Speech by

John-Paul Langbroek

MEMBER FOR SURFERS PARADISE

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CORONERS AND BIRTHS, DEATHS AND MARRIAGES REGISTRATION AMENDMENT BILL

Mr LANGBROEK (Surfers Paradise—Lib) (9.34 pm), in reply: I thank members of the parliament who have contributed to this debate this evening, especially members on the coalition side and the member for Gladstone. The common theme of their thoughtful input was a genuine desire to improve the state of the health system in Queensland. Of course, this is in stark contrast to the members opposite, including the honourable the Attorney-General, who this evening basically said to Geoff Davies, AO, who conducted the Davies review, 'What we think about your great review is that your recommendations are costly and problematic. The time frame you suggest is arbitrary. Thanks for all the work, but we do not really need what you have done, Mr Davies.' Basically, he was telling us that this will not capture every death that needs coronial review but it will capture those that do not.

I was shocked to hear the Attorney-General come up with such a trite response as, 'We have a review in place because it has come from the Health Quality and Complaints Commission.' I was on the select committee that had a look at the implementation of the Health Quality and Complaints Commission. Let us have a look at what the Health Quality and Complaints Commission came up with as part of its seven standards. The minister says he is happy to throw Geoff Davies out the door and replace him with the HQCC.

We conducted hearings around the state and we spoke to public providers, private providers, private hospitals and nursing homes. Here is what the providers said about consultation in relation to the commission's standards—the seven standards of the HQCC by which the Attorney-General has just said we will review deaths. The report states—

During the review, health service providers across the board raised concerns about the level of consultation prior to the release of the standards by the HQCC on 1 July 2007 ... In some instances, providers also queried the requirement for particular standards and their evidence base.

It seems to suggest that the HQCC and its standards and their evidence base have been questioned by the Private Hospitals Association of Queensland. The general manager of St Stephen's Private Hospital in Hervey Bay said—

A lot of consultation happened after the standards were developed and key groups were not involved significantly in the development of the standards.

Mr Shine: No, you endorsed the standards.

Mr LANGBROEK: The Attorney-General has endorsed these standards this evening. So now we are going to look back at the seven standards which the HQCC, by its own admission, consulted on during an eight-week period. That is not as good as Geoffrey Davies, AO, conducting his royal commission—no, seven weeks is enough—between 5 March and 21 April 2007.

I return to the *Review of the Health Quality and Complaints Commission and the Health Quality and Complaints Commission Act*. It states—

During the consultation period, the commission sought feedback on matters such as the need for the standards—

The HQCC went to other people and said, 'Do you think we need a death standard?'

An opposition member: That might be a good idea.

Mr LANGBROEK: 'That might be a good idea. Maybe we do need a death standard. Shall we use the one of Geoffrey Davies, AO? No, we probably do not need that.' In the words of the Attorney-General, 'That might be costly and problematic with a time frame that is arbitrary.' The report goes on—

During the consultation period, the commission sought feedback on matters such as the need for the standards, the ability of the proposed standards to address gaps in other health service standards, the quality monitoring component of the standards and the proposed reporting measures.

The select committee heard that the commission did not distribute the interpretation guide and the self-assessment mechanisms to the standards prior to convening the education sessions.

So it had some education sessions where it told people, 'We're going to have all these standards, but we don't have an interpretation guide. We don't have a self-assessment mechanism so you can tell how you're going to apply this standard, but that's a standard that we think we're going to apply'—that is, the Health Quality and Complaints Commission will apply—'and it's superior to Geoff Davies AO and his royal commission.' Is the Attorney really serious in telling us that this standard from the HQCC is superior to that recommended by Geoff Davies? I ask members opposite to consider if they are really serious. What else did the HQCC say? The HQCC said—

We will go through ongoing processes to look at reviewing of standards to see if we could have done something better within those standards ...

Even the HQCC was saying that it knew it brought in these standards pretty quickly and it would have to review them to see if it could have done something better, because everyone we spoke to said that the actual interpretation of the standards in terms of deaths that occurred in hospitals would be completely unwieldy.

I cannot remember the statistic, but I think there are something like 30,000 deaths in Queensland every year of people who have been in hospitals, private hospitals and nursing homes. Many of the hospitals said to us, 'Do you know what? We don't know what happens to those people when they leave the hospital.' As I said, people providing services in both the public sector and the private sector said to us, 'We don't know the outcome of every person who has been in this hospital.' In other words, many of them leave hospital and die. They may be extremely old and told to or choose to go home and they die. A hospital does not always find out what happens to these people. The member for Sandgate is in the chamber, and I guarantee that she will remember these same words being spoken.

With regard to all of the seven standards of the Health Quality and Complaints Commission, the standard about which most questions were raised was the death standard. Tonight the Attorney-General has come in here and discounted this bill, which was a lift—and I am happy to admit it—from Geoff Davies, because I think Geoff Davies's recommendation is one that we should be adhering to. The Attorney-General is happy to say that—

Mr Shine: But did that apply to private hospitals?

Mr LANGBROEK: If we are going to apply it to every hospital and every nursing home and they say that they cannot apply the rule as the HQCC has as its draft standard, then it is not going to work, and it is not going to work more effectively than what Geoff Davies said in his report.

Mr Shine: But your bill does not apply to private hospitals—your bill!

Mr LANGBROEK: Even the commissioner of the Health Quality and Complaints Commission said—

We will go through ongoing processes to look at reviewing of standards to see if we could have done something better within those standards, whether the evidence has changed or if something is different that we need to take into account from the point of view of the providers' perspective.

Recommendation 20 of the Health Quality and Complaints Commission Select Committee that I was a part of states—

That the Health Quality and Complaints Commission consults with health service providers regarding existing standards—

and remember, these are the standards that the Attorney-General has endorsed unequivocally tonight as being superior to those of Geoff Davies AO—

for quality improvement and prior to the implementation of any new standards. This would include consultation in relation to issues of implementation, data collection, compliance measurement and reporting mechanisms.

The Attorney-General said that this bill was ill conceived and would cause financial delays and distress to families in traumatic times. With regard to his words that the bill will not capture every death

needing coronial review but will capture those that do not, there are at least 15 deaths in Bundaberg where there are serious question marks as to whether they needed coronial review and they did not receive it because of the inappropriate way that the deaths were reported. Of course, those are matters that are yet to be raised in court, hopefully, following the events of earlier today. I understand the sense of not wanting to cause unnecessary concern for families and distress at difficult times, but for the Attorney-General to come in here and say that the time frame of the bill I have presented is arbitrary—the 30 days, which is something I am sure the commission thought through extensively—and that it is costly and problematic when I have just dissected the one that he thinks is better—the Health Quality and Complaints Commission death review—is just specious to say the least.

The Attorney also made the point that the Health Quality and Complaints Commission death review standard had been in effect for only three months when the opposition presented this bill. That is because the committee went around the state and I heard of the deficiencies in the standard and thought, 'There's got to be a better way to do it.' I looked at the Davies review and there was the recipe. I also find it unbelievable that there is only one person from the government who is prepared to speak on this bill.

I want to go back to the Davies report to acknowledge that the impetus for the bill came from the Davies report. I refer to pages 535 and 536. Recommendation 7.50 states—

I—

that is, Geoffrey Davies AO—

make the following recommendations:

(a) The Coroners Act 2003 be amended by:

(i) adding a new subparagraph to s8(3) after subparagraph (d) to read:

'The death happened within 30 days of an elective health procedure'.

(ii) adding a new definition in Schedule 2, to read:

'"Elective Health Procedure" means a health procedure that can be delayed for a period of 24 hours without death being a likely outcome.'

…

(b) The Births Deaths and Marriages Registration Act 2003 be amended to ensure that:

(i) in the event of a death happening within 30 days of an elective health procedure, the health practitioner in charge of the procedure is obliged to provide to the coroner his opinion on the cause of death;

(ii) all deaths otherwise occurring in public hospitals are certified by the health practitioner responsible for the care of the deceased person;

This bill acted on these recommendations. This bill sought to amend the Coroners Act 2003 and the Births, Deaths and Marriages Registration Act 2003 in order to implement the advice of an independent auditor commissioned by the Beattie-Bligh government to provide advice on how they can improve Queensland's embattled health system. Tonight the same government that vowed to fix our health system has failed Queenslanders again.

The Davies commission of inquiry arose out of complaints relating to Dr Patel at Bundaberg Base Hospital in 2004 and early 2005. Dr Patel has been linked to the deaths of 17 former patients. We know now that he has been arrested and is facing extradition. He is facing multiple charges.

Mr SCHWARTEN: I rise to a point of order. I am wondering whether you could seek some advice, Mr Acting Speaker, on the nature of the statements that the honourable member is now making. I think they are running close to the bone of sub judice.

Mr ACTING SPEAKER: I agree that they are running close to the bone and I am listening closely. I call the member for Surfers Paradise.

Mr LANGBROEK: Following the Bundaberg Hospital inquiry and the Forster report into the Bundaberg Hospital events and the state of Health more generally, the Premier and health minister commissioned another independent review of Queensland's public hospitals. The minister stated that he wanted a warts-and-all report on where Queensland's hospitals were lacking and where improvements needed to be made for patient safety. It is no surprise, then, that we got a weighty tome—a 558-page analysis. Davies made a raft of recommendations that he thought should be implemented to improve the state of our public hospitals.

In the commission's final report, chapter 7 examined the practice of reporting hospital deaths to the coroner. The chapter entitled 'Amendments to the Coroners Act' begins with an ominous statement Patel made after surgery. 'This isn't my fault,' he said. 'This has nothing'—

Mr ACTING SPEAKER: Order! Are you quoting from the report?

Mr LANGBROEK: I am quoting, Mr Acting Speaker, from chapter 7 of the commission's final report.

Mr ACTING SPEAKER: Please continue.

Mr LANGBROEK: The reports states—

This isn't my fault. This has nothing to do with my surgery.

I am hopeful that that question will be tried in a court of law, although we may have to wait a while yet. In his investigation into how so many unexpected deaths could go unnoticed, Davies found that only two deaths out of 17 were reported to the coroner under the relevant act. It is relevant to note here that 10 of these deaths occurred within 30 days of an elective health procedure carried out by Dr Patel. The current act requires referral in any case where death was not a reasonably expected outcome of a health procedure. It seems very likely that none of these deaths linked to Patel was a reasonably expected outcome of the procedure carried out by him. Despite this, Davies concluded that Patel was able to circumvent the requirements of the Coroners Act 2003 by falsifying death certificates to avoid scrutiny or suspicion. In his analysis of the current practice, Davies identified glaring inadequacies in the current laws which allowed Patel to instruct junior doctors to certify the cause of death—

Mr SHINE: I rise to a point of order. These are really matters that are the subject of some of the charges. In the interests of what we all want to see—

Mr ACTING SPEAKER: I do agree. The member is making allegations against Dr Patel. I would ask you to leave that subject alone and get back to the bill.

Mr LANGBROEK: I thank you for your guidance. The opposition believes, and Davies clearly found, that there are glaring inadequacies in the current laws. Under the Births, Deaths and Marriages Registration Act 2003 a death certificate can be issued only if the doctor is able to form an opinion as to the probable cause of death. If the doctor is unable to form an opinion as to the probable cause of death, it is referred to the coronial system. The problem with the current reporting system is that it is dependent upon a doctor correctly identifying deaths that should be reported in referring those cases to the coroner. Clearly, this arrangement is grossly impractical. The current legislation provides a disincentive for doctors to report the unexpected death of a patient because they are likely to come under investigation as a result. Anyone in that situation would think twice about such self-incrimination. However, the danger for patients is that the current reporting system cultivates the concealment of medical error or neglect or, worse, crime or wrongdoing.

Davies sought to introduce a new standard for the reporting of hospital deaths. He wanted to reduce the opportunity for the misuse of individual hospital codes of conduct by introducing an objective standard upon which deaths are referred to the coroner. Davies wanted all deaths that occurred within the peri-operative period, that is within 30 days of an elective health procedure, to be subject to investigation by the coroner. No ifs, no buts, no exceptions. The report states further—

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 Davies recommendation sought to remove the risk of misuse and abuse of the current act by mandating all deaths that occurred within 30 days of an elective health procedure being investigated. That is what this bill sought to achieve. Clause 3 of the bill achieves the recommendations contained in paragraph 7.50(a)(i) by amending section 8 of the Coroners Act 2003. Clause 5 of the bill implements recommendation 7.50(a)(ii) by amending schedule 2 of the act.

I note that the Scrutiny of Legislation Committee in its appraisal of the bill raised the question as to whether the bill did, in fact, implement the Davies recommendations. I responded to the Scrutiny of Legislation Committee report and it would have discovered, but did not note in its final report, that the bill does, in fact, wholly implement the legislative recommendations set down in the final report of the Queensland Public Hospitals Commission of Inquiry.

An opposition member: Faithfully.

Mr LANGBROEK: Faithfully. I take that interjection. Clause 4 seeks to amend the Coroners Act 2003 by inserting a new section 10B regarding notification about cause of death in elective health procedures. In the event of a reportable death, defined by proposed section 8(3)(da), the bill requires the doctor in charge of the relevant health procedure to give a coroner a written notice stating the doctor's opinion as to the cause of the person's death, as per Davies' recommendation. While prima facie the clause appears to be in different terms, the object of clause 4 of the bill is to implement recommendation 7.50(b)(i) of the Davies report, which recommends amendments to the Births, Deaths and Marriages Registration Act 2003. However, upon legal advice in addition to Parliamentary Counsel's recommendation, it was agreed that this recommendation would be better achieved by incorporating it into the Coroners Act 2003. This bill implements the legislative recommendations made by Geoff Davies at chapter 7 of his report.

Finally, I want to return to the comments made by the Attorney-General. The minister said that he will not support the bill because there is a standard by the HQCC. I have dealt with that standard. I say to the Attorney-General: tell that to the victims at Bundaberg. Davies identified serious shortfalls in legislation

and practice which left the door open to impropriety in our hospitals. The minister hid behind the Health Quality and Complaints Commission standards. The procedure advocated by the HQCC is a three-tiered system where a self and/or clinical team review is initially carried out, followed by an in-house review if necessary and, as a last resort, an external review. However, this regime is not mandated in legislation. Instead, the Attorney-General is relying on individual hospitals and individual clinicians to implement the standard despite no legal imposition to do so. Again, this system lends itself to abuse. Doctors may just as easily circumvent the HQCC standard as they may the legislation that is the subject of this amendment.

The HQCC estimates that some 30 to 40 per cent of death certificates are inaccurate. Furthermore, there is evidence in Queensland and interstate that suggests doctors may not be referring all reportable deaths to the coroner. A recent study by the Victorian Parliament Law Reform Committee found that up to 30 per cent of all death certificates inaccurately recorded the actual cause of death. In addition, it found that 20 per cent of doctors surveyed suggested that they would be prepared to alter certificates to avoid the scrutiny of the coroner. As members can see, this problem is not unique to Queensland, but the problem of this government is.

The Bligh government had the opportunity to take a real step towards improving Queensland Health for public patients. Instead of engaging in endless rhetoric about health action plans, the members opposite had the chance to make minor changes to legislation that would improve the integrity of reporting in Queensland hospitals. It would have set up an early warning system. How many lives may have been saved if this system had been in place?

While the HQCC standards represent an improvement to the current reporting system, they do not address the issue of subjectivity in determining the cause of death in issuing death certificates. Only legislative action will achieve that end. I remind members opposite that this is not my recommendation. This is my bill, but this is not my recommendation. This is the recommendation of an independent former judge of the Queensland Court of Appeal. No matter through which ideological prism we view this legislation, this is good policy and it is policy which has the potential to save lives.

I am disappointed that the Bligh government cannot bring itself to support good policy—and for the second time I have said this today—for the sole reason that it did not originate on its side of the House. To the Attorney-General I say: go read the Davies report. He should read it again or, if he has not read it, he should read it and make note of the recommendations that have been implemented on the watch of his government. I envisage that by the end of it he will be staring at a blank page.