do they know how hospitals and medical-treatment deaths occur? You need someone with expertise. There are a lot of problems, particularly interstate in a couple of states, and in regional Queensland, with magistrates sitting on inquests. Sometimes the transcript may be 11 pages, and it has virtually just been opened and closed and it has been recorded as a natural death, and there is no invitation to the family to give evidence, not even to provide statements. It is very worrying. Every time I see these findings I say that this is not a finding, they have just done a process.
Mr HILTON — Have you seen any of those in Victoria that you feel are in that category?

Ms LONG — A couple of country ones, yes; Bendigo. Also some families have expressed annoyance — especially when talking about country towns — that the magistrate lives in the country town and then he switches hats and becomes coroner. The families feel he is protecting his medical colleagues because he lives in the town. They say that there should be a coroner hearing it and he should come from out of town; he should have no contacts from living in the local area. That is where families feel they have had an unfair hearing.

Mr MAUGHAN — In your submission you encourage more autopsies rather than less. Given that there is still some stigma attached to autopsies in the mind of the general community, are you saying that the people in your organisation have not got that impediment and would rather have autopsies so that we can discover the truth?

Ms LONG — Yes, that is the view of families Australia wide. They want autopsies. They are denied autopsies because of resources. There have been several cases in New South Wales over the last two weeks. With one family the body went to the coroner’s office; the family was told, ‘Come and pick up the body and go and find your own pathologist. We do not have the resources. If you want to have it done you have to pay for it yourself’. When the family contacted me they said, ‘Where do we get an autopsy done?’. That is unacceptable. This family has still got their father in the coroner’s office, in the morgue, still trying to find a pathologist who will conduct an autopsy. It is a disgraceful situation. The more autopsies that are done, the more young doctors learn about the causes of death. If the family does not believe what has happened, the autopsy can clarify and determine what the cause of death is as much as medical science can. You certainly do not want to be going through an exhumation.

The CHAIR — Lorraine, we have run out of time, but can I thank you very much for taking the time to come down to Melbourne and speak to us. Your submission was very clear and succinct and it raised a number of very interesting issues, and you have expounded on those today and we appreciate that.

Witness withdrew.