THE LAW SOCIETY
OF NEW SOUTH WALES

Our ref: MedicoLegal:REIw:898749

16 September 2014

The Director
Justice Policy
Department of Justice
GPO Box 6
SYDNEY NSW 2001

By email: justice.policy@agd.nsw.gov.au

Dear Director,

Review of the *Coroners Act 2009*

I write to you on behalf of the Medico Legal Liaison Committee ("the Committee") of the Law Society of New South Wales to provide its submission in relation to the statutory review of the *Coroners Act 2009* ("the Act").

The Committee comprises both lawyers and medical practitioners, who meet regularly to work together on matters of mutual interest in the medico-legal field. Many members have significant experience in the coronial jurisdiction, representing families and other interested parties, including health professionals and health care entities. It also includes medical practitioners who act as independent expert witnesses in a variety of contexts.

1. Civil liability

The Committee submits that the aims of the Act would be furthered by amendments to sections 81 and 82 to preclude suggestions by the coroner of civil liability on the part of a person or entity. Such amendments would both clarify the focus of the coronial jurisdiction and ensure consistency with other state jurisdictions. The Committee believes that any consideration of civil liability in a coronial investigation or inquest goes beyond the objects of the jurisdiction set out in section 3 of the Act, relevantly to establish circumstances and cause of death, and to make recommendations, including for public safety and further investigation.

The Committee is concerned that some inquests have involved the canvassing of issues related to civil liability even if only in an indirect or unintentional way. This has been observed particularly in relation to inquests involving health care. Committee members have seen experts commissioned by the coroner address those issues without any prompting, and witnessed questions put by counsel or sergeants assisting the coroner which touch on such issues. This may often happen unintentionally. While coroners do often emphasise carefully that coronial investigations and inquests do not involve issues of civil liability, the Committee has questioned the necessity of some criticism made by coroners in view of the objects and functions of the inquest.

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In particular, it is the Committee's concern that those persons or entities potentially subject to such criticism will often not have had a proper opportunity to respond to any suggestion of civil liability in the coronial jurisdiction as is provided in a civil court governed by different imperatives and rules of evidence.

By way of comparison, coroners in Queensland (sections 45 and 46, *Coroners Act 2003* (Qld)), South Australia (section 25, *Coroners Act 2003* (SA)) and Western Australia (section 25, *Coroners Act 1996* (WA)) are precluded from indicating or suggesting in their findings and recommendations that a person is civilly liable.

The Committee is concerned that the absence of clear guidance provides scope for the issue of civil liability to be explored, however unintentionally. The Committee respectfully submits that amendments to sections 81 and 82 of the Act, precluding any suggestion of civil liability in findings or recommendations, would avoid these issues arising and confirm the function and scope of the coronial jurisdiction.

Noting the Committee's later proposals in relation to potential professional disciplinary issues, the Committee's proposals in regards to civil liability are not meant to apply in relation to those other issues.

2. Suggestions or findings relating to disciplinary issues

The Committee seeks amendment of the Act to ensure that health professionals and entities who may be the subject of:

(a) findings or recommendations which may make suggestions of unprofessional, unsatisfactory or unethical conduct, or breaches of expected professional standards; and / or

(b) referrals for investigation,

are given an appropriate opportunity to respond before any such findings or suggestions are made, and that such findings or suggestions cannot be made without the opportunity to respond being provided.

It is acknowledged that suggestions or findings relating to such issues often go hand in hand with the coroner's function to make recommendations relating to public health and safety, and referrals for investigation. However, the Committee is concerned that where such steps can involve serious, adverse implications to the reputation and position of individuals or entities in question, that they have a proper opportunity to respond.

The Committee acknowledges that professionals or entities who may be the subject of adverse comment or referral for investigation are often given a proper opportunity to respond through giving evidence, being granted leave to appear and making submissions as interested parties. However, there is no clear mechanism for this to occur, creating the risk of inconsistency. In addition, what the coroner or those assisting are contemplating in terms of findings or referrals is not always clear.

The Committee respectfully submits that it is necessary that those potentially the subject of such suggestions, findings or referrals are made aware of this and are given an opportunity to respond, preferably by being granted leave as an interested party and being able to make submissions on those issues.

3. Referral of a health professional for investigation

The Committee proposes that section 82 of the Act be amended so as to set out the issues to be considered by the coroner in deciding whether to refer the conduct of a health professional or health care entity to the NSW Health Care Complaints Commission ("HCCC") for investigation.

At present, the Act does not offer any guidance on the circumstances in which a professional or entity should be referred to another body for investigation. However, one may infer from the reference in section 82 to "public health and safety" that referrals are considered where such issues arise. However, this is a criteria which lacks clear guidance and is open to inconsistent interpretation.

The HCCC, to which referrals of health professionals and other health care entities are made, has its own criteria for investigation. This is set out in section 23 of the *Health Care Complaints Act 1993* (NSW), namely:

(a) if a professional council wants the matter to be investigated (such councils being arguably best placed to judge whether certain conduct warrants investigation);

(b) a significant issue of public health and safety is raised (which is a higher threshold than set out in section 82 of the Act);

(c) the complaint may provide grounds for disciplinary action;

(d) the complaint if substantiated would involve gross negligence;

(e) the complaint raises a significant question as to the appropriate care or treatment; or

(f) the compliant involves certain issues relating to promotion of health services or provision of health care by deregistered or prohibited persons.

Although the Committee acknowledges that, on one view, a coronial referral to the HCCC has merely the effect of a complaint, which the HCCC then considers whether to investigate, from the experience of its members such referrals are often considered as meeting the threshold for investigation, even though the same test has not been followed.

4. Section 61 - Privilege in respect of self-incrimination

The Committee requests that consideration be given to an extension of the scope of section 61 of the Act. It is submitted that such an extension would assist in fulfilling the objects of determining manner and cause of deaths, and making recommendations to enhance public health and safety, as provided in section 3 of the Act.

At present, section 61 provides an opportunity for witnesses giving evidence in coronial proceedings to seek a certificate preventing use of their evidence in a variety of other contexts against them. The coroner will provide such a certificate if there are reasonable grounds for the witness to object to giving evidence on the grounds that it may tend to prove they have committed an offence, or that they are liable to a civil penalty.

The section 61 mechanism does not extend to written statements sought by a coroner prior to the inquest. In these circumstances, witnesses must consider whether to decline to give a statement, or to provide only a truncated statement, if they are concerned that the statement may be used against their interests in any other context. The opportunity exists for an

interested party granted leave to appear at a directions hearing prior to the inquest to seek a section 61 certificate for a statement they subsequently provide. However, such directions hearings are usually only held in the weeks leading up to the inquest, and the coroner and those assisting them therefore receive such statements very late, after substantive investigations are completed. The late provision of such statements can mean the focus of inquests is changed at a late stage, which can result in wasted costs and the requirement for further investigations.

The problems caused by the lack of a section 61 mechanism for statements sought by the coroner apply particularly to health professionals. Under section 82 of the Act, the coroner has power to refer individual health professionals to the HCCC to consider possible disciplinary action. The possibility of such a recommendation can cause health professionals and their representatives significant reservations about providing any, or any meaningful, statement at the coroner's request prior to inquest if there is any concern that their actions may be open to criticism and there is no protection available at that stage against self-incrimination.

The Committee suggests that the objects of the Act would be furthered by fulsome, open provision of information sought by the coroner from witnesses at an early state of investigation. It is of the view that the present scope of section 61 causes inconsistency, compromises coronial investigations and can lead to inefficient conduct of inquests, where changes in focus and further investigation can be necessary at too late a stage.

A useful comparison can be drawn with the conduct of root cause analysis ("RCA") investigations in public and private hospitals under Division 6C of the *Health Administration Act 1982* (NSW) and Part 4 the *Private Health Facilities Act 2007* (NSW). Such investigations focus on assessing the cause/s of health care incidents and improvements which can be made to prevent similar incidents. Under section 20R of the *Health Administration Act* and section 47 of the *Private Health Facilities Act*, notifications to health care bodies relating to issues of unsatisfactory conduct, or RCA reports, cannot be used in evidence in other contexts. Clearly, this facilitates full and frank disclosure by health professionals when health care incidents are being investigated, providing the best opportunity for investigators to determine why something occurred and how it can be prevented. Coronial investigations and inquests face similar imperatives.

The Committee proposes that the scope for section 61 be extended to situations where the coroner seeks a written statement from a witness at any time prior to or during an inquest, utilising the same mechanism as presently provided for in the provision. Accordingly, if a certificate was granted, a privilege would attach to such material in subsequent criminal, civil and disciplinary proceedings. This would allow a witness, from whom a statement is sought, to consider whether there are reasonable grounds to seek a certificate and:

(a) if there are reasonable grounds, for the witness to receive a certificate; or

(b) if there are not reasonable grounds, there remains the opportunity for the witness to renew their request for a certificate after the statement has been provided. Coroners may alter their decision based on further information.

The Committee acknowledges that the coroner and those assisting them may face difficulty in determining, before a statement is provided, whether there is a proper basis to grant a certificate. However, it is submitted that in many contexts, particularly that of health care involving contemporaneous records, there would often already be considerable information available to the coroner and those assisting to allow a considered decision to be made. In any event, the opportunity remains for the application for a certificate to be renewed after the statement is provided.

5. Findings when an inquest has been dispensed with

Currently section 25 of the Act provides that a coroner may dispense with an inquest in certain circumstances as specified in the section. Section 26 provides for reasons to be given by a coroner for dispensing with an inquest. However, the Act does not provide for a coroner to make findings as to manner and cause of death in circumstances where an inquest is dispensed with. According to section 81 findings as to cause and manner of death are to made by a coroner in circumstances where a matter has proceeded to inquest and at the conclusion of or on the suspension of an inquest.

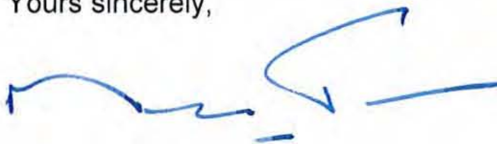
It is submitted that it may be appropriate for a coroner to make findings as to cause and manner of death in circumstances where a decision is made to dispense with an inquest pursuant to section 25 and that consideration be given to amending the Act to provide for this. Importantly, any such amendment would need to include sufficient safeguards to ensure procedural fairness and that the Act explicitly provide that the coroner must not include in the findings any statement or suggestion that any person or body is, or may be, either guilty of an offence or civilly liable. It is further submitted that the power to make recommendations currently contained in section 82 of the Act should be limited to circumstances in which a matter has proceeded to inquest.

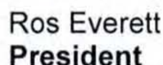
Currently, in some other Australian jurisdictions, it is not mandatory that an inquest be held prior to a coroner making findings. For example, the *Coroners Act 2003* (Qld) provides that a coroner investigating a death must, if possible, make findings as to matters set out at section 45(2) including how the deceased person died and what caused the person to die and to provide a written copy of the findings to a family member of the deceased person. According to section 45(6) the section applies whether or not an inquest is held. Similarly, section 67 of the *Coroner's Act 2008* (Vic) provides that a coroner investigating a death must make certain findings, if possible, although this is not required if an inquest is not held.

It is submitted that enabling a coroner to make findings when dispensing with an inquest, may potentially assist many families of deceased persons obtain a better understanding of the cause of death and closure. The proposal is consistent with an efficient use of resources of the coronial jurisdiction for the public benefit both in terms of providing greater access to information obtained as a result of coronial investigations and minimising expenditure of resources in matters proceeding to inquest to enable findings to be made.

The Committee thanks you for the opportunity to make this submission. If you have any questions please contact Leonora Wilson, policy lawyer for the Committee on (02) 9926 0323 or by email to leonora.wilson@lawsociety.com.au .

Yours sincerely,





Ros Everett
President