Speech by

John-Paul Langbroek

MEMBER FOR SURFERS PARADISE

Hansard Wednesday, 17 October 2007

CORONERS AND BIRTHS, DEATHS AND MARRIAGES REGISTRATION AMENDMENT BILL

Second Reading

Mr LANGBROEK (Surfers Paradise—Lib) (11.46 am): I move—

That the bill be now read a second time.

The Coroners and Births, Deaths and Marriages Registration Amendment Bill 2007 seeks to amend the Coroners Act 2003 and the Births, Deaths and Marriages Act 2003 in order to implement a number of recommendations of the Queensland Public Hospitals Commission of Inquiry report by the Hon. Geoffrey Davies. The objective of the bill is to improve the integrity and reporting practices of deaths that occur within the perioperative period following an elective health procedure, pursuant to recommendation No. 7.50 of the Davies report.

The Davies commission of inquiry arose out of complaints relating to Dr Jayant Patel at Bundaberg Base Hospital in 2004 and early 2005. Jayant Patel has been linked to the deaths of up to 17 former patients at Bundaberg Base Hospital and is facing extradition on 16 charges, including multiple charges of manslaughter and grievous bodily harm.

In spite of the unexpected nature of the deaths of Patel's former patients, only two deaths were reported to the Coroner under the Coroners Act 2003. Ten of the deaths linked to Dr Patel occurred within 30 days of an elective procedure carried out by him. It seems likely that none of these deaths were reasonably expected outcomes of the relevant procedure. In light of the time, I seek leave to have the remainder of my speech incorporated in *Hansard*.

Leave granted.

The current Act requires referral in any case where death was not a reasonably expected outcome of a health procedure. It was identified in the Davies Report that doctors may be able to circumvent the requirements of the Coroners Act by falsifying death certificates in order to avoid scrutiny.

Under the current Births, Deaths and Marriages Registration Act 2003, a death certificate can only be issued if the doctor is 'able to form an opinion as to the probable cause of death'. Where a cause of death certificate cannot be issued the death becomes subject to the coronial system.

The Davies Report identified loopholes in the current laws, which can allow senior doctors to instruct junior doctors to certify the cause of death based on false and/or misleading opinion, thus evading the examination of the Coroner. Under the current Act doctors may also falsely certify the cause of death without the imposition of referring it to the Coroner.

The problem with the current reporting system is that it is dependent upon a doctor correctly identifying deaths which should be reported and then notifying a coroner of those deaths. As Davies submitted, this gives rise to the risk of concealment of medical error or neglect or, more seriously, crime or other wrongdoing. As the referring doctor is likely to come under investigation the law as it stands acts as a disincentive for doctors to report unexpected or suspicious deaths.

The Davies standard seeks to reduce the opportunity for the misuse of codes of conduct by introducing an objective standard upon which deaths are referred to the coroner. The bill mandates all deaths which occur within the peri-operative period of an elective health procedure where death was not a reasonably expected outcome be subject to investigation by the coroner.

The bill seeks to establish an objective standard by which deaths are referred to the Coroner for investigation by expanding the definition of 'reportable death' for the purposes of reporting deaths to the coroner under section 7 of the Coroners Act 2003. The

addition of a new subparagraph to the section 8 definition of a reportable death mandates all deaths that happen within 30 days following an elective health procedure be referred to the State Coroner.

An elective health procedure is defined in the bill as a surgical operation that can be delayed for a period of 24 hours without death being a likely outcome of the delay.

'The requirement that all deaths happening within a certain period of time following an elective health procedure are reportable, removes the dependence presently placed upon a single doctor to decide whether a death was reasonably expected.'

The aim of the bill is to improve reporting practices of deaths which occur in hospitals or within 30 days of an elective surgery operation to ensure all reportable deaths are referred to and investigated by the coroner, thus strengthening the integrity of the health system. I commend the bill to the House.