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INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: New South Wales Nurses and Midwives' Association

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NSW NURSES & MIDWIVES' ASSOCIATION

Submission to the NSW Legislative Council Select Committee on the Coronial Jurisdiction in New South Wales

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Recommendations

1. The Committee consider appropriate funding for the Coroner's Court as well as the Crown Solicitor's Office and the Department of Communities and Justice, in relation to services to the Coroner's Court.

2. The Committee consider the adequacy of training of NSW Police in relation to coronial matters, the allocation of officers as an OIC and a protocol highlighting the rights of people who are asked to provide a statement in coronial matters.

3. The Committee consider what provisions could be made to facilitate access to hearing transcripts to all parties at no cost.

4. The Committee consider the provision of access to specialised resources and counselling for witnesses.

Foreword

The New South Wales Nurses and Midwives' Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes: registered nurses; enrolled nurses and midwives at all levels including management and education, and assistants in nursing and midwifery.

The NSWNMA has approximately 73,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

NSWNMA strives to be innovative in our advocacy to promote a world class, well-funded, integrated health system by being a professional advocate for the health system and our members. We are committed to improving standards of patient care and the quality of services of all health and aged care services whilst protecting and advancing the interests of nurses and midwives and their professions.

We welcome the opportunity to provide a submission to this Inquiry.

This response is authorised by the elected officers of the New South Wales Nurses and Midwives' Association

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NSWNMA INVOLVEMENT IN CORONIAL INQUESTS

Each year, the NSWNMA receives hundreds of requests for legal advice and representation from our members in relation to coronial inquiries.

The NSWNMA, through its employed legal officers and NEWLaw Pty Ltd, provide this advice and representation at no additional cost to members. As an industrial and professional association, the NSWNMA is a not-for-profit entity.

The NSWNMA thanks the Select Committee for the opportunity to provide input into this inquiry. This input is based on the experiences of our members and those who represent them.

CONNECTION BETWEEN CORONIAL INQUESTS AND NURSING AND MIDWIFERY PRACTICE

Nurses and midwives may be asked to provide statements and/or be subpoenaed to give evidence in relation to reportable deaths that occur in connection with their work. These deaths are often the unexpected deaths of patients in a clinical setting. These deaths are also commonly those that occur in the context of someone being detained e.g. inmates, detainees and those detained in declared mental health facilities.

For nurses and midwives, involvement in such adverse events and processes may be an unavoidable professional and psychosocial hazard.

RESPONSE TO TERMS OF REFERENCE

1.(a)(ii) the adequacy of its resources

The adequacy of the resources of the Coroner's Court should not be reviewed in a vacuum. The resources of those Government agencies working to assist the coroners, being the Crown Solicitor's Office and the Department of Communities and Justice should also be carefully considered.

In the lead up to the hearing of an inquest, our staff engage regularly with those agencies. Matters are increasingly being heard in circumstances where last-minute decisions are made regarding issues and witnesses which is hampering preparation by all parties. This is despite employees of those agencies regularly working and communicating with parties via email at unsociable hours - indicating significant workloads.

Due to briefs of evidence now being provided electronically, it is also becoming increasingly common that updates to a brief of evidence will be trickled through regularly in the lead up to, during, and, at times, even after hearings. The inability for parties to comprehensively prepare for a matter prior to hearing can contribute to further delays.

How a matter progress depends largely on the available resources of both the Coroner's Court as well as the agency assisting them. Obviously increased resourcing of the Coroner's Court as well as those

agencies who provide assistance to coroners will result in improved processes and fewer delays associated with matters not being ready for hearing.

Reducing the time between a death and the hearing of an inquest is important to ensure that necessary recommendations can be made and implemented as soon as possible to reduce the risk of recurrence of a death in similar circumstance.

It is also ideal for our members who are involved these matters to have some assurance about the level of participation required by them. NSWNMA members who provide statements can sometimes wait up to 5 years to find out whether or not they will be subpoenaed by the Coroner to give evidence. The uncertainty for witnesses in these matters can be distressing.

Recommendation 1: that the Committee consider appropriate funding for the Coroner's Court as well as the Crown Solicitor's Office and the Department of Communities and Justice, in relation to services to the Coroner's Court.

1.(a)(vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health

At present, the experience of our members and officers with approaches taken by the NSW Police Force in the investigation of a reportable death varies greatly.

Unfortunately, NSW Police often hamper attempts by the NSWNMA to obtain access to a copy of the medical records of the deceased person in order to prepare a statement.

Our members are regularly informed by NSW Police and their employers (including those that are employed by Local Health Districts) that they are 'required' to provide a statement (even to the extent that they are told that they are required to attend a police station to be formally interviewed), when no such requirement exists. This misinformation can lead to members providing statements to police without the benefit of receiving legal advice or having access to relevant records. Such statements not only may be of limited assistance to a coroner; the denial of access to records may create unnecessary discrepancies in evidence that take time and resources to resolve.

Due to the manner in which the investigation of reportable deaths are allocated by NSW Police, it is not uncommon that the police officer who is deemed the Officer in Charge (OIC) is someone who has never been involved with a coronial matter nor have they ever received any training specific to the conduct of coronial investigations.

The absence of such training and experience can create unnecessary tensions between the OIC and the legal representatives acting on behalf of a member who has been asked to provide a statement.

Police officers have indicated on numerous occasions that they receive little guidance as to the processes involved with the request for statements in coronial investigations.

It would be helpful for all parties and agencies if NSW Police had clear and accessible protocols relating to the investigation of coronial matters, particularly in relation to how requests for statements should be made and what documents witnesses may need access to before providing a statement. In particular, police who are acting as an OIC should have a clear understanding of the exemptions that apply to NSW Police in the *Health Information Records Privacy Act 2002* (NSW).

Recommendation 2: the Committee consider the adequacy of training of NSW Police in relation to coronial matters, the allocation of officers as an OIC and a protocol relating to requests for statements from people who have had involvement with the deceased in the context of the provision of health care.

1.(d) Any other related matter

Access to transcripts

The use of transcripts in part-heard matters as well as for the purpose of submissions is becoming increasingly frequent. The provisions of Part 5 of the *Civil Procedure Amendment (Fees) Regulation 2020* apply to the Coroner's Court. This prescribes the fees that parties who wish to have access to transcript must pay. This is an extremely costly process.

These fees are the same regardless of whether production of a transcript is ordered by a coroner and made 'available' to the parties or when a party seeks the production of a transcript.

Where a coroner orders the production of a transcript and makes such transcript available to parties, it should be provided at no cost to all parties. This would ensure that all parties have equal access to the available evidence regardless of their economic means. As a not-for-profit organisation, the cost of accessing a transcript can be prohibitive. In hearings where transcript is made available, particularly those that are part heard, the hearing could easily run for over 10 days.

No party to a proceeding should be disadvantaged with regard to access to available evidence, especially in circumstances where counsel assisting the coroner, and others, rely on such evidence in their cross-examination and/or submissions.

We understand that there are currently provisions made by the Coroner's Court for fees to be waived for the family of the deceased, however these provisions do not generally extend to other parties.

Recommendation 3: The Committee consider what provisions could be made to facilitate access to hearing transcript to all parties at no cost.

Support for witnesses

It is acknowledged that being involved in an unexpected death can be deeply traumatic. Although the impact on those who have provided care to a deceased patient cannot compare with those who have lost a loved one, it is important to understand the ongoing distress and trauma experienced by witnesses in these matters.

For our members, they may be involved in a traumatic event such as the unexpected deterioration of a patient or finding a patient who has self-harmed or committed suicide. Beyond this they *may* be involved in a number of investigative processes such as an employer investigation, a Root Cause Analysis, a Health Care Complaints Commission investigation in addition and alongside the coronial investigation. The stress associated with these processes can compound the trauma experienced by our members.

The Coronial jurisdiction is unique; and for witnesses to be best able to assist a coroner they must be provided with access to specialised resources including counselling and/or psychological support that are not connected with their employment. There are currently no specialised resources or counselling services that are available to witnesses such as nurses and midwives involved in these matters.

Recommendation 4: that the Committee consider the provision of access to resources and counselling for witnesses.

INTERSECTION BETWEEN THE CORONIAL JURISDICTION AND WORK, HEALTH AND SAFETY LAWS

The NSWNMA thanks the Committee Chair for the invitation to comment specifically on the intersection between the coronial jurisdiction and work, health and safety laws, particularly in terms of work-related fatalities.

Fatalities of nurses and midwives who could potentially be categorised as 'work-related' are far more common than those deaths that have occurred whilst on duty. Unfortunately, statistical data on such deaths is difficult to obtain. The NSWNMA is aware of deaths of members that have occurred from suicide and health conditions in circumstances where their work was identified as a substantial contributing factor.

Since the introduction of the current *Coroners Act* in 2009, there have been three deaths of nurses in NSW that occurred whilst on duty. These were in 2011, 2019 and 2020. The NSWNMA was not involved in the first inquest and the subsequent deaths have not yet proceeded to hearing.

The primary concern for the NSWNMA in relation to the deaths on duty in 2019 and 2020 is that SafeWork declined to undertake a full investigation into these deaths *because* these matters were being investigated by the police on behalf of the Coroner.

Such an approach fails to appreciate the distinct purposes of each investigation as well as the importance of a SafeWork investigation in the early identification and management of WHS risks present that may not be readily apparent during an inspection.

Recommendation 5: that the Committee considers how best to reinforce the need for multi-agency approaches to investigations in the case of industrial deaths.