Risk education essentials

Dr. Margaret Daley
March 2016

Indemnity

- What does it mean?
- MDOs
- Your hospital indemnifies you (for what ??)

Indemnity

- MONEY– who pays if you get sued?
- Employer Indemnified- what does that mean?
- Hospital can also assist in Coronial process for most of of you (Level 1 SS, employees)
- AHPRA /HCCC Complaint
- Hospital/LHD investigations

Insurance

- Appropriate cover for the work that you do

From you MDO
ie employee, SS , VMO, Locum.
Zero hours VMO

Private hospital work , differs depending on which hospital

Working interstate ,different Health Dept have different cover .

Always check your contract.
Changing MDOs , retro date, run off cover (ROCS)

Claims

- Tort reform impact on the frequency of claims
- A number of minor claims have now been removed
- Significant medico-legal resources being siphoned into disciplinary matters
- AHPRA receiving more patient complaints
- Better communication required at point of consultation to minimise adverse impact on the scarcest of your resources – TIME!

Recent medical indemnity history

- Insurance crisis in early 2000s. HIH and UMP collapsed. MII subscriptions were becoming unsustainable
- Australia-wide tort reform introduced – this made it more difficult for patients to initiate claims and be successful
- However increase in the ways health practitioners are '*targeted*' through complaints to the Medical and Dental Boards and various complaint entities throughout Australia
- MDOs concentrates considerable resources in assisting members with these matters
- Complaints can be avoided and / or be better managed

Cover for possible claims made against you

Healthcare compensation cover

indemnifies you for any claims made against you that arise from *healthcare incidents* and for approved defence costs

Important things to remember:

- Medical Board registration requires appropriate indemnity
- always confirm your indemnity arrangements in writing
- Make sure you are in the correct category
- claims can be made against members in private or public practice
- public hospital employees are usually covered for negligence under the hospital's medical / professional indemnity policy

What is the personal / professional risk?

The risk has the potential to affect your:

- conditions of practice
- ability to practice
- reputation
- standing

Risks stem from:

- complaints and allegations regarding your practice and clinical performance
- complaints and allegations regarding your behaviour
- investigations into your practice and/or your behaviour and/or your health

What is personal / professional risk?

Following complaints made by:

- a patient, a member of their family or an advocate
- a colleague,
- your hospital or employer
- an organisation

To:

- an administrative body
- a disciplinary body
- a regulatory entity
- other professional body

Complaints

- Many complaints are unrelated to adverse medical outcome
- Perception of poor service
- Attitude and manner of the staff
- Inappropriate criticism of the role of others
- Don’t promise what you can’t deliver

Communication

- Hospitals can be stressful places for the sick and their families

- Introduce yourself
- Explain your role in the situation

- Simple strategies help decrease that stress and this results in less complaints

Adverse Incidents

- Happen all the time, it is how they are dealt with that seems to be a critical factor in to what happens next.
- Let me first outline all the many different complaint situations that can involve you as a hospital doctor

Case study- clexane incident

- Patient in ED on Friday evening
- History of multiple PE now with dysphagia, on clexane for gastric biopsy the following Monday.
- Documented in the notes that “clexane is to be ceased on the day of the procedure”
- Not sure who made the error but the clexane is withheld from the Friday night ,ward RMO or nurse ?
- Was restarted on the Tuesday but too late
- Died later that week PE

- IMMS incident management system
- SAC severity assessment category (this case level 1
- RCA (or less severe London protocol)
- Similar processes in other states
- RCA is an enquiry of process, should be confidential, but often released.
- Treat an RCA interview seriously even if the reviewers just want to talk to you quickly!

RCA vs Hospital Investigation

- If an RCA finds that a particular person is at fault the matter is referred to the Director of Medical Services for investigation
- If severe enough action can be taken while being investigated ie suspension, taken off on call roster
- Always review the notes before attending and interview, take a support person with you
- Senior consultant , ASMOF, AMA , MDO, lawyer

Outcome of hospital investigations

- Can have serious implications for future work
- Referral to HCCC
- Name on the Service Check Register
- Some LHD put names on the SCR before the matter is investigated, while legally not incorrect, can cause major problems even if the HCCC have found no fault
- Dr S – a cautionary tale

HCCC

- Can be to the hospital or to you individually
- If hospital , the hospital responds but may ask for information from you to do so
- If addressed to you individually , you must respond , always get help
- In NSW all complaints to the HCCC are considered jointly with the NSW Medical Council
- If investigation is required the HCCC keeps it, the most severe outcome is prosecution before NCAT (Medical Tribunal)

NSW Medical Council

Three pathways

- Health or Impairment
- Performance
- Conduct

- Conduct interviews, Counseling Interviews, Impairment Review Panels, Performance Interviews- Medical Support
- Section 150 Hearing with in 7 days of the complaint – Legal support, has the power to impose conditions while waiting for HCCC investigative process

Understand the Board's objectives
Understand your risk

- Health practitioner regulation is **'national law'**
- AHPRA – Australian Health Practitioner Regulation Agency

Objectives of the 'national law' in relation to a complaint notification…

Provide for **protection of the public** by ensuring that only practitioners who are suitably trained and qualified to practice in a **competent and ethical manner** are registered

Guiding principle

Restrictions / conditions on practice to be imposed only if necessary to ensure health services are provided safely and are of appropriate quality

Conditions can however be imposed immediately

Understand the Board's regulation
Understand your risk

- **Codes and guidelines** articulating expectations:
  Code of Conduct : Good Medical Practice for Doctors in Australia
- **Investigations of notifications (complaints about you)**
  Protective jurisdiction

Notifications can be made by patients, their families, your employer, other health professionals and health complaint entities and yourself

- **Mandatory notifications**
- **Voluntary notifications (majority)**

The word notification is deliberate and reflects that a Board is not a complaints resolution authority

Mandatory reporting obligation

Section 140 of the National Law requires that a registered health practitioner must
notify the Board if, in the course of practising their profession, they form a reasonable belief that another registered health practitioner has behaved in a way that constitutes 'notifiable conduct'.

Notifiable conduct is defined as when a practitioner has:

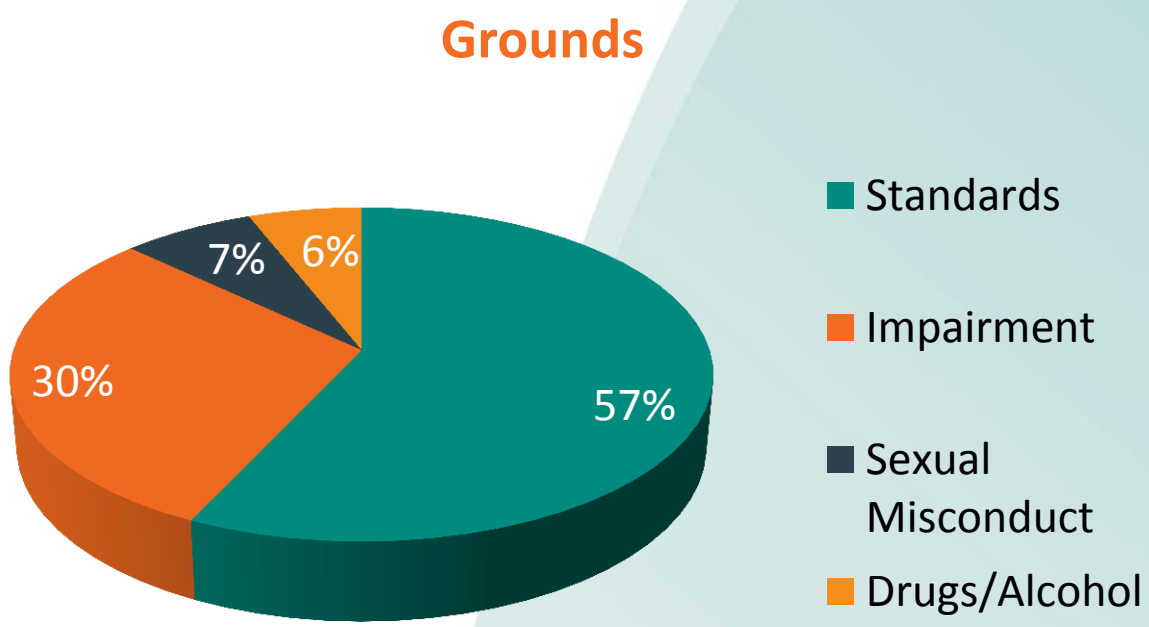
1. practised the profession while intoxicated by alcohol or drugs, or

2. engaged in sexual misconduct in connection with their profession, or

3. placed the public at risk of substantial harm in their practice because they have an impairment, or

4. placed the public at risk of harm during their practice because of a significant departure from professional standards.

Mandatory notifications



Actions of the Board

- No further action
- Caution
- Reprimand
- Impose conditions
- Refer to a health panel
- Refer to performance and professional standards
- Panel
- Refer to a tribunal

Strategies to avoid complaints

- Better **communication** at the point of consultation
- Informed consent / honesty – don't raise false expectations
- Do not practice beyond your training, experience and skills - ASK
- Remember the Board's Codes of Conduct
- Utilise open disclosure
- Prompt notification to MDO of an adverse or unexpected adverse outcome, complaint, claim or investigation (a policy condition)
- Be totally candid, properly reflect & take their advice

Mitigate the situation
Do not escalate

How to mitigate complaints
Do's and Don'ts

- Don't respond to a complaint yourself
- Do keep good medical records
- Do consult MDO or Head of Dept in the first instance
- Do work with the patient to mitigate an adverse sequelae
- Do show insight into the issues raised
- Do demonstrate steps have been taken to ensure this won't happen again
- In the event of a Board notification:
  - do cooperate with Board personnel
  - don't adopt defensive or aggressive behaviour.
  - don't blame.

- Do start with and end with credibility –be professional
- Consider "what is in the best interests of my patient?"

How to Prepare for a Panel or investigation

- Appropriate dress, manner and attitude

- Can be appropriate to bring support documentation, a reference letter, record of continuing education
- Letters of reference are only useful if they are in context , useful if writing these for others too.
- Showing insight is invaluable, acknowledge what happened and reflect on what can be improved

Disputes or employment related issues with your hospital / employer

Strategies

- Follow your employment protocols and employment contractual conditions
- Be mindful of workplace health and safety requirements regarding appropriate behaviour
- Training issues

- AMA , ASMOF, College can be useful for help as well

Other complaint entities / authorities

- notifications to AHPRA (Medical Board/HCCC)
- disputes or employment related issues with your hospital/employer
- Coronial Inquests
- investigations and prosecutions by State/Territory drugs & poisons units
- complaints to disability, privacy, equal opportunity bodies
- billing investigations by Medicare, motor & workers comp authorities

- Follow your employment protocols and employment contractual conditions
- Be mindful of workplace health and safety requirements regarding appropriate behaviour, particular reference to bullying
- AMA , ASMOF, College

- Take all these actions and investigations seriously
- Take mitigating action, do not escalate with any *'counter attacks'*

Medico-legal requirements

Professional

- ✓ Managing health records
- ✓ Informed consent
- ✓ Duty to follow up

Personal

- ✓ Your physical and mental wellbeing

Managing health records

- Health practitioners have ethical, moral and legal obligations to maintain an accurate current record of healthcare treatment
- Health practitioners are bound by a code of conduct concerning the management of health records in Australia
- Understand your employer or hospital procedures in managing patient records

Good Medical Practice for Doctors in Australia – Medical Board

8.4 Medical Records

8.4 Maintaining clear and accurate medical records is essential for the continuing good care of a patient. Good medical practice involves:

8.4.1 Keeping accurate, up to date and legible records that capture relevant details of the clinical history, clinical findings, investigations, information given to patients, medication and other management details.

8.4.2 Ensuring that medical records are held securely and are not subject to unauthorised access.

8.4.3 Ensuring that your medical records show respect for your patients and do not include demeaning or derogatory remarks.

Good Medical Practice for Doctors in Australia

Australian Health Practitioner Regulation Agency

8.4.4 Ensuring that records are sufficient to facilitate continuity of patient care.

8.4.5 Making records at the time of the events, or as soon as possible afterwards.

8.4.6 Recognising patients' right to access information contained in their medical records and facilitating that access.

8.4.7 Promptly facilitating the transfer of health information when requested by the patients.

AHPRA will use this code as the standard against which your professional conduct (including record management) will be measured by the Board..

www.medicalboard.gov.au

- **Codes and Guidelines**
- **Go to Good Medical Practice**
- **8.4 Medical Records**

mips

Records

- Healthcare records are fundamental in determining the strength of allegations of sub optimal care during a negligence complaint or claim
- In the event of an adverse outcome, patient records may be sought by the patient and/or solicitor . Patient records may be used to gauge the performance of the practitioner and/or support a negligence claim
- Current legislation in NSW allows patients, to have a copy of their medical records , so be mindful.

Use of records

Medical records are critical during:

- Complaints or civil claims against you or your hospital
- Coroner's Court inquests involving you/the hospital
- investigation into your professional standing by AHPRA/Medical Board, Medicare , Drugs & Poisons or any other regulatory or complaints body

What your records should look like

As a medical defence organisation, MIPS emphasises that medical records should, as a minimum;

- ✓ be legible, electronic ED records have helped this
- ✓ show clinical history
- ✓ show clinical findings (tests/investigations)
- ✓ record advice provided
- ✓ record examination performed
- ✓ record management plan
- ✓ contain details of informed consent
- ✓ list drugs prescribed, and
- ✓ contain your protocol for referral or follow up on other investigations/tests or treatment

Records as a defence

Do not alter records.

- If you must add something, date the addition.

How a Court might sum up the situation several years post consultation:

- If it is not in your notes, you didn't think of it
- If you didn't write it down, you didn't think of it

"Records may be the only source of truth…"

Hospital records

In reality, doctors and particularly junior doctors, are likely to only spend a short time with patients and less time building doctor-patient relationship. Therefore patient records should;

- ✓ be legible
- ✓ Utilize the electronic records properly
- ✓ identify treating doctor, problems with staying logged on, others using your login
- ✓ contain date of treatment
- ✓ be adequate for handover
- ✓ state findings
- ✓ list different treatment plans offered
- ✓ record consent process

Legislation

Confidentiality

All information divulged in a doctor-patient relationship is confidential – this applies to all medical records (ethical).

Privacy

Privacy Law - National Privacy Act 1988 Updated Mar 2014 - applies to all health service providers and compliance is necessary.

13 Australian Privacy Principles

www.oaic.gov.au/privacy/privacy-act/australian-privacy-principles

Follow your hospital procedures

Privacy and ownership issues

- ✓ Only access records for an appropriate medical reason (not because they are a famous celebrity)
- ✓ Do not give out information or records without consent
- ✓ Consent is provided by the patient or signed authority, this can either be a formal letter or other legally enforceable document
- ✓ You must view consenting documentation, to ensure it meets basic requirements

If record disclosure is compelled by law (Coroner, Centrelink, Police), discuss and co-operate

Police request for notes can need patient consent , so always check before giving police records. Example patient seen after assault in ED

Privacy and ownership issues

www.privacy.com.au/faq/health

- ✓ Family breakups can be difficult scenarios for doctors. There are issues of custody, consent and records to consider
- ✓ As a general rule, either parent is entitled to details unless there is precluded by Court Orders.
- ✓ Always seek the assistance of your supervisor, employer, hospital or MDO when you are unsure of a privacy issue

Consent

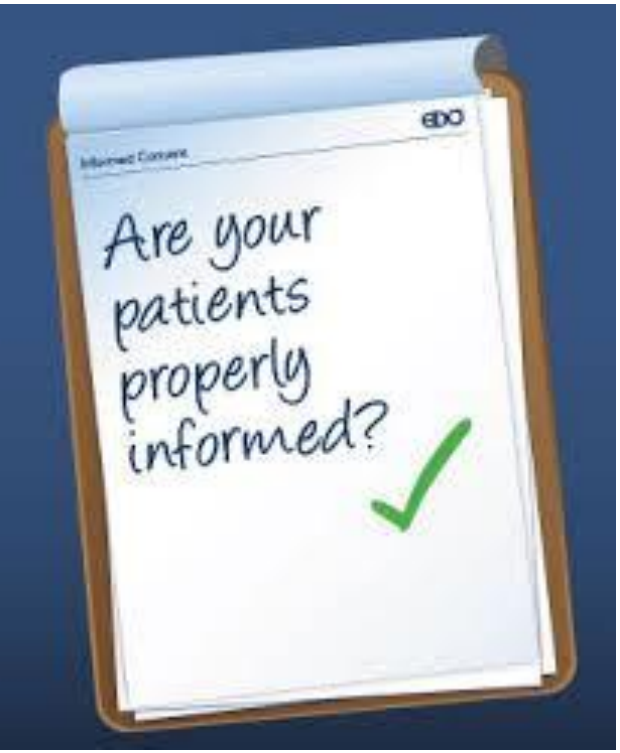
Good Medical Practice Code for Doctors in Australia: 3 Working with Patients

3.5 Informed consent

A person's voluntary decision about medical care that is made with knowledge and understanding of the benefits and risks involved.

- Technically/legally you should not touch the patient without consent (patient autonomy) - could be battery or criminal assault – this is rare.
- Chaperone
- A suitable warning and explanation should be provided of your intentions regarding examination and investigations
- Lack of informed consent or failure to warn where there is a poor or adverse outcomes can be a cause of negligent medical advice cases – commonly added in medical negligence cases

Consent



- Can be oral, written or implied
- You should confirm that consent has been given
- Written consent is preferable for major procedures
- Ultimately responsibility for obtaining consent lies with the clinician in charge of the treatment
- Patients can refuse treatment and/or withdraw consent

Consent – Duty to warn

- Explain the broad nature and effects of the treatment which must include information about “material risks”
- At law, a “material risk” is one that in the patient’s particular position, if warned of the risk, the patient would be likely to attach significance to it. That is, they may change their view about the treatment and may not proceed
- **Private practice** – there may be a requirement for informed financial consent

Where consent is not required

- An emergency – proportionate to the patient's needs
- Valid advance directive or refusal of treatment certificate
- Blood alcohol testing after MVA
- Compulsory exams and treatment for sexually transmitted disease
- Under relevant mental health legislation

Case study – Consent
Rogers & Whitaker (1992) High Court

- Dr Rogers an ophthalmologist found negligent by the High Court when he failed to warn a patient of a 1 in 14,000 chance that she may develop sympathetic ophthalmia and blindness.
- Almost totally blind in her right eye, due to an accident at the age of 9. Despite the injury she had lived a substantially normal life .
- She was advised that surgery on her injured eye would not only improve the its appearance but would probably restore some sight to it.
- In the end the patient lost all sight in her left eye and there was no restoration of sight in her right eye
- At no stage was the patient warned of this complication. It was alleged that Rogers had a duty to inform the patient of the risk as the patient would *not* have agreed to the procedure had she known of the risk to her left eye.

Adverse or unexpected outcomes after surgery

- colonoscopy – perforation
- knee/hip replacements – infection, product failures, foot drop
- breast implants - infection, leakage
- Sterilisation – failure rate
- high incidence in regard to plastic surgery and cosmetic procedure – “unsatisfactory result”

- Adverse outcomes of ED procedures

Typical allegations made in failure to warn cases

- no consent obtained
- process of obtaining consent was poor/rushed
- complication not mentioned
- alleged experimental nature
- alternative treatment not offered

Follow up

The Code of Conduct does not provide guidelines on follow up but there is clear medico-legal precedent and requirement for follow up.

Your duty of care to following up:

- Where abnormal or clinically significant results are anticipated or found including

- Where normal results are received that do not assist diagnosis of an illness that leads to damage that could have been prevented if further tests should have been undertaken to allow earlier diagnosis and treatment

Follow up

The courts have determined that the duty of care owed to patients extends to:

- following up the information (results are expected)
- making reasonable attempts to contact patients for follow up of clinically significant or abnormal test results (or normal test results in the presence of other clinical indicators of a serious disease process)

Differences in policy may exist in your hospital, however the fundamental legal concept applies to all. Follow hospital protocols

Follow up – Your responsibility?

- Have your recommendations been followed?
- Fine balance between respecting patient autonomy and the principle of beneficence (patients interest come first and role of doctor is to further those interests – noting patient autonomy and right of self determination)

A number of adverse outcomes to patients may be preventable by doctors instigating proper follow up systems , difficult in ED

Your are not likely to see patient again

Document clearly details of follow up

Case Dr M failure to alert patient to the need to follow up lung mass

Physical and mental wellbeing

A health setback may be a major setback to your career

Be aware of the personal risks:

- The pressures on junior doctors
- Performance problems
- Drugs and alcohol
- Social and professional isolation

And take time out to relax.

Physical and mental wellbeing

- You have a duty to also look after yourself
- Never do it all yourself; seek assistance
- Note Code of conduct references at 9 Ensuring doctors' health and mandatory reporting requirement of employers & colleagues if the public is at risk
- Seek assistance , supervision, help, guidance and support when you require it
- Create a work, rest and play balance
- See your own GP as needed
- Do not treat yourself or your family and friends

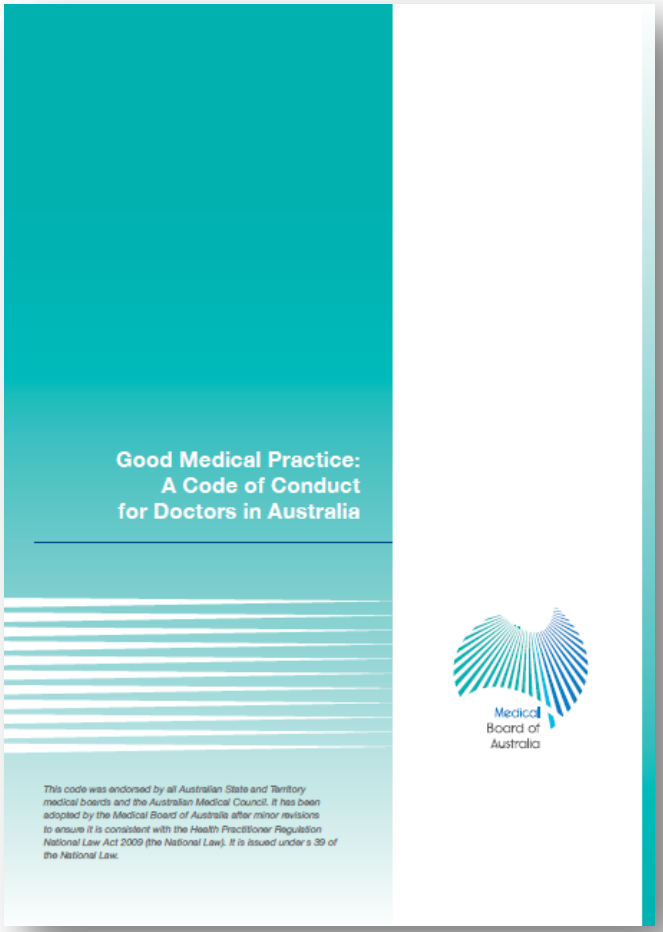
Death – The Final Complication

Dr Margaret Daley
March 2016

Workshop discussion

- Providing information to the Coroner
- What happens at an inquest?
- Assistance MDO can provide
- Risk management aspects
- Your responsibilities
- Death Certificates
- What is a Reportable Death?
- The role of the Coroner

Your responsibilities



Good Medical Practice: A Code of Conduct for Doctors in Australia

3.12. End of life care

3.12.10 Communicating bad news to patients and their families in the most appropriate way and providing support for them while they deal with this information.

3.12.11 When your patient dies, being willing to explain to the best of your knowledge, the circumstances of the death to appropriate members of the family and carers, unless you know the patient would have objected.

Code of conduct continued

Good Medical Practice: A Code of Conduct for Doctors in Australia

8.8 Medical reports, certificates and giving evidence

- community trust in you, given authority to sign documents such as **death certificates**
- complete honestly and accurately, verify the content, opinions to the best of your knowledge

Your code of conduct.

Note your local rules but generally the steps are:

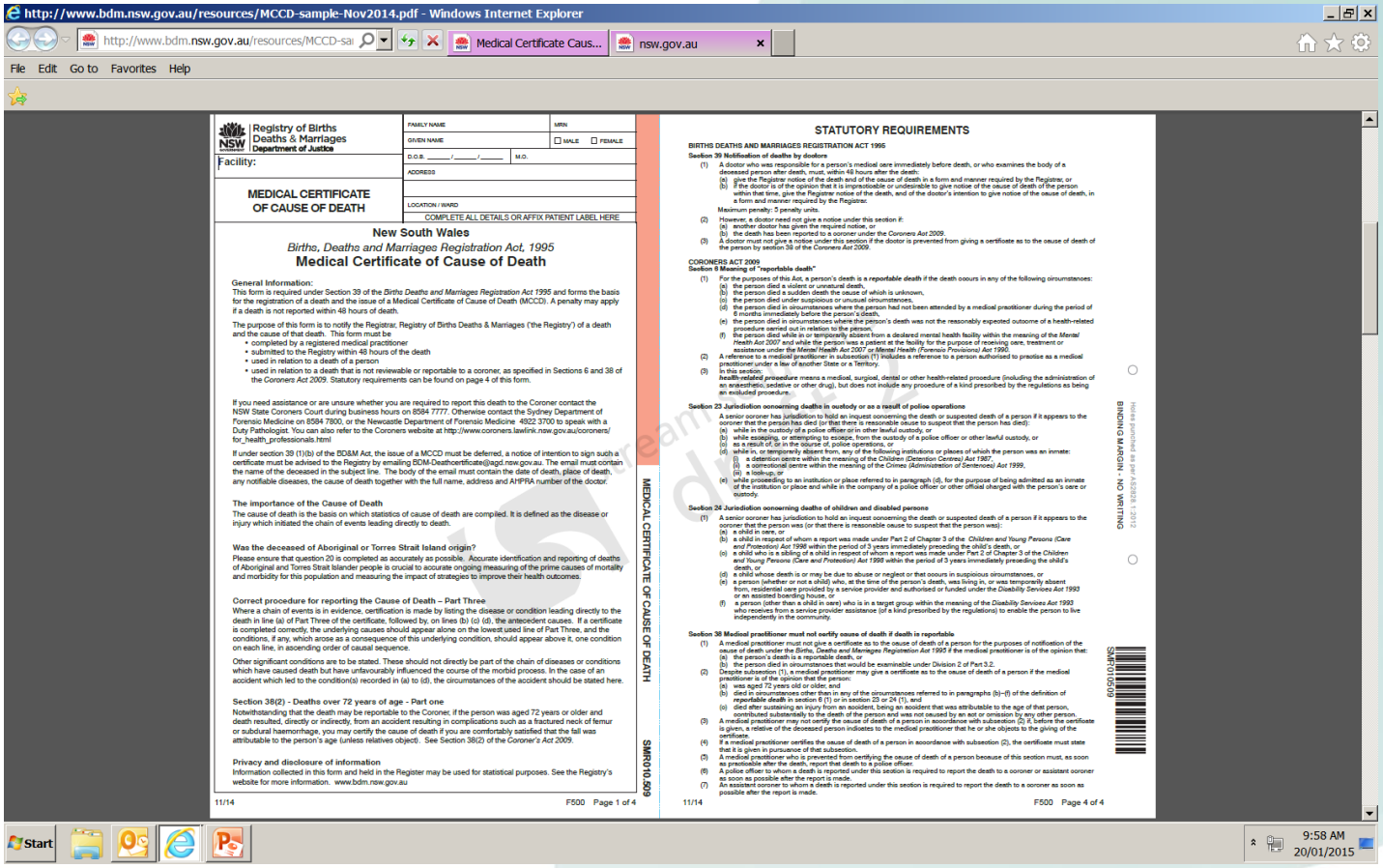
1. Verifying life extinct
2. Issuing Medical Certificate of Cause of Death (MCCD) or refer to Coroner.
3. Cremation certificate

1. Obtaining a burial or cremation order.
2. Registering the death is required (generally within 14 days).

New South Wales form

www.bdm.nsw.gov.au/bdm-mcd.html

The new Medical Certificate Cause of Death (MCCD) took effect from **8 Dec 2014**.



Case study
…sometimes things can be complicated

- Paediatric registrar on a weekend shift
- Boy aged 7 years referred from ED on Sun pm with viral gastro

Patient history

- Splenectomy post MVA aged 4 years
- Immunisation history unknown

Case study (continued)
…sometimes things can be complicated

Treatment

- Paediatric registrar accepted the patient for interim management on ward at 1800h as very busy on birth suite and transfers. Vitals normal
- Registrar checked on nurse caring for child but did not actually see the patient as many other duties. SR kept up to date
- Night registrar started at 2000h and saw child
- Also diagnosed viral gastro, bloods and IV

Case study (continued)
…sometimes things can be complicated

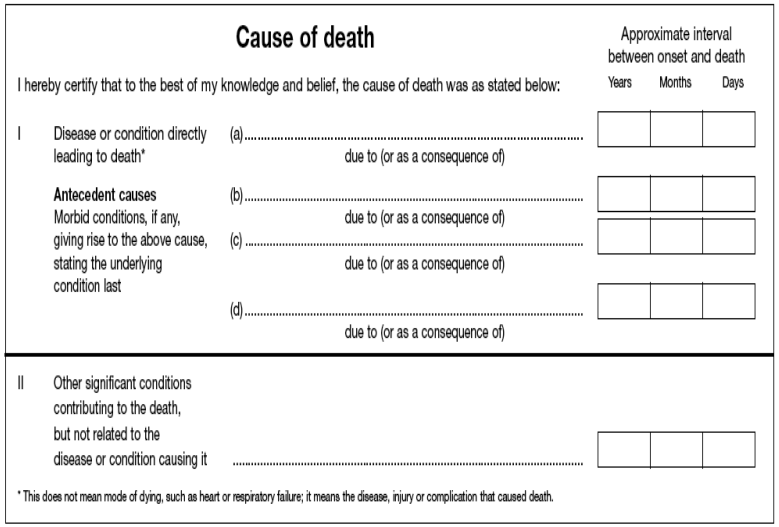
Outcome

- FBC at 2100h reported as 32. Still apyrexial
- At ward round next morning, headache, mottled, pyrexial and soon after had seizure
- Resuscitated, intubated
- Fixed and dilated pupils died a few hours later
- Family demanding an inquest and wants answers

Would you report to the Coroner or complete a MCCD, or both?

MCCD vs Death Certificate

MCCauseD



Cause of death

I hereby certify that to the best of my knowledge and belief, the cause of death was as stated below:

Approximate interval between onset and death — Years | Months | Days

I Disease or condition directly leading to death* (a) ..... due to (or as a consequence of)

Antecedent causes Morbid conditions, if any, giving rise to the above cause, stating the underlying condition last

(b) ..... due to (or as a consequence of)

(c) ..... due to (or as a consequence of)

(d) ..... due to (or as a consequence of)

II Other significant conditions contributing to the death, but not related to the disease or condition causing it .....

* This does not mean mode of dying, such as heart or respiratory failure; it means the disease, injury or complication that caused death.

A Medical Certificate of Cause of Death (MCCD) is the correct term but is commonly referred to as a death certificate.

Medical Certificate of Cause of Death

- All deceased people in Australia have one
- No legal requirement for you to complete if you're not comfortable doing so
- HOWEVER you do have a legal and moral duty to complete accurately – these are very important legally enforceable documents.

Complete MCCD only if….

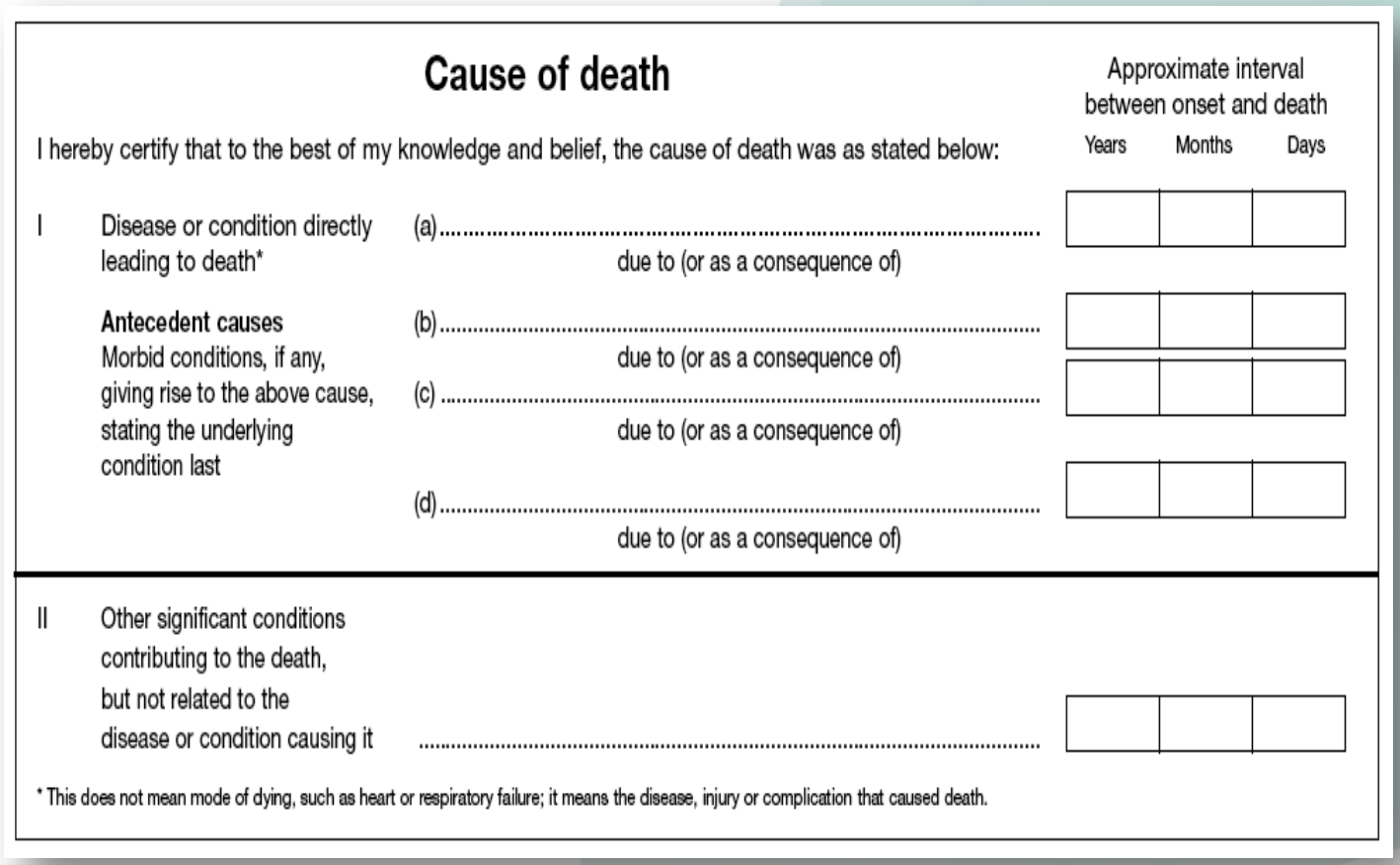
- ✓ You are '**comfortably satisfied**' as to cause of death
- ✓ It's not a ***Reportable Death to the Coroner*** *(discussed later)*
- ✓ You are a **registered** medical practitioner

Why MCCDs Matter

- Legal ramifications, such as an individual's life insurance
  - In some cases policies are of significant value and give rise to disputes,)
- Family history
  - Personal records, dispute resolution and historical importance
- Statistical and public health purposes
  - International mortality statistics (current certificate format designed by WHO)
  - DVA entitlements for widows
  - Errors can lead to distress

Statistics

- **Cause of death** is especially important and should be accurately and fully disclosed. An example:



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Cause of death

- When completing “cause of death “
- What the patient died of, not the method of dying.
- Not symptoms or signs
- Try to be as specific as you can
- multi organ failure, confusion or even diabetes - you may need more information
- Otherwise you can be contacted to clarify

FAQ

Q. Can I see the records?

A. Yes, it is recommended you access them before signing a certificate.

Q. Can you speak to other practitioners.

A. Yes this is also recommended, but not always practical

Q. How long can I take to decide?

A. In most states 48hrs.

Q. I haven't seen the deceased when alive

A. There is no requirement except in **ACT 3/12** and **NSW 6/12.**

FAQ

Q. I haven't seen the body…

A. There is no requirement if you have been treating the patient however it's prudent to do so if possible.

Q. I don't know the exact cause of death although I know it was natural causes.

A. You must form an opinion as to the probable cause of death

Q. The deceased wasn't my patient I have never seen them.

A. There is no requirement for you to have treated the person however extra care is required to obtain the necessary evidence for you to consider the cause

‘Certificate of Registered Medical Practitioner Authorising Cremation’

Prior to authorising cremation a practitioner must:

1. Carefully read the Application for Cremation
2. Have examined the body
3. Usually you have also completed the medical certificate cause of death

- You cannot authorise a cremation where the deceased has a cardiac stimulator or a device equipped with radioelements
- You can authorise a cremation even when the deceased has an orthesis or a prosthesis (eg a hip replacement device).

Case history

Complaint from a family member

- An 84 year old male had elective surgery for recurrent colon polyps and had previously had cancer of the colon
- Patient assessed by cardiologist and anaesthetist.
- Patient elected to have an end ileostomy
- 2/7 post op – confusion
- Sudden collapse
- Presumed PE
- Discussed with coroner

Complaint received from the son of the deceased man

- *Why wasn't the death reportable?*
- Disputed the cause of death

Reportable deaths

- Varies in each jurisdiction in NSW
- **Reportable if**

  - The death was **unexpected** and the **cause is unknown.**
  - The death was **violent or unnatural, suspicious or unusual circumstances**
  - Not attended a doctor for **6 months**
  - The death was **" not the reasonably expected outcome of a health related procedure." This includes medial, surgical or dental procedures**
  - Person in or temporarily absent from **a mental health care facility for involuntary treatment**
  - The identity of the person who has died is **unknown**

  - **A doctor is unable to sign** a MCCD giving the cause of death.

Reportable Deaths

A death is examinable even if caused by natural disease must be reported if

- In custody of police or attempting to escape
- Result or in the course of police operation
- Inmate of child detention centre or correctional centre (even if temporarily absent)
- Child in care
- Child with report of significant harm in the last 3 years or sibling of such a child
- Child whose death may be due to neglect

Reportable deaths

- Living in residential care provided by or funded under the Disability Services Act, or assisted boarding house
- Person has a disability within the meaning of the Act and receives government assistance to live independently
- Still birth is not a death
- Special consideration for geriatric deaths

Notifications to the coroner

- Natural cause deaths need only be reported if the probable cause in unable to be identified. It is not necessary to have a complete understanding of the mechanism

- Seek advice ,the duty forensic pathologist can be called in office hours.
- Senior member of the treating team completes a Form A , and if associated with an anaesthetic the form formerly known as Form B should be completed

Reportable deaths

"There is significant underreporting of deaths to the coroner, and medical practitioners have difficulty recognising reportable deaths".

MJA 199 (6) · 16 Sept 2013

- In 2013 there were two inquests through the Victorian Coroners Court specifically relating to **an organisation's failure to notify the Coroner of a reportable death.**

One example from the Vic cases

- Drug affected patient taken to ED
- Diagnosed with anoxic brain damage secondary to cardiopulmonary arrest and died
- ICU registrar did not report to Coroner but wrote a death certificate
- Registrar of Births, Deaths and Marriages reviewed and reported to the Coroner
- Inquest was then called to examine the medical professions obligation of reportable deaths to Coroner

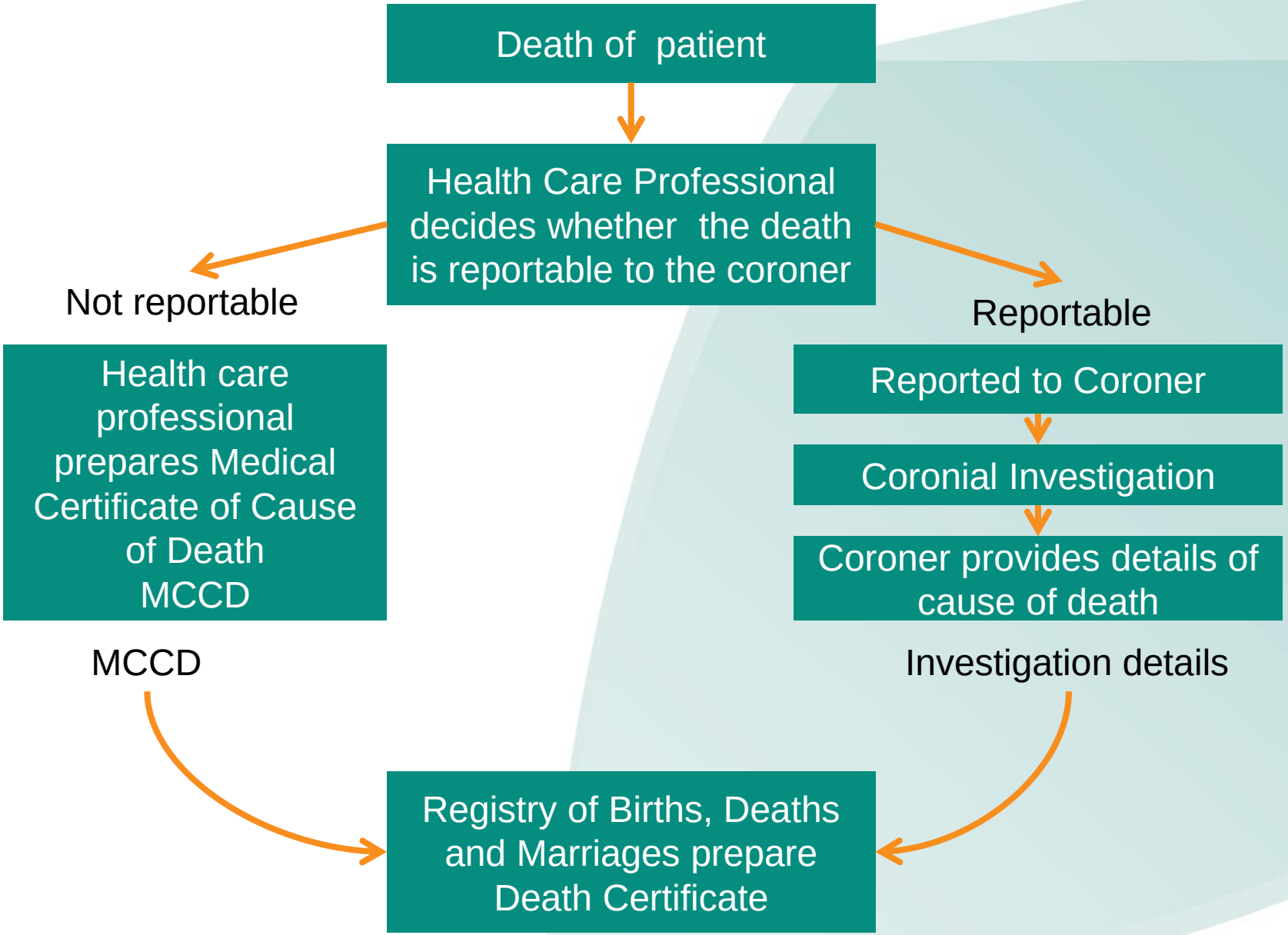
Reporting a death

If you report a death to the Coroner do not issue a MCCD as well unless asked to by the Coroner

Often the coroner will review the notes , or a limited autopsy will be done and then a certificate issued.

Not every death reported to the coroner gets or needs and inquest

Other factors can determine what does get an inquest including in some cases family concern


Death of patient
Health Care Professional decides whether the death is reportable to the coroner
Not reportable
Reportable
Health care professional prepares Medical Certificate of Cause of Death MCCD
Reported to Coroner
Coronial Investigation
Coroner provides details of cause of death
MCCD
Investigation details
Registry of Births, Deaths and Marriages prepare Death Certificate

Role of the Coroner and inquests

Coroner - A judicial officer of the justice system for each State/Territory responsible for the independent investigation of certain reportable deaths

- General aim is to promote improved public health and safety
  - Inquests are discretionary – can be “on the papers’ only
  - Mandatory inquests especially death in Police custody

Information to the Coroner

Your duty to the coroner:

- You must **assist the Coroner** and meet requests for information usually from the police
- **Copy of the medical records** to go to the Coroner – keep originals safe
- You may be required to **provide a statement** addressing issues specified - advise your hospital/employer and your MDO to obtain advice and assistance
- You may require **legal representation** for a inquest if you are deemed a person of interest
- Doctors/health service may become an **'interested party'** to the investigations, you should usually be warned about any investigations being undertaken

Statement to the Coroner

- Police usually act for the coroner, if acting on behalf of the coroner , they have the authority to request notes and ask for a statement.
- Your request as a hospital doctor usually comes via medical admin. The hospital releases the notes, not you individually.
- But the statement must be yours , better to do so in writing , rather than interview which the police then type up (more common in other parts eg ACT)

Statement to the Coroner

- Never sign a statement unless you are sure it is absolutely correct
- Never do from memory , always ask for a copy of the notes.
- If you no longer work in that location , if the hospital will not provide the notes , ask the police to.
- Statement to the coroner are about your involvement. Can refer to history , but make your time frame very clear
- Make your statement clear , do not use abbreviations without clarification
- At MIPS we are always happy to check statement
- At times legal assistance is needed
- Case of Intern called to inquest to give evidence to her statement

Inquest

- An inquest is not a trial, rather it is an investigative process to shed light on the cause and circumstances of a death.
- Most coroners are non medical and so accurate, practical medical information is vital
- The Coroner's Court is less formal than other courts. It is not bound by the same laws of evidence and is not too technical or legalistic.
- In making a decision the Court can also make recommendations to any relevant authorities that may result in changes to laws or practices in order to prevent similar deaths in the future.
- **Coroner's regularly refer practitioners to AHPRA/Medical Board if they feel their medical conduct/practice should be reviewed. Can be referred to the DPP**
- Always advise MDO of any involvement to ensure best representation and advice

Inquest

- Inquests can be used to gauge potential for a common law civil claim.

  For example: loss of dependency or nervous shock claims from family members

- Any criticisms of your healthcare add weight to potential for a claim

- A good coroner will keep this under control

Risk management

-
- Advise your MDO as soon as possible if you have any involvement.
- For hospital employees , likely to be covered by the hospital's insurer and assisted by their legal advisers.
- If required to give a statement

  - ✓ Respond only to the questions asked
  - ✓ Stick to the facts
  - ✓ Do not speculate unless requested to
  - ✓ Do not be emotional
  - ✓ Do not be defensive
  - ✓ Do not be critical of others

Coronial Inquests

- Issues of media coverage cannot be prevented

Often only the opening statements are reported , Can be reporters and cameras outside and reporters inside. Public hearings

- Not always clear when you write your statement often a year or two before the inquest if you will be needed to give evidence
- Three types of medical witnesses

1. treating doctor providing medical information
2. person of interest ,this is a treating doctor with potential risk, the crown solicitors office will notify you of this. You will need legal assistance for this.
3. Medical Expert

If a Person of Interest to the Coroner

- **A pre inquest Conference** was held with the member, the MIPS file manager, the solicitor and barrister
- The member was again **counselled on the role of the coroner** and **purpose of the inquest**. The members role is to assist the coroner
- The member was advised it is a **public hearing and media may attend**
- The member again reviewed his statement and any **issues clarified**
- He was advised on the **appropriate method of giving evidence**

Death Certificates

DO

- Do take these very seriously – **they are a very important document**
- Do **contact the Coroners office , or your MDO** if you need clarification
- Do **write a certificate** if you have an opinion regarding the cause of death from reading the medical records or talking to other practitioners but have never seen the patient or the body
- Do **promptly comply with requests** from the coroners office
- Do **request a copy of Coroner's final report**
- Do treat a deceased patient's **medical records with confidentiality** if they are in your possession in order to write a report

Death Certificates
DON'TS

- **Don't be pressured** into providing one if you have any uncertainty
- **Don't write a death certificate if you are not comfortably satisfied** as to the cause
- No death certificate is required if you have notified as a **reportable death**
- **Don't report to the Coroner if you have provided a Death Certificate**

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1800 061 113