Submission No 5

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: MIGA

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General Enquiries
and Client Service
P 1800 777 156
F 1800 839 284

Claims and Legal
Services
P 1800 839 280
F 1800 839 281

www.miga.com.au
miga@miga.com.au

Postal Address
GPO Box 2048, Adelaide
South Australia 5001

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The Hon Adam Searle MLC
Chair
Select Committee on the coronial jurisdiction in New South Wales
Parliament of New South Wales

Via online submission

Dear Chair

MIGA submission – Coronial jurisdiction in New South Wales

As a medical defence organisation and professional indemnity insurer, MIGA appreciates the opportunity to provide a submission to the committee's inquiry into the coronial jurisdiction in New South Wales.

Summary - MIGA position

MIGA supports the overall framework and operation of the New South Wales coronial system, but proposes

- Initiatives to improve operation and efficiency in coronial healthcare matters
- A range of changes to the *Coroners Act 2009* (NSW).

It is also supportive of the Coroners Court of New South Wales becoming a stand-alone court.

MIGA's interest

MIGA advises assists, educates and advocates for medical practitioners, medical students, healthcare organisations and privately practising midwives across New South Wales and throughout Australia.

With more than 36,000 members nationwide MIGA has represented the medical profession for over 121 years and the broader healthcare profession for more than 18 years.

For many years MIGA has supported its members and clients in coronial matters both in New South Wales and across the country. It participated in the Attorney-General's review of the *Coroners Act 2009* (NSW) and the Coroners Court of New South Wales medico-legal users group. As part of its risk education activities it educates the profession on coronial processes.

Coronial processes in healthcare matters

There is no question the coronial jurisdiction is a busy one.

Much work is done 'behind the scenes', particularly on the many coronial matters which do not go to inquest.

Inquests themselves are time intensive and resource heavy, particularly those involving healthcare.

MIGA is concerned by delays in healthcare matters being finalised, whether through inquest or otherwise. This is not a new issue. Delays of between 4 to 5 years between deaths reported to the Coroner and inquests are not in the interests of family members, those involved in a deceased's healthcare and Coroners Court itself.

Whether the Coroners Court is sufficiently resourced for healthcare matters and more generally deserves careful consideration. However MIGA is conscious that resources are finite. Additional resourcing is not the answer to all issues of operation and efficiency in coronial matters.

For healthcare matters there are a range of other measures that could assist with coronial operation and efficiency.

Between 2015 to 2017 the Coroners Court medico-legal users group (which MIGA was part of) contributed to a number of initiatives directed at improving conduct and efficiency of healthcare matters. This included practice notes / guidance, evidence gathering, matter management and inquest conduct. MIGA would like to see this productive mechanism, involving a range of interested stakeholders, resume.

As part of the work of a users group and / or more broadly, consideration should be given to the following

- Clarifying with the healthcare profession deaths reportable to the coroner
- Using only police trained in healthcare coronial matters to gather evidence and prepare coronial briefs of evidence
- Greater reliance on persons / entities involved in a deceased's healthcare to provide statements (usually via their healthcare facility, professional indemnity insurer or professional association), rather than police taking the lead in statement preparation
- Early engagement of lawyers by the coroner where a healthcare matter is likely to proceed to inquest
- Earlier scope for liaison between the coroner, police and interested parties, including via case management conferences and directions hearings, in healthcare matters
- Criteria / factors for holding / dispensing with a healthcare inquest.

MIGA is aware of the Improving Timeliness of Coronial Procedures Taskforce, involving the Coroners Court and various government agencies, established in mid-2019. It sees the taskforce's remit as being directed towards matters which do not require investigation or inquest. In addition, it is not focused on healthcare matters.

Proposed changes to the Coroners Act

A range of changes to the *Coroners Act* would also improve operation and efficiency of the coronial jurisdiction, both in relation to healthcare matters and more broadly. These include

- Including as a guiding principle the need to provide procedural fairness to those involved in coronial processes, particularly those whose interests may be impacted by adverse findings and recommendations
- Moving from an essential presumption that an inquest will be held, to providing discretion to hold an inquest in certain circumstances (ss 21, 25 and 27)
    - The current approach may contribute to prolonged, unnecessarily wide investigations and late decisions not to hold an inquest
    - An approach where an inquest is not the default could assist in improving efficiency of coronial matters, particularly through more focused investigation
- Extending the existing scope for a coroner to grant a certificate against use of evidence in other contexts to written statements provided prior to inquest or in an investigation where no inquest is held (s 61)
    - This would extend to use of statements in criminal, civil, disciplinary and administrative contexts
    - Such protections would provide significant comfort to interested parties, particularly healthcare and other professionals, in providing statements at an early stage
    - Concern about use of statements in civil or disciplinary matters can be an impediment to provision of early, fulsome statements and may also contribute to more matters proceeding to inquest
    - There is no compelling reason why such a protection exists for evidence given in inquests / proceedings only, and not in the context of an investigation
- Removing the requirement for a subpoena to be served by police or the sheriff (s 68)
- Clarifying that coroners cannot make findings or suggestions of civil liability (ss 81 and 82)
    - Issues of civil liability are beyond the scope of the coronial jurisdiction
    - This would assist in avoiding inappropriate references in evidence or submissions to civil liability
    - Similar preclusions already exist in other states' coronial legislation

- Clarifying issues to be considered by a coroner before referring the conduct of a professional or entity to another body (s 82)
    - This would assist in determining the appropriate entity to make a referral to and whether such a referral is necessary
    - It would also help in determining the nature of the referral which should be made – for example, there can be confusion when a matter is referred to the Health Care Complaints Commission whether it is a matter recommended for assessment or investigation
- Ensuring that professionals and entities
    - Who may be subject to findings and recommendations which suggest professional disciplinary breaches (such as under the *Health Practitioner Regulation National Law* as it applies in New South Wales) and / or
    - Are referred to other entities for review / investigation,

  have an appropriate opportunity to respond before such findings, suggestions or referrals are made (s 82)
- Allowing service of documents and other material by electronic means (s 105).

A stand-alone Coroners Court

MIGA would support the Coroners Court becoming a stand-alone body, separate to the Local Court of New South Wales, as is the case in other Australian states.

It believes this could assist in

- Ensuring coroners can have necessary tenure to develop specialist expertise required for coronial matters
- Better assessing funding and resourcing needs
- Allowing broader scope for coronial data collection and analysis, including through dissemination in a stand-alone annual review / report.

Next steps

MIGA would welcome the opportunity to explore these issues further with the committee.

If you have any questions or would like to discuss, please contact me.

Yours sincerely

Timothy Bowen
Manager – Advocacy & Legal Services