NEW ZEALAND LAW SOCIETY

NZLS EST 1869

CORONERS AMENDMENT BILL

25/03/2015

SUBMISSION ON THE CORONERS AMENDMENT BILL

1. The New Zealand Law Society (Law Society) welcomes the opportunity to comment on the Coroners Amendment Bill (Bill). The changes proposed in the Bill – in particular the proposals to impose time limits on coroners' findings – are welcome and timely. This submission sets out the Law Society's comments on some issues which are of a technical nature.

Proposed amendment to the purpose of the Coroners Act 2006 (Act) – clause 4

2. Clause 4 makes consequential changes to the purpose provision to reflect the new section 57A and the repeal of the definition of "specified recommendations or comments". Proposed section 57B requires the coroner to:

   a. notify certain persons, including any persons or organisations to whom a recommendation or comment is directed, of a proposed recommendation or comment; and

   b. record any comments received from those persons or organisations (or a summary of those comments) in a register that is available to the public.

3. Drawing recommendations to public attention may reassure the public that action is being taken to prevent a similar incident but it is not clear that it will "reduce the chances of further deaths". There is empirical evidence that shows it is the interaction with the organisation concerned that is more likely to reduce the chance of further deaths.

4. The Law Society recommends that the Act, and in particular the new section 57B, be strengthened by adding a requirement to report back on what has been done in response to a recommendation and publishing any failure to respond or inadequate response. There is evidence that this would be effective in ensuring recommendations are taken seriously.[1]

Proposed amendment to the interpretation section of the Coroners Act 2006 (Act) – clause 7

5. There is currently no definition of "adverse comment" in the Bill or in the 2006 Act.

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1 See Moore, J. *An Empirical Approach to the New Zealand Government's Review of the Coronial Jurisdiction* (2014) 21 *Journal of Law and Medicine* 602, 614-620.

6. There is evidence that the definition of "adverse comment" presents issues for some coroners and organisations.[2] Different coroners take different approaches to what constitutes adverse comment and, therefore, whether parties should be notified under section 58. The requirements of section 58 are important to protect natural justice rights where a coroner proposes to make an adverse comment about a party. It is important the scope of this provision be as clear as possible.

7. The Law Society recommends that "adverse comment" be defined in section 9 (clause 7 of the Bill).

Suicide Reporting – clause 38

8. The Law Society supports the amendments to provisions relating to suicide reporting contained in clause 38 of the Bill. The clause replaces sections 70 and 71 of the Act with new sections 70 to 71A. Section 71 and 71A implement the Law Commission's recommendations on suicide reporting.

9. Section 71 provides greater clarity about what cannot be made public, subject to exemptions. The Law Society supports this approach, particularly the inclusion of the proposed section 71(2)(c). The description of a death as a suicide needs a finding to be made by the coroner, and such a finding can only be made after a high evidential threshold is met.

10. The proposed new section 71A enables the Chief Coroner to grant exemptions from restrictions in proposed section 71. The Law Society supports this amendment in broad terms.

11. Although the Chief Coroner "may" request advice from the suicide and media expert panel, there is no express requirement in section 71A for the Chief Coroner to consult with or seek the view of interested parties when deciding whether to grant an exemption. A new definition of "interested party" will be inserted by the Bill into section 9 of the Act. It will include representatives of the immediate family of the deceased; any person whose conduct

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[2] Moore, J. *An Empirical Approach to the New Zealand Government's Review of the Coronial Jurisdiction* (2014) 21 Journal of Law and Medicine 602, 620; Moore, J and Henaghan M. (October 2014) Final Report: New Zealand Coroners' Recommendations, 2007 – 2012. (Funded by NZLF, Wellington and Dunedin, 2014). http://www.lawfoundation.org.nz/?page_id=2565

is likely to be called into question during the course of the inquiry; and any other person that the responsible coroner considers has an interest in the death or suspected death.

12. The Law Society recommends that section 71A be amended to include a requirement that the Chief Coroner consult with interested parties when deciding to grant an exemption. Such a requirement would be fair to those most likely to be affected by possible publicity. It would also be consistent with the proposed amendment to sections 23 and 24 of the Act (see clause 16).

13. The Law Society accepts that consideration of any application to the Chief Coroner must be dealt with promptly (new section 71A(2)(a) and 71A(4)). Nonetheless, the identity of interested parties will be known at the point the application is considered by the Chief Coroner. Any potential delay can be mitigated by the imposition of time limits on the interested parties to provide their responses to the coroner. If the coroner is permitted to request advice from a suicide and media expert panel, then a window of time exists for interested parties to be consulted.

Deaths in Custody - clause 41

14. The objective of clause 41 (which replaces section 80 of the Act) is to remove the need for an inquest to be held in respect of every death occurring in official custody or care, taking into consideration that a percentage of such deaths appear to be from natural causes. It changes section 80 from a mandatory provision, to one requiring a coroner, in deciding whether to hold an inquest, to consider whether either or both of two sets of circumstances apply.

15. Proposed new section 80 states:

> *(1) A coroner conducting an inquiry into a death must decide whether to hold an inquest for the purposes of the inquiry.*
>
> *(2) In deciding whether to hold an inquest, a coroner must consider whether either, or both, of the following applies in relation to the death:*
>
> *(a) the dead person was, at the time of death, a person in official custody or care (as defined in section 14(3)) and the negligence or misconduct*

of a person other than the dead person appears to have contributed to the dead person's death:

(b) an inquest would assist the inquiry into the death by providing an opportunity for persons who have not been involved in the inquiry to –

(i) scrutinise evidence considered by the coroner as part of the inquiry; or

(ii) offer new evidence in respect of the death.

16. The Law Society supports the removal of the need to hold an inquest for all deaths in custody. The wording of new section 80(2) should however be clarified to ensure that it is interpreted in the manner intended. The wording could be taken to mean that section 80(2) introduces threshold considerations: i.e. circumstances that must exist before an inquest can be held. As the Law Society understands it, that is not the intention. Rather the intention is that section 80(2) confer a broad discretion, and a decision not to hold an inquest could be reached even if (for example) section 80(2)(a) applied.

17. The objective of clause 41 could be met by a simpler approach. Subsections 80(2)(a) and (b) could be replaced with a section 80(2) that requires a coroner to consider any evidence that suggests the death was due to natural causes. If the evidence is sufficient, on the balance of probabilities, to show that the death was due to natural causes then a coroner would have discretion after considering the evidence, not to hold an inquest and to comply with section 77 instead (being a hearing on the papers and a chambers finding). Issues of negligence or misconduct are already addressed in the provisions of the Act that give a coroner the power to make recommendations or refer the death to other investigating authorities if it is in the public interest.

18. The Law Society recommends that proposed section 80(2) be amended along the following lines:

"In deciding whether to hold an inquest a coroner must consider all of the evidence relating to the causes and circumstances of death and whether such evidence indicates, on the balance of probabilities, that the death in official custody or care was due to natural causes."

Healthcare-related Reportable Deaths – clause 9

19. Clause 9 replaces sections 13 and 14 of the Act, which set out the circumstances in which a death must be reported to the Police.

20. The reporting requirements set out in the proposed amended section 14(2)(b)(ii) and (2)(c)(ii) include the statutory test of whether a reasonable health practitioner would have expected a death to occur in the particular circumstances.

21. Coronial legislation is typically drafted to require the reporting of deaths which may have occurred as a result of adverse medical events. However, "the linkage between the legislative definitions of reportable death and adverse medical treatment events is not always clear."[3] Furthermore, "confusion and lack of clarity in the legislation"[4] often make it difficult for doctors to determine reportable deaths in health care.

22. The Law Society understands that many medical and other health practitioners find it difficult to determine whether particular deaths that occur in the hospital environment require reporting.[5] There are inconsistent practices around the country with different coroners having different expectations.

23. Another issue is that there is currently no way of monitoring whether health care related deaths that should have been referred to the coroner have in fact been referred.

24. The proposed amendment introduces the new concept of whether the "reasonable health practitioner" would have expected a death to occur in such circumstances. This raises a number of questions, such as how the particular practitioner is expected to make this assessment; whether formal consultation with colleagues is required; whether the medical literature should be consulted; and whether there will be guidelines to assist health practitioners making this determination.

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3 Ian Freckleton and David Ranson "The Evolving Institution of Coroner" in *Disputes and Dilemmas in Health Law* (Federation Press, Sydney, 2006) 296, 298.

4 Ibid, at 300.

5 Jennifer Moore and NZ Law Commission "Review of Death and Cremation Certification in New Zealand: Submissions Analysis" (NZLC, Wellington, November 2011) 41.

25. Section 10AA of the Queensland Coroners Act 2003 (**attached**) defines health care related death as one where:

> *"a person dies at any time after receiving health care that either caused, or is likely to have caused, or contributed or is likely to have contributed to the death, and immediately before receiving the health care, an "independent person **would not have reasonably expected that the health care would cause or contribute to** the person's death".* (Emphasis added)

26. The approach in Queensland differs from that proposed in the Bill in a number of respects.

27. First, it introduces the concept of the "independent person", which could replace the "reasonable health practitioner". The concept of independence emphasises the need for an assessment of the health care to be made objectively by someone unconnected with the particular health care case, having regard to relevant matters. Requiring health professionals who have been involved in the particular health care case to determine what needs to be reported has proven problematic.

28. Second, section 10AA also includes in the definition of health care related deaths, failures to provide health care. This could encompass conscious decisions made by a health professional not to start a lifesaving treatment such as CPR, in the admittedly mistaken belief that a person was already dead, when CPR may have resuscitated the person.

29. Third, section 10AA does not differentiate between deaths resulting (or appearing to result from) a medical procedure, anaesthetic, and deaths resulting from pregnancy or childbirth (the latter two being dealt with under proposed subsections 14(2)(c) and (d), respectively). The differentiation in subsections 14(2)(c) and (d) creates uncertainty for health professionals.

30. In addition, practice notes on the reporting of health care related deaths could be issued by the Chief Coroner to assist health professionals with making decisions on what deaths need to be reported.

31. The Law Society recommends that:

a. proposed section 14(2)(b) be redrafted to provide a more objective test viewed from an "independent person" rather than the "reasonable health practitioner" and to adopt other features of the Queensland definition; and

b. the Act be amended to enable the Chief Coroner to issue practice notes on the reporting of health care related deaths.

Retention and Return of Human Tissue (clauses 27 and 28)

32. The Law Society agrees with the intent of clauses 27 and 28 and in particular the removal of requirements which place unnecessary distress on families when minute human tissue samples are retained.

33. The definitions of "immediate family" in the Human Tissue Act 2008 and Coroners Act 2006 differ slightly:

> *Human Tissue Act 2008*
>
> *" … (b) to avoid doubt, includes a person whose relationship to the dead individual was, or was a relationship that is established through, 1 or more of the following relationships: … "*
>
> *Coroners Act 2006*
>
> *" …. (b) to avoid doubt, includes persons whose relationship to the dead person is, or is through, 1 or more relationships that are, that or those of —…"*

34. The Law Society recommends that these definitions should be consistent and that the Human Tissue Act definition is preferable as it is less confusing.

35. Clause 27 of the Bill replaces section 50 of the Coroners Act, requiring notice to be given to the immediate family (and any representative of the family recognised under section 22 of the Act) if a body sample is being retained. Section 22 provides as follows:

> *22 Representative for liaison with immediate family*
>
> *"[subsection 22(1) to be repealed by clause 15 of the Bill]*
>
> *(2) To facilitate effective liaison with the immediate family on the duties and processes required by law to be performed or followed in relation to the*

death, the coroner may, on a request by, or on behalf of, the immediate family, recognise and, after recognition, liaise mainly with, 1 or more representatives of the immediate family.

(3) The coroner may recognise under this section only the smallest number of representatives necessary to represent fairly the interests of all the different members of the immediate family.

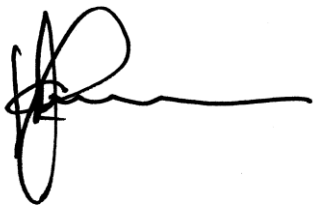
(4) No recognition under this section is effective until the coroner is given a proposed representative's name and contact details.

(5) Nothing in this section requires the performance or exercise of functions, powers, or duties in relation to the death to be delayed until a representative is recognised, or until his or her details are given to the coroner."

36. There is no provision for the resolution of intra-family conflicts regarding the return of samples or identification of the family member or representative to whom they will be returned. The Law Society recommends that these issues be addressed in the legislation. Alternatively they could be the subject of guidance from the Chief Coroner.

Conclusion

37. The Law Society does not wish to appear in support of this submission. However, the Law Society is willing to meet with the Committee or officials advising if the Committee considers that would be of assistance.



Chris Moore
President
25 March 2015

Attached: section 10AA, Queensland Coroners Act 2003

Section 10AA, Queensland Coroners Act 2003

10AA *Health care related death* defined

(1) A person's death is a ***health care related death*** if, after the commencement, the person dies at any time after receiving health care that—

(a) either—

(i) caused or is likely to have caused the death; or

(ii) contributed to or is likely to have contributed to the death; and

(b) immediately before receiving the health care, an independent person would not have reasonably expected that the health care would cause or contribute to the person's death.

(2) A person's death is also a ***health care related death*** if, after the commencement, the person dies at any time after health care was sought for the person and the health care, or a particular type of health care, failed to be provided to the person and—

(a) the failure either—

(i) caused or is likely to have caused the death; or

(ii) contributed or is likely to have contributed to the death; and

(b) when health care was sought, an independent person would not have reasonably expected that there would be a failure to provide health care, or the particular type of health care, that would cause or contribute to the person's death.

(3) For this section—

(a) health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had not been provided; and

(b) a failure to provide health care contributes to a person's death if the person would not have died at the time of the person's death if the health care had been provided.

(4) For this section, a reference to an independent person is a reference to an independent person appropriately qualified in the relevant area or areas of health care who has had regard to all relevant matters including, for example, the following—

(a) the deceased person's state of health as it was thought to be when the health care started or was sought;

Example of a person's state of health— an underlying disease, condition or injury and its natural progression

(b) the clinically accepted range of risk associated with the health care;

(c) the circumstances in which the health care was provided or sought. Example for paragraph (c)—

It would be reasonably expected that a moribund elderly patient with other natural diseases would die following surgery for a ruptured aortic aneurysm.

(5) In this section—

commencement means the commencement of this section.

health care means—

(a) any health procedure; or

(b) any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health.