Submission to Victorian Parliament Law Reform Committee
July 2005

Review of the Coroner's Act 1985

GPDV is the peak body for the 30 divisions of general practice in Victoria, which work with local GPs to improve health through enhancing the quality of general practice, and through better coordination between general practice and other parts of the health system. Over 80% of GPs in Victoria are members of divisions.

One of the important roles of divisions is to deliver education and training programs to GPs. Divisions also act as a conduit to local practices for a wide range of health programs that originate at both state and commonwealth level. These two functions appear to be particularly relevant to some of the changes that might follow the Review, such as better education about death certification processes, reportable deaths and coronial processes generally; and also attempting to create system-wide changes in matters that have been identified by the Coroner as problems in the health system.

In 2003, at GPDV's annual conference (attended by about 350), we held a session that focused on the way quality patient care is monitored in general practice. Bearing in mind that most of the quality measures are voluntary, we invited a panel of speakers from various organisations to talk about aspects of general practice on which they collect information and how problems might be identified and addressed (or not). Representatives from the Department of Human Services, the College of GPs (RACGP), general practice accreditation services (AGPAL) and the State Coroner and the Health Services Commissioner participated. The session was entitled "Harold Shipman – Could it happen here?" but it was not only the extreme example of a serial killing doctor that was discussed (a poor basis for creating public policy, it was agreed), but wider and more routine quality issues. We have drawn on relevant aspects of this conference discussion to inform our response to the Review.

Additionally, we have held discussions over the last month with a number of GPs through focus groups. 25 GPs have provided input, and some of their verbatim comments are included throughout the submission. Their main concerns related to:

- Problems in the current death certification system
- Concerns that the changes proposed in the discussion paper would not resolve the problems, and would be difficult to implement
- The need for clearer information and for education and training to give doctors a better understanding of the Act and its requirements

The other main points in our submission relate to:

- The need to strengthen the Coroner's role in injury and death prevention by making some response to certain coronial recommendations mandatory
- System-wide changes in the health system that may be identified by the Coroner, and the need to use divisions as the contact point for any system change in general practice.

Q.1
a) Do doctors have a good understanding of what is meant by this category of reportable deaths?
b) Do you think that Coroner-issued guidelines would assist doctors understanding? If so, who should be responsible for writing, updating and publicising the guidelines and who should be consulted?

The discussion paper makes cogent points about the inadequacy of the definitions of "unexpected" and "unnatural" deaths, under the Act. Guidelines to clarify what is meant by unexpected and unnatural would assist doctors. As part of the process of writing and updating the guidelines, it would be useful to consult representatives of general practice as well as hospital-based doctors in ensuring that the guidelines meet doctors' needs. As the setter of standards for general practice, the RACGP would be an appropriate group to approach.

As far as publicising the guidelines is concerned, this needs to be considered as part of a larger education program to ensure that doctors are well-versed in the processes of certifying deaths and reporting them to the Coroner where appropriate. Discussions with a number of practising GPs suggest that doctors are aware they need more training in this area. There appears to be a need for medical schools to spend more time on this area, and/or for it to be a more significant part of registrar training. It may also be worth considering development of a continuing professional development (CPD) course for practising doctors to undertake, through their current education and training providers, including divisions of general practice.

Q2
(a) Do you think the Act gives doctors a clear indication of when to report a death involving medical treatment or do you think that it would be preferable to have a more detailed provision such as in the ACT or Queensland?

(b) Is there currently an "under-reporting" of deaths involving medical treatment to the Coroner? If so, why do you think this is happening and how can this be changed?

In 2003, at a GPDV conference session on quality systems in general practice (entitled "Harold Shipman – could it happen here?"), the Victorian State Coroner pointed out that while the Australian Council for Patient Safety and Quality in Health Care found that approximately 11,000 deaths each year across Australia involved medical error, about 1,000 cases are reported to the Victorian Coroner, of which about 250-300 might be attributed to medical error. Clearly under-reporting appears to be significant, and this is borne out by anecdotal evidence among GPs.

Recent discussions with practising doctors about this discussion paper suggest that there is a poor understanding of when deaths involving medical treatment should be reported, partly because they are not a distinct category. This may well contribute to the problem of under-reporting. More detailed provisions could only assist, as long as they are backed up by effective education.

(See also comments below in response to Q6 and 10 about under-reporting.)

> *"GPs need more training."*
> *"I haven't ever seen a copy of the Act. Often I'm in front of a death certificate and think 'what do I write for immediate cause of death?'"*
>
> - Comments at GP focus groups

Q6
(a) Should the Act or Coroner's Guidelines be more specific as to the degree of certainty required for a diagnosis?
(b) Do the current VIFM guidelines provide for an appropriate degree of certainty in diagnosis?

> *"Many colleagues have come to me and said, "What do I do? I have an 80-year-old patient who's had one minor stroke in the past and one minor heart attack and has high blood pressure. She dies in the middle of the night. What am I going to put down on the death certificate?"*
> *They toss a coin and put down heart attack or stroke. You've got a family who require a Death Certificate for the patient to be buried. They don't want it to be made into a coroner's case.*
>
> *If we put 'unknown' [so it thereby became a coroner's case], we would flood the Coroner's Office overnight."*
>
> - A GP panellist and RACGP member at GPDV's 2003 conference session 'Harold Shipman – could it happen here?'

> *"…The data is completely inaccurate – whether that is a big deal or just upsetting the stats, I don't know. There is no option for 'I don't know but it's not suspicious. But you can't really leave it blank and report it to the Coroner every time a 90 year old succumbs."*
>
> - Comment at GP focus group

We hear many stories from practising GPs like the ones above. In fact, doctors claim that the way the system currently operates encourages doctors **not** to report deaths to the Coroner, where there is some uncertainty about the exact cause of death (but where the doctor is satisfied that the death was from natural causes). Some doctors have commented that staff at the Coroner's Office encourage them over the phone to sign the death certificate, guessing from the medical records as to a possible (likely) cause of death, when the doctor is not confident about the precise cause of death. Doctors are often reluctant to report deaths to the Coroner in these cases because of the consequent delay in funeral arrangements, and distress to the family. Doctors have also commented on the intense pressure they face from funeral directors when attempting to report a case to the Coroner, where the cause of death is unknown. Such circumstances undoubtedly add to the problem of under-reporting.

An additional problem raised by GPDV board is that this uncertainty about cause of death affects the statistics that underpin public health planning and service delivery. Obviously, massive resources go into these planning exercises and programs. In the Australian health system, the success of programs delivered through (private) general practice depends on how effectively GPs are persuaded to participate. Apart from some financial incentives, the leverage for persuading GPs is good argument that they are based on existing needs, and will improve people's health. GPs' level of trust in the statistics about cause of death and the burden of disease is an important factor. Making these statistics more reliable would of course have many benefits – just one would be that doctors might be more willing to deliver health programs based on these statistics.

Q9 Are there any other issues with the current system of death certification?

> *"The current system of certifying deaths is appalling. More than half the time it's a guess."…*
>
> - Comment at GP focus group

[Re a fit, 75-year-old golfer, whose GP saw her the previous week: GP had no idea why she had died, so referred the case to the Coroner.]
"The funeral directors told the family that I was deliberately holding up the funeral, that I was being a pedantic little pain. I had them on the phone 5 times in 48 hours harassing me, saying 'What difference does it make? She was 75 - just put anything.'"

- Comment at GP focus group

Q10 Does the death certification system in Victoria need to be strengthened? If so, how?

Some law reform options to consider include:
Option A. The system recommended by the Shipman Inquiry in its third report:
All deaths should be reported to a coroner so that the Coroner makes the decision about which deaths require further investigation. The Coroner should be responsible for certifying all deaths whereas doctors should only provide a medical opinion on the cause of death. The Coroner should also consult with the family of the person who has died on the cause of death.

Option B. The system recommended in the Luce Report:
The Coroner should continue to only be informed of notifiable deaths but that all death certificates would be scrutinised by a medical assessor at the Coroner's office. For deaths not reportable to the Coroner, two professional medical opinions should be required to certify the cause of death.

Option C. The system proposed by the UK government in 2004:
Doctors should continue to certify the cause of death but two doctors should be required to certify a death. The second doctor should be attached to the Coroner's office so that the office would have the opportunity to scrutinise all deaths. A clinical team supervised by the medical examiner should screen cases and will be able to request further information from the deceased person's family about the circumstances of the death.

Our anecdotal evidence bears out the small-scale research studies quoted in the discussion paper about inaccurate death certificates. Difficulty in correctly completing death certificates, especially because of uncertainty about cause of death, and lack of confidence that they have up-to-date information about the law and the process were raised as key concerns by GPs we consulted at recent focus groups.

We appreciate that in the current system the Coroner depends on the skill and integrity of the certifying doctor, which has particular problems, particularly in light of the Shipman case and the remote but frightening possibility that such cases could occur here undetected. But the options suggested in the discussion paper would be unlikely to substantially improve the situation. Doctors believe it is likely that a second signatory would make the process more lengthy and bureaucratic, and not really function as an effective check, but rather as a rubber-stamp.

(It is worth noting that the requirement for a second signatory for cremation forms did not stop Shipman. The GP who became suspicious because of the large number of forms she was asked by Shipman to sign **did** sign them, although she also reported him two years before he was arrested, but the investigation at that stage did not identify any problem.)

GPs consulted in focus groups pointed out that they are paid for completing cremation forms, but not death certificates, which appears a strange anomaly, as well as an unintended incentive.

Having two signatories does little to solve the other problems outlined in the discussion paper, about the inability of the Coroner to monitor deaths that are not reported; about the lack of any audit to establish whether deaths are appropriately reported; and about lack of audit or quality assurance of certification (when deaths are not reported). We believe the focus needs to be on these aspects, rather than only on who signs.

Rural doctors in many areas would have practical difficulties in finding a second doctor to sign, which in turn would make that signature likely to be little more than a rubberstamp.

Reservations were expressed about how resource-intensive Option A would be. GPs whose experience of the Coroner's Office was that it encourages them to fill in the cause of death even when they are not completely certain, because of resource issues, could not believe that the Coroner would really be able to certify all deaths. They were concerned at the level of detail in the information doctors would need to supply, to enable the Coroner to certify the death, given the ever-increasing workload in general practice, and its structure and funding which makes it difficult for GPs to spend time on detailed report-writing, for which they are not paid. The increasing demands made by paperwork on GPs' time gave rise to the national Red Tape Taskforce Review in 2003-4, which made a number of recommendations to reduce 'red tape' in general practice, in order to free up more time for health care delivery. GPs are concerned that all the options outlined in the discussion paper appear likely to increase the burden of reporting.

We believe that a better solution to ensure public safety would be to review data from Births, Deaths and Marriages for unusual patterns which may require further investigation, and may eventually need to be referred to the Coroner.

Q 29
(a)How effective do you think the current system is in preventing death and injury?
(b) Do you think that the preventative role of the Coroner should be expanded in any way? Should the preventative role be a specific function of the Act?
(c) Should the Act require a mandatory response to certain coronial recommendations? Should the State government be required to provide a written response to certain coronial recommendations within a specified timeframe? Should responses to recommendations be required to be tabled in Parliament?

The Coroner's role in injury and death prevention is an important one, and should therefore be written into the Act. For that role to be most effective, the Act should require responses to the Coroner's recommendations.

Q30
(a) Do you think that the Coroner's current role allows an appropriate level of involvement in improving general patient safety in the Victorian health care system?
(b) In your experience, are there any obstacles or issues preventing a coroner from fulfilling this role?
(c) What strategies or system improvements could be implemented to overcome these obstacles?

"We all make errors as human beings. It's how protective the system is against those errors resulting in an adverse event that is the question."

- Graeme Johnstone, State Coroner, at GPDV's 2003 conference session 'Harold Shipman – could it happen here?'

The matter of system-wide safety recommendations from the Coroner is more likely to be relevant to hospitals than to general practice but we support the principle that the Coroner makes recommendations on system change. At GPDV's 2003 conference session on monitoring quality in general practice, Graeme Johnstone spoke eloquently about the sort of system that is necessary to promote system change: one where the culture is not of blame, but of improvement, where health practitioners are able and inclined to report errors and give their views on how such errors may be avoided across the whole health system in future. We encourage the emphasis on quality improvement rather than punishment. This is consistent with much of the work taking place in general practice through divisions. A constructive beginning would be to educate GPs in the relevance of the Act and the use of death certificates, as discussed earlier.

If system changes in general practice, or perhaps in the relationships between general practice and other parts of the health system (e.g. the communication of referrals and discharges) are identified as defective through coronial processes, divisions of general practice would be the relevant organisations through which to reach, and work with, general practice.

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