Coronial Council of Victoria – Reference 2 – January 2012

Coronial Council of Victoria

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31 January 2012

Our ref: DG/12/3021

The Honourable Robert Clark MP
Attorney-General
Level 26, 121 Exhibition Street
MELBOURNE VIC 3000

Dear Mr Attorney

It is my pleasure to present you with the Coronial Council of Victoria's advice regarding asbestos-related deaths and the coronial jurisdiction.

I would be happy to meet with you to discuss the content of the attached report, if you wish.

Yours sincerely

James T Duggan
Chairperson

State Government Victoria

CD/13/352807

Overview

The Coronial Council of Victoria

The Coronial Council of Victoria (the Council) was established under section 109 of the *Coroners Act 2008* (Vic). The Council is unique in Australia and the only known body of its kind internationally. The Council provides advice and recommendations to the Attorney-General in respect of:

- issues of importance to the coronial system in Victoria;
- matters relating to the preventative role played by the Coroners Court of Victoria (the Court);
- the way in which the coronial system engages with families and respects the cultural diversity of families; and
- any other matters relating to the coronial system that are referred to the Council by the Attorney-General.

The Council may provide advice of the Council's own motion, or, as in the case of this report, at the request of the Attorney-General.

The Council acts in a way that:

- does not impinge on the independence of a coroner's decision-making and investigation of death as well as the role of the State Coroner;
- delivers strategic advice reflecting the changing physical, social and political environment to foster a modern and responsive coronial system;
- promotes and strengthens different relationships including collaboration between agencies across the coronial system;
- focuses on advice to strengthen services to families and improve the prevention role of the coroner;
- ensures that the views of bereaved families are reflected in the development of advice;
- complements existing governance structures in the State coronial system; and
- promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

Council membership

The State Coroner, Her Honour Judge Jennifer Coate, the Director of the Victorian Institute of Forensic Medicine, Professor Stephen Cordner, and the Chief Commissioner of Police, Mr Ken Lay[1] are statutory members of the Council.

[1] For the duration of this reference, the Chief Commissioner of Police was represented on the Council by his delegate, Acting Deputy Commissioner, Mr Tim Cartwright.

The Governor in Council has appointed an additional seven members: Judge Jim Duggan (Chairperson), Mr Stephen Dimopoulos, Dr Ian Freckelton SC, Mr Christopher Hall, Professor Katherine McGrath, Dr Rob Roseby and Dr Sally Wilkins.

Asbestos-related deaths and the coronial jurisdiction

In January 2004, the former Victorian State Coroner made a direction that all deaths caused by asbestos, or where asbestos was a contributing factor, were to be reported to the State Coroner's Office under section 3 (now repealed) of the *Coroners Act 1985* (Vic).[2] The catalyst for the direction appears to have been concern about the impact of the home renovation boom of the 1970-90s, during which many old houses and buildings were renovated or demolished. It is thought that the reporting of asbestos-related deaths (ARDs) and subsequent findings were intended to be used as an educative tool.

Under the previous *Coroners Act*, the State Coroner's Office considered that ARDs resulted from 'accident or injury' or an 'unnatural' cause; the former related to the initial exposure to the asbestos fibres which eventually lead to asbestos-related disease, while the latter related to the manufactured asbestos sheeting which created the hazard.

In November 2009, the current State Coroner, Her Honour Judge Jennifer Coate, determined that ARDs were not 'unnatural' deaths under the new *Coroners Act 2008* (the Act),[3] and were therefore no longer reportable. However, ARDs would still be reported to the Coroners Court if the deaths were reportable for other reasons.[4]

This announcement prompted Gippsland Asbestos Related Deaths Support Inc (GARDS)[5] to engage in correspondence with the former Attorney-General, the Hon Rob Hulls MP, and the State Coroner about the implications of the direction on data collection and public awareness of asbestos safety issues.

In December 2010, the State Coroner provided a letter to GARDS which outlined the view of the Court and the Victorian Institute of Forensic Medicine on this matter. The letter indicated that the investigation into and collection of data regarding ARDs is best served by the establishment of a comprehensive asbestos-related disease registry, supported by specialist occupational health professionals.

During 2011, GARDS contacted the current Attorney-General, the Hon Robert Clark MP, about this issue.

[2] See Appendix A
[3] See Appendix B
[4] See Appendix C
[5] GARDS is a non-profit, non-government, voluntary organisation dedicated to supporting the victims of asbestos and their families. GARDS also works to raise the level of asbestos awareness in the community, industry and at all levels of government (http://www.gards.org/, accessed 19 September 2011)

The reference

In response to the concerns raised by GARDS, on 16 June 2011, the Hon Robert Clark MP made a reference to the Council in the following terms:

> *The Coronial Council is requested to provide advice as to whether asbestos related deaths should be the subject of coronial investigations. The Council is invited to make additional comments, if deemed appropriate, in relation to this issue.*

The Attorney-General also recommended that the Council or its representatives meet with Ms Vicki Hamilton, CEO/Secretary of GARDS.[6]

The making of the reference follows on from the Victorian Parliament Law Reform Committee's 2006 review of the *Coroners Act 1985*, which concluded (at p165):

> "...issues concerning the way in which these kinds of deaths are reported and investigated requires further strategic and expert analysis and ... this [is] most appropriately undertaken by a Coronial Council... On advice from the Council, and after due consideration of public policy implications by the Department of Justice, appropriate matters can then be included in the regulations as prescribed circumstances." [7]

[6] See Appendix D
[7] See Appendix E

Asbestos

Asbestos-related diseases are caused by the inhalation or ingestion of asbestos fibres, which are released in a 'dust' when asbestos is disturbed. Although Victoria has no history of asbestos mining, the widespread use of asbestos in transport, building and manufacturing has resulted in Victorians developing asbestos-related diseases.

Asbestos-related diseases are generally associated with inhaling asbestos over a long period of time. Accordingly, individuals exposed to asbestos as a result of their work are at greater risk of developing asbestos-related diseases. However, a small number of people may develop an asbestos-related disease after brief exposure; hence there is no 'safe' level of exposure to asbestos containing materials.

The use of asbestos is now restricted in Australia – since 2003 it has been illegal to store, sell, install or reuse any products containing asbestos. However, any asbestos products that are already in place are allowed to remain and asbestos can still be found in products such as those used for water supply and sewage piping, casings for electrical wires, fire protection material, chemical tanks, electrical switchboards, clutch facings and brake linings for cars, small appliance components, heat protective mats, ceiling and floor tiles, paints, coating and sealants.

Asbestos-related diseases

There are four principal diseases related to asbestos exposure:

1) Asbestos-related pleural disease

Pleural plaques
A plaque is a thickened patch on the pleura (the two layers of membrane which line the chest wall and cover the lungs). Pleural plaque disease is quite common and generally causes no symptoms, although sufferers may experience a dull pain or, more rarely, breathlessness. Pleural plaque disease generally requires no treatment and does not lead to cancer.

Pleural thickening
Pleural thickening may be indicative of asbestos exposure (it takes at least seven years to develop after asbestos exposure), but may also be caused by a lung infection. Diffuse pleural thickening can severely impair ventilation and cause significant restrictions on lung function. It may lead to rounded atelectasis (infolding of the lung as a result of pleural thickening).

Benign pleural effusions
Benign pleural effusions occur in a small percentage of asbestos workers, usually less than 20 years after initial exposure to high concentrations of asbestos.

Mesothelioma
See below.

2) Asbestosis
Asbestosis takes 10 years or more after asbestos exposure to develop. It causes scarring of the lungs, which prevents oxygen from moving into the bloodstream. Asbestosis also causes breathlessness, coughing and chest pain. Asbestosis may lead to disability or death, as it slowly progresses over time. Individuals with asbestosis may also develop lung cancer.

3) Lung cancer
Lung cancer may not develop until decades or more after asbestos exposure, and is much more likely to develop in smokers and people with asbestosis. Asbestos exposure also contributes to other cancers including laryngeal and ovarian cancer.

4) Mesothelioma
Mesothelioma is a form of cancer that may take 30 - 40 years after asbestos exposure to develop. The most common type starts in the pleura, forming growths which enlarge and spread gradually to surrounding areas. Mesothelioma may also arise in the lining of the abdomen (peritoneum). Occasionally, mesothelioma arises in the membrane around the heart (pericardium) or the reproductive organs. Mesothelioma can, in almost all cases, be attributed to asbestos exposure.

Incidence of asbestos-related disease

The World Health Organisation estimates that more than 107,000 people worldwide die each year from asbestos-related diseases.[8]

Australia
Asbestosis usually develops in asbestos workers with significant exposure, so new cases in Australia are becoming uncommon. However, Australia has one of the highest incidence rates of mesothelioma in the world. In 2007, there were 660 new cases diagnosed, and 551 deaths were attributed to mesothelioma (Safe Work Australia 2011).

Due to the long latency of many asbestos-related diseases, a peak in Australian deaths attributable to exposure is currently not expected until 2017 – 2020.[9] It is estimated that by 2020, Australia will have 13,000 cases of mesothelioma and a further 40,000 cases of asbestos-related cancers (NSW Ombudsman 2010).

Recent research findings indicate that there has been a marked increase in mesothelioma cases related to exposure from home maintenance and renovation over the past two decades (Olsen et al, 2011).

[8] World Health Organisation 2010 'Asbestos: elimination of asbestos-related diseases' http://www.who.int/mediacentre/factsheets/fs343/en/index.html, accessed 29 September 2011
[9] Australian Council of Trade Unions (ACTU) submission to the Australian Government Asbestos Management Review dated 9 September 2011, http://www.deewr.gov.au/WorkplaceRelations/Policies/AMR/Documents/Submissions/042_ACTU_Response.pdf, accessed 29 September 2011

Victoria

Figures from the National Coronial Information Service (NCIS) indicate that an average of 163 deaths per year in Victoria between 2005 and 2010 may have been due to asbestos exposure. 'Mesothelioma and asbestosis' was the third most common mechanism of fatality for unintentional external cause deaths in Victorian males between 1 January 2005 to 31 December 2008, accounting for 17.5% of such deaths, behind transport accidents (33.3%) and poisoning (19.9%).

Data released recently by the Cancer Council Victoria indicates that in 2009, lung cancer was the fifth most common cancer, and remains the leading cause of cancer death, accounting for 1936 deaths (19% of all cancer deaths) (Cancer Council Victoria 2011).

The Latrobe Valley has the highest incidence of asbestos-related disease in Victoria due to the heavy use of asbestos in the electricity industry post World War II, and high levels of housing built with materials containing asbestos.

Coronial investigation of asbestos-related deaths

Victoria

Between 2004 and 2009, the former State Coroner's Office undertook a number of investigations into ARDs. By September 2006, the State Coroner's Office had attributed 31 ARDs to asbestos exposure arising from home renovation work.

In many cases, it appears the coronial investigation was limited to a review and assessment of the medical cause of death by relying on the death certificate and medical records. That is, after notification to the State Coroner's Office by the Registry of Births, Deaths and Marriages of a relevant death, the Victorian Institute of Forensic Medicine (VIFM) compared the medical records against the cause of death listed on the death certificate. This degree of examination enabled confirmation of death by asbestos-related disease, but yielded little additional information to influence public health or prevention outcomes.

Recommendations made by the State Coroner focused on the development of public education programs and the need for cooperation by industry with government agencies. In some cases copies of the findings were widely distributed throughout government, industry, unions, the media and universities.

In 2003, the Department of Human Services produced an educational resource regarding asbestos safety in the home (see Appendix F).[10] However, it is unclear whether this resource was produced as a result of the former State Coroner's recommendations. It is also unclear whether any other positive preventative action was taken.

Difficulties with the Victorian coronial jurisdiction undertaking comprehensive investigations into ARDs include:

- problems with identifying the episode of exposure that may have led to the disease, especially for individuals whose exposure to asbestos did not occur during the course of their employment.

- the lengthy period of time between exposure and diagnosis, which further complicates the exposure assessment process. Evidence regarding exposure and medical history is best collected *before death*, by health professionals engaging in discussions with the affected individual after a diagnosis has been made.

[10]: http://www.health.vic.gov.au/environment/downloads/asbestos_home_2010.pdf, accessed 26 October 2011
The Department of Health is now responsible for this publication, however enHealth (which represents the state and territory environmental health agencies) has produced a further resource on asbestos, which will supersede the Department of Health publication. The new publication, 'Asbestos - A guide for householders and the general public', has now completed focus testing and will be launched in early 2012.

- the need for an autopsy. Families of the deceased may object to an autopsy being undertaken; family wishes need to be balanced against the public health benefits in proceeding with an autopsy.

Australia and New Zealand

The current approach taken by the Coroners Court in Victoria to ARDs is consistent with the position in other Australian coronial jurisdictions (and in New Zealand), where deaths from asbestos or other slow-acting diseases resulting from chemical exposure are not investigated.

The Queensland State Coroner's Guidelines explain this position:[11]

> 'By convention, diseases due to the longstanding effects of repeated or relatively low-level exposure to chemicals are generally not regarded as unnatural. One reason for this is that the diseases that ultimately develop often involve the complex interplay between multiple environmental and genetic factors. Diseases arising in this way include cirrhosis in chronic alcoholics, lung cancer in smokers, mesothelioma in asbestos workers and dust-induced lung diseases in certain occupations.'

The United Kingdom and Ireland

In the United Kingdom and Ireland, coroners routinely investigate deaths from industrial diseases, such as asbestosis, on the basis that such deaths are 'unnatural' deaths.[12] In such cases, an inquest will be held to determine the cause of death and whether it was due to occupational asbestos exposure or a naturally occurring disease process.

Certain classes of industrial diseases which are related to a specific occupation are also notifiable by the coroner to certain agencies, for social security or similar purposes. However, coroners are not limited to investigating deaths caused by the diseases prescribed and may investigate industrial diseases where a particular occupation is not involved.

The Council notes there are considerable differences between the coronial jurisdictions in the UK / Ireland, and those in the Australian states and territories. For instance, coroners in the UK are only required to make findings regarding the identity of the deceased and the cause of death. However, in Victoria coroners may be required to make findings regarding the circumstances of death, which involves significantly greater resources being applied to a coronial investigation.

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[11] http://www.courts.qld.gov.au/__data/assets/pdf_file/0004/84919/m-osc-state-coroners-guidelines.pdf, accessed 26 October 2011

[12] Section 8(1) of the *Coroners Act 1998* UK provides that an inquest must be held:

> "… where there is reasonable cause to suspect that the deceased:
> (a) has died a violent or unnatural death;
> (b) has died suddenly and the cause of death is unknown; or
> (c) has died in prison or in a place or such circumstances as to require an inquest under any other Act."

Existing data collection mechanisms

Certain cancer and asbestos-related disease registries are already in operation in Australia. Various public health and safety bodies are also involved in broader asbestos management activities (such as Safe Work Australia and enHealth) but there is currently no single entity responsible for managing asbestos-related issues in Australia.

State and territory cancer registries

All malignant cancers are required by law to be notified to the relevant state or territory cancer registry. In Victoria, the body responsible for receiving notifications of cancer is the Cancer Council Victoria, which manages the Victorian Cancer Registry.[13] The Cancer Registry maintains a record of all cases of cancer diagnosed in Victoria since the beginning of 1982.

Accordingly, lung cancers and cases of mesothelioma are subject to **mandatory** reporting by hospitals and pathology laboratories, along with basic patient details (such as name, date of birth, country of birth and details of the notifying doctor/institution). All state, territory and national registers must comply with strict privacy legislation when collecting, storing and disclosing the personal details of cancer patients.

Computerised death certificates are also obtained from the Registry of Births, Deaths and Marriages on a regular basis (Cancer Council Victoria 2002).

The Cancer Registry publishes regular reports showing numbers of cases and rates of different types of cancer in summary form, using de-identified data.

There is no exposure assessment undertaken by the Victorian registry and therefore cancers recorded on the Victorian register are unable to be attributed to asbestos exposure.

National Cancer Statistics Clearing House[14]

Australian states and territories are required by law to maintain a cancer registry of new cases of malignant cancer. In order to co-ordinate cancer statistics on a national basis, the National Cancer Statistics Clearing House was established in 1986 at the Australian Institute of Health and Welfare and is supervised by the Australasian Association of Cancer Registries.

[13] http://www.cancervic.org.au/about-our-research/registry-statistics, accessed 19 September 2011
[14] http://www.aihw.gov.au/national-cancer-statistics-clearing-house/, accessed 19 September 2011

Australian Mesothelioma Registry[15]

The Australian Mesothelioma Registry (AMR) is hosted by the Cancer Institute of NSW and managed by a consortium including the Monash Centre for Occupational and Environmental Health, the University of Sydney, the Asbestos Disease Research Institute and state and territory cancer registries. The registry is funded by Safe Work Australia (the independent statutory agency responsible to improve occupational health and safety and workers' compensation arrangements across Australia).

The AMR collects and investigates notifications of mesothelioma cases diagnosed from 1 July 2010. Notification occurs through State and Territory cancer registries, although notification to the AMR is **not** mandatory and the AMR does not collect data on any other asbestos-related disease. Following notification, information about asbestos exposure is collected from consenting individuals with mesothelioma through a postal questionnaire and telephone interview.

The AMR will publish yearly statistical reports using non-identifying data to show the rates of new cases and deaths from mesothelioma in Australia. The reports will also include information about patterns of exposure to asbestos in mesothelioma patients. The first report is due to be released in August 2012, and will be made widely available to the public, governments, clinicians and researchers. It is not expected that the AMR reports will contain any recommendations or commentary regarding public health and safety issues arising from asbestos exposure.

Surveillance of Workplace Based Respiratory Events

The Monash Centre for Occupational and Environmental Health maintains the Surveillance of Workplace Based Respiratory Events (SABRE) database. SABRE is a voluntary, anonymous surveillance scheme providing data on occupational respiratory disease. Lung cancer, mesothelioma and pleural diseases have been reported to SABRE, which has been operating in Victoria and Tasmania since 1997 and in NSW since 2001. The SABRE project aims to determine the incidence of work-related respiratory disease and inhalation injury in the States in which it operates and to disseminate information about respiratory disease.

Other

Data regarding deaths, including causes of death, is recorded by the Victorian Registry of Births, Deaths and Marriages.

[15] http://www.mesothelioma-australia.com/home-page.aspx, accessed 29 September 2011

Government review of asbestos management activities

The federal Department of Education, Employment and Workplace Relations is currently undertaking an 'Asbestos Management Review' (the Review). The Review will provide recommendations for the development of a National Strategic Plan by the Australian Government to improve asbestos awareness and management.

The Chair and Advisory Group of the Review released an issues paper in July 2011.[16] Public comment on the issues paper was sought to September 2011, with further public consultation to occur between January and May 2012. The final report is due to be provided to the Federal Government by 30 June 2012.

One issue considered by the Review concerns medical data collected around asbestos-related diseases and ARDs. The Review Advisory Group sought feedback on the following questions:

- Is nationally consolidated information or a database on all asbestos-related diseases required?

  If so:
  - How can this data be collected?
  - Who should provide the data and when? And how often should it be updated?
  - Who should be responsible for the coordination of data collection and reporting?
  - Who should be able to access the data and under what circumstances?
  - Identify and privacy issues that need to be addressed in relation to the collection of data and reporting on asbestos-related diseases. How should they be addressed?
  - How should provision of data be enforced?

- What activities, if any, should be included in a national strategic plan with respect to collection of medical data? Who is best placed to deliver these activities?

Public submissions in response to the issues paper make a variety of suggestions around this issue. At least two submissions (including the submission from GARDS) suggest an expanded role for the Coroner.[17] Other submissions indicate that expansion of the AMR to include all asbestos-related diseases is desirable.[18]

[16] http://www.deewr.gov.au/WorkplaceRelations/Policies/AMR/Pages/default.aspx, accessed 19 September 2011
[17] GARDS submission dated 1 September 2011 and submission of Mr Mike van Alphen dated 9 September 2011
[18] Australian Manufacturing Workers Union submission dated 9 September 2011 and Asbestos Victims Organisation (SA) submission dated 9 September 2011

Other submissions refer to the establishment of a new, independent statutory body, the National Asbestos Authority (NAA). The NAA would have responsibility for all aspects of asbestos management in Australia including the annual publication of medical data around asbestos-related disease.[19]

The ACTU submission suggests that the NSW Dust Diseases Board represents the 'high water mark' for data collection of this nature in Australia,[20] but that data collection measures should improve the capture of occupational data relating to exposure to materials containing asbestos. The NAA would be responsible for the development of consistent notification and reporting requirements, and potentially the development of an 'overall' database.[21]

[19] Cancer Council Australia submission dated 9 September 2011 and ACTU submission
[20] The NSW Dust Diseases Board provides a no-fault compensation scheme to workers who have contracted a dust disease (including asbestosis, asbestos-induced carcinoma of the lung, asbestos-related pleural disease, and mesothelioma) through their employment. Compensation is also available for dependents of deceased workers. The Dust Diseases Board collates statistical and related data to facilitate actuarial valuations of liability and research into dust diseases.
[21] ACTU submission, pp20-21

GARDS' submission to the Coronial Council

On 30 September 2011, Ms Vicki Hamilton provided a submission to the Council on behalf of GARDS. Two letters of support, written by Professor Arthur William Musk, a respiratory physician based in Western Australia, and Professor Douglas W Henderson, based in South Australia, accompanied the submission.

Also included with the submission were two recent research articles regarding the link between asbestos exposure and home renovations. Copies of correspondence between GARDS, the Attorneys-General, and the State Coroner, were also attached.

The Chair of the Coronial Council, His Honour Judge Duggan, met with Ms Hamilton on 4 October 2011 to discuss GARDS' concerns.

GARDS submits that:

- The incidence of asbestos-related diseases has not yet peaked in Australia, and mesothelioma will become more common than melanoma and ovarian cancer in the next five years.

- The danger from asbestos exposure is not confined to the past. While ARDs previously arose from occupational exposure (with both workers and workers' families being affected), a 'new wave' of exposures is occurring due to the continued popularity of DIY home renovation works.

- There is a lack of public awareness about the prevalence of materials containing asbestos containing in the built environment. There are strict regulations in place regarding asbestos removal from commercial premises. However, there is very little regulation or information regarding the danger that asbestos poses to those undertaking ordinary household renovations. As a result, individuals are unwittingly putting themselves and others at risk.

GARDS submits that the Coroners Court of Victoria should investigate ARDs for the following reasons:

- ARDs are 'unnatural' deaths and the role of the coroner is to investigate unnatural deaths. ARDs are investigated by coroners in the UK.

- Reporting of ARDs needs to be mandatory, as doctors and pathologists will not report unless they are under an obligation to do so. Making ARDs reportable to the coroner would achieve this outcome. Mandatory reporting also alleviates issues with privacy concerns, which may otherwise prevent reporting from taking place. Statistics collected from voluntary reporting processes are liable to be inaccurate and therefore misleading.

- Existing registers for asbestos-related diseases have serious deficiencies. For example, the AMR reports only on mesothelioma and reporting to the AMR is not mandatory. Statistics on ARDs kept by the Registry of Births, Deaths and Marriages are inaccurate, as the stated cause of death may not indicate the presence of an underlying asbestos-related disease.

- Securing funding to establish and maintain a data register is a very difficult process. It is therefore preferable to utilise an existing register if possible. The NCIS is an operational, funded register and reporting through the coroner would ensure all ARDs are reported and exposure assessments are undertaken. Data from the NCIS can be analysed and shared by a wide range of users.

- The Coroners Court has the resources to undertake investigations to establish the source of exposure for ARDs, whether occupational or otherwise. The Court also has unique powers, including the power to compel the production of documents, and has skill and experience in conducting investigations.

- The former State Coroner's investigations provided valuable information regarding the incidence of ARDs and identified home renovations as the source of exposure in a number of cases.

- Inquests into ARDs are not necessarily required, as valuable information can be obtained through a less-comprehensive investigation process. For instance, the coroner can obtain medical and employment histories from asbestos cases that are litigated in the courts, as well as gathering information from families, employers and medical practitioners directly. If an autopsy is considered necessary for a proper investigation, this will be possible in some instances, as not all families would object to autopsies being carried out.

- The coroner's ability to make recommendations is very valuable; coronial recommendations carry greater weight than submissions from a volunteer, not-for-profit group like GARDS, and are significantly more likely to gain political traction. There is an urgent need for preventative action to be taken on asbestos, at all levels of government. The coroner can direct a whole-of-government approach to prevention by making recommendations. Good awareness has been created around public health and safety issues such as skin cancer/melanoma, smoking, breast cancer and drink driving (through the use of campaigns such as 'Slip, Slop, Slap' and 'Pink Ribbon Day'). However, there remains little public awareness around the dangers of asbestos, which contributes to a significant number of deaths in Australia.

- The book entitled 'The Aftermath of Death: Coronials, Law, Pathology, Counsellors, Safety, Media' suggests that ARDs could be considered 'unnatural' deaths and the coroner should take a role in this area (see p161)[22]:

> 'The risks may be well known by specialists, but without the sometimes necessary intervention and re-examination of the issues by an office such as the coroner, the public may be blissfully unaware and improvements in preventative strategies may not have been considered or adopted.'

[22] Selby, H (ed) (1992) *The Aftermath of Death: Coronials, Law, Pathology, Counsellors, Safety, Media* Federation Press. Extracts of this publication were attached to the letter from GARDS to the State Coroner dated 19 January 2011.

Discussion and conclusion

The legal position

As noted previously, ARDs are not currently investigated by the Coroners Court in Victoria, unless a particular death is otherwise reportable. The basis for this position was a determination by the State Coroner, Her Honour Judge Jennifer Coate, that ARDs do not constitute 'unnatural' deaths within the meaning of the *Coroners Act 2008* (Vic).

The Council has considered GARDS' submission that ARDs are 'unnatural' deaths within the meaning of the legislation, and therefore such deaths are reportable to the Coroners Court. The Council has concluded there are sound medical and legal factors that support the State Coroner's position that ARDs are not reportable. Accordingly, the Council does not propose to comment further on the State Coroner's legal determination on this point.

However, the Council has considered whether, as a matter of policy, ARDs should be the subject of coronial investigations.

Policy issues

Historically, deaths caused by exposure to agents such as cigarettes and alcohol which result in illnesses acting over the long term, have not been investigated by the coroner. The court does not have sufficient resources to investigate deaths caused by smoking or alcohol consumption, and the public interest in doing so is questionable when the health risks of smoking and alcohol abuse are already well known by medical professionals and the community.

The Council considers that ARDs are analogous to these kinds of deaths. Accordingly, if the court were required to investigate ARDs, then deaths resulting from smoking, alcohol or exposure to other chemical agents acting over the long term should also be investigated. The Council does not consider that expanding the coronial jurisdiction to such a degree would be justifiable considering the relatively small public benefit that is likely to result, and given the resources required to support the expansion.

The Council also notes that there are significant practical difficulties in the court undertaking investigations into ARDs, particularly where a death results from a non-occupational exposure to asbestos. Investigations undertaken by the coroner, which necessarily occur post-mortem, do not have the benefit of first-hand evidence from the individual affected regarding episodes of asbestos exposure. The need for an autopsy is also problematic, as families may object to a post-mortem examination being carried out (particularly where it appears to the family that the cause of death is 'obvious').

Given the significant resourcing implications and practical issues associated with expanding the coronial jurisdiction to include ARDs, the Council also examined the feasibility of the court undertaking less comprehensive reviews of ARDs (and analogous deaths). In considering this option, the Council noted that many of the former State Coroner's Office investigations into ARDs were restricted to a review of existing medical information to determine whether a death attributed to asbestos exposure could be confirmed as being asbestos-related. If the court were to adopt this approach, a lesser commitment of resources would be required and the potential for conflict with bereaved families regarding post-mortem examinations would be reduced.

However, the Council has concluded that limited examinations of this type are unlikely to yield meaningful information that would assist with prevention efforts. Rather, the Council's view is that a thorough examination of the circumstances of an asbestos-related death would be necessary for any public health benefit to result from the investigation. In the absence of any public health benefit, the justification for coronial involvement is considerably weaker.

The Council considers that if a coronial investigation cannot produce the best possible information, other avenues for obtaining this information should be utilised. This is particularly so for investigations of this type, which are likely to be extremely resource intensive and burdensome for the court. In this case, the Council's conclusion is that coronial investigation into ARDs is not warranted.

Additional comments

Having carefully considered GARDS' submission, as well as the research material provided by the Council's Secretariat, the Council recognises the importance of further action being taken to prevent the Victorian community from being exposed to asbestos.

In particular, the Council has identified two important issues from GARDS' submissions:

- the need for **greater public awareness** about the risk of asbestos exposure, particularly amongst those undertaking DIY home renovations, and

- the need for **accurate and comprehensive data** on asbestos-related illnesses and deaths, to inform prevention efforts.

GARDS contends that the coronial jurisdiction is the appropriate forum to progress both of these matters, in light of the coroner's focus on public health and safety and prevention, and the availability of the coroner's existing powers and resources to investigate and collate data regarding ARDs.

Public awareness

The Council agrees that further public education on the dangers of asbestos is required. While the general public may be aware in broad terms of the dangers of

asbestos exposure (particularly in an occupational context), the continuing and specific risks faced by individuals confronted with asbestos in the built environment are poorly understood.

In particular, the material placed before the Council indicates that there is a significant and potentially increasing problem with exposure to asbestos for those undertaking home renovation or repair work. The Council considers that further education efforts directed towards this sector of the community would be valuable. Particular emphasis should be placed on educating communities located in regions that are more likely to be affected by asbestos-related illness due to their proximity to materials containing asbestos, such as the Latrobe Valley.

It may also be appropriate to target areas of socioeconomic disadvantage, whose residents may face an increased likelihood of coming into contact with materials containing asbestos due to economic pressures (i.e. these residents being more likely to engage in DIY renovations as a less-costly alternative to engaging tradespersons, and being less likely to be able to afford to engage specialised contractors to undertake asbestos removal).

The prevention role of the coroner

The Council believes that the coroner has an important role to play in promoting public health and safety. Indeed, one of the purposes of the Act is to "contribute to the reduction of the number of preventable deaths … through the findings of the investigation of deaths …, and the making of recommendations, by coroners".[23] Pursuant to section 72 of the Act, a coroner "…may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death…which the coroner has investigated, including recommendations relating to public health and safety…".

The Council notes that the coroner's ability to effect change through the recommendation-making process has been strengthened by the introduction of a requirement for parties to respond to recommendations within 3 months. The response must specify what action has, or will be taken, in relation to the recommendations made by the coroner.[24]

The previous coronial legislation did not have a comparable provision. Accordingly, the implementation and impact of recommendations made by the former State Coroner following investigations of ARDs is difficult to assess. The 'Asbestos in the Home' booklet produced by the Department of Health appears to be the only public education activity introduced around the time investigations into ARDs were undertaken by the former State Coroner's Office.

The Council notes that the introduction of a mandated response requirement may result in greater action being taken in the future, by the entities to which recommendations are directed. However, ultimately the Council does not consider

[23] Section 1 of the *Coroners Act 2008* (Vic)
[24] Subsections 72(3) and (4) of the *Coroners Act 2008* (Vic)

that the coronial jurisdiction is the best avenue through which education and prevention measures should be developed. Rather, the Council's view is that public health authorities are better placed to develop and undertake public education initiatives regarding the risks of asbestos exposure.

The Council suggests that WorkSafe and the Victorian Department of Health are the appropriate bodies to formulate public awareness campaigns on asbestos in Victoria. Alternatively, comparable entities at federal level may be able to direct a national approach to public health and safety around asbestos.

Data collection and exposure assessments

GARDS contends that current databases for recording asbestos-related illnesses and deaths in Australia are not sufficient. The GARDS submission argues that mandatory reporting of ARDs to the coroner would assist with the compilation of accurate figures regarding ARDs. GARDS also argues that coronial investigation would enable exposure assessment to be undertaken, yielding valuable information regarding current sources of asbestos risk.

The Council agrees that there are deficiencies with the current system. For instance, reporting to the recently re-established AMR is not mandatory, and the register only records mesothelioma cases. Reporting to state and territory cancer registries is mandatory and captures lung cancer cases as well as mesothelioma cases, but exposure assessments are not undertaken.

The Council also recognises that accurate recording and investigation of ARDs is necessary to inform public health bodies of the extent of the asbestos problem, and to demonstrate the need for urgent implementation of prevention activities.

However, the Council does not believe that the coronial system is the best mechanism for data collection activities. The Council has concluded that action should be taken in the public health sector instead, and therefore suggests that GARDS' advocacy efforts be directed towards relevant health officials or bodies.

As noted earlier, the limited coronial examinations undertaken previously by the State Coroner's Office yielded little information of assistance to public health entities, given the difficulties with undertaking exposure assessments post-mortem. As a result, data obtained from coronial investigations are likely to be very limited in scope and may be comparable to data which can already be ascertained through other sources (for example, the cancer registries).

The Council agrees with the State Coroner's advice that data collection issues would be best addressed "…by the establishment of a comprehensive asbestos disease registry which would identify cases on diagnosis, and undertake systematic and comprehensive investigations into asbestos exposure and medical histories".[25]

[25] Letter dated 2 December 2010 from the State Coroner to GARDS (see Appendix G)

The Council has noted GARDS' concern that establishing and maintaining a disease registry is a difficult process. The Council therefore suggests, as an alternative to an asbestos-specific disease registry, that it may be appropriate for asbestos-related diseases to be notifiable under public health legislation. The health departments of the states and territories currently collect notifications for 65 diseases and conditions under their respective legislative schemes, compiled by the federal Department of Health and Ageing as part of the National Notifiable Diseases Surveillance System (NNDSS).[26]

The Council recognises that the diseases included in the NNDSS are communicable diseases, and that asbestos-related diseases do not fall within this category. However, mandatory reporting of asbestos-related diseases could be achieved if these illnesses were notifiable as part of the NNDSS, or a similar scheme. Reporting through public health channels, rather than through the coronial system, would also have the benefit of enabling exposure assessments to be undertaken while the affected individual is able to assist with inquiries.

Alternatively, given the considerable impact of asbestos-related diseases on various communities in Victoria, it may be appropriate for a consultative council on ARDs to be established. The Council suggests that consideration be given to the establishment of an entity similar to the specialist bodies currently constituted to investigate certain types of deaths in the community (for example, the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, which reviews all maternal, peri-natal and paediatric deaths in Victoria).

Current action

The Council notes that the Australian Government is currently taking steps to deal with a range of asbestos issues, including possible improvements to data collection measures and enhanced prevention activities, through its Review. The Council identifies merit in these important issues being addressed at a national level, and hopes that state and territory governments will work collaboratively to assist the Federal Government in this initiative.

The Council has been advised that the results of the Review are due to be announced in mid-2012. The Council hopes that timely, positive action is taken as a result of the Review to improve data collection of asbestos-related diseases, sources of asbestos exposure, and rates of death. Accurate data on the prevalence of illness and the source/s of exposure should also assist with targeting prevention activities more effectively.

The Council would also support public education initiatives resulting from the Review, particularly those directed towards informing home owners of the risks of DIY renovations.

[26] http://www.health.gov.au/internet/main/publishing.nsf/Content/cda-cdi3502atoc.htm (accessed 16 January 2012)

Closing remarks

The Council wishes to emphasise that it considers ARDs to be an important public health and safety issue. Illnesses and deaths caused by asbestos exposure are preventable, but further action is urgently needed to enhance public education and improve data collection systems.

The Council's view that the coronial jurisdiction is not the most appropriate avenue for driving prevention or data collection efforts does **not** diminish this finding in any way.

Recommendations

The Council does not consider that coronial investigation into ARDs is warranted.

However, the Council recommends that the Attorney-General consider:

1) raising with the Victorian Minister for Health, the need for greater public awareness about the risks of asbestos exposure, particularly for those engaged in non-occupational home renovation activities

2) raising with the Victorian Minister for Health, the possibility of establishing a consultative council on asbestos diseases or a specialist asbestos disease registry

3) providing support for state-based or local initiatives recommended by the federal Review, particularly those which assist with enhancing data collection efforts around asbestos-related diseases and deaths, and seek to raise awareness of asbestos risk in the community

4) advising GARDS to raise its concerns regarding data collection of asbestos-related diseases and lack of community awareness of the risks posed by materials containing asbestos with appropriate contacts in the public health field (for example, the federal Minister for Health and the Department of Health and Ageing).

Acknowledgements

The Council commends GARDS for its commitment to increasing the awareness of asbestos-related diseases in the community, and supporting sufferers of asbestos-related disease. Voluntary organisations of this kind provide valuable advocacy and support services and the Council recognises the benefit to the community of such organisations.

The Council also wishes to thank Ms Vicki Hamilton, CEO/Secretary of GARDS, for making time to meet with the Chairperson. The Council's understanding of the relevant issues was greatly enhanced as a result of the discussions with Ms Hamilton.

The Council also thanks the Secretariat, Ms Lisa Nicholas, for assisting with the preparation of its advice.

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3 Reportable death means a death-

(a) where the body is in Victoria; or

(b) the death occurred in Victoria; or

(c) the cause of which occurred in Victoria; or

(d) of a person who ordinarily resided in Victoria at the time of death—

being a death-

(e) that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or

(f) that occurs during an anaesthetic; or

(g) that occurs as a result of an anaesthetic and is not due to natural causes; or

(h) that occurs in prescribed circumstances; or

(i) of a person who immediately before death was a person held in care;

(j) of a person whose identity is unknown; or

(k) that occurs in Victoria where a notice under section 19 (1) (b) of the Registration of Births Deaths and Marriages Act 1959 has not been signed; or

(l) that occurs at a place outside Victoria where the cause of death is not certified by a person who, under the law in force in that place, is a legally qualified medical practitioner.

4 Reportable death

(1) In this Act, a death of a person is a ***reportable death*** if—

(a) the body is in Victoria; or

(b) the death occurred in Victoria; or

(c) the cause of the death occurred in Victoria; or

(d) the person ordinarily resided in Victoria at the time of death—

and the death was a death specified in subsection (2).

(2) For the purposes of subsection (1), the deaths are—

(a) a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury; or

(b) a death that occurs—

(i) during a medical procedure; or

(ii) following a medical procedure where the death is or may be causally related to the medical procedure—

and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death; or

(c) the death of a person who immediately before death was a person placed in custody or care; or

(d) the death of a person who immediately before death was a patient within the meaning of the **Mental Health Act 1986**; or

(e) the death of a person under the control, care or custody of the Secretary to the Department of Justice or a member of the police force; or

(f) the death of a person who is subject to a non-custodial supervision order under section 26 of the **Crimes (Mental Impairment and Unfitness to be Tried) Act 1997**; or

(g) the death of a person whose identity is unknown; or

(h) a death that occurs in Victoria if a notice under section 37(1) of the **Births, Deaths and Marriages Registration Act 1996** has not been signed and is not likely to be signed; or

(i) a death that occurs at a place outside Victoria if the cause of death is not certified by a person who, under the law in force in that place, is authorised to certify that death and the cause of death is not likely to be certified by a person who is authorised to certify in that place; or

(j) a death—

(i) of a prescribed class of person;

(ii) that occurs in prescribed circumstances.

Coroners Court of Victoria

INFORMATION FOR HEALTH PROFESSIONALS

1. What is the coroner's role?

The coroner is a judicial officer who is responsible for the independent investigation of reportable deaths (and fires), with the objective of reducing the number of preventable deaths (and fires) and promoting public health and safety.

In an investigation into a death, the coroner must find, if possible:

- the identity of the deceased person;
- the cause of death; and
- in certain cases, the circumstances in which the death occurred.

2. What is a reportable death?

Reportable deaths are defined in section 4 of the *Coroners Act 2008* as deaths where:

- the body is in Victoria; or
- the death occurred in Victoria; or
- the cause of the death occurred in Victoria; or
- the person ordinarily resided in Victoria at the time of death.

In addition the death must also be one where:

- the death was unexpected;
- the death was violent or unnatural;
  - *For example, homicide; suicide; drug, alcohol and poison related deaths;*
- the death resulted, directly or indirectly, from an accident or injury (even if there is a prolonged interval between the incident and death);
  - *For example, drownings; deaths caused by a traumatic event such as a motor vehicle accident or a fall resulting in complications such as a fractured neck of femur or subdural haemorrhage*
- the death occurs during a medical procedure or following a medical procedure[1] where the death is or may be causally related to the medical procedure and a registered medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death[2] *(Please refer to Question 3).*
- a Medical Certificate of Cause of Death has not been signed and is not likely to be signed;
  - *For example, where an opinion about the probable cause of death cannot be formed*
- the identity of the person is unknown;
- the death occurred in custody or care (as defined in the *Coroners Act 2008*);
- the person was a patient within the meaning of the *Mental Health Act* 1986; or
- the death is otherwise specified in section 4 of the *Coroners Act 2008*.

The *Coroners Act 2008* requires the reporting to the coroner of any reportable death.

3. When does a medical procedure related death become reportable?

A death is reportable under this category if it meets the following two criterion:

Criteria One – the death occurs during a medical procedure; or following a medical procedure where the death is or may be causally related to the medical procedure

AND

Criteria Two – a reasonably equally qualified medical practitioner would not, immediately before the procedure was undertaken, have reasonably expected the death

In determining whether the death meets Criteria One, the medical practitioner should consider the following questions:

- Would the person have died at about the same time if the medical procedure was not undertaken?
- Was the medical procedure necessary for the person's recovery?

If 'no' to any of the above (and the death meets criteria two) - the death is reportable.

In determining whether the death meets Criteria Two, the medical practitioner should consider the following questions as a reasonable competent practitioner of that kind would [3]:

- Before the medical procedure was performed, was the person's condition such that death was foreseen as more likely than not to occur?
- Was the decision to perform the medical procedure reasonable given the person's condition including their quality of life?

If 'no' to any of the above (and the death meets criteria one) - the death is reportable.

Please note: the above information is provided as a suggested guideline only.

1 The new term 'medical procedure' is defined in the *Coroners Act* 2008 as being a procedure performed by, or under the general supervision of, a registered medical practitioner and includes imaging, internal examination and surgical procedures.

2 Note: the new definition of a reportable death replaces the former references to 'during' or 'as a result of an anaesthetic' (as contained in the *Coroners Act* 1985).

3 A 'reasonably competent practitioner of that kind' should be an ordinary skilled practitioner exercising and professing to have the capabilities required in the particular field of medical practice under consideration; who hypothetically would possess information about all relevant matters including: the person's known state of health before the medical procedure was performed, the clinically accepted range of risk associated with the medical procedure, etc.

4. Are asbestos-related deaths still reportable?

With the commencement of the new *Coroners Act* , the State Coroner has indicated that the meaning of 'unnatural' in the definition of reportable death, will no longer extend to asbestos-related deaths, and therefore no longer be considered by the Coroners Court to be a reportable death. The death will still be considered reportable if it also appears to have been unexpected; violent; to have resulted directly or indirectly from an accident or injury; etc. as per section 4 of the *Coroners Act 2008*.

5. Was the deceased held in custody or care?

A death must be reported to the coroner if the person who died[4] was:

- a child taken into safe custody;
- under the control, care, custody (including deemed legal custody) or under the guardianship of the Department of Human Services;
- in the legal custody of the Department of Justice or the Chief Commissioner of Police;
- in the custody of a member of the police force or a protective services officer;
- admitted or committed to an assessment or treatment centre under the *Alcoholics and Drug-dependent Persons Act* 1968;
- a patient in an approved mental health service;
- in the process of being taken into custody by a member of the police force or prison officer;
- a person who was dying from an injury incurred while in the custody of the State (including Commonwealth detention); or
- being detained or was in the process of being taken into custody to be detained in a Commonwealth detention facility.

The person who had care, control or custody of the deceased (i.e. the 'Responsible Person') must report the death to the coroner. *For example, the treating psychiatrist of an involuntary patient who dies 'in care' while undergoing treatment for a mental illness.* Failure to do so may result in a fine of 20 penalty units*.

6. Is a still-birth considered a reportable death?

Under the *Coroners Act 2008* the coroner cannot investigate still-births[6]. Rather, still-births should be referred to the 'Consultative Council on Obstetric and Paediatric Mortality and Morbidity' (ph: (03) 9096 7022).

7. What is a reviewable death?

Under the *Coroners Act 2008*, the death of a child is a reviewable death if the deceased child is the second or subsequent child of either of the deceased child's parents to have died. Such a death must be reported to the State Coroner by a medical practitioner (who was present at or after the death of the child) or any person who has reasonable grounds to believe that it has not been reported. Failure to do so may result in a fine of 20 penalty units*.

The State Coroner then has discretionary powers in relation to further investigation and/or referral to the Victorian Institute of Forensic Medicine. If deemed appropriate, the Family and Community Support Service of the court will contact the family.

The death of a second or subsequent child of a parent will not be considered a reviewable death if the death occurs in a hospital and the child was born at a hospital and had always been an in-patient of a hospital[7] (and the death was not also a reportable death)

8. Who must report a reportable or reviewable death?

A medical practitioner has an obligation to notify the coroner of reportable and reviewable deaths.

Moreover, anyone who becomes aware of a reportable or reviewable death must report it to a coroner if they have reasonable grounds to believe that it has not already been reported.

Failure to report is a statutory offence and may incur a fine of 20 penalty units*. If a person is unsure about whether a death has been reported, they should contact the Coroners Court on 1300 309 519 and ask for the Initial Investigations Office (open 24 hours/7 days a week).

9. How are deaths reported to the coroner?

Reportable and reviewable deaths can be reported directly to the Initial Investigations Office of the Coroners Court (Ph 1300 309 519) by the doctor who had been treating the deceased person or who was involved in the management of their care. In some circumstances (for example, where the death occurred in a hospital), the doctor will be required to complete a Medical Deposition form.

10. Why do police attend?

Police will attend a hospital (or a scene of death) on behalf of the coroner to obtain details about the deceased, and gather information about the death from health care staff, family, friends and other witnesses.

11. Do confidentiality laws apply?

The usual obligation to maintain confidentiality regarding patient information under the *Health Records Act* 2001 (Vic) and the *Privacy Act* 1988 (Cth) does not apply to requests for information by someone acting on behalf of the coroner.

Hence, if health care providers are requested by the coroner (or a police member acting on their behalf) to give any information or assistance for the purposes of a coronial investigation they must provide it. There are penalties in the *Coroners Act 2008* for failing to comply with such a requirement.

4 A death in care is reportable even if the person died in another place, for example, in hospital.

6 A stillborn child is defined in the Births, Deaths & Marriages Registration Act 1996 to mean a child who is at least 20 weeks' gestation or with a body mass of at least 400 grams at birth, that exhibits no sign of respiration or heartbeat, or other sign of life, after birth.

7 Even if more than one hospital is involved, as may be the case with inter-hospital transfers.

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12. Can medical apparatus be removed from the body of the deceased?

Consideration must be given to maintaining the placement of medical apparatus in situ (for example, cannulae, catheters, central lines, ET and NG tubes), as well as devices attached to these (for example, IV bags, syringes, drain bottles and bags, urine bags). Ideally, the body should also be left as it was at the time of death and not washed, so as to provide the forensic pathologist with all the relevant information for their medical examination.

Exceptions can be made to the general rule if there are special circumstances (e.g. removing a needle so the body can be safely handled) or where the family of the deceased desire the removal of surgical apparatus. Please contact the Initial Investigations Office (open 24 hours/7 days a week) in such cases on 1300 309 519.

13. Who completes the Statement of Identification?

All deaths reported to the coroner require a formal identification to be completed. This can be completed at the hospital or at the scene of the death, if deemed appropriate. Someone who was close to the deceased immediately prior to their death and has known them for a reasonable length of time can complete the formal identification of the deceased person.

The Statement of Identification requires the identifier to fill in the personal details of the deceased person, as well as their own details, including their relationship to the deceased and the length of time they were known to them. The form should then be signed by the identifier and witnessed by an appropriate person, for example, by a doctor, police member, etc.

The Statement of Identification must then be forwarded to the Coroners Court with the deceased or via the attending police member. Please contact the Initial Investigations Office for any further information regarding the Statement of Identification on 1300 309 519.

14. What records are required by the coroner?

Medical Records

The original medical record should be transported to the Coroners Court as soon as possible after the death. While the original medical record is usually transported with the deceased person, it is sometimes acceptable to fax the most recent information and courier the original medical record soon after (upon receiving advice from the Coroners Court). Furthermore, in some instances, the coroner may not require the entire medical record at the time of the death, but will require the most recent volume(s) (again advice should first be sought from the Coroners Court). A photocopy of the medical record can be made and kept at the health service for their future reference.

Discharge Summary

Health Services should also include in the medical record any relevant discharge summaries. These summaries should outline the care and treatment received by the deceased person at the health service.

Death Certificate

If a Medical Certificate of Cause of Death has been previously signed in relation to a reportable or reviewable death, a copy of this certificate should also be forwarded with the above documentation.

15. What happens after the Coroners Court is notified of the death?

Upon notification of a reportable or reviewable death, the Coroners Court will arrange for a contracted funeral director to convey the deceased person to a mortuary.

- If the deceased is in Melbourne, they will usually be transported to the Coroners Court in Southbank.
- If the deceased is in rural or regional Victoria, they may be transported to either a local hospital mortuary or to the Coroners Court in Southbank.

Personal property of the deceased person is not normally transported with the body. Items may be given to a family member at the health service (or scene) or alternatively sent to the local police station for collection.

16. Can a doctor issue a death certificate for a reportable death?

Section 37(4) of the *Births, Deaths and Marriages Registration Act* 1996 states that a doctor must not issue a Medical Certificate of Cause of Death in relation to a death if a coroner is required to be notified of the death, where the death is a reportable and/or reviewable death. A fine may also apply for a breach of this section (12 penalty units*).

17. Is there a requirement to provide a requested document or statement?

After considering the information provided in the Medical Deposition form and the police member's report (also known as a VP Form 83), the coroner may request the police member or coroner's registrar to conduct further investigations. As part of such an investigation, a coroner may require that one or more health practitioners provide a document (for example: medical records, notes) and/or prepare a statement addressing matters specified by the coroner. Failure to comply with a coroner's request within the period specified may incur a fine of 20 penalty units*.

18. What other penalties are contained in the *Coroners Act 2008*?

Apart from the fines previously mentioned, the new *Coroners Act 2008* also contains penalties for:

(i) a failure to give any information or assistance that the coroner requests for the purpose of the investigation (20 penalty units*);

(ii) a failure to comply with a direction made by the coroner (or member of the police force) to produce a document, operate equipment and/or access information from the equipment (60 penalty units*); and

(iii) contempt of court, the penalty for which can include a period of up to 12 months imprisonment or a fine of 120 penalty units* (or a fine of 600 penalty units* in the case of a corporation).

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19. Who can obtain information about a case being investigated by the coroner?

Generally, a health practitioner (or their health service) need to be an 'interested party' in an investigation to obtain information about a case. To become an interested party, the health practitioner (or their health service) must write to the court and request to be named as an interested party, detailing their (or their organisation's) interest in the case and what documents are required. The coroner will decide if they (or their health service) can access the document(s) sought.

A coroner can also name another person as an interested party if:

- The coroner is satisfied the person has a sufficient interest
- It is appropriate for the person or organisation to be an interested party.

A coroner may also release a document to[8]:

i) a party if the coroner is satisfied that the party has a sufficient interest in the document,

ii) a statutory body to allow the statutory body to exercise a statutory function,

iii) member of police force for law enforcement purposes ,

iv) researchers where the research has been approved by an ethics committee, or

v) any person if the coroner is satisfied that the release is in public interest

20. What happens after the coroner concludes their investigation?

Once the coronial investigation has been completed, the coroner must make written findings about:

- the identity of the deceased,
- what caused them to die, and
- in certain cases, the circumstances in which the death occurred.

The coroner may also make recommendations about matters connected with the death such as public health and safety or the administration of justice. These recommendations are aimed at preventing similar deaths from occurring in the future.

While the coroner cannot make a finding that someone is guilty of a criminal or civil offence, the coroner can refer a matter to the Director of Public Prosecutions or to a disciplinary body (for example, the Australian Health Practitioner Regulation Agency) for consideration and possible action.

As of 1 November 2009, in cases which have gone to inquest, and those where recommendations are made, the coroner's findings will be published on our website, unless otherwise ordered by the Coroner.

21. Who can verify deaths?

In addition to registered medical practitioners, both registered nurses (divisions 1 & 3) and paramedics are now able to verify death.

The Department of Health, through the Nursing Policy unit, has developed a guidance note for the 'verification of death' in Victoria. For this guidance note and further information, please visit the website: www.health.vic.gov.au/nursing/verification-of-death-by-nurses-and-paramedics.

22. Are there any publications that the Coroners Court produces for families?

With the commencement of the *Coroners Act 2008*, the court has produced new printed materials for bereaved persons affected by a reportable or reviewable death. These include:

1. What do I do now? (brochure)
2. Family and Community Support Service (brochure)
3. The Coroners Process (booklet)

Copies of these (and other) publications can be downloaded from our website or ordered by filling in an order form – also available on our website or by contacting the court on 1300 309 519.

23. What support service does the Coroners Court offer families?

The Family and Community Support Service of the court offers free, short-term, personal and confidential support and counselling to relatives and anyone else affected by a death. For more information about the Family and Community Support Service contact the court on 1300 309 519 or visit our website at www.coronerscourt.vic.gov.au

24. Where can I get more information?

For more information about the coronial process contact the Coroners Court on 1300 309 519 or visit the website at www.coronerscourt.vic.gov.au

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To **report a Reportable or Reviewable death**, ring
1300 309 519
and ask for the Initial Investigations Office.

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8 To apply, an application for Access to Documents Form must be completed. To obtain a copy of the application form please contact the Court on 8688 0700 or download the application form from our website www.coronerscourt.vic.gov.au

* 1 Penalty unit = $119.45 (as of 1/7/2010)

CD/13/352807

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Our ref: CD/11/199717

His Honour Judge James Duggan
Chairperson
Coronial Council of Victoria
Level 1, 204 Lygon Street
CARLTON VIC 3053

Dear Judge Duggan

Coronial Council reference – asbestos related deaths

I refer to the above matter and, pursuant to section 110 of the *Coroners Act 2008*, make the following reference to the Coronial Council of Victoria -

> *The Coronial Council is requested to provide advice as to whether asbestos related deaths should be the subject of coronial investigations. The Council is invited to make additional comments, if deemed appropriate, in relation to this issue.*

I would be pleased to receive your response to this reference by 1 February 2012.

In the course of your consideration of the reference, I recommend that the Council or its representatives meet with Ms Vicki Hamilton, and representatives of the Gippsland Asbestos Related Diseases Support group ("GARD").

I thank you in anticipation of the Council's consideration of this matter.

Yours sincerely

ROBERT CLARK MP
Attorney-General

16/6/11

State Government Victoria

CD/13/352807

Extract of findings of the Victorian Parliament Law Reform Committee

The Committee noted that the former State Coroner made reporting of ARD mandatory without utilising the regulation making power in the former Coroners Act. However, the Committee concluded (at p161) that:

> "... there is merit in the proposal that deaths of persons from certain diseases be prescribed as reportable deaths under the regulations to the Act ... Use of this power would be consistent with the preventative role of the coroner as it would allow for the monitoring of deaths resulting from emerging diseases or epidemics should be the need arise."

The Committee noted (at p164) VIFM's submission that:

> "... the question of whether deaths from mesothelioma and other slow-acting diseases attributable to industrial exposure to poisonous or otherwise dangerous agents should be reported to the coroner for investigation is one of public policy. Investigation of statistically significant numbers of these types of deaths could produce extremely important information and findings for use in a number of public health and legal arenas.
>
> The above issue raises a larger question about how death investigation resources are expended and whether a more policy-driven approach could be taken to delineating which deaths are reported and what level of investigation is undertaken for different categories of deaths."

Relevant recommendations of the Victorian Parliament Law Reform Committee

Recommendation 32:

That the proposed Coronial Council consider the following issues:

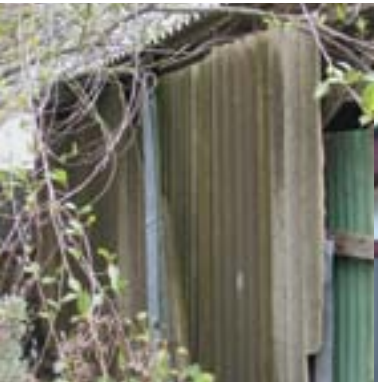
(a) whether particular workplace deaths, such as deaths from industrial diseases or deaths where employment or previous employment may have been connected with the death, should be reported to the coroner; and
(b) how such deaths should be reported and investigated.

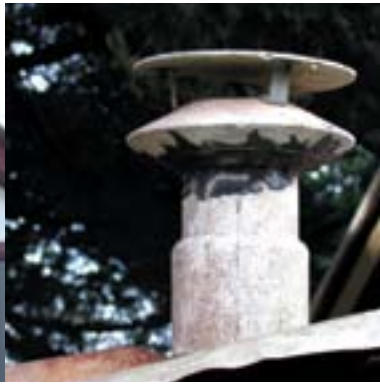
Recommendation 138:

> That the Department of Justice establish a Coronial Council to provide policy guidance and stakeholder input into the operations of the Coroners Office.

Asbestos in the home

Health and safety in the home





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Victoria
The Place To Be

Did you know?

- Asbestos is the name given to a group of fibrous silicate minerals that can potentially cause lung disease if inhaled.
- Asbestos can be found in a number of products used in the Australian building industry between the 1940s and late 1980s, and in the brakes, clutches and gaskets of many cars.
- The most commonly found household building materials that contain asbestos are asbestos-cement products (also called 'fibro' and 'AC sheeting').
- Generally the presence of asbestos in home building materials does not pose a risk to health unless the material is broken, deteriorating, or disturbed in such a way that dust containing asbestos fibres is produced.
- Special precautions should be taken by anyone needing to disturb any asbestos.

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Also published on www.health.vic.gov.au/environment

CD/13/352807

Authorised by the Victorian State Government, 50 Lonsdale Street, Melbourne.

This booklet has been developed for householders who intend to work with or remove asbestos from their home, shed or fence; or carry out maintenance on car brakes, clutches and gaskets at home.

It provides information on precautions that should be taken by anyone needing to disturb asbestos-containing materials in the home environment, and details how to safely dispose of asbestos waste.

The advice in this booklet is based on the most recent information available. It is recommended that you follow this advice to minimise the risks of exposure to asbestos in the home environment.

We cannot guarantee that following this advice will eliminate all risks as circumstances vary depending on the type and condition of the asbestos-containing material, and other factors. If you are uncertain about any of the advice in this booklet, it is recommended that you make further enquiries using the contact details listed at the end of this booklet prior to commencing any work.

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What is asbestos?

Asbestos is the name given to a group of fibrous silicate minerals that occur naturally in the environment. Asbestos was commonly used in many building materials between the 1940s and late 1980s because of its durability, fire resistance and excellent insulating properties. Asbestos is also present in the brakes, clutches and gaskets of many cars.

Generally, the presence of asbestos in home building materials or in car parts does not pose a risk to health unless they are:

- broken;
- in poor or deteriorated condition; or
- disturbed during activities that produce dust containing asbestos fibres.

What are the health effects of exposure to asbestos?

Some people have developed asbestos-related lung disease, such as asbestosis, lung cancer or mesothelioma, after inhaling asbestos fibres. Asbestos-related disease is generally associated with long-term exposure to asbestos in an occupational setting. However, as the level of exposure that may cause health effects is not known, exposure to asbestos fibres or dust containing asbestos fibres should always be kept to a minimum.

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Where can asbestos be found in the home?

Asbestos fibres may be found either firmly or loosely bound in a number of products once used in the Australian building industry.

Firmly-bound asbestos ('non-friable' asbestos)

Fibre-cement products formerly contained asbestos fibres, firmly embedded in a hardened cement matrix. Cellulose fibres have since replaced asbestos in today's fibre-cement products.

Asbestos-cement products that may be found around the home include:

- Flat or corrugated sheeting (commonly called 'fibro' or 'AC sheeting').
- Water or flue pipes.
- Roof shingles.
- Flexible building boards.
- Imitation brick cladding.

Other materials that may contain firmly bound asbestos fibres include:

- Plaster patching compounds.
- Textured paint.
- Vinyl floor tiles.
- The backing of linoleum floor coverings.

Loosely-bound asbestos ('friable' asbestos)

The loose form of asbestos fibres may be found in a few older forms of insulation used in domestic heaters and stoves, and in ceiling insulation products. It should be noted, however, that ceiling insulation containing asbestos was generally used in commercial buildings and it is unlikely that the ceiling insulation in a domestic building will contain asbestos. In most cases, glass fibres have replaced asbestos in today's insulation products.

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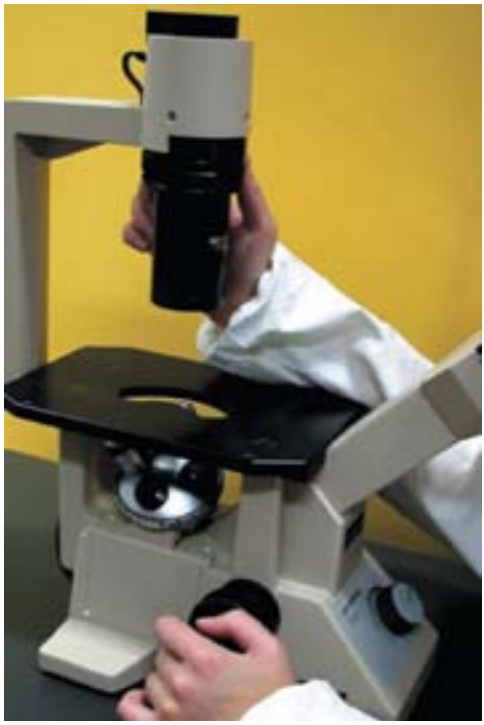
Where can asbestos be found in cars?

Care must be taken by anyone carrying out maintenance on their car brakes, clutches or gaskets.

Asbestos has been used by the automotive industry in brake linings, clutch facings, and gaskets, for many years. Asbestos-free parts are now available, and any new parts purchased or installed after 31 December 2003 must not contain asbestos.

What does asbestos look like?



It is very difficult to identify the presence of asbestos by eye. As a general rule, certain building materials installed before the late 1980s may contain asbestos. However, the only way to be certain is to have a sample of the material analysed by a laboratory. Contact the National Association of Testing Authorities (NATA) (see contact details at the end of this booklet) for an analytical laboratory in your area that is accredited to identify asbestos. This should be carried out before any general maintenance, renovation or demolition activities proceed.

If you do not want to go to the expense of testing to determine if asbestos is present, then the material should be treated as though it contains asbestos.

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What should I do if I find asbestos?

In many cases the presence of asbestos-containing building materials in the home is no cause for alarm and these materials can be left in place. For example, internal asbestos-cement sheet walls or ceilings that are in good condition and coated with paint do not pose a risk to health. Also, external asbestos-cement roofs and wall cladding do not need to be replaced unless they are broken or the surfaces have deteriorated.

Can I remove asbestos from my home myself?

A householder may legally remove asbestos from their property. As asbestos poses a health risk during removal, packaging, transport and disposal, it is important that it is handled safely during these operations.

It is recommended that loosely-bound asbestos only be removed by a licensed professional, as the health risks associated with handling this type of material are far greater than for firmly-bound asbestos.

What should I do if I need to disturb any asbestos?

Asbestos-cement building products can be maintained, removed or disposed of safely, as long as certain precautions are taken. These precautions are detailed in the next sections, and will reduce exposure to asbestos during procedures that release asbestos fibres or dust. It should be noted that if these precautions cannot be followed you should call in a licensed asbestos removalist to do the work.

It is not advisable to do any work yourself with materials that contain loosely-bound asbestos due to the increased potential health risks in handling such material. In this case, always consult a licensed asbestos removalist. A list of licensed asbestos removalists can be obtained from the Service Provider Directory at the WorkSafe Victoria website (see contact details at the end of this booklet).

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Consider your neighbours

When deciding how to work with, remove or dispose of asbestos-containing materials do not forget your neighbours. Under the nuisance provisions of the *Public Health and Wellbeing Act* 2008, any nuisances which are, or are liable to be, offensive or dangerous to health could be investigated by an environmental health officer of your local council. Consequently, any asbestos work carried out without appropriate precautions may be investigated.

Other things to consider:

- Some renovation or demolition activities may require planning approval, and/or building/demolition permits. Contact your local council's building and planning departments for more information.
- If you are employing someone to remove asbestos products from your property, that person may need to be a licensed asbestos removalist. Unlicensed contractors (tradespeople or handymen) are not allowed to remove loosely-bound asbestos, and may only remove firmly-bound asbestos if the amount to be removed is less than 10m^2 in area and they conduct asbestos removal for less than 1 hour in any 7-day period. Contact WorkSafe Victoria for more information (see contact details at the end of this booklet).

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How do I safely work with or remove asbestos-cement products?

When handling asbestos-cement roofing, sheeting or other 'fibro' products, a number of precautions need to be observed to minimise the release of asbestos fibres and dust.

Protect yourself:

- Ordinary dust masks are not effective in preventing the inhalation of asbestos fibres and dust. Wear a half-face filter respirator fitted with a class P1 or P2 filter cartridge, or a class P1 or P2 disposable respirator appropriate for asbestos. These are available from safety supply stores (refer to the Yellow Pages) and some hardware stores. Respiratory protection devices should comply with *Australian/New Zealand Standard 1716:2003.* Males should be clean-shaven, and the wearer should ensure the respirator has an airtight fit.

- Wear disposable coveralls to prevent contamination of any clothing.
- Wear a disposable hat and disposable gloves.
- After the work is complete, remove the coveralls, hat and gloves. Seal these in a container and mark 'asbestos contaminated clothing' for disposal (dispose of contaminated clothing with other asbestos waste—see later section). Leave the respirator on until contaminated clothing is removed, bagged and sealed.
- Thoroughly wash your hands and shower and wash your hair after handling asbestos.

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When working outdoors:

- Keep all windows and doors of the house closed, and cover air vents to prevent asbestos fibres and dust from entering the building.
- Avoid contaminating the soil by covering the ground and vegetation with heavy duty plastic sheeting to catch dust, debris and off-cuts.
- Remove play equipment, personal belongings and vehicles from the work area.
- Keep household members and pets away from the area until the work is completed.
- Tell your neighbours that they should close their windows and doors while the work is being undertaken.

- **Don't work with asbestos on a windy day.**

When working indoors:

- Isolate the area you are working in from the rest of the building by closing doors. However, exterior doors and windows should be left open so as to maximise ventilation.
- Cover the floor with heavy duty plastic sheeting to catch dust, debris and off-cuts.
- Keep household members and pets away from the area until the work is completed.

- **Don't walk debris through the building.**

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When handling asbestos-cement products:

- Work with asbestos-cement products in well-ventilated areas, and where possible, in the open air (but not on windy days).
- Thoroughly wet down the material before you start work by lightly spraying it with water. Keep it wet while working to reduce the release of fibres and dust. Do not use high-pressure water jets as this may increase the spread of any loose fibres or dust. Also, do not wet down sheets if it creates a high risk of slipping from a roof.
- Only use non-powered hand tools (for example a guillotine, hand-saw, or hand-powered drill) as these generate a smaller quantity of predominantly coarser dust and waste chips.
- If removing asbestos-cement sheeting, pull out any nails first and remove the sheeting with minimal breakage. Carefully lower, but not drop, the sheets to the ground and stack them on two layers of polythene sheeting, approximately 0.2 mm thick (for example heavy duty builders plastic). Avoid skidding one asbestos-cement sheet over the surface of another as this may abrade the surface of the materials and increase the likelihood of the release of fibres and dust.
- Minimise cutting or breaking up of the asbestos-cement products.

- **Don't use power tools, abrasive cutting or sanding discs, or compressed air on asbestos-cement products.**
- **Don't walk on corrugated asbestos-cement roofs, if it can be avoided. Many people have been injured by falling through weathered asbestos-cement roofs while attempting to treat or repair the roof surface.**
- **Don't leave asbestos-cement products around the garden where they may be broken or crushed.**

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As soon as practicable after the work is finished:

- Clean up any asbestos-cement residues remaining in the work area using either a wet mop or a vacuum cleaner fitted with a High Efficiency Particulate Air (HEPA) filter. Mops should be cleaned by thorough washing in a sink connected to the sewer or septic tank system. Vacuum cleaners should comply with *Australian/New Zealand Standard AS/NZS 60335.2.69:2003.* It is unsafe to use a domestic vacuum cleaner due to the poor containment of asbestos fibres and dust.
- Keep all asbestos waste wet until it is wrapped in plastic and sealed. Transport it from the site as soon as practicable, as detailed in the next section.

- **Don't clean the work area by dry sweeping, or by using a conventional vacuum cleaner.**
- **Don't store or reuse asbestos-cement sheeting. The storage, installation and reuse of asbestos-containing materials are prohibited under the Occupational Health and Safety Regulations 2007**
- **Don't leave asbestos-cement products around the garden where they may be broken or crushed.**

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How do I safely package and dispose of asbestos-cement products?

Take the following precautions when removing and disposing of asbestos-cement products:

- Protect yourself, as described previously.
- Thoroughly wet down the material before you start, and maintain it in a wet condition until packaged.
- Carefully package asbestos-cement waste, including any off-cuts, in two layers of polythene sheeting, approximately 0.2 mm thick (for example heavy duty builders plastic). Completely seal up the packages with adhesive tape and keep them to a manageable size.
- Smaller-sized asbestos waste such as tiles, off-cuts and dust can be placed in double polythene bags, approximately 0.2 mm thick. Completely tie or seal these up.
- Clearly label packages to identify the contents as shown below.

Caution—Asbestos

Do not open or damage bag

Do not inhale dust

Continued on next page...

- Place the packages in the cargo-carrying compartment of the vehicle and dispose of them at an asbestos waste disposal site, licensed by the Victorian Environment Protection Authority (EPA). Contact the EPA (see contact details at the end of this booklet) for details of a licensed asbestos waste disposal site in your area. Many sites require 24–48 hours notice before the arrival of asbestos waste.
- Alternatively, property owners can hire a mini-skip from some licensed asbestos removal companies to fill with asbestos waste, and then have it collected by the removalist. Check the Yellow Pages telephone directory under 'asbestos removal' for details of companies that provide this service.
- Contact the EPA (see contact details at the end of this booklet) for further advice on the packaging, transport and disposal of domestic asbestos waste.

- **Don't dispose of asbestos waste in a normal rubbish skip.**
- **Don't dump asbestos waste.**
- **Don't dispose of asbestos during council 'hard rubbish' collections.**

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How do I safely carry out maintenance on my car brakes, clutch or gaskets?

Asbestos is present in the brakes, clutches and gaskets of many vehicles. These parts can safely be worked on, provided the following precautions are taken:

- Work in the open air if possible, and exclude other people and pets from the area you are working in.
- Use plastic drop sheets to collect dust and debris.
- Protect yourself by wearing a respirator and disposable coveralls (as described on page 7 of this booklet).
- Use hand tools, as these minimise dust generation.
- Wet parts, before starting work, to prevent fibres and dust from becoming airborne. This method is only effective if a fine mist is used.
- Wipe parts with a damp cloth to clean them, and dispose of this cloth after use.
- Clean the work area after the job is completed, using either a wet mop or a vacuum cleaner fitted with a High Efficiency Particulate Air (HEPA) filter. Clean the mop thoroughly by washing in a sink connected to the sewer or septic tank system.
- Package and dispose of waste as described on pages 11 and 12 of this booklet.

- **Don't use compressed air to clean or help remove parts that could contain asbestos, as this will disperse asbestos fibres.**
- **Don't clean parts by either dry brushing or hitting them against a surface, as this causes dust and fibres to become airborne.**
- **Don't use air tools or power tools.**
- **Don't clean the work area by dry sweeping or using a conventional vacuum cleaner.**

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Who do I contact for further information about asbestos?

Local Council

(Environmental Health Officer)
For enquiries or complaints regarding the incorrect removal or disposal of asbestos in your neighbourhood, and for enquiries regarding the potential health effects of exposure to asbestos in the home environment.
(Refer to telephone directory)

Department of Health

(Environmental Health Unit)
For enquiries regarding the potential health effects of exposure to asbestos in the home environment.
Tel 1300 761 874
www.health.vic.gov.au/environment

Environment Protection Authority

For a list of licensed asbestos disposal sites in your area, and enquiries relating to the correct disposal of asbestos-containing materials.
Tel (03) 9695 2722
www.epa.vic.gov.au

WorkSafe Victoria

For a list of licensed asbestos removalists in your area, complaints regarding work carried out by an asbestos removalist, and enquiries or complaints regarding asbestos in the workplace.
Tel 1800 136 089
www.workcover.vic.gov.au

National Association of Testing Authorities

For a NATA-accredited laboratory in your area that can identify asbestos.
Tel (03) 9329 1633
www.nata.asn.au

This booklet was prepared by the Environmental Health Unit, Victorian Government Department of Health, in consultation with WorkSafe Victoria, the Environment Protection Authority, local government and the Building Commission.
February 2010.

CD/13/352807

State Government Victoria Department of Health

Coroners Court of Victoria
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F 03 8688 0703
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Ms Vicki Hamilton
CEO
GARDS Inc
P.O. Box 111
Moe
VICTORIA 3825

COPY

2 December 2010

Dear Ms Hamilton,

Asbestos related Deaths

Thank you for your letter of 1 November, 2010. I apologise for the delay in a formal written response to you, but as I indicated when we met recently, I have been making a number of enquiries in order to address the concerns you have raised. I considered it more appropriate to wait until the information I sought had been collected, rather than responding in a piecemeal way.

As I have already indicated to you, prior to 2004, asbestos related deaths were not reported to the coroner in Victoria unless circumstances revealed that the death occurred within another definition of reportable death.

In 2004, I am advised that the previous State Coroner made a direction that asbestos related deaths should be reported to the coroner. It is not clear as to whether this direction was given based on an interpretation of the meaning of *reportable death*. As I have indicated to you, I have canvassed all of the other jurisdictions and confirmed that there is no other jurisdiction in Australia or New Zealand that interprets a "reportable death" as a matter of law to include death as a result of asbestos related disease. I agree with this interpretation of the law, that is, that death as a result of asbestos related illness does not fall within the definition of "reportable death" *per se*. As discussed with you, if your group sought to have the coronial jurisdiction extended in Victoria to include asbestos related death prescribed as a "reportable death", you may wish to request the Attorney- General refers this issue to the newly established Coronial Council for consideration.

Many of the deaths that were reported to the coroner after the 2004 direction were not investigated by means of an autopsy being undertaken, or indeed the deceased being transported to the Coronial Services Centre. Instead, many of the cases appear to have involved a review and assessment of the medical cause of death by relying on the death certificate and medical records. On my enquiries, it is not clear how such investigations would assist in adding to any public health and safety issues surrounding asbestos related disease.

To obtain a medical perspective on the issue, I sought assistance and advice from Associate Professor David Ranson, the Acting Director of the Victorian Institute of Forensic Medicine. I provided him with copies of your correspondence. Dr Ranson confirmed that there were a

variety of disease and pathological processes associated with exposure to asbestos. Some of these processes may occur over years or even decades.

Dr Ranson confirmed that in his view, examinations of medical records, confirming the presence of asbestos related disease added little to public health advances in this area.

I have also sought information from the National Coroner's Information System. This enquiry produced the following information. In Victoria, the figures indicate that deaths reported to a coroner over the past 5 years, which *may* have been due to asbestos exposure averaged 163 a year. Dr Ranson identified that in order to undertake a comprehensive investigation of deaths that may be due to asbestos exposure, specialised occupational health expertise would be required in view of the delayed onset of asbestos related diseases. Further, any proper investigation of such deaths would, amongst other investigatory matters, require a pathological examination, (that is, an autopsy), a matter that requires balancing families' distress over such an examination and a public health issue that is now well known and regularly litigated.

As a consequence, Dr Ranson opined that this issue would be best served by the establishment of a comprehensive asbestos disease registry which would identify cases on diagnosis, and undertake systematic and comprehensive investigations into asbestos exposure and medical histories. This type of system would have the advantage of being able to obtain information directly from the affected individual by an occupational health professional, and through the gathering of accurate and reliable epidemiological information. Dr Ranson indicated that there are a number of specialist disease registries in Australia and advised that Professor John McNeil from Monash University is heavily involved in the organisation, management, sponsorship and evaluation of such registries.

Further, the Coroners Court through the Coroners Prevention Unit (CPU) have identified that the establishment of an Australian Mesothelioma Registry was announced by the then Deputy Prime Minister, the Hon Julia Gillard MP in April 2010. This registry is based in the Cancer Institute of NSW and managed by a consortium including the Monash Centre for Occupational and Environmental Health, the University of Sydney, Western Australian Cancer Registry and the Asbestos Disease Research Institute. The Registry is funded by Safe Work Australia, and will collect and investigate all notifications of new cases of mesothelioma from the cancer registries of all states and territories. This registry should be able to provide your organisation with details of its operation, and the future availability of statistics and reports. Such a register may indeed, be beneficial and useful to meet the needs of GARDS.

Finally, I understand that your interest with respect to our jurisdiction is to use our information for the purposes of data collection. As I mentioned to you recently, the Registry of Births, Deaths and Marriages would be a better source of accurate data collection for your purposes.

I hope this information is of assistance to you.

Yours sincerely

Judge Jennifer Coate
State Coroner