

**CORONERS, MEDICINE and PRIVACY:
Inconsistencies of coronial legislation and privacy**

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Introduction:

The topic given to me by the conference organisers to discuss was inconsistencies between coronial and privacy legislation. In the program, you will have seen a number of dot points. These were suggestions made by the program organisers but I hope that they and participants in this conference will forgive me if I take slightly different course.

In his speech to the 2008 Conference of the Asia-Pacific Coroners Society in Adelaide, Julian Burnside QC discussed “The Role of the Inquest in a Decent Society”.¹ He posed the question, ‘Can a Just Society tolerate the presence of humiliating institutions?’ His answer, as you undoubtedly anticipate, is that it cannot.

His argument was that:

Self-respect precedes all other basic goods – freedom of thought, speech and movement; food and shelter; education and employment – because self-respect is necessary if a person’s existence is to have any meaning at all. Without the possibility of self-respect, a person’s life can have no purpose, and pursuit of life’s other goals is meaningless. A decent society cannot tolerate the existence of humiliating institutions; a society which is not decent cannot claim to be Just.

He went on to argue that ‘coroners are sometimes the only agency which can expose the existence of humiliating institutions in Society, because vested interests often prefer to leave them unnoticed or unexplored.’

It will not shock you to hear that I agree with that proposition, not because it is flattering but because argument that lies behind it is powerful. After outlining a number of examples of important inquests, he went on to say:

¹ Unpublished paper, Adelaide, November 2008.

In all these cases [of sudden, unexpected death], and many others, the community has a legitimate interest in knowing the truth of the matter. However, these things will not be investigated by the police unless a criminal offence is suspected. They will not be investigated in litigation unless someone has the resources and the incentive to bring proceedings. They will not be investigated by a Royal Commission unless the government of the day is fairly confident that it will not be implicated in anything politically unmanageable.

In short, in most cases the only investigation will be by the coroner. The work of coroners is not only important for the better protection of the State: it is a means of seeing whether the bargain between citizen and State is being honoured. It is the mechanism by which citizens can see why the State's promise of protection failed, and whether responsibility for that failure is a failure of the State.

To be fair others, Burnside possibly overstates the singularity of the coroner's importance. Certainly there are large numbers of regulatory and investigative agencies which aim to protect citizens and to maintain the social contract – the Health Care Complaints Commission, Workcover and the Office of Transport Safety Investigation spring to mind – but coroners have an honourable place in a just, decent, democratic society because the work they do is independent and judicial in nature.

In this paper, therefore, I will deal with laws touching on privacy (in the generic sense) in the coroners' jurisdiction but only as a basis for an argument as to why the inconsistency between specific modern privacy legislation and coronial substantive and procedural law is both necessary and desirable.

I will deal, first, with statutory provisions concerning privacy in coronial proceedings. Some enable coroners, in the interests of justice, to obtain and disseminate information that would in other circumstances generally be protected by privacy laws. Others shield personal information even from coroners. Yet others give rise to discretionary decisions for coroners. For example, coroners have powers to make non-publication orders.

Second, I will discuss what happens in an inquest and show why coroners are exempted from privacy laws.

Last, I will consider some privacy issues, in the broad sense, raised by coronial proceedings.

Law, privacy and coroners

Paradoxically, as technology has enhanced our capacity for uninhibited expression of solipsistic, narcissistic and exhibitionist tendencies, and as the opportunities to expose

ourselves globally not only multiply but are grasped with both hands by enthusiasts, we have developed industrial-strength privacy laws.

The need for them may have arisen as habits of discretion, shyness, courtesy, sympathy and so on have been discarded in favour of Full Monty disclosure of anything and everything. Being a society of paparazzi (direct and indirect – they take the photos/videos, we buy the magazines, download the images, watch the reality shows) and gossips, we may need privacy laws to protect ourselves from ourselves.

There are, however, small pockets of our NSW society where a different tension between privacy and disclosure obtains. The coronial jurisdiction is one of them. In the interests of justice and for the public good, coroners breach people's privacy every day.

With certain limited exceptions, NSW public sector agencies and public officials are bound by the provisions of the *Privacy and Personal Information Protection Act 1998* or the *Health Records and Information Privacy Act 2002* or both. Coroners, however, like courts, tribunals and Royal Commissions are exempt from the operation of these provisions when exercising their judicial functions.² The Commonwealth *Privacy Act 1988* provides that the Federal Parliament intends that the Act is not to affect State privacy legislation. This reverses the default position in statutory construction that Commonwealth law overrides State laws to the extent of any inconsistency.³

In relation to coroners, those Acts define “judicial functions” as “such of the functions of the coroner as relate to the conduct of inquests and inquiries”. I am unaware of any judicial interpretation of the latter phrase but, in my view, were a challenge mounted against a coroner on the grounds of a breach of privacy legislation, it is likely that the Supreme Court would construe it broadly. Almost everything a coroner does – except giving papers such as this – usually relates in some way or another to “the conduct of inquests and inquiries” even if it is only to ascertain sufficient information to make a decision to dispense with an inquest or inquiry.⁴

² Section 6 of the PPIP Act and s.13 of the HRIP Act.

³ Section 109 *Constitution*; s.3 *Privacy Act 1988 (Cth)*.

⁴ Note that an “inquest” is an inquiry relating to the death of a human being; an “inquiry”, under the Coroners Act, is an inquiry into a fire or explosion.

It is a standard maxim⁵ of statutory interpretation that a specific provision will override a general provision insofar as there is an inconsistency. Even if a view were taken that a function of a coroner was administrative rather than judicial, it may well be that the specific provisions of the *Coroners Act* would be construed as taking precedence over the general provisions of the privacy legislation. In any event, coroners in NSW have not been challenged on this basis thus far.

Are there any privacy protections in the coronial jurisdiction?

While coroners have broad scope to act lawfully outside the strictures of privacy legislation, some privacy protections nevertheless obtain within the coronial sphere.

Section 33 of the *Coroners Act* provides that coroners are not bound by the rules of evidence and procedure in conducting inquests and inquiries. This is to enable them to receive hearsay, opinions and other types of evidence inadmissible in civil and criminal litigation. In this respect they are like administrative tribunals. The *Evidence Act 1995* does not apply to coroners' proceedings⁶ and thus the protections found in the *Evidence Act*, such as privileges and public interest immunities, are not picked up directly in inquests.

Nevertheless, this does not mean that inquests are open slather. The rules of procedural fairness apply. The High Court has held that even where the rules of evidence do not apply, "every attempt must be made to administer 'substantial justice'".⁷ Accordingly, a coroner must carefully consider the probative value of evidence which would be inadmissible in civil or criminal proceedings, such as hearsay evidence, opinion evidence or propensity evidence,⁸ even though such evidence is clearly admissible in inquests. Relevance, reliability and fairness are therefore the touchstones for admissibility in coronial proceedings.

Whether s. 33 overrides legal professional privilege has never been formally decided. Legal professional privilege is an "important common law right" or "immunity" that will only be taken to have been abolished by express language or clear and unmistakable implication in

⁵ *Generalia specialibus non derogant*: "universal things do not detract from specific things"

⁶ See *Decker v State Coroner of NSW* [1999] NSWSC 369; 46 NSWLR 415.

⁷ *R v War Pensions Entitlement Appeal Tribunal; Ex Parte Bott* (1933) 50 CLR 228 at 256.

⁸ As to the admissibility of propensity evidence, see, for example, *Doomadgee and Anor v Deputy State Coroner Clements* [2006] 2 QdR 352.

statutes.⁹ The language of s. 33 falls far short of the express language which would be required in this regard. It seems unlikely, therefore, that Parliament intended to give coroners power to override legal professional privilege.

Other privileges of similar type, such as “professional confidential privilege”¹⁰, “sexual assault communications privilege”¹¹ and religious confessions¹², are statutory creations established not by common law but by the *Evidence Act*. The *Evidence Act* also enables potential witnesses to object to giving evidence against their spouses, de facto partners, children or parents.¹³ As the Act does not apply to coronial proceedings, these privileges have no application in coronial proceedings. Nonetheless, a coroner should be astute to only require such confidences to be broken if strictly necessary in the interests of justice.¹⁴

Public interest immunity, like legal professional privilege, is unlikely to have been abolished in coronial proceedings. Public interest immunity refers to the rule that a court will not compel or permit the disclosure of information that would be injurious to the public interest.¹⁵ When public interest immunity is claimed, the question to be decided is whether the public interest in admitting the material outweighs the public interest in preserving confidentiality. Public interest immunity claims have been upheld in respect of cabinet minutes, material that would disclose the identity of an informer to a government agency, material that would disclose confidential policing methodology and documents the disclosure of which would prejudice national security.

Like legal professional privilege, public interest immunity will only be abolished by express statutory language. Again, on this test, the language of s. 33 falls far short.

In the medical sphere, the Root Cause Analysis¹⁶ methodology and the legislation supporting it in NSW health services provides an interesting study in the tensions between the

⁹ *Daniels Corp International Pty Ltd v Australian Competition and Consumer Commission* (2002) 192 ALR 561 at 565 per Gleeson CJ, Gaudron, Gummow and Hayne JJ.

¹⁰ See ss. 126A-126F *Evidence Act 1995*.

¹¹ See ss. 126G-126I *Evidence Act 1995*.

¹² See s.127 *Evidence Act 1995*.

¹³ Section 18 *Evidence Act 1995*.

¹⁴ *Jervis on Coroners*, (12th ed, Sweet & Maxwell, London, 2006 at [12-132]).

¹⁵ *Sankey v Whitlam* (1978) 142 CLR 1 at 38 and 48.

¹⁶ Root Cause Analysis is an investigation into critical that take place in the health system. It is based on the theory that deaths and other serious incidents in hospitals are often avoidable and are consequences of a systems failure. It seeks to identify any such systems failures and rectify them. A similar system has long been operated in US teaching hospitals. Known as the ‘Morbidity and Mortality Conference’ or ‘M&M’ to practitioners it is designed to teach doctors to learn from their mistakes without legal penalty or public humiliation. See

inquisitorial method and privacy considerations. Division 6C of the *Health Administration Act 1982* provides a statutory basis for the conduct of RCA in the NSW public health system. Among all the features of the RCA system practised in NSW public health bodies, mainly hospitals, the confidentiality of the process is perhaps the most prominent.

Section 20N prohibits the disclosure of the names of the health professionals and patient(s) the subject of the investigation or any information that may identify them. Section 20P prohibits disclosure of the records of the RCA team or information acquired during the investigation except for limited purposes to do with the RCA itself and other strictly regulated purposes. Section 20Q is of particular interest to coroners and other lawyers: RCA team members are not competent or compellable as witnesses. This means that the law deems them to be incapable of giving evidence about the RCA investigation or to produce documents generated in the course of the investigation and prevents courts, including the Coroners Court, from compelling them to appear and give evidence. The only exception to this rule is where some sort of proceedings are taken concerning acts or omissions by the RCA team itself. In short, their investigations are confidential unless they themselves are investigated. Section 20R provides that the findings of RCA teams are not admissible in courts to prove that a practice or procedure was careless or inadequate.¹⁷

Again, the language of s.33 evidences no intention by Parliament to abrogate these very specific confidentiality provisions. Coroners accept that they cannot go behind RCA reports to dig out the records of the investigation and to identify particular people who may have been involved in some way in a person's death. (It is conceivable that RCA investigation documents would fall within the same category were they not already specifically protected by the *Health Administration Act 1982*.)

The rationale for the confidentiality of RCA investigations is well-known. Angus Corbett, a legal academic, describes it this way:

The shift from the notion of individual failure producing medical error to the notion that error may be the result of system design failure is fundamental to current strategies for reducing the level of medical errors. This focus on the capacity of the system to produce error builds

Gawande, A. *Complications: A Surgeon's Notes on an Imperfect Science* Metropolitan Books, NY (2002) p.57ff.

¹⁷ RCA reports are frequently admitted in inquests but not, of course, for this purpose. In some cases, the RCA report will exonerate the medical staff. In other cases, it might provide a basis for a recommendation for systemic reform.

on the idea that the level of medical errors cannot be reduced by simply increasing levels of training or by calling on health care providers to work harder and more carefully.¹⁸

The privilege against self-incrimination is another instance of personal information being protected within the coronial sphere. Since the abolition of torture as a legal device for the obtaining of evidence, the common law has protected suspected offenders from being forced to incriminate themselves. That protection has been extended by statute and practice to those in potential jeopardy of civil liability or even disciplinary proceedings.¹⁹ While not strictly “privacy” legislation, s.33 of the *Coroners Act* allows for witnesses in coronial proceedings to object to giving answers when they may tend to incriminate the witness. This is not the place for an extensive analysis of the privilege against self-incrimination but it is noteworthy as a form of protection of personal information which coroners cannot override except by granting the witness a certificate under s.33AA which is intended to prevent that evidence being used against them.

At present, however, s.33AA certificates do not shield witnesses from their evidence being used against them in disciplinary proceedings and therefore are of limited value either to the witness or the coroner. Where a witness may face disciplinary proceedings, most coroners, knowing that a certificate is not worth the paper it is written on, are reluctant to force the witness to answer potentially self-incriminating questions. A significant gap may be left in the evidence for this reason.

A bill we expect to go to Parliament in the Autumn session will address this issue to some degree. Nevertheless, s.33AA certificates will only provide protection in NSW tribunals and courts.

In what ways do coroners lawfully invade people’s privacy?

There are few more powerful intrusions on person’s privacy than to be called as a witness in a court case where his or her reputation is in potential jeopardy. An inquest is, fortunately, for most people a rare experience. Even for those with nothing to hide, it is daunting to be compelled to answer the questions, sometimes impertinent, of strangers, especially those who have a vested interest in presenting another story. It is a form of running the gauntlet.

¹⁸ “Regulating Compensation for Injuries Associated with Medical Error” (2006) 28 Sydney L.R 259-296 at 271.

¹⁹ See s.128 *Evidence Act 1995*.

Reluctant witnesses can be subpoenaed and compelled to give evidence.²⁰ I have read somewhere that a survey of Americans found that a majority of the sample said that they would rather die than speak in public. If this is true, it is probably a universal phenomenon and the analogy with giving evidence as a subpoenaed witness is readily apparent. Witnesses who fail to appear to give evidence can be arrested under warrant and brought before the court.²¹

Coroners can obtain documents containing personal information. By serving a notice in writing, coroners can demand the production of documents or things to enable them to decide whether to dispense with the holding of an inquest. This power is usually exercised to get hold of medical and nursing home records but has wider application.²²

Coroners, of course, order post mortem examinations to be conducted on bodies.²³

Whether dead persons have rights, let alone rights of privacy, is an unsettling philosophical argument.²⁴ The NSW *Privacy and Personal Information Protection Act 1998* says that they have.²⁵ If so, coroners often override those rights. Opening someone up and examining their organs is, to say the least, an intrusion.

The rider in the *Coroners Act* is that the dead must be treated with dignity when an autopsy is conducted.²⁶ This reflects a general understanding and philosophy in the community that the living have obligations to the dead.²⁷ We respect their wills. We honour them in death by ceremonies and tombs and graveyards. The coronial system as it operates in Australia seems to me to demonstrate a fundamental belief that the death of anyone, whether he or she stands high in the communal pecking order or not, is of significance to everyone. We do not just sweep up the bodies of the poor and throw them without further ado into a pit.

²⁰ Section 35 *Coroners Act 1980*.

²¹ Section 39 *Coroners Act 1980*.

²² Section 14F *Coroners Act 1980*.

²³ Section 48 *Coroners Act 1980*.

²⁴ This question is much discussed and even litigated in archaeological and anthropological circles. See, for example, the 'Kennewick Man case': *Bonnichsen v US* (2003) 367 F.3d 864 in which American anthropologists obtained a court order enabling them to scientifically examine an ancient skeleton over the protests of Native Americans who argued that the skeleton ought be buried immediately pursuant to the provisions of the *Native American Graves Protection and Repatriation Act*.

²⁵ See s.4 of the PPIP Act which defines personal information as including information about a person who has not been dead for 30 years. The information includes body samples.

²⁶ Section 53AA *Coroners Act 1980*.

²⁷ For further discussion, see, for example, Wisnewski, J "What We Owe the Dead" (2009) 26 *J of Applied Philosophy* 54-70.

(I digress to say that good intentions can fail. It may seem surprising that it is necessary to make a law that the bodies of the dead must be respected. It came about because in 2001 an inquiry into the conduct of the morgue at Glebe produced evidence that some pathologists were using some bodies for unauthorised and unethical experiments and research.²⁸ My impression is that the forensic pathologists with whom I work today are ethically very sensitive.)

The power to order an autopsy is subject to a next of kin's right to object. For some people, an autopsy is culturally abhorrent and we need to deal with such sensitivities sensitively. If the circumstances of a death are not suspicious and a cause of death is reasonably apparent – for example, if someone has hung him- or herself or jumped off a bridge, coroners will usually uphold the objection.

Coroners also have a power to exhume bodies for post mortem examination or special tests.²⁹

A death may affect a wide range of persons and bodies. If an inquest is called there may be a need, as a matter of fairness, to provide them with material and information gathered by investigators, pathologists and other experts on behalf of the coroner. The *Coroners Act* provides that those with a “sufficient interest” may have access to, for example, a post mortem report or parts of the coronial file.³⁰ The coroner's file, of course, contains a large amount of personal information relating to the deceased person but may also contain information relating to others, such as family members, “persons of interest”, witnesses and so on. It will sometimes include copies of medical records obtained by the coroner from doctors, hospitals and nursing homes but will certainly include the post mortem report and a toxicology report. They, of course, were not owned by the deceased person but by the service provider.

As a matter of natural justice or procedural fairness, persons whose interests (a term interpreted widely to include reputations) may be affected by an inquest are generally entitled to such information as affects or may affect their interests.³¹ If an inquest is conducted, those

²⁸ *Inquiry Into Matters Arising from the Post-Mortem and Anatomical Examination Practices of the NSW Institute of Forensic Medicine* (“The Walker Report”).

²⁹ Section 53 *Coroners Act 1980*.

³⁰ Section 51, 34(4), (6) *Coroners Act 1980* respectively.

³¹ See, for example, *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596; *Musumeci v Attorney-General of NSW* [2003] NSWCA 77; 57 NSWLR 193; 140 A Crim R 376.

with a sufficient interest will generally be given access to subpoenaed material such as medical records.

What do coroners really do?

Death raises troubling questions and issues. Civilised societies know that what harms one of its members may harm many and therefore coroners, from ancient times, have sought to throw light into dark places, to allay suspicions and fears and to help the living commemorate the dead with some peace of mind. In our society, coroners are given the special role of examining unnatural, unexpected, sudden and suspicious deaths. They are not unique in this activity, especially as science has advanced, but they have a rare capacity to marshal resources from different disciplines, to test hypotheses and evidence and to embrace robustly independent analyses of disquieting facts, without fear or favour, affection or ill-will in public.

The evidence available to a coroner is necessarily incomplete because the primary witness to the circumstances of his or her death is the deceased person. The search for truth, therefore, may not answer all the questions raised by an unexpected or unnatural death. Nor are coroners or witnesses infallible. Despite the best efforts of the coroner and those who assist him or her in the inquiry, there can be no guarantee that the whole truth will be discovered.

Coroners also seek to learn from experience to help prevent similar sorts of deaths recurring. Although it would be completely presumptuous of a coroner to believe that he or she can 'bring closure' to grieving families, a coroner's promise to seek ways of preventing further similar deaths can sometimes provide comfort to the surviving family members. But, of course, there can be no guarantees of this.

A properly run inquest is neither a witch-hunt nor a whitewash. It is not designed to reach certain conclusions, to punish individuals, to assign blame. Those of a certain age, or have an interest in old TV shows, will remember Det Joe Friday of *Dragnet*: "All we want are the facts, ma'am". This could be the motto of a good coroner.

A properly conducted inquest ought also recognise the living human being whose death is the subject of the inquiry. In death it is the living person who is commemorated and in whose

death we seek to find meaning for ourselves and others. Coroners are often said to “speak for the dead”. Bereaved families members often say something like, “If she could speak now, I think my mother would say that she would not want this to happen to anyone else...”

It is also important to emphasise that inquests can have cathartic effects. As well as being blind to the future, we are afflicted by perfect hindsight. Those close to a deceased person, whether they are family members or friends or treating doctors or police or ambulance officers or others, are sometimes filled with regrets and remorse, even with a powerful sense of guilt or shame. I am not about to suggest that these feelings are inappropriate. Indeed, shame can be a civilising emotion. But it can also distort and cripple those who suffer from it. If people are being punished, whether by themselves or others, the punishment must be proportional and must not crush people. I have often observed in inquests that it is a release and a relief for doctors, nurses, police officers and bereaved family members to listen to one another speak about their own experiences and offer one another acceptance and understanding.

Coroners are given very broad powers of inquiry. They can direct police officers to investigate deaths, and, as we have seen above, they can order forensic pathologists to undertake the very invasive procedure of an autopsy, they can obtain medical and other records, they can subpoena witnesses who are compelled to give evidence unless that evidence may be self-incriminating. They have the resources of the State behind them. These are not unlimited but they greatly exceed those available to the average citizen.

The baby boomers among us will remember Monty Python’s Spanish Inquisitors, Cardinals Ximinez, Biggles and Fang:

Ximinez: NOBODY expects the Spanish Inquisition! Our chief weapon is surprise...surprise and fear...fear and surprise.... Our two weapons are fear and surprise...and ruthless efficiency.... Our three weapons are fear, surprise, and ruthless efficiency...and an almost fanatical devotion to the Pope.... Our four...no... Amongst our weapons.... Amongst our weaponry...are such elements as fear, surprise.... and nice red uniforms - Oh damn!

In certain quarters, perhaps including the medical profession, the Coroners Court is regarded as a Star Chamber or a Spanish Inquisition. Although our methods are inquisitorial – that is to say that we seek the truth through broad inquiry without the strictures of rules of evidence rather than the traditional adversarial method of most common law courts – they are not designed to provoke fear or surprise. Indeed, we are bound by rules of natural justice or procedural fairness not to ambush people unfairly. A universal scarcity of government funds,

as well as our fundamentally compassionate natures, prevents NSW coroners from developing the ruthless efficiency of a Torquemada.³²

Inquests are not negligence cases or disciplinary hearings. There are no parties as such. A coroner does not adjudicate rights or liabilities, does not award damages, does not impose penalties. It is true, however, that some people come to inquests with their own agendas. Bereaved families will sometimes seek to use the process to develop a case against a doctor or a hospital. The Legal Aid Commission is explicit in declaring that it will represent next of kin in certain cases if an inquest might lead to litigation on behalf of that person or family. We regularly see barristers briefed by medical defence bodies and the Nurses Association to defend doctors and nurses who may be subject to adverse comment by a coroner. Although damages cannot be awarded, or anyone held to be legally liable to compensate another person, reputations are obviously at stake in an inquest. Swords, therefore, are sometimes crossed at inquests.

Coroners are prohibited from declaring that an identified person has committed a crime related to the death of the person the subject of an inquest. The *Coroners Act* does not specifically prohibit comment in terms of civil liability but, given the absence of rules of evidence, and the differing purposes of civil and coronial proceedings, it would be inappropriate for a coroner to make a finding of civil liability or to speculate about possible civil liability. The practice in the NSW Coroners Court is that coroners do not make findings using terms such as “negligence” which carry with them implications beyond the scope and purpose of coronial proceedings or express legal conclusions regarding liability.

All of that said, it cannot be denied that an inquest is an earthy experience for those obliged to undergo it, bereaved families and others. They are often very emotionally charged affairs. As objective and impartial as coroners try to be, and as formal and regulated as inquests are, pain and sometimes fear course through them. The public nature of inquests often heightens the flight-fight responses of participants, most of whom, fortunately, have never experienced anything like them before in their lives.

Coroners recognise that participants in inquests are under great stress and make allowances for this. Experience has taught, however, that the formal, legalistic structure of the

³² Tomas de Torquemada, a Spanish Dominican monk and first Inquisitor-General of Spain. He became known as “The Grand Inquisitor”. He was famously described as “the hammer of heretics, the light of Spain, the saviour of his country, the honour of his order” and infamous for his auto-de-fés or burnings of “heretics”.

proceedings is an aid to maintaining civility and rationality but we are also fortunate in having highly experienced, well-trained court counsellors to assist families and others who are distressed, and we coroners rely on them heavily for the services they provide to participants in inquests and for the advice they provide us in handling delicate situations.

The ultimate aim of many inquests is to find ways of preventing a recurrence of whatever it was that led to the particular death. I am struck again and again that bereaved families want to prevent others from experiencing their experiences or, more precisely, that they want to prevent other loved ones dying in the same ways as theirs. They do not want the deaths of their sons, daughters, mothers, fathers, siblings to have no meaning or social yield. They pay the enormous price of losing someone they love, the cost to them compounded by having to undergo an inquest which comes on months or even years after the event, and they want something beneficial for others to come out of that experience. The importance of this to bereaved families cannot be overstated. Unless they are unusually stoical or have a Zen-like approach to life, it is in offering their experience for the benefit of others that so many people find some sort of hope and peace in their grief.

The reaction of some bereaved people is to search for someone or something to blame. Others are simply looking for answers. It is natural for those who feel the brunt of the emotions generated by a sudden or unexpected death to feel defensive. But experience suggests that it is counter-productive. The literature on the subject³³, as well my own experience in medical inquests, tells me that communication between doctors and patients (and their families), patient care and patient's confidence in their treating medical practitioners is likely to improve where the health professionals are honest with their patients.

The story of Mrs M is one such case. Mrs M was a 72 year-old woman who suffered from Type II Diabetes Mellitus, end-stage renal failure, significant oedema and chronic ischaemic heart disease. As a result of these conditions, especially the renal failure and diabetes, she required dialysis three times weekly at the Hospital.

³³ See, for example, N. Berlinger *After Harm: Medical Error and the Ethics of Forgiveness* Johns Hopkins U. Press, Baltimore (2005); A. Corbett "Regulating Compensation for Injuries Associated with Medical Error" (2006) 28 Sydney Law Review 259-296; A. Gawande *Complications: A Surgeon's Notes on an Imperfect Science* Metropolitan Books, NY (2002) p.57; Studdert, D et al "Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy" (2006) 26 *Health Affairs* 215-226.

While in the hospital recovering from surgery, she died when an infected fistula that had been constructed in her arm to enable her to receive dialysis through it ruptured, causing her to haemorrhage massively.

The treating vascular surgeon, Dr F, explained the acuteness of the quandary the medical team treating Mrs M faced. Mrs M had to have dialysis to remain alive. A “vas cath”³⁴ in her neck was not a viable long-term solution because of the dangers of infection it was likely to cause. Mrs M was suffering significant discomfort from it, disliked it and wanted to be rid of it if possible. To give her a long-term future with dialysis she required an arteriovenous fistula (or ‘AVF’), yet two previous attempts to create one had failed. There are a limited number of points in the human body suitable for the creation of an arteriovenous fistula and this was, in practical terms, probably her last chance to create a viable AVF.

When the AVF site became infected, the doctors had only two real options available: to try to save the fistula by treating Mrs M with antibiotics or to ligate it to prevent the infection breaking down the tissue of the fistula causing a severe and possibly uncontrollable haemorrhage.

If the AVF were taken down by being ligated, this effectively would condemn Mrs M to the long-term use of the vas cath for her dialysis with all the risks of infection that this entailed. This in turn would have significantly reduced her life expectancy.

On the other hand, the antibiotic treatment was, in effect, a race against time. Infection breaks down tissue. Once the fistula was infected, the risk of the tissue in the anastomosis (the junction between the two blood vessels that had been grafted to form the fistula) rupturing and an uncontrollable haemorrhage occurring was very real. Dr F was acutely aware of the risk but was determined to try to save the fistula if possible to give Mrs M a chance of removing the vas cath. Without the AVF her future was bleak.

An independent expert, Professor B, took the view the fistula ought to have been ligated because sentinel or warning bleeds had occurred around the AVF site. In cross-examination he maintained his view but conceded the difficulty facing the Hospital team.

Before the inquest, the family had read a rather short statement from Dr F and a much lengthier, rather critical expert report commissioned by the coroner from Professor B. They

³⁴ A specialised central venous catheter used in dialysis.

were full of apprehension and suspicion that their much loved mother had been the victim of a bungle.

Seeing Dr F give his evidence frankly and honestly, explaining the difficulties the surgical team faced and making reasonable concessions, both led to Professor B moderating his criticisms of the Hospital team's decisions and to the family finding relief in hearing the story explained to them fully and in a comprehensible fashion. Mrs M's daughter gave evidence about her experience and her sense of loss. It seemed to me to be a very cathartic and healing experience for them. It cleared the air for the doctors, the nurses and the family. Finally, they received a coroner's independent summation of the evidence and his interpretation of it. This was a good inquest.

Shame, privacy and coroners

Disgrace and fear are natural concomitants of some deaths. The American surgeon, Atul Gawande, describes "a sense of shame like a burning ulcer" that followed his botched first attempt at an emergency tracheostomy and his patient's cardiac arrest.³⁵ He was saved from even greater humiliation by a senior colleague who revived the patient before she suffered hypoxic brain injury but his experience of humiliation is, one suspects, a common one for surgeons and other doctors. He admitted, "When things go wrong, it's almost impossible for a physician to talk to a patient honestly about mistakes."³⁶

American professor of law, Steven Lubet, challenging the proposition that the medical profession is secretive about mistakes because of fear of litigation, asks, "Was there ever a golden age, before rampant malpractice litigation, when doctors communicated freely with their patients, openly acknowledging errors and confronting mistakes in the spirit of humble co-operation? I don't think so."³⁷

An ex-State Coroner, Mr Kevin Waller, has observed:

In the years when I was City Coroner, 1970-1974, I gained the strong impression from members of the public, and from the legal profession, that inquests into deaths in hospitals were of value in that they tend to keep medical and nursing staff alive to their responsibilities. There is a

³⁵ *Complications: A Surgeon's Notes on an Imperfect Science* Metropolitan Books, NY (2002) p.61.

³⁶ Gawande (2002) p.57.

³⁷ *The Importance of Being Honest: How Lying, Secrecy and Hypocrisy Collide with Truth in Law* New York University Press, NY (2008) p.233.

feeling within the community that circumstances surrounding deaths in hospitals are often hushed up, and that doctors close ranks to shut out the possibility of criticism ... An inquest is the only avenue open to curious or dissatisfied relatives to have a full and open inquiry into the cause of death.³⁸

But the tendency to deny or conceal mistakes is not unique to the medical profession. A sense of shame and a fear of humiliation accompany many a witness in the Coroners Court. In inquests, it is standard operating procedure for police officers, on the advice of their union, to assert their right to silence and object to giving evidence whether or not they are actually in jeopardy of being disciplined by the Commissioner. Indeed, it is common for government agencies and others to argue that a coroner should not make recommendations – the attitude often appears to be that if a coroner does so it is a ‘loss’ or an ‘own goal’ for that party, carrying an implication of fault.

“Persons of interest”³⁹ – usually people who are thought to have information about a suspicious death – have privacy issues to worry about too, sometimes for obvious reasons. As we have discussed above, persons in compromising situations may, to use the colloquialism employed by criminal lawyers, be entitled to “take the Fifth”: exercise a right to object to giving evidence on the grounds of possible self-incrimination. Unless they are mentally ill, “persons of interest” in homicide cases almost invariably object to giving evidence in coronial proceedings. This also carries with it humiliating implications.⁴⁰

Among other reasons, it is to overcome these natural and predictable tendencies to conceal embarrassing information that coroners are given wide powers to collect evidence, call police investigators in aid and to compel witnesses to answer questions.

To quote Waller again:

³⁸ Waller, K. “Anaesthetic Deaths – A Coroner’s Viewpoint” *Australian Journal of Forensic Sciences* 10 (1978) 78 at 85.

³⁹ A phrase not found in the *Coroners Act* but a term of art well understood by the legal profession and the wider community as implying that a person *may* have some critical information relating to a death or fire which, if revealed, may place them in jeopardy of criminal prosecution.

⁴⁰ Indeed, Chester Porter QC astutely observed in an unpublished paper (“Appearing at an inquest: the functions of an advocate” [1993]):

“The temptation is to take advantage of the Fifth Amendment and close the client’s mouth. It is a course which has all the attractions of safety. However it must be appreciated that for certain persons in the community to take such a course will subject them to considerable criticism within their professional calling, e.g. a doctor who refuses to describe how an operation was performed, or a police officer who refuses to answer a suggestion of assault. The decision as to whether to take the Fifth Amendment cannot be published in the media (S.45 (3) (b). without the coroner’s express permission, that permission may well be given. In any event the recourse to the Fifth Amendment quickly becomes known in the witness’s profession or calling.”

Coronial cases are not popular with everyone. The more prominent cases attract much media attention and every person involved is apprehensive that he or she may be criticised at the hearing, with consequential adverse publicity. These fears are real and well-grounded. The more important the person or body in question, the greater is the concern. Steps are sometimes taken to try and stop the coroner holding a particular inquest.⁴¹

Coroners must gather what personal information is relevant to answering the questions “Did this missing person die?” and “Who is this dead person?”, “Where and when did he or she die?”, “What was the cause of death?” and “What was the manner of his or her death?” is available, and they are exempted from the operation of privacy legislation to do so.

Apart from that of deceased persons themselves, coronial proceedings may touch on the personal information of many others. An obvious example is information given by doctors and staff of hospitals in the course of Root Cause Analysis investigations. Coroners are sometimes urged by bereaved families to subpoena the records of the RCA investigators but, as we have seen above, this information is sealed. The patient’s medical records, however, are not and doctors, like other witnesses, are compellable.

Although the stigma that used surround suicide has probably largely dissipated due to far better community understanding of mental illness, especially depression, it remains a sensitive topic for many families. This is another subject which has been dealt with by statute.

Specious claims sometimes made by journalists about the public’s ‘right to know’ are rightly dismissed. In the coronial sphere, however, the public interest in seeking and disclosing personal information, with certain exceptions, trumps personal privacy because coroners are literally dealing with matters of life and death.

Conclusion

I began this paper by referring to Julian Burnside’s argument that independent coroners can bring the State to account. Our newspapers, especially in NSW, are full of horror stories of disasters in hospitals, railways and elsewhere. We know that many avoidable deaths take place in NSW hospitals. We also know that medical error is not confined to a tiny sub-set of dangerous doctors, despite the impressions that some high-profile cases may suggest. As Dr

⁴¹ Waller, K. *Coronial Law and Practice in New South Wales* Butterworths, Sydney (1994) p9.

Gawande has put it, “the fact is that virtually everyone who cares for hospital patients will make serious mistakes, and even commit acts of negligence, every year.”⁴²

Although there are in-built safeguards and protections which provide a margin for error, such as RCA, they cannot and do not eliminate all human error. We are wrong if we place too great a confidence in a concept that sheets home all blame for any mistake to “the system”. While I think that in medical cases coroners need to concentrate predominantly on systems failure, it cannot be to the exclusion of examining the personal skill, care and responsibility of the system’s agents, namely health professionals.

Burnside is right to argue that we cannot tolerate humiliating institutions in a Decent Society. I do not know of a health professional who wants to work in one. But the tendency to conceal fault and deny responsibility when something goes badly wrong is powerful. Institutions are, ultimately, not so much systems and buildings as bonds of trust between people. Coroners can help maintain those bonds and, for those outside the institutions on which we depend, provide fresh confidence in them by occasionally subjecting them to a searching examination.

⁴² Gawande (2002) p.56.