Improving healthcare rights through better complaints systems and advocacy

Submission to the Joint Parliamentary Committee on the Health Care Complaints Commission

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The Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit law and policy organisation that works for a fair, just and democratic society, empowering citizens, consumers and communities by taking strategic action on public interest issues.

PIAC identifies public interest issues and, where possible and appropriate, works co-operatively with other organisations to advocate for individuals and groups affected. PIAC seeks to:

- expose and redress unjust or unsafe practices, deficient laws or policies;
- promote accountable, transparent and responsive government;
- encourage, influence and inform public debate on issues affecting legal and democratic rights; and
- promote the development of law that reflects the public interest;
- develop and assist community organisations with a public interest focus to pursue the interests of the communities they represent;
- develop models to respond to unmet legal need; and
- maintain an effective and sustainable organisation.

Established in July 1982 as an initiative of the (then) Law Foundation of New South Wales, with support from the NSW Legal Aid Commission, PIAC was the first, and remains the only broadly based public interest legal centre in Australia. Financial support for PIAC comes primarily from the NSW Public Purpose Fund and the Commonwealth and State Community Legal Services Program. PIAC also receives funding from the Industry and Investment NSW for its work on energy and water, and from Allens Arthur Robinson for its Indigenous Justice Program. PIAC also generates income from project and case grants, seminars, consultancy fees, donations and recovery of costs in legal actions.

PIAC's work on health care complaints and healthcare rights

PIAC has undertaken a considerable amount of work on patient or health care rights during its 29 years of operation, in particular regarding patient safety, complaints and investigations processes and the development of an Australian Health Consumers' Charter. PIAC:

- participated in the consultation process that led to the Australian Commission on Safety and Quality in Health Care 's draft charter and provided a written submission in response to the Commission's Consultation Paper;
- welcomed the endorsement of the Australian Charter of Healthcare Rights by the Australian Health Ministers in July 2008, having previously advocated and supported such a proposal;
- played a significant role in the consultation process leading to the enactment of the *Health Care Complaints Act 1993* (NSW);
- has provided legal representation to clients in relation to complaints about medical practice in NSW, including, for example, in the New South Wales Royal Commission into Deep Sleep Therapy (the Chelmsford Royal Commission); and
- has been active in the consultations and in public debate about a national registration scheme for health professionals.

Introduction

PIAC welcomes the opportunity to make this submission to the Joint Committee on the Health Care Complaints Commission.

In this submission, PIAC will make some comments and observations in relation to the term of reference:

> Consumer awareness and understanding of the complaint handling systems and processes available to them both within the hospital system and in relation to external systems.

In particular, the submission will mount a case for the re-establishment of a healthcare advocacy service in NSW, as well as a more accessible and consistent system of complaints/information officers located in NSW hospitals.

The submission also raise several issues that effect the overall functioning of the Health Care Complaints Commission (HCCC), as well as the safety and quality of health care in NSW.

The first is the privilege afforded to any documentation and communication arising out of the Root Cause Analysis (RCA) process and the effect this has on the HCCC, the Coroner and other investigative bodies, in particular on the ability of these bodies to maximise the safety of the public in hospitals, and in the case of the Coroner, to prevent deaths.

The second is the related issue of the lack of medical expertise in the investigation of deaths on behalf of the Coroner, and the lack of formal co-operation between the Coroner and the HCCC where deaths occur in a hospital or other healthcare setting.

Consumer awareness and understanding of the complaint handling systems

The HCCC has greatly improved the quality and volume of information it provides about its role and complaints process in recent years.

Currently, to advise consumers of local complaint handling systems (that is, the complaint handling systems of public and private health providers), requires knowledge of the hundreds of different complaints handling systems in existence.

Regularising and co-ordinating complaints handling systems in all the various private providers would not be possible or achievable. However, it would be possible, and desirable, to implement a more accessible, standardised and well-publicised system of complaints handling in the NSW public health system. This would be of great assistance to consumers wishing to raise complaints and concerns locally, as well as to the HCCC and other bodies that provide advice to consumers about how to raise their concerns with public health providers directly.

If this were coupled with a well-resourced independent advocacy service that could assist and advise consumers in local resolution of their complaints, then HCCC resources could be better focused on dealing with serious threats to patient safety and allegations of misconduct against health professionals that require investigation and potential disciplinary action.

Currently, the HCCC, via its Inquiry Service and more generally, provides information (both online and in hard copy) emphasising the importance of local resolution of complaints and concerns about health practitioners and health services. Resolving complaints directly with the health provider is referred to as local resolution.

Complaints involving serious breaches of public safety, serious ethical violations, sexual misconduct in a health practitioner—patient setting or negligence on the part of a health professional are generally inappropriate for local resolution. However, the majority of complaints received by the HCCC are not in this category. They are often about communication problems between health professionals and their patient/client. In many instances, they are simply a request (or even a desperate plea) for more information about an incident or course of treatment.

The latter category of complaint can be dealt with at the local level and we consider that the HCCC is acting appropriately when it tries to steer complainants to local resolution, at least as a first step.

However to make this work more effectively, PIAC submits what is required is:

(1) an easily accessible and relatively independent system of dealing with complaints within the public health system in NSW; and
(2) an appropriately funded advocacy service, either operating autonomously within the HCCC or independently of the HCCC.

Local resolution of complaints in public sector health

The current system of what are variously called patient advisors, patient representatives and complaints officers who are employed in major hospitals is very ad hoc. Only some hospitals have such persons employed. They operate at different levels of autonomy and independence. Their existence often pre-dates the more formal clinical governance units that also previously undertook a complaints function and were developed in the each area health service over the past fifteen years.

PIAC submits that there needs to be a consistent model of complaints management across all of NSW Health. Complaints/information officers should replace the current ad hoc system, potentially be located in the major hospitals, but have responsibility for dealing first hand with complaints across the whole of the health service. Whatever name is chosen for such an office, it should be universally used throughout the NSW health system. Officers should have a degree of autonomy and independence so that they are not perceived as a ‘mouthpiece’ for hospital administrations.

Information about the local complaints process as set out above should be prominently displayed in hospitals and easily accessible online. At the moment, if any information is supplied to consumers about complaints, it is usually about the HCCC. This information is essential to consumers, but should be in the same place as whom to contact if consumers want to resolve their complaints or concerns locally.

Quite often consumers articulate that they do not want to complain, but just have access to information. Any material available should clearly indicate that any such information /complaints units is available also to help consumers obtain answers to questions as well as respond to complaints.

PIAC is also concerned that the previous role that the Clinical Governance Units had in taking a leading role on principles of open disclosure and in developing best practice complaints management, has been diminished or removed in the new local health districts, as an unintended consequence of recent structural reforms and changes in the delivery of public health services in NSW.PIAC understands that, if such units still exist in a local health district's administrative structure, they have been considerably downgraded in size and influence.

Effective local resolution of health care complaints can only be achieved when there are accessible and consistent people and places where consumers can raise concerns and complaints, as well as practices such as open disclosure that are embedded in the culture of the health providers and reinforced by clinical governance practices and procedures.

Advocacy services

To have effective resolution at the local level, before a complaint or concern unnecessarily escalates to a formal complaint to the HCCC, there should be a system where advocates are available to advise and assist, if necessary, in the resolution of local complaints and concerns of health consumers. PIAC submits that there should be well-funded and adequately resourced independent consumer advocacy services throughout NSW. PIAC recommends that these services be modelled on the New Zealand Health and Disability Advocacy Service (NZHDAS).

Crucial to PIAC's view on these matters is the contention that consumers and providers are not on an equal footing in the resolution of complaints. Health care providers have the resources of either government or private enterprise (and sometimes of the community sector) to answer and deal with complaints. They hold the overwhelming majority of any written documentation relevant to complaints. Consumers have to seek access to this information. Large private sector providers of health care often have large and well-funded complaints and risk management departments, with dedicated officers skilled in complaints handling. Doctors have the services of medical defence unions. Consumers just cannot match these resources.

Consumers and/or their family and friends are unlikely to have the skills or experience to match those of complaints managers, general managers and health professionals when trying to resolve a complaint. They are often angry and frustrated with a provider before they make a complaint. Relatives and friends, after the death of a family member or friend, are also likely to be going through different stages of the grieving process, at the very same time as the complaints resolution process is taking place. This means that, particularly after a critical incident, consumers or their family and friends are not in the right frame of mind to negotiate a successful and appropriate resolution that responds to their concerns; at least, not without the assistance of dedicated advocates.

The NZHDAS was established in 1996, under the New Zealand Health and Disability Commissioner's legislation, as a result of the Cartwright Inquiry[1] recommendation that there was a need for advocates to be on the side of the consumer to ensure their healthcare rights were upheld.

The NZHDAS is a free service available to any person in New Zealand who has a concern or a complaint about a health or disability service. It also deals with complaints referred by the Health and Disability Commissioner. The independent advocates play an active role, on behalf of the complainant, in initiating and guiding the resolution process.

Significantly, the NZHDAS operates independently of the Health and Disability Commissioner, practitioners/providers and government agencies. Advocates also have a key education role, in that they provide education sessions for both consumers and providers, to promote awareness and understanding of the rights of consumers, and the responsibilities of providers as outlined in the *Code of Health and Disability Services Consumers' Rights.* As the NZHDAS states:

> Health and disability advocates use what is called 'empowerment advocacy' to assist or act on behalf of a consumer. This requires them to direct the process to assist the consumer to resolve his or her complaint rather than directing the content of the complaint.[2]

The Joint Committee on the Health Care Complaints Commission made references to the New Zealand model of advocacy services in a report on localised health complaint resolution procedures in 1997[3].That report concluded that there was a demand at the local level for independent patient advocates.[4] Patient Support Officers (PSOs) in the HCCC originally took on an advocacy role, similar to the New Zealand model. PSOs handled concerns from the general public as well as matters referred to them by the HCCC.The Committee was positive towards the advocacy role of PSOs:

> Patient Support Officers. …offer a reasonably independent alternative to consumers who feel powerless or are confused about the system, or distrust the objectivity of Patient Representatives.[5]

The role of PSOs, however, evolved into Resolution Officers, only dealing with matters referred by the HCCC, and they ceased to be advocates. They continue to facilitate the resolution of health complaints, usually at a local level, but take a position of neutrality in the course of the resolution process, rather than act as an advocate for consumers and their families. Significantly,

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1 Silvia Cartwright, an Auckland District Court Judge, was appointed by the New Zealand Minister of Health, Michael Bassett, in June 1987, to conduct an Inquiry into allegations concerning the treatment of cervical cancer at the National Women's Hospital, and other related matters. <http://www.cartwrightinquiry.com/?page_id=29> at 8 February 2012.

2 New Zealand Health and Disability Advocacy Service, *Models of Advocacy* <*http://advocacy.hdc.org.nz/resources/models-of-advocacy*> at 7 February 2012

3 Parliamentary Committee on the Health Care Complaints Commission, Parliament of NSW, *Report on localised health complaint resolution procedures,* 16 September 1997.

4 Ibid 36.

5 Ibid 37.

they only become involved after a written complaint is received by the HCCC and a complaint is assessed by the Commissioner. This severely restricts the Commission's ability to deal with complaints and concerns that may not be about serious threats to patient safety, but nevertheless could be resolved quickly and easily by an advocate communicating with the health provider on behalf of the consumer, before they escalate into conflict that leads to a formal complaint.

Whilst there is also a role for HCCC employees at all levels to try to facilitate resolution through conciliation or other forms of alternative dispute resolution in complaints that do not involve professional misconduct or threats to public safety, PIAC believes the current absence of independent health advocacy services is a significant gap in the assistance and support available to health consumers in NSW.

PIAC considers that such an advocacy service would be of substantial benefit to both consumers and the providers of health care. For the year ending 30 June 2011, NZHDAS advocates managed a total of 4,271 complaints.[6] The New Zealand experience demonstrates that having advocacy services, readily accessible to consumers, greatly assists in preventing consumer complaints and concerns escalating into formal complaints, with all the intendant time and costs to both the HCCC and health providers that this entails.

Root cause analysis and privilege

An area of concern to PIAC is the current situation where investigation material gathered under Root Cause Analysis (RCA) concerning critical incidents in hospitals and other places where health care is provided, including after deaths, is privileged and not available to the HCCC or the Coroner.

RCA is a process analysis method, which is used in health care and other settings to identify the factors that cause adverse events. The use of RCAs is seen as part of the broader changes in the strengthening of systems to improve the safety and quality of health care in Australia.[7]

The functions of RCA teams and the privilege accorded to information and communications arising from their investigations is found in Part 6C of the *Health Administration Act 1982.* There are also mirror provisions for private health facilities in the *Private Health Facilities Act 2007.*

Section 20U of the *Health Administration Act 1982* (NSW) (*Health Administration Act*) required a review of the provisions after three years of the legislation being enacted. The report of the inquiry by the General Purpose Standing Committee of the Legislative Council into complaints handing in 2006 also called for an urgent review of the provisions[8].

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6 New Zealand Health And Disability Commissioner *Annual Report* 2010-2011, 23.

7 Clifford Hughes and Patricia Mackay, 'Sea change: public reporting and the safety and quality of the Australian health care system' (2006) 8 *Medical Journal of Australia*, Supplement 44

8 General Purpose Standing Committee, NSW Legislative Council, *Review of inquiry into complaints handling in NSW Health,* 2006.

The result was a discussion paper[9] issued by NSW Health in June 2009 and a final report[10] by NSW Health in August 2009. The final report recommended continuation of the privilege of RCA documents and communication.

The HCCC made a submission in response to the discussion paper.[11] The final Report stated that HCCC was the only stakeholder to oppose the continuation of the privilege of RCA reports and communications.[12] This may well be because the discussion paper was not widely disseminated. It was only sent to agencies and organisations that NSW Health considered to be stakeholders. No consumer organisations were on the list of organisations provided with a copy of the discussion paper.[13] Neither was there any widespread information disseminated by NSW Health that might have alerted consumer groups to the significance of the questions involved.

The privilege accorded such documents is justified on the basis of promoting the principle of open disclosure and encouraging disclosure and openness by health professionals after a critical incident. Without the privilege, the argument runs, health professionals would be reluctant to participate in RCAs. The opposite of 'open disclosure' is seen to be engaging in the 'blame game', which is seen lead to negative outcomes, inhibiting rather than encouraging systemic change.

PIAC is certainly supportive of open disclosure.[14] The HCCC submission argues that the retention of the absolute privilege over RCA communication makes RCAs 'largely useless' for the purpose of facilitating open disclosure.[15] PIAC agrees with this conclusion.

The role of the HCCC is one of investigating serious threats to patient safety with the aim of identifying conduct of health professionals that warrants action to protect health consumers and identifying practices and conduct in places where health services are provided that endanger patient safety and diminish healthcare rights, recommending system change to minimise or eliminate such practices and conduct.

The role of the Coroner in NSW is to establish the manner and cause of certain deaths. The Coroner cannot find individual fault (although a Coroner can refer a 'person of interest' to the Director of Public Prosecutions and investigative bodies like the HCCC and Workcover). However, Coroners can, and often do, identify systemic problems and have the power to make

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9 NSW Health, *Discussion Paper – Review of statutory privilege in relation to root cause analysis and quality assurance committees,* June 2009.

10 NSW Health, *Review of statutory privilege in relation to root cause analysis and quality assurance committees,* August 2009.

11 Health Care Complaints Commission (HCCC), Submission re *Discussion Paper – Review of statutory privilege in relation to root cause analysis and quality assurance committees*, 24 July 2009 <http://www.hccc.nsw.gov.au/Publications/News/Review-of-the-Root-Cause-Analysis--RCA--legislationReview-of-the-Root-Cause-Analysis--RCA--legislation/default.aspx> at 25 January 2012.

12 NSW Health, above n.9, 8-9.

13 Ibid Appendix A, 52-3.

14 PIAC, *National open disclosure project, report on initial discussion phase: Report to Australian Council for Safety and Quality in Health Care*, April 2002

15 HCCC, above n.11, 7

recommendations to remedy them. Therefore, a major role of the Coroner is to highlight when a death was preventable and to make recommendations to ensure that a similar death does not occur in the future.

PIAC is concerned that the absolute privilege afforded to RCA reports and investigation reports robs both the HCCC and Coroners of vital information that in the case of the HCCC might lead to increased patient safety, and in the case of the Coroner, might greatly assist in preventing deaths. PIAC believes the public interest in maintaining the absolute privilege of RCA documents should not override the public interest in the HCCC and NSW Coroners having every piece of available and relevant information to carry out their important functions as set out above.

An example of both the public interest in Coroners and the HCCC having access, and the disadvantages of the current absolute privilege afforded RCA documents is found in PIAC's recent experience in representing the family of the late Mark Holcroft at the Inquest into his death. Mr Holcroft died in custody in a prison van travelling on the four-hour journey from Bathurst Correctional Centre to Mannus Correctional Centre in 2009.

A week before he died, Mark Holcroft had complained to Justice Health staff of chest pains, was given medication, and tests (ECG) were ordered. The test results were read by a Justice Health employed GP. No further medication was prescribed and he suggested that some follow up was required in a week. No record of the need for a follow up was actually recorded in the Justice Health system.

PIAC understands that a RCA was conducted after Mr Holcroft's death. There was no information about the treatment Mr Holcroft received, or any information about possible errors or concerns about his treatment, in the original brief of materials prepared by the police for the Coroner.

On PIAC's request, the Coroner ordered an expert report of Mr Holcroft's medical treatment. The report was from Associate Professor Raftos. Professor Raftos's report found that the Justice Health doctor had misread the test results and that Mr Holcroft should have been in hospital on the day of his death, recovering from a stent operation..

Deputy State Coroner MacMahon, in his decision, accepted Associate Professor Raftos's expert opinion and found that Mr Holcroft's death was 'entirely preventable and that had he been provided with proper medical care on 20 August 2009, that necessitated transfer to hospital, it is very probable that he would have experienced a normal lifespan'[16].

PIAC has no knowledge whether these issues were canvassed in the RCA. Had the Holcroft family not been legally represented at the Inquest, it is doubtful whether these issues would have been raised at the Inquest at all. If the RCA report had been made available, the medical and healthcare issues may have least have been canvassed in some way in the police brief provided to the Coroner.

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[16] Deputy State Coroner MacMahon, *Decision in the Inquest into the death of Mark Holcroft*, 12 August 2011, 10 <http://www.piac.asn.au/new-south-wales-state-coroner%E2%80%99s-court-holcroft-inquest-finding> at 25 January 2012.

In 1995 David Ranson, then Deputy Director of the Victorian Institute of Forensic Medicine, observed, in relation to the Coroner's role in medical treatment related deaths, that, because of the role of medical practitioners in reporting deaths to the Coroner:

> They (doctors) therefore act as gatekeepers controlling coroners' access to information about deaths occurring in a medical setting.[17]

The advent of open disclosure policies and RCA on critical incidents should have changed this situation. However the continued existence of absolute privilege for RCA documents reinforces that this reality still exists for hospital deaths in 2012 in NSW.

Another reason that RCA documents should become generally available is because the principle of open disclose does not just mean disclosure to one's employer. That is, consumers and their families should have all the information available to them about a critical incident in a hospital, if they have been the subject of or affected by, that incident

The HCCC submission in response to the NSW Health Discussion Paper quotes Bret Walker QC, who conducted the Inquiry into Campbelltown and Camden Hospitals in 2004.

He observes that:

> … it should be borne in mind that a patient care complaints system, in order to be respectful of the dignity and interests of the patients and families who make complaints or are involved in complaints, must respond to the complaints in a clear fashion.
>
> In my opinion, it is not good enough for them to be told, as it were, that their comfort should be that the experience they found so awful has been an interesting or useful learning experience for the profession.[18]

One of the most concerning issues raised by the HCCC submission is that, despite the statutory requirement of mandatory reporting of unsatisfactory professional conduct or professional misconduct, the HCCC at the time of writing of the submission, had only received one referral about the conduct of an individual practitioner arising from a RCA team investigation. The Commission concluded that it suspected that 'RCA teams do not appropriately identify and refer issues of individual responsibility.'[19]

The HCCC submission concluded that the privilege should not continue. This conclusion was reached on the basis that the privilege actually frustrates open disclosure in relation to serious adverse events. It notes that these are the very matters where full disclosure of the reasons of adverse outcome is sought by patients and their families. It also notes the lack of objective

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17 David Ranson, *How effective? How efficient: The Coroner's role in medical treatment related deaths* 1998, 23 Alternative Law Journal 284,286.

18 HCCC ,above n.10,5.

19 Ibid 7.

evidence that the privilege encourages participation in RCA investigations or that RCAs have been effective in systems improvement. PIAC agrees with this position.

However, PIAC further submits that the current situation could be greatly improved, even if the HCCC and the Coroner had restricted access to RCA documents and communication, and the privilege applied in other areas.

The Coroner has power under the *Coroners Act* 2009 (NSW) to make suppression and not-for-publication orders as well as power to clear the Court and hear evidence in-camera. These powers are common to most courts and tribunals.

If the Parliament wanted to take the restriction of evidence further, it could look to provisions like s.35 (2) of the *Administrative Appeals Tribunal Act 1975* (Cth), which states:

> Where the Tribunal is satisfied that it is desirable to do so by reason of the confidential nature of any evidence or matter or for any other reason, the Tribunal may, by order:
>
> (a) direct that a hearing or part of a hearing shall take place in private and give directions as to the persons who may be present; and
>
> (aa) give directions prohibiting or restricting the publication of the names and addresses of witnesses appearing before the Tribunal; and
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> (b) give directions prohibiting or restricting the publication of evidence given before the Tribunal, whether in public or in private, or of matters contained in documents lodged with the Tribunal or received in evidence by the Tribunal; and
>
> (c) give directions prohibiting or restricting the disclosure to some or all of the parties to a proceeding of evidence given before the Tribunal, or of the contents of a document lodged with the Tribunal or received in evidence by the Tribunal, in relation to the proceeding.

The HCCC, despite its general requirement to apply the rules of procedural fairness, also has power under its legislation to restrict the access of health professionals to the nature and contents of complaints against them in certain circumstances.[20] Although the HCCC is subject to the *Government Information (Public Access) Act 2009* and privacy legislation, there are legislative exceptions that qualify the general principles of access to information found in this legislation.

PIAC, as previously stated, agrees with the HCCC that the privilege is not necessary to meet the its stated purpose according to NSW Health. The continuation of the privilege is contrary to the principles of open disclosure.

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[20] *Health Care Complaints Act 1993* (NSW) ss. 16 and 28.

However, if the privilege is to be maintained, PIAC submits there should be a legislated exception to allow the Coroner and the HCCC access to otherwise privileged RCA documents and communication.

Consequently, PIAC submits that the NSW Government should refer the issue of RCA privilege to the NSW Law Reform Commission (NSWLRC), so that considered law and policy changes can be developed after a period of public consultation. The NSWLRC should consider whether the general privilege accorded to RCA communications should be continued and if so, whether there should be statutory exceptions to the general privilege.

The HCCC, the Coroner and medical investigations

Another issue that PIAC considers should be the subject of law and policy reform is the related issue of the lack of medical expertise in investigations for the Coroner of deaths in hospitals and other healthcare settings.

The Law Reform Commission of Western Australia (WALRC), as part of its review of coronial practice in Western Australia, issued a discussion paper in 2011 that raised this issue.[21] The discussion paper stated:

> Police are not medically trained and depend largely on the doctors involved in the deceased's care to volunteer the specific information required to evaluate the potential for errors or negligence in medical treatment. In addition, coroners in Australia generally have no medical training and have varying access to specialist advice on medical matters.[22]

PIAC submits that this statement equally applies to NSW. PIAC again refers to the Inquest into the death of the late Mark Holcroft. PIAC, not the Police Coronial Unit, first raised the issue of the medical treatment Mr Holcroft received from Justice Health with the Coroner. This led to the Coroner seeking expert advice, which in turn lead to the Coroner's finding that Mr Holcroft's death was preventable but for the inappropriate standard of care he received from Justice Health.

As the WALRC noted, the police are not experts in healthcare matters. Had there been a specialist healthcare related investigation team in NSW, they would have at least been able to advise the police and the Coroner that there were questions to ask about Mark Holcroft's health care. These questions could have been raised and dealt with earlier, and an appropriate investigation could have been commenced at the same time as the police investigated the immediate events leading to Mr Holcroft's death. In some matters, it may be too late to properly investigate these matters when an inquest finally becomes listed at the Coroner's Court. This delay was not crucial in the Holcroft inquest, but in other matters, because of faded memories and lost evidence, time could be crucial in ensuring the effectiveness and accuracy of the investigation.

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21 Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia: Discussion Paper,* 2011 <http://www.lrc.justice.wa.gov.au/3_coronial_pub.html> at 25 January 2012.

22 Ibid 97.

Ranson noted that, in 1995 at least, the percentage of hospital related deaths investigated by coroners was very small.[23] He refers to a study he undertook examining coronial findings where an independent medical investigation team had identified problems with the medical treatment that they believed had directly contributed to a patient dying from what were medically considered to be survivable injuries. This study identified 14 deaths where adverse events were considered by a group of medical professionals to be preventable deaths.[24] Ranson reports that:

> Examining the coronial findings in these cases revealed that in six cases, the Coroner's finding did not mention the fact that medical treatment had been given. In four of the 14 findings medical treatment was described as being provided but no comment was made as to its efficacy or its quality. In two of the 14 findings a detailed description of treatment was given in the coronial finding, but no finding of contribution of the medical treatment to death was made. In the final two cases the medical treatment was investigated in considerable detail by the Coroner and a number of issues identified, although the Coroner did not make any final legal determination regarding contribution.[25]

He concludes:

> …..it indicates that even where the coronial service investigates deaths where medical treatment has been provided, there is a high likelihood that the Coroner's investigation will not uncover issues that a medical panel would identify as significant in contributing to the death.[26]

The WALRC, in its discussion paper, raised the following proposal:

> That a specialist healthcare-related death investigation team comprising of the current medical advisers to the State Coroner, a medical liaison administrative officer, and at least three investigators be established within the Office of the State Coroner. The functions of this team should include:
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> - investigation of deaths in hospitals;
> - provision of medical advice to the coroner including an initial assessment of whether a case may warrant further investigation at inquest;
> - assistance in informing the coroner about the appropriateness and formulation of proposed recommendations impacting the healthcare sector; and
> - development, in collaboration with the Office of Safety and Quality in Healthcare in the Department of Health, of education and other strategies to improve health professionals' understanding of the coronial system and enhance cooperation between the Coroners Court and the healthcare sector[27].

PIAC supports this proposal and calls for its implementation in the NSW context, including the introduction of the position(s) of medical advisers to the Coroner. In NSW, the HCCC should also have a designated role in advising and liaising with such an investigation team.

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23 Ibid 285.

24 Ibid 286.

25 Ibid 286.

26 Ibid,286

27 Ibid 101

PIAC notes that in New Zealand, there is a memorandum of understanding between the New Zealand Health and Disability Commissioner (HDC) and the Coroner.[28] Cooperation takes place between the two in healthcare related deaths. Section 7 (l) of the *Coroners Act 2006* (NZ) States that the Chief Coroner has the function:

> To help to avoid unnecessary duplication and expedite investigation of deaths by liaison, and encouragement of co-ordination (for example through development of protocols), with other investigating authorities.

The Memorandum of Understanding provides for both the Coroner and the HDC to advise each other when they are dealing with a death in a healthcare setting. The protocol provides for a mutual determination of whether an inquest or a HDC determination will go first, with an inquest generally to take precedence. The Memorandum, significantly, encourages sharing of information between the two bodies.

Although the NSW Coroner has the power to refer matters to the HCCC following an inquest in NSW, there does not appear to be active cooperation between the Coroner and the HCCC like that which occurs in New Zealand.

PIAC submits that there should be a similar memorandum of understanding between the NSW State Coroner and the HCCC. Such formal co-operation could greatly augment the role of a specialist healthcare related death investigation team, attached to the Office of the NSW State Coroner.

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28 *Memorandum of understanding between the Office of the Chief Coroner and the Office of the Health And Disability Commissioner*, March 2009.