Victorian Institute of Forensic Medicine

Clinical Communiqué

VOLUME 4. ISSUE 4.
December 2017 Edition
ISSN 2204 - 0099

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Next Edition: March 2018

EDITORIAL

Welcome to the December 2017 edition of the Clinical Communiqué. For the final edition of the year, we have chosen to present a selection of cases that demonstrate some of the important non-clinical aspects of coronial investigations and inquest findings.

Each case provides an example of the variations seen in the 'procedural history' of an inquest. That is, the 'what happened' in the course of the coronial investigation. Factors such as the purpose, timing, people involved, and the disposition of an investigation, are all worth consideration by clinicians when reading coroners' findings. These factors are relevant to understanding why some cases go to inquest, and others don't, and why a coroner may choose to investigate a selected topic in a particular manner.

Examples of these include an approach taken by a coroner into a case that is concurrently reviewed by an industry regulator ('Standing Alone'), or the time it takes to finalise an investigation, and the use of experts ('A Protracted Procedure'). Alternatively, as demonstrated in the case, 'Doubling the Risks', cases that go to inquest may be conducted either singly or grouped together, for the predominant purpose of exploring a wider public health issue, even when the clinical management in the events leading to the death are considered reasonable under the circumstances.

To complement our edition on coronial processes, we have the immense privilege of including an expert commentary written by Dr Ian Freckelton, an experienced Queen's Counsel at the Victorian Bar. He has appeared in many of Australia's most significant coronial inquests over the past 25 years, including latterly the inquest into the deaths at the Lindt Café in Sydney. He is currently briefed in the Bourke St Mall inquest and the Brighton Terrorist inquest. Ian is also a Justice of the Supreme Court of Nauru, a Professorial Fellow in Law and Psychiatry at the University of Melbourne, an Adjunct Professor of Forensic Medicine at Monash University, and a member of Victoria's Coronial Council.

Ian's commentary is designed as a response to the clinicians who have authored case summaries for the Clinical Communiqués over the years. These clinicians were asked to imagine that they were sitting with a lawyer experienced in coronial matters, and to pose questions that they would like answered. The result is the highly informative and extremely valuable commentary – *'Helping Clinicians Better Understand the Coronial Process'*.

The commentary refers to Victorian legislation, however, the Coroners Act for each State and Territory is easily accessible on the internet and clinicians should be aware of the relevant provisions in their own jurisdictions. The Coroners Court websites are important resources as well, with specific information about coronial processes, inquest findings, locations and contacts. A list of the websites for each of the Australian jurisdictions can be found on the Clinical Communiqué website via the following link http://www.vifmcommuniques.org/?p=5215.

CASE #1 STANDING ALONE

Case Number:
Non-inquest findings, 2014 QLD

Case Précis Author:
Dr Nicola Cunningham
B.Med, MForensMed,
FFCFM (RCPA), FACEM

CLINICAL SUMMARY

Mr O was an 82-year-old male who fell at home and fractured his ankle. He was admitted to hospital to enable management of the fracture and investigation of potential underlying causes for the fall. Mr O was attached to a cardiac monitor which showed occasional missed beats that were asymptomatic. These were attributed to his medication (bisoprolol, a beta-blocker generally used to treat hypertension), and in response the treating team titrated the dose down. At the time of his admission, Mr O refused to consider surgical repair of his fracture, but changed his mind a short time later. An orthopaedic registrar consented Mr O for an operation involving internal fixation of the fracture, and he also requested a pre-operative anaesthetic review. The anaesthetist, Dr H, saw Mr O the day prior to surgery and made notes on the front of the anaesthetic record. During the operation, Mr O became progressively hypotensive and hypoxic, a cardiac arrest followed and despite return of spontaneous circulation, Mr O died five days later.

PATHOLOGY

The cause of death was hypoxic-ischaemic encephalopathy due to cardiac arrest as a result of a fractured right fibula (surgically treated). At autopsy, the pathologist found evidence of pulmonary embolism and cardiomyopathy, both of which were ascribed as contributory factors in Mr O's death.

INVESTIGATION

Following Mr O's death, the hospital became aware of allegations made against Dr H and referred the case to the Queensland Health Ethical Standards Unit, the Australian Health Practitioner Regulation Authority (AHPRA), and the Health Quality Complaints Commission. The allegations were that:

- *Dr H failed to identify that Mr O's vital signs had deteriorated to the extent emergency intervention was required.*

- *Dr H failed to intubate Mr O in order to ensure adequate ventilation and failed to take advice from clinical staff in this regard.*

- *Dr H directed nursing staff not to push the emergency button that would have summoned medical assistance to deal with the emergency.*

- *As a result of Dr H's actions and/or departure from normal practices, Mr O was placed on life support systems and later died when those systems were removed.*

An expert opinion was obtained from a consultant anaesthetist who considered that Dr H did not fully appreciate and respond to Mr O's deteriorating condition.

Mr O's death was also reported to the coroner. Both the hospital and the Office of the State Coroner knew of previously reported cases where patients had died while under Dr H's care. As the peri-operative details regarding Mr O's death were being investigated by AHPRA, the coroner focussed solely on the pre-operative period, and requested an opinion from the Clinical Forensic Medicine Unit (CFMU) about Dr H's pre-operative assessment of Mr O. The CFMU found that the assessment was incomplete, with many sections of the anaesthetic record left blank.

An expert opinion was obtained from a consultant anaesthetist who considered that Dr H did not fully appreciate and respond to Mr O's deteriorating condition. The expert stated that Dr H, *"should have obtained assistance earlier as it was very difficult for one person to adequately deal with the crisis that was developing"*.

Dr H was suspended, and his employment with the health service was subsequently terminated.

AHPRA compelled Dr H to undergo a performance assessment, and at the conclusion of their investigation, agreed on a schedule of undertakings that prescribed future conditions of work and supervision for Dr H.

CORONER'S FINDINGS

The coroner acknowledged the decision of AHPRA and chose not to hold an inquest as the matter was considered to have been sufficiently addressed.

KEYWORDS

AHPRA, anaesthetist, surgery, orthopaedic, non-inquest, deteriorating patient

ACKNOWLEDGEMENTS

This initiative has been made possible by collaboration with the Department of Forensic Medicine (DFM), Monash University, Victorian Institute of Forensic Medicine (VIFM) and Victorian Managed Insurance Authority (VMIA).

FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to:

cc@vifmcommuniques.org

CASE #2 A PROTRACTED PROCEDURE

Case Number:
CD 279/2003 ACT

Case Précis Author:
Dr Gerard J Fennessy,
FCICM

CLINICAL SUMMARY

SM was an obese 21-year-old male who suffered from autism and severe intellectual disability with episodes of violence behaviour. He used a sign language to communicate and required 24-hour direct supervision. Despite his history, he had a very good rapport with his two main carers, who were effective at recognising behavioural deterioration and managing his violent outbursts.

In 2003, SM began experiencing severe pain in his wisdom teeth. His behaviour also progressively deteriorated with more frequent episodes of violence. His carers, General Practitioner (GP), and his psychiatrist all felt that the dental pain was the major contributor to this deterioration, and it was agreed that wisdom tooth extraction would be beneficial for him. Due to the anticipated difficulty with SM's behaviour, plans were made for the surgery to be performed at a major tertiary hospital.

Following an extensive multidisciplinary meeting involving his carers, support services and hospital specialists, it was agreed that after the surgery, SM would remain intubated for 7 days in an intensive care unit (ICU). This was in order to prevent behavioural issues hindering his medical recovery, particularly until the wounds in his mouth had healed.

The plan also involved an expedited return to his facility with a strategy that when SM was to be extubated in ICU, he would be monitored and recover in the ambulance bay near to the disability van – in order to give him a sense of familiarity. Then if he was assessed as medically stable, he would return to his residential address under the care of his normal carers.

One of the predominant reasons for the large number of submissions was the disparity in views as to the likely cause of death.

It was acknowledged by all parties that this was an unusual practice, but under the circumstances was considered a reasonable plan for SM, as his behaviour was both a danger to himself and to staff.

There were no notes recorded of this meeting.

The operation proceeded uneventfully, and SM was transferred to the ICU. Although the initial plan was to keep him intubated for seven days, the extraction was not as complicated as predicted, with less swelling and bleeding, and so it was felt that he could be extubated on day three.

The development of pneumonic changes visible on CXR was thought to be associated with the ventilator. The medical opinion was that this supported the plan for earlier extubation. There was concern expressed by SM's caregivers about discharge in light of these findings, but it is not clear how this was resolved.

SM was extubated at 1pm on day three, and though he refused an oxygen mask, he was not hypoxic. He was transferred down to the ambulance bay, where the disability van was parked. There, he was monitored for several hours by experienced medical staff. At 6pm he was able to ambulate independently into the van, and was discharged from hospital. Of note, although the carers had current first aid qualifications, neither had formal medical training.

Once home, SM was unsteady, but managed to walk to his room unassisted. Over the next few hours his carers regularly assessed him. At 7:30pm he came out of his room, requested a glass of water, and returned to the room. He was noted to be alert and mobile. Shortly afterwards, the carers noticed that his breathing had become shallow and then absent. CPR was commenced and paramedics called to attend. SM was unable to be revived and he died at 8:46pm on the day of discharge.

PATHOLOGY

Following a post-mortem examination, the forensic pathologist was of the opinion that SM died as a result of a combination of septicaemia and respiratory failure caused by acute bilateral pneumonia of three to four days duration.

INVESTIGATION

Unusually, the inquest and coronial findings took almost nine years to finalise. The coronial process began in 2003, however, after an initial brief of evidence was presented in 2005, a number of further expert opinions were requested by the coroner. Subsequently, there were submissions from a large number of interested parties, including the hospital, disability services, physicians directly involved in SM's care, and independent expert witnesses.

These took some time to prepare and were presented over several days in 2006 and 2007. The submissions included 800 pages of transcripts of complex medical evidence and opinions.

Furthermore, immediately after the final submissions in 2009, but prior to making a finding in this case, the chief coroner who was presiding in the case unexpectedly resigned.

One of the predominant reasons for the large number of submissions was the disparity in views as to the likely cause of death. There were multiple medical opinions from practitioners in intensive care, anaesthesia and pathology, who were either expert witnesses or directly involved in SM's care. Importantly, there was no prevailing consensus as to the cause of death, with 11 doctors presenting opinions ranging from pneumonia, acute negative-pressure pulmonary oedema, seizures, upper airway obstruction (due to bleeding, vomiting, laryngospasm or mucous plugging), and an intrinsic cardiac conduction abnormality resulting in arrhythmia.

The error rate in clinical practice in the attribution of cause of death relative to post-mortem findings was acknowledged to be in the order of 20-30%.

The pathological diagnosis of pneumonia was based on both macro- and microscopic examination of the lungs which revealed intra-alveoli neutrophils, as well as focal areas of necrosis, indicating pneumonia of several days duration. There were also significant amounts of bacteria in the blood, indicating septicaemia. Two other forensic pathology expert witnesses agreed with this diagnosis. However, clinicians directly involved in SM's care, other expert witnesses, and the hospital representatives, contended that the diagnosis of pneumonia was not supported by the clinical findings in the peri-discharge period. Extensive discussion followed regarding disagreement between clinical diagnoses and autopsy findings. The error rate in clinical practice in the attribution of cause of death relative to post-mortem findings was acknowledged to be in the order of 20-30%. Indeed, it was not in dispute that the degree of pneumonia found at autopsy was inconsistent with SM's clinical observations at the time of discharge.

The case was allocated to another coroner in 2012 who reviewed the extensive set of materials collated during the initial investigation. A large amount of the coroner's time and effort went towards considering the competing theories presented by the medical witnesses about cause of death.

CASE #2 A PROTRACTED PROCEDURE (Continued)

Ultimately, the coroner decided that on balance, each of the alternate diagnoses was less likely than the original diagnosis of pneumonia made by the forensic pathologist who performed the autopsy.

CORONER'S FINDINGS

The coroner made a number of recommendations that focussed on improving public health and the medical treatment of vulnerable and high-risk patients under the care of government agencies. These included:

– Careful multi-disciplinary planning for such cases, involving both medical and non-medical interested parties, and that this planning should be clearly documented. The discussion should ensure that (non-medical) carers are satisfied with the plan. Any changes to this plan should only be made after consultation with these parties.

– High level nursing care should be made available to these patients after discharge, at their normal place of residence, until the carers and medical staff agree that the patient can be successfully managed in their usual environment.

– Specific medical services and facilities should be developed to deal with these difficult and challenging cases, where the current health service does not have the resources or ability to manage vulnerable patients needing medical care.

This case highlights that even with careful planning, things can go wrong.

There were no adverse findings made regarding the hospital or medical staff. It was found that the treatment plan was appropriate, and that the risks involved were far outweighed by the potential benefit to SM's health. His death was acknowledged as tragic and unanticipated.

AUTHOR'S COMMENTS

This case highlights that even with careful planning, things can go wrong. There was a concerted effort by both the medical and disability services to acknowledge the needs of a high-risk and vulnerable patient, and provide him with an optimal standard of medical care despite the challenges that this might entail.

Medical decisions appeared to be focused on achieving the best outcome for the patient, and were generally made in consultation with his caregivers. Staff then revisited and revised the plan to try to mitigate the developing risks to the patient.

Unfortunately, despite these efforts, Mr SM succumbed to an unanticipated medical complication following surgery.

Finally, this case emphasises the coroner's important role in public health, whereby a gap was identified in the ability of our current health services to provide much-needed care to our most vulnerable patients.

Although the coronial inquest took an extended period of time to be finalised, it was clear that the coroner wanted to thoroughly investigate the uncertainty over the diagnosis, in order to reach an accurate conclusion. For the people involved, not least the family and carers, this delay would potentially cause further suffering and distress.

Finally, this case emphasises the coroner's important role in public health, whereby a gap was identified in the ability of our current health services to provide much-needed care to our most vulnerable patients.

KEYWORDS

Disability, autism, public health, pneumonia, expert witnesses

CASE #3 DOUBLING THE RISKS

Case Number:
D0020/2012 NT and D0033/2012 NT

Case Précis Author:
Rohit D'Costa
MBBS, FRACP, FCICM

CLINICAL SUMMARY

DD: DD was a 24-year-old man from South Arnhem Land. He had lived in the community most of his life and had visited the local clinic a number of times for minor complaints. His co-morbidities included obesity and smoking. On the 19th February 2012, DD complained of dizziness and non-specific pain at the half-time break of the community football game he was playing. He was unusually diaphoretic and tachypnoeic, and was taken to the local clinic where the nurse on duty was called. The nurse made a provisional diagnosis of dehydration, and fluid therapy was initiated orally then intravenously. No blood pressure reading was able to be obtained, and no pulse rate was recorded. There was little to objectively suggest that DD was responding to fluid over the following two and a half hours, yet no alternative diagnosis was entertained. In particular, ECGs and troponin tests were not performed, and telephone advice was not sought from the doctor. The patient suffered a cardiac arrest, and after 13 minutes of CPR (performed alone), help was sought from nursing and medical colleagues. DD could not be revived.

FG: FG was a 27-year-old man from East Arnhem Land. He had no relevant past medical history (except that he was a smoker) and had limited contact with the local clinic. On the 29th of January 2012, FG played a game of football at the local oval and felt persistently short of breath on its completion. The nurse from the local clinic visited him at home and escorted him to the clinic. After a period of time FG reported feeling better, and there being no abnormalities on multiple observations taken, he was allowed to return home. Unfortunately, 45 minutes later he suffered a cardiac arrest. He was taken back to the clinic, and advanced life support was attempted unsuccessfully. In this resuscitation attempt, the nurse sought help both from nursing colleagues as well as telephone advice from the on-call doctor in a nearby town.

PATHOLOGY

DD: The autopsy revealed acute coronary thrombosis in the left anterior descending artery causing myocardial ischaemia. This had led to ventricular fibrillation and eventual death.

FG: The autopsy revealed a blockage of the left anterior descending artery with evidence of longstanding atherosclerosis.

INVESTIGATION

The two deaths were investigated in 2014 in related inquests. The broader recommendations (outlined below) were detailed in the report concerning DD's death. The coroner relied on evidence not just from nursing and medical personnel involved in the clinical management in each case, but also on expert advice from the acting Chief Rural Medical Practitioner for the Northern Territory (NT), the Director of Cardiology at Royal Darwin Hospital, and an independent interstate cardiologist. The NT experts provided significant local context and experience about the scale of the problem of cardiac disease in young indigenous people in the Territory.

DD: The investigation focussed on the care provided to DD at the clinic, not just on the day of his death, but on 25 separate occasions in the five years prior to his death. This painted a picture not just of perceived errors of judgement on that evening, but also of multiple missed opportunities to consider his cardiovascular risk factors and provide advice and support regarding lifestyle modifications such as smoking cessation. The coroner was critical of the care given by the clinic nurse in the hours prior to his death – in particular the failure to seek an alternative diagnosis and call for help.

Whilst the cause of death was similar in both cases, the coroner found that DD may have survived if the care had been of a higher standard.

FG: The investigation focussed on whether there was a rationale to investigate for an acute cardiac event at the time of his initial presentation. Given the lack of specific symptoms or signs and the normal observations, the coroner found that the care provided was appropriate.

CORONER'S FINDINGS

Whilst the cause of death was similar in both cases, the coroner found that DD may have survived if the care had been of a higher standard. In contrast, the nursing staff looking after FG were found to have acted "competently and professionally".

The wider public health issues in young Indigenous adults of risk factor management (in particular smoking), coronary disease screening, and community awareness were discussed, with a recommendation that the NT Department of Health embark upon a coordinated strategy to address the concerns raised.

The coroner made a number of recommendations ranging from procedural edits to the Central Australian Rural Practitioners Association (CARPA) manual, to educational initiatives for staff, and provision of diagnostic equipment to remote clinics.

The wider public health issues in young Indigenous adults of risk factor management (in particular smoking), coronary disease screening, and community awareness were discussed, with a recommendation that the NT Department of Health embark upon a coordinated strategy to address the concerns raised.

AUTHOR'S COMMENTS

The cases are striking in their contextual and clinical similarity as well as in their tragedy, even though the care provided in the lead up to death was contrasting. An important feature of the inquests related to the Court's broader role in considering matters of "public health or safety or the administration of justice" (*Coroners Act 1993* (NT)). These non-inquisitorial functions are similarly set out in all state and territory coronial laws.

There was considerable media interest at the time of the inquests. While much of the focus was understandably on the performance of the nurse looking after DD, and the potential that his death may have been preventable, the imperative to more closely examine the screening for, prevention and management of coronary artery disease in young Indigenous Australians was clearly highlighted.

KEYWORDS

Indigenous health, smoking, coronary artery disease, risk factor prevention, nursing care

EXPERT COMMENTARY

HELPING CLINICIANS BETTER UNDERSTAND THE CORONIAL PROCESS

Q and A session with Dr Ian Freckelton QC

1. I have been called to give evidence at inquest as one of the clinicians peripherally involved in the care of a patient who died on an inpatient ward. I am concerned that I have not been made aware of the issues being examined, and I do not understand why I have been called. Can I request access to material already collected about the case? Can I expect to be briefed by coronial staff prior to giving evidence?

It is common, unfortunately, for medical practitioners to be asked to provide information to a coroner without being assisted to appreciate the full context in which they are supplying such information. The practitioner can request the inquest brief but that is generally only provided to parties to an inquest. The practitioner can expect to be given some information by coronial staff prior to giving evidence and, potentially, also by the coroner's assistant or, in a major inquest, by counsel assisting. However, there is no guarantee that this briefing will fully address the information deficit which may exist from the perspective of the practitioner. Rather, it may simply be introductory and such as to orient the practitioner to the task of giving evidence to the coroner. Nonetheless, taking as many steps as are feasible to understand the context within which the practitioner is to give evidence is a sensible step prior to testifying.

2. A case has gone to inquest, apparently not because there were any suspicious circumstances, but because the person was 'under care'. What does that mean and will I still be called to court as a witness?

The question of whether the practitioner will be called to court will depend upon whether the death is one of a person under care and, if so, whether the death was attributable to natural causes, and if not whether the practitioner has evidence considered useful by the coroner to the issues in the inquest.

A variety of deaths are reportable deaths under the Coroners Act 2008 (Vic). Coroners must investigate such deaths (section 15). A category of reportable death (defined by section 4) is the death of a person "who immediately before death was a person placed in custody or care" who, in turn is defined in section 3 of the Act.

By virtue of section 52(2)(b) of the Act a coroner is obliged to hold an inquest into a death if the deceased was, immediately before their death, a person placed in custody or care. However, by reason of section 52(3A) of the Act a coroner is not required to hold an inquest in such circumstances if they consider that the death was due to "natural causes", on the basis of an assessment by a medical investigator.

It may be that the practitioner's evidence will go to the question of whether or not the death was attributable to "natural causes".

3. I feel emotionally attached to the case - do you have any tips on how to write a factual report without letting my emotions rule my mind?

The role of an expert witness in the Coroners Court is to assist the court by providing reliable information to assist the coroner's fact-finding role. It requires professional detachment and recognition that the practitioner's primary responsibility shifts away from being an advocate for their patient to assisting the court. Thus, it is the legal responsibility of the practitioner to adjust their mindset so that they provide a dispassionate, objective account of the necessary matters so as to assist the coroner to fulfil his or her statutory responsibilities. Just as there are clinical situations in which it is necessary for practitioners to put to one side emotional attachments they may feel toward a patient, so too is that exercise necessary for forensic purposes when providing a report for the coronial process.

4. I am having trouble remembering the exact details of the case, and the coronial staff are pressuring me for a report. I have asked the hospital for a copy of the notes to refresh my memory, but have not received them. Should I just write the report from memory?

A report written for a coroner by a medical practitioner is an important document. It is foreseeably likely to be relied upon by the coroner in relation to matters such as whether to hold an inquest and in relation to decision-making about findings. Just as a doctor would not generally reach a diagnosis or write another form of forensic report without adequate recourse to relevant clinical information, so too should a practitioner generally avoid writing a report for a coroner without being able to sight such material. Preferably no report should be written until such material has become available. However, if the practitioner elects to write a report prior to such material becoming available, he or she should identify in the report that the report is written based upon unassisted memory which is precluding precise recollection of pertinent details, and that no access has been possible to the clinical notes.

5. My supervisor has written a report and asked me to sign it to give to the coroner - I don't agree with everything in the report. Should I sign it? Do I need my own lawyer?

A report for a coroner is a forensic report. The practitioner has ethico-legal duties of candour and accuracy in circumstances where the ramifications of the report may be significant. If the practitioner is not entirely comfortable with the content of the supervisor's report, it is important that they not add their signature to it. By endorsing the report with a signature, the practitioner is assuming personal responsibility for everything that is in the report. If there is any diffidence on the part of the practitioner with the supervisor's report, it would be improper to concur with its contents by signing it. To do so could generate disciplinary consequences.

In a related context, from 1 June 2016, the Supreme Court (Chapter I Expert Witness Code Amendment) Rules 2016 provide pointedly that when a conference of experts takes place, *"Each expert witness shall exercise his or her independent judgment in relation to every conference in which the expert participates pursuant to a direction of the Court and in relation to each report thereafter provided."* The same principle applies to the independent exercise of judgment in respect of reports provided for coroners' investigations.

In such a situation, there is no need for legal advice although there is no harm in procuring it. The principal issue is to avoid giving a false impression – that the practitioner agrees with the facts recounted or opinions expressed in a report with whose draft the practitioner is not wholly comfortable.

6. What is the role that families of the deceased have in cases that proceed to inquest? Are their perspectives obtained via interview or statements during the course of an investigation?

A distinctive characteristic of the *Coroners Act* 2008 (Vic) is that family members are given a number of entitlements. These include rights in respect of provision of information in the course of the coroner's investigation. It is common for family members to give oral evidence at an inquest although sometimes if they have information that is relevant to the factual findings to be made by a coroner they are also asked to make a written statement and to give evidence to explain further what is in the statement. On occasions family members write their own statement, raising issues that concern them in relation to the circumstances leading up to the death of their loved one. This will generally be placed on the inquest brief, which contains the material which will constitute the evidentiary basis for the coroner's findings.

EXPERT COMMENTARY (Continued)

7. I am concerned that if I tell the truth, I will be made to look bad and open myself up to medicolegal liability. What should I do?

If a practitioner is concerned about adverse consequences flowing from what they write in a report they are asked to make for a coroner or in evidence they give, they should seek legal advice. In certain circumstances where they may be incriminating themselves they are entitled to a certificate which protects against collateral usage of their evidence. However, while such a certificate can only be issued by the coroner under section 57 of the Coroners Act, there are certain other self-incrimination protections in relation to the investigative period prior to an inquest (under s42A of the Coroners Act). For the issuing of a certificate the coroner must be satisfied that there is a real risk that without the certificate what the practitioner says may expose them to liability in relation to the commission of a criminal offence. It is best to obtain legal advice about the availability of these options. In general terms however, exposure to civil liability or embarrassment or notoriety is not an adequate basis for declining to assist a coroner during his or her investigation or at an inquest

8. What is the most common shortcoming of clinicians giving evidence and how do we minimise/address it?

A common shortcoming in evidence given by medical practitioners is the making of assumptions without explaining the bases for such assumptions. When this occurs, it removes from any opinions expressed most of their authority because if the bases for opinions are not clearly identified, the coroner is in no position to evaluate the views expressed and to attach weight to the opinions. Thus, practitioners should make every effort to set out clearly what underlies their opinions, whether that be things that they have perceived – heard, done, seen, etc. – and if they have made assumptions what they are and why they have made them. This enables the reasoning process that leads to opinions expressed to be transparent and assists the evaluative process which a coroner is likely to be required to undertake.

9. What elements of an opinion make it compelling - the doctor's experience? Reasoning based on empirical evidence? The ability to explain concepts in a simple effective way? Or something else?

The authority of an opinion is a product of the practitioner's experience and expertise, the information to which they are privy, and the robustness of the reasoning in which they engage. Opinions vary enormously. Sometimes they arise principally from observations made of a patient and how they are interpreted. In such circumstances, much will depend upon the quality of the documentation generated by the doctor, and the care that they have taken to record it, as well as their diagnostic expertise, which in turn will be a product of their experience and the extent of their knowledge of the condition in question.

On other occasions, the evidence may rely upon clinical literature or empirical evidence and its relevance to the case in question. On still other occasions, issues in relation to credibility of the practitioner and whether their opinions are subject to any form of conflict of interest may be important.

The ordinary principles of giving evidence as an expert are as applicable in the context of a coronial inquest as in any other forensic context. Thus, judicious selection of language and clarity of expression are important in communicating the professionalism and objectivity that should be the hallmarks of any expert evidence given by a medical practitioner. There should be adherence to scientific method and the practitioner should not in any way seek to function as an advocate for their patient. They should endeavour to assist the coroner by careful exegesis of facts and objective analysis of data, explaining the reasons for each and every opinion that they express, eschewing speculation or any form of conjecture.

10. How much of the court's remit relates to determining a cause or sequence of events leading to death, and how much relates to determining a modifiable process or event that can prevent deaths?

One of the matters that a coroner must determine, if possible, is the circumstances of a death. This involves an analysis of what occurred in the period preceding the death, evaluating whether particular matters contributed to the death. This is part of the coroner's role in setting the factual record straight, a responsibility that is important to family members and to the general community in terms of understanding what occurred and allaying rumours, suspicion and innuendo that may not have a proper factual basis. A coroner must also make findings about what caused the death, recognising that causation is often multifactorial.

Increasingly, coroners seek to identify matters that may prevent avoidable deaths in other cases. This is part of the prophylactic role of the coroner in which comments or recommendations may be made "to speak for the dead to protect the living".

Sometimes such preventative matters are prominent in inquests; on other occasions they are not so prominent because comments and recommendations can only properly be made on the basis of findings about circumstances and causes of death. The principal role of coroners is to make such findings but an aspect of the modern coronial role which gives it contemporary relevance and utility is the preventative role of the coroner – in some respects the role of the coroner is as a public health official.

This means that coroners are appreciative of having their attention drawn to matters which they might consider in terms of promoting health and safety – issues of systemic deficiency that might be addressed to reduce risks. However, coroners are usually reserved about extrapolating too generally from a particular instance so one of the issues that they endeavour to consider is whether a practice or issues that have emerged were a one-off or illustrative of a more general problem or risk which could be addressed by coronial recommendations. If this is explained clearly and sensibly, practical suggestions can be made by a practitioner, for which coroners tend to be very appreciative. In addition, the practitioner will have made a very constructive contribution to reducing risk and protecting public health.