Submissions

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QUEENSLAND COURTS

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The Honourable Geoffrey Davies AO
Commissioner
Queensland Public Hospitals Commission of Inquiry
Level 9
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363 George Street
BRISBANE Qld 4001

Dear Commissioner

Thank you for your letter of 4 October 2005. In accordance with your invitation I **enclose** herewith a submission containing my views about the reporting and investigation of hospital deaths.

Please feel free to contact me if you wish me to clarify or expand upon any of the matters raised in it.

Yours sincerely

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encl

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Queensland Public Hospitals Commission of Inquiry

Submission of Michael Barnes, State Coroner

Introduction

1. This submission contains my views on the appropriateness of the definition which determines whether hospital deaths are reported to a coroner and observations about how such deaths are dealt with by coroners. It also contains suggestions about how those processes might be improved.[1]

2. Although there is some overlap, the challenges encountered by coroners in responding to deaths that occur in a medical setting or are contributed to by suboptimal medical care can be grouped into two categories, namely, issues concerning the reporting of such deaths and the difficulties of investigating them.

Reporting problems

3. The *Coroners Act 2003* by s8(3)(d) requires a death to be reported to a coroner if it *"was not reasonably expected to be the outcome of a health procedure"*. This replaces the requirement of the *Coroners Act 1958* to report deaths that occurred while the deceased was *"under an anaesthetic in the course of a medical, surgical or dental operation."*

4. Presumably, the change was designed to shift the focus from when the death occurred to why the death occurred. It is easy to think of examples in which a death might occur during an operation which would not excite the interest of a coroner whose primary focus is to investigate unnatural, sudden or suspicious deaths; equally the fact that the patient survives the operation only to die a day or so later should not preclude a coroner from considering whether substandard care contributed to the death. However the change of wording, designed to cause the involvement of coroners in cases which suggest that something might have gone wrong, brings with it other problems.

5. For example, whose expectation is it that triggers the obligation to report? When discussing the subsection with doctors I have suggested the test is whether a medical practitioner familiar with the condition of the patient before the procedure that led to the death would feel

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[1] This submission deals only with the circumstances that apply to deaths covered by the *Coroners Act 2003* which applies to deaths which occur or are reported after 30 November 2003. I recognise that some of the deaths being examined by this Inquiry and many of the deaths still being dealt with by coroners occurred before that date.

obliged to warn the patient and his/her family that there was a real and substantial risk of death rather that just the ordinary risk that accompanies, say, every general anaesthetic. The difficulty is determining when the possibility of death becomes so great that it can be said to be a reasonable expectation. I am aware that some hospitals employ risk assessment systems that enable them to express the risk of a fatal outcome in terms of a percentage. I do not consider that approach conclusive for determining of whether a death is reportable.

6. Another problem is establishing with sufficient certainty that the health procedure has caused the death rather than the underlying condition that made it necessary.

7. In respect of both of these issues, in some clear cut cases these questions are easily answered; for example, if a patient presents with a ruptured aortic aneurysm the chances of emergency surgery saving him or her are very slight. Accordingly, during such an operation death would not be "*not reasonably expected*". Rather it would be foreseen that it was unlikely that the patient would be able to be saved and that death was a likely outcome. However as death is certain if the procedure is not undertaken it usually will be. Alternatively, it could also be reasonably concluded that the procedure did not cause the death but rather it was caused by the aneurysm. On both accounts the death would therefore not be reportable. On the other hand, if during a colonoscopy the bowel is perforated and the patient dies of peritonitis, there would be a low expectation of death prior to the procedure being undertaken and little doubt that it was caused by the health procedure. The death is therefore reportable, because it satisfies both elements of the definition.

8. However, while these examples may be fairly easy to categorise, in other cases the delineation may be less obvious. Expectation and causal contribution are not matters that can be easily quantified or calibrated; they are to a large extent subjective and best assessed in a qualitative and relative manner. So that in cases that are less obvious or unambiguous a different assessment may result depending upon who undertakes it.

9. Suggestions that elective surgery that results in death should always be reported because death would never reasonably be an expected outcome, in my view, over simplify the issue. For example, a neonate with congenital heart malformation might not be at risk of immediate death but his life expectancy may be no more than a few years and the intervening quality of life poor. Surgical intervention in some of these cases has better chances of success if undertaken as soon as possible. It is high risk but whether a death in these circumstances is required to be reported depends on an assessment of how likely was a fatal outcome.

10. From one perspective, the person best placed to make that assessment is the person who knows the most about the patient's condition leading up to the death. However, he/she is usually also the person whose performance will be scrutinised if a coroner investigates the death and he/she might therefore not be seen as sufficiently impartial to make an independent judgment on these issues.

11. This potential or apparent conflict of interest is not limited to post operative deaths however. General practitioners treating patients in their surgeries or the patients' homes frequently issue cause of death certificates in accordance with the obligation placed on them by s30 of the *Births, Deaths and Marriages Registration Act 2003* in circumstances where there is no independent check of whether misdiagnosis or inappropriate treatment by the certifying doctor has caused or contributed to the death. It was the abuse of this arrangement that allowed the mass murder committed by Dr Shipman to remain undetected by the English authorities and led to the *Luce Report* commenting that *"there is no reliable mechanism to check that deaths which should be investigated by the coroner are reported to him."*[2]

12. That report recommend that all deaths be subject to a second certification by a doctor who has not been involved in the treatment of the deceased[3] and the creation of a new post in the coroner's office, filled by a doctor, who would audit death certificates relating to deaths not reported to a coroner to ensure the criteria for reporting deaths were being observed.[4]

13. The Public Inquiry set up to look into how Dr Shipman's murder of 215 of his patients had gone undetected for over 20 years went further and recommended that all deaths be reported to a coroner and that there be both medical coroners and judicial coroners. These recommendations were made in recognition of the difficulty, at the time of death, of effectively separating unexpected deaths that warranted some investigation from expected deaths that do not need any scrutiny.[5]

14. As would be expected, I have been working with stakeholders to review the operations of the relatively recently proclaimed *Coroners Act 2003.* In the course of that process the chief forensic pathologist from Queensland Health Scientific Services made contact with numerous medical superintendents and surgeons and sought their views on whether the wording of s8(3)(d) could be improved. No suggestions

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[2] The Home Office, 2003, *"Death certification and investigation in England, Wales and Northern Ireland"*, The report of the fundamental review, p42
[3] *ibid*, p51
[4] *ibid*, p43
[5] The Shipman Inquiry, 3rd report, *"Death certification and the investigation of deaths by coroners"*, chapter 19

were forthcoming. I consider it appropriately describes the deaths that should be reported.

15. In summary, the challenges raised by deaths that occur in a medical setting, so far as their reporting to a coroner is concerned, are determining whether a death is reportable and ensuring that those which do meet the criteria are reported.

16. I have sought to address these issues by taking every opportunity to discuss them with medical practitioners and encouraging them to call me or their local coroner if they are in any doubt.[6] This approach is buttressed by s26(5) of the Act which provides that a doctor must not issue a cause of death certificate if *"the death appears to the doctor to be reportable unless a coroner advises the doctor that the death is not a reportable death"* and s7 of the Coroners Act that makes it a criminal offence not to report those deaths which come within the definition. Notwithstanding, I not infrequently become aware that some hospital doctors do not understand or do not comply with their obligation to report.[7] There is a widespread belief among state and territory coroners and forensic pathologists that these deaths are significantly under reported.

17. I am not aware of any systematic checking or auditing of compliance with the reporting obligations. As a bare minimum I consider that post operative deaths should be at least reviewed by a doctor more senior than those involved in the procedure that preceded the death so that some independence can be introduced into the assessment of whether the death should be reported. That would, however, provide no reassurance in relation to deaths which occur in the home and are certified by the deceased person's regular treating general practitioner.

Difficulties in investigating medical deaths

18. Once a death is reported to a coroner on the basis that it was not an expected outcome of a health procedure, the coroner needs to determine the extent and manner of the investigation of the death.

Which matters warrant investigation?

19. The Coroners Act in s12(2)(b) recognises that not all reportable deaths need to be extensively investigated. That section enables a coroner to authorise a doctor to issue a cause of death certificate even though the

[6] Since my appointment I have made 25 presentations to medical audiences explaining their obligation to report deaths. Those presentations always conclude with my mobile phone number and the advice that I am available to discuss these issues 24 hours a day, seven day a week.

[7] For example, funeral directors occasionally refer to me cause of death certificates indicating that the death has been preceded by trauma and when making presentations to hospitals questions from the audience cite examples of deaths that should have been reported but were not.

death comes within one of the categories of reportable deaths set out in s8.

20. Some uncontroversial examples of the appropriateness of such a course are set out below:-

    a. A deceased person is found naked in his home with copious blood about his person and possessions. It is reported as a suspicious death but family members and the treating GP subsequently notify the reporting police officer that the person suffered from a severe peptic ulcer. That condition (and a number of others) can result in sudden death and the vomiting of a large volume of blood. An inspection of the residence reveals no signs of forced entry or other interference. The coroner authorises the GP to issue a cause of death certificate showing a bleeding peptic ulcer as the cause of death.

    b. An elderly woman living at home falls out of bed and factures the neck of her femur. She under goes surgery to enable it to be pinned. Two weeks later while recuperating in hospital, she dies of pneumonia brought on as a result of the immobility and underlying chronic obstructive airways disease. The death is reportable because it can be traced to the trauma of the fall but little is to be gained by conducting an autopsy and investigating the death. The coroner authorises the medical registrar in the hospital to issue the certificate listing the pneumonia, the COAD and the fractured NOF as the descending causes of death.

21. The provision may also have application in a preoperative setting when the death is an unexpected outcome of a health procedure. For example, an elderly person with chronic heart disease undergoes surgery for a coronary artery bypass and to replace a leaking mitral valve. The surgical team explain to the patient and his family that the operation is highly risky. The patient dies. The death is reportable because it was not reasonably expected but nor was it completely unexpected and there is no basis on which to suspect that any substandard medical practice caused the death.

22. A special form 1A has been created for completion by a doctor who seeks the authorisation of a coroner to issue a cause of death certificate in relation to a reportable death. It requires the doctor to provide information about the circumstances of the death and to submit a draft cause of death certificate for the consideration of the coroner.

23. However the difficulty for the coroner considering such a request is that he/she is reliant on the advice of the treating team that nothing untoward occurred and that no aspects of the death warrant investigation. I seek to augment that advice by discussing questionable cases with one of the forensic pathologists from the John Tonge Centre who are always very obliging. I routinely also discuss the proposed

course of action with the family of the deceased to ensure that they are comfortable with the proposal not to investigate the death.

24. In my view, I and the local coroners need access to a dedicated medical officer to review medical charts and the forms 1A to assist in determining whether a cause of death certificate should be issued without further investigation of the death.

How should medical deaths be investigated by a coroner?

25. Once a death that has occurred in a medical setting has been identified as warranting a coronial investigation, the next challenge for a coroner is determine how that should be undertaken and by whom.

26. Most coronial investigations are undertaken by police officers who have a reasonable level of expertise in investigating matters such as suicides, motor vehicle accidents, homicides and many other matters that frequently come before a coroner. When a death occurs in a more unusual setting that might require an understanding of that esoteric context, specialised investigative bodies undertake the investigation and report to the coroner. For example, inspectors from the Department of Natural Resources and Mines undertake the investigation of mining deaths and officers from Maritime Safety Queensland investigate boating accidents. Aircraft accidents are investigated by officers from the Australian Transport Safety Bureau.

27. There is no doubt that the investigation of deaths that occur in a medical setting are particularly complex and challenging, yet there is no specialist body that regularly investigates such matters on behalf of coroners. These investigations are left to police officers who have to struggle with two main problems. First, they have little or no expertise in isolating the issues that need to be examined and so even identifying the appropriate people to be interviewed and then deciding what to ask them can be difficult. Second, hospitals frequently fail to co-operate with police investigations. From across the state I continue to receive complaints from police and local coroners that doctors and nurses will not provide statements despite repeated requests; indeed on occasions police even have to resort to search warrants to obtain medical files. Hospital administrators seem unable or unwilling to help address the problem.

28. In the past, the medical profession was very reluctant to discuss with patients or their families unexpected negative outcomes of medical procedures for fear of litigation. That reluctance has diminished as medical institutions have recognised their ethical obligation to share information about these incidents with those most affected and realised that full disclosure is more likely to reduce litigation rather than contribute to more and/or bigger civil damages claims.

29. Most, but not all, hospitals have mortality and morbidity committees that examine adverse events that lead to death or an unexpectedly poor outcome. The processes by which these committees operate and the extent to which they disseminate their findings is varied but they demonstrate that clinicians realise that they are best placed to unpack these troubling events. However, they provide little assistance to coroners as the proceedings of such committees are usually cloaked in secrecy and anonymity which make their deliberations difficult to access.

30. In my view, similar expertise needs to be made available to coroners so that the families of patients who die can be properly informed about the death, the public can be assured that these death investigations are reviewed by a tribunal independent from the institution in which the death occurred, and the results of the investigation can be appropriately disseminated so that preventive strategies highlighted by the death become more widely known.

31. Currently, as a result of an arrangments I have put in place with the former chief health officer (CHO), coroners who need to access independent expert medical opinions can approach the CHO to have her nominate such an expert. However those experts can only be provided with medical records and the self serving statements clinicians may have provided as there is no system in place for these witnesses to be effectively interviewed.

32. On occasions I have received reports of investigations undertaken by senior clinicians appointed to act as investigators under the *Health Services Act 1991*. I have found them to be very useful. I understand the department's "sentinel events policy" envisages an investigation being undertaken in relation to all hospital deaths. Consequently, at the conclusion of an inquest I recently undertook, I recommended that the CHO with my assistance develop a policy and process for the independent and expert investigation of all deaths that are not reasonably expected to be an outcome of a health procedure. I also recommended that the reports of such investigations should be made available to the coroner and the family of the patient as soon as possible.[8]

33. The Victorian State Coroner has a more sophisticated system for dealing with such deaths. They are all initially reviewed by a multi-disciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that he/she accepts the advice of this Clinical Liaison Team that it does need investigation, the team then advises what investigative steps are appropriate and what independent experts might need to provide an opinion in the matter. This information is fed to the police officers undertaking the investigation.

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[8] Findings of the inquest into the death of Katherine Sabadina,@ http://www.justice.qld.gov.au/courts/coroner/findings.htm

Conclusions

34. In my view no changes are needed to the relevant definition of reportable death because the current wording sufficiently describes those deaths which warrant external scrutiny before registration.

35. I consider there needs to be ongoing training provided to all doctors to ensure they remain cognisant of their obligation to report.

36. I recommend that a senior clinician not involved in the treatment of the deceased be required to review each hospital death to determine whether the death should be reported.

37. I consider there should be some systematic auditing of the compliance with the reporting obligation.

38. Coroners need better access to independent medical opinion to assist them determine whether deaths that are referred to them by hospitals are reportable and/or warrant investigation. They also need similar assistance to help them effectively investigate these deaths. There needs to be at least one dedicated medically trained person available to assist with theses issues.

39. I recommend Queensland Health put in place a policy to ensure an investigation is undertaken in relation to each death that occurs in a facility operated by them and that a report of that investigation be provided to the coroner and the family of the deceased.

Michael Barnes
State Coroner
14 October 2005