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**Coronial Inquiries into Fatal Adverse Events
in South Australian Hospitals:
From Inquest to Practice**

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Abstract

The role of coroners as investigators and advocates of death and injury prevention has gained considerable attention from stakeholders interested in improving quality and safety in acute hospitals. In Australia, it is estimated that over 5,000 deaths per year are caused by unintended injury, errors and/or iatrogenic causes related to the medical management of patients. A coronial inquest into a single such hospital death, or a series of these deaths, can result in a comprehensive source of information for future analysis and may also result in a set of findings and recommendations aimed at preventing or reducing the likelihood of future death or injury. This thesis examines whether coronial findings have any value in safety and quality improvement, particularly at the level of bedside practice in an era where sophisticated risk assessment has become an increasingly important part of hospital management.

The modern South Australian coronial system, like others across the world, is a product of its social, political and legal history. A detailed analysis of the impact these factors have on how the coroner has come to manage fatal adverse events provides answers to explain why many recommendations are not being implemented in practice. The office of coroner was created 800 years ago to represent the Crown's interest and although it has undergone multiple reforms over the years, it remains an office largely driven by political agendas and government interests. While coroners enjoy some degree of judicial independence, when it comes to recommending changes to the way in which the state run health system operates, implementation processes are often overshadowed by professional control issues and broader government agendas associated with cost containment and minimising public exposure of failures in the health system.

This thesis also contends that social attitudes toward death have changed significantly over the last century, largely due to improved public health and medical advances that prolong life. In general, the public expect to live a long and healthy life and, if they become acutely ill, they expect a straightforward and

uncomplicated hospitalisation. When errors and mishaps occur they are viewed as unacceptable, blameworthy and warranting compensation.

There is a growing body of knowledge about the causes of adverse events and many solutions have been proposed to reduce the incidence. The findings of my study indicate that the coroner regularly and repeatedly identifies the same factors underlying fatal adverse events as those recognized in the literature. Despite this knowledge, and the fact that many adverse events are predictable and preventable, there is little evidence that the incidence of medical fatalities is declining. Consumers of health care services as well as those who work in the health system are deserving of a safer hospital system. If government and health bureaucrats are serious about preventing fatal adverse events, then serious attention needs to be given to implementing recommendations handed down by the coroner and strategies developed to address deficiencies. Immediate actions should include overcoming obstacles that impede hospital deaths being reported to the coroner; improving the communication of coronial findings to clinicians (the group most likely to benefit from this form of education), and, lifting the barriers that currently impede change at the practice interface.