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# The New Zealand Coroners Amendment Bill's proposed approach to health care-related deaths that are reportable to the coroner

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*When must a death that occurs in a health care setting be reported to the coroner? This article explores this question by analysing the Coroners Act 2006 (NZ) and the amendments to the health care-related deaths provisions in the Coroners Amendment Bill 2014 (NZ). At the time of writing, the Bill was at the Select Committee stage. This article examines whether the amendments may improve the inconsistent clinical and coronial practices with respect to reportable health care-related deaths. It concludes that, while the proposed amendments are an improvement on the current legislative drafting, doubt remains about whether they will solve the challenges presented by health care-related reportable deaths. The second and third readings of the Bill should give serious consideration to the submissions received by the New Zealand Law Commission that express the view that the Queensland and Victorian legislation should be used as models.*

## INTRODUCTION

When must a death that occurs in a health care setting be reported to the coroner? According to the New Zealand legislation, the *Coroners Act 2006* (NZ), deaths that “must” be reported include deaths:

- without known cause;
- by suicide;
- that are unnatural or violent;
- for which no doctor’s certificate is given;
- during medical, surgical, or dental operation, treatment, etc; and
- in official custody or care.<sup>1</sup>

Section 13(1)(c), regarding deaths that occurred “during medical, surgical, or dental operation, treatment”, includes numerous subsections specifying that a reportable death is every death:

- (i) that occurred while the person concerned was undergoing a medical, surgical, dental, or similar operation or procedure; or
- (ii) that appears to have been the result of an operation or procedure of that kind; or
- (iii) that appears to have been the result of medical, surgical, dental, or similar treatment received by that person; or
- (iv) that occurred while that person was affected by an anaesthetic; or
- (v) that appears to have been the result of the administration to that person of an anaesthetic or a medicine (as defined in s 3 of the *Medicines Act 1981*)

These provisions have caused confusion. The “lack of clarity in the legislation”<sup>2</sup> often makes determinations of reportable deaths in health care difficult for health practitioners. The New Zealand Law Commission’s 2011 analysis of legal and medical professionals’ submissions about this issue

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<sup>1</sup> *Coroners Act 2006* (NZ) ss 13(1)(a)-(g), 14(2).

<sup>2</sup> Ian Freckelton and David Ranson, “The Evolving Institution of Coroner” in Ian Freckelton and Kerry Petersen (eds), *Disputes and Dilemmas in Health Law* (Federation Press, Sydney, 2006) 300.



revealed that practices differ across New Zealand's hospitals, and coroners' expectations and approaches vary.<sup>3</sup> There is under-reporting. Doctors do not always report all health care-related deaths. Sometimes this is because there is confusion about the legal requirements, or debate about whether the death should be reported. There is also inconsistency among coroners' decisions about when they should take jurisdiction. New Zealand District Health Boards reported to the Law Commission that when they have seemingly similar unexpected deaths, Coroner X will say the death is reportable and take jurisdiction, but Coroner Y will say the opposite.<sup>4</sup>

Health care-related deaths comprise a significant proportion of coroners' work.<sup>5</sup> A "health care-related death" (which is sometimes also called a "medical treatment-related death") refers to the death of a patient which is related to the provision of health/medical treatment. According to the United States Institute of Medicine, medical treatment-related deaths are among the 10 most common causes of death.<sup>6</sup>

Definitions of reportable health care-related deaths in coronial legislation are typically drafted to require deaths which may have occurred as a result of adverse medical events to be reported. Approximately 10% of all hospital admissions are associated with an adverse event, with the specific reported rates for New Zealand at 10.7%.<sup>7</sup> The "linkage between the legislative definitions of reportable death and adverse medical treatment events is [however] not always clear".<sup>8</sup>

These observations in the literature were confirmed by the medical submissions received by the New Zealand Law Commission in 2011. It is unsurprising, therefore, that there was overwhelming support for the legislative definitions of health care-related deaths in the *Coroners Act 2006* to be defined better.

One of the aims of the *Coroners Amendment Bill 2014* (NZ) is to address the problems caused by the health care-related deaths provisions in the *Coroners Act 2006*. The Bill's "general policy statement" explains that a "key change" is "better defining which cases need to be reported to the coroner or go to inquest".<sup>9</sup> In particular, the Bill aims to do so by:<sup>10</sup>

Focusing the requirement to report medical-related deaths on cases where the death was not reasonably expected immediately prior to the treatment, operation, or procedure so that families are not necessarily disrupted by the death being reported to the coroner.

Does the *Coroners Amendment Bill 2014* achieve its goals concerning the health care-related deaths provisions? Is the Bill's definition of health care-related deaths "better"? The purpose of this article is to explore these questions. Specifically, we review the amendments and analyse whether the proposals may improve the difficulties that health practitioners experience when dealing with health care-related deaths that may be reportable to the coroner. We examine whether New Zealand should consider adopting the equivalent provisions in the Queensland (Australian) coroners legislation. The authors aim to bring both legal and clinical lenses to the analysis. One author (Moore) is an academic health lawyer, while the other two authors (Stokes and Gray) are clinicians.

We accept that it will not be possible to solve this complex issue via legislative change alone. A range of interventions (such as educational training and decision aids) will be required to ensure that practitioners change their reporting practices based on the legal amendments. Nevertheless, clarity in the legislative reporting requirements is necessary, and will greatly assist practitioners.

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<sup>3</sup> Jennifer Moore and New Zealand Law Commission, *Review of Death and Cremation Certification in New Zealand: Submissions Analysis* (NZLC, Wellington, November 2011) 32.

<sup>4</sup> Moore and New Zealand Law Commission, n 3, 41.

<sup>5</sup> Freckelton and Ranson, n 2, 298.

<sup>6</sup> Linda Kohn, Janet Corrigan and Molla Donaldson (eds), *To Err is Human: Building a Safer Health System* (Committee on Quality of Health Care in America, Institute of Medicine, Washington DC National Academy Press, 1999).

<sup>7</sup> Peter Davis et al, "Adverse Events Regional Feasibility Study: Indicative Findings" (2001) 114 NZ Med J 203.

<sup>8</sup> Freckelton and Ranson, n 2, 298.

<sup>9</sup> Explanatory Note, *Coroners Amendment Bill 2014* (NZ) General Policy Statement, 2.

<sup>10</sup> Explanatory Note, *Coroners Amendment Bill 2014* (NZ) General Policy Statement, 2.

## NEW ZEALAND CORONIAL JURISDICTION

Coronership is an ancient judicial office. It has been described as “shape-shifting”<sup>11</sup> because of its dramatic evolution over the centuries. There is some evidence that a coroner existed as early as the 9th century.<sup>12</sup> However, it is generally accepted that the office of the coroner was established in England in 1194 with the Articles of Eyre.<sup>13</sup>

New Zealand inherited the English coronial system. Its own coronial legislation was adopted in the mid-1800s with the passing of the *Coroners Ordinance 1846* (NZ).<sup>14</sup> The Ordinance was repealed by the *Coroners Act 1858* (NZ).<sup>15</sup> Various amendments followed.<sup>16</sup> The major overhauls to the New Zealand coronial jurisdiction were in 1984,<sup>17</sup> and the early 2000s. A report published by the Law Commission in 2000 concluded that the coronial service was under-resourced, culturally insensitive, lacking in leadership, and insufficiently valued.<sup>18</sup> Recommendations for reform were issued, prompting the introduction of the 2006 Act.<sup>19</sup> The Act, which came into force on 1 July 2007, provides the legislative framework for the operation of the coronial jurisdiction in New Zealand. The purpose of the Act is to help prevent deaths and to promote justice through:

- (a) investigations, and the identification of the causes and circumstances of sudden and unexplained deaths, or deaths in special circumstances; and
- (b) the making of specified recommendations or comments that, if drawn to public attention, may reduce the chances of the occurrence of other deaths in circumstances similar to those in which those deaths occurred.<sup>20</sup>

New Zealand coroners are lawyers appointed as judicial officers. Coroners must have at least five years' experience as a barrister or solicitor before appointment.<sup>21</sup> Coroners are appointed by the Governor-General, on the advice of the Attorney-General, after consultation with the Minister of Justice. Every coroner vacates that office, if s/he has not earlier done so in another way, on attaining the age of 70 years.<sup>22</sup> The Governor-General may, if s/he thinks fit, remove a coroner from office for inability or misbehaviour.<sup>23</sup>

New Zealand's 16 coroners and the Chief Coroner investigate sudden, unnatural and violent deaths.<sup>24</sup> There are approximately 29,000 deaths in New Zealand per year.<sup>25</sup> About 20% of those

<sup>11</sup> Ian Freckleton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, Melbourne, 2006) v.

<sup>12</sup> Freckleton and Ranson, n 11, 4.

<sup>13</sup> Paul Matthews, *Jervis on Coroners* (Sweet and Maxwell, London, 2002) 1.

<sup>14</sup> Freckleton and Ranson, n 11.

<sup>15</sup> *Coroners Act 1858* (NZ) s 13.

<sup>16</sup> The *Coroners Act 1867* (NZ) followed the 1858 statute and was amended in 1908. The *Coroners Act 1951* (NZ) consolidated the New Zealand and English law of the time.

<sup>17</sup> The 1984 *Final Report of the Working Party on Delays in the Release of Bodies for Burial* was the catalyst for the next redraft of coronial legislation. The Working Party's findings were reflected in the *Coroners Act 1988* (NZ), which remained the key piece of coronial legislation until the overhaul of the coronial system in the early 2000s.

<sup>18</sup> New Zealand Law Commission, *Coroners*, Report No 62 (2000).

<sup>19</sup> Jennifer Moore, “An Empirical Approach to the New Zealand Government's Review of the Coronial Jurisdiction” (2013) 21 JLM 602, 605.

<sup>20</sup> *Coroners Act 2006* (NZ) s 3(1).

<sup>21</sup> *Coroners Act 2006* (NZ) s 103.

<sup>22</sup> *Coroners Act 2006* (NZ) s 103(4).

<sup>23</sup> *Coroners Act 2006* (NZ) s 114(1).

<sup>24</sup> The Chief Coroner has additional functions: see *Coroners Act 2006* (NZ) s 7.

<sup>25</sup> See data and statistics on mortality at New Zealand Ministry of Health <[www.health.govt.nz](http://www.health.govt.nz)>.

deaths must be reported to the coroner.<sup>26</sup> In the introductory section of this article, we outlined the statutory requirements for reportable deaths. The coroner decides whether to open an inquiry and whether to hold an inquest.

### The New Zealand Law Commission’s 2011 review of burial and cremation law, and reportable health care-related deaths

As the previous section highlighted, the New Zealand coronial jurisdiction underwent reform in the early 2000s. In 2010, the Law Commission commenced a review of burial and cremation law. This project also included a review of the coronial jurisdiction, primarily because of the overlap between the burial and cremation legislation and the coronial statute. One of the authors of this article (Moore) worked on this project at the Law Commission.

The Law Commission received submissions from various organisations and professional groups including medical organisations, medical professionals, government agencies, legal professionals, the funeral industry, the insurance industry, and individual citizens. Nineteen submitters responded to the Law Commission’s question: “Do the circumstances in which doctors are required to report deaths which are ‘without known cause’ or deaths which occur ‘during medical, surgical, or dental operation or treatment etc’ to a coroner need to be better defined in the *Coroners Act 2006*?”<sup>27</sup> All but one submitter (18/19) thought that s 13 of the *Coroners Act 2006* requires amendment. The table below provides a summary.

Do the circumstances in which doctors are required to report deaths which are “without known cause” or deaths which occur “during medical, surgical, or dental operation, treatment etc” to a coroner need to be better defined in the <i>Coroners Act 2006</i> ?		
	Yes	No
Medical organisations	7 <sup>28</sup>	
Medical professionals	4 <sup>29</sup>	
Government	4 <sup>30</sup>	
Legal profession	1 <sup>31</sup>	1 <sup>32</sup>
Funeral industry	1 <sup>33</sup>	
Individuals	1 <sup>34</sup>	
TOTALS	18	1

<sup>26</sup> S Johnson, “Births, Deaths and Coroners’ Inquiries” in Rebecca Keenan (ed), *Health Care and the Law* (Brookers, Wellington, 2010) 424.

<sup>27</sup> New Zealand Law Commission, *Final Words: Death and Cremation Certification in New Zealand*, Issue Paper No 23 (2011) 49.

<sup>28</sup> College of Intensive Care Medicine, Critical Care Medicine, Medical Council, Nurse Maude, New Zealand Medical Association, Mercy Hospice, Palmerston North Women’s Health Collective.

<sup>29</sup> Dr Maplesden, Dr Searle, Dr Sage, Dr Sijnja.

<sup>30</sup> Mortality Collection, Health Quality and Safety Commission, Police, Regional Public Health.

<sup>31</sup> Ministry of Justice.

<sup>32</sup> Coroners.

<sup>33</sup> Cremation Society.

<sup>34</sup> Rosaleen Robertson.

Legal opinion was divided, whereas medical opinion was unanimous in favour of amendment of s 13. The Coroners rejected the proposal to amend s 13 of the Act, arguing that:

While it is very broad and requires constant explanation as new generations of medical practitioners come through the system, it is better to have it on the broad side rather than too narrow.<sup>35</sup>

In contrast to the Coroners, other submitters (across all stakeholder groups) supported an amendment. The Police, for instance, endorsed better definitions in the Act in order to “overcome the present requirement for Police notification to the Coroner despite the Coroner previously taking jurisdiction.”<sup>36</sup> Frequently mentioned arguments were that “clear definitions are important”<sup>37</sup> and that there is currently “inconsistency”<sup>38</sup> concerning reportable health care-related deaths. This inconsistency has been discussed in the coronial law and medical literature. An unfortunate corollary is that the “credibility of the coronial service can be diminished in the eyes of the medical profession, and there is a risk that this could lead to a reduction in the reporting of reportable deaths”.<sup>39</sup>

Inconsistency was a recurring theme in the submissions. For example, the College of Intensive Care Medicine observed that:

We also believe that there is currently too much inconsistency between coroners when deciding which cases they wish to take jurisdiction over.<sup>40</sup>

Similarly, the Mortality Collection expressed concerns about inconsistencies:

There have been occasions where doctors have interpreted the provisions of the *Coroners Act 2006* around reportable deaths differently to the District or Chief Coroner, so it would be beneficial if those provisions were better defined.<sup>41</sup>

Likewise, the Medical Council raised concerns about inconsistency and coroners' decision-making about jurisdiction:

The Council is also concerned about how and when the Coroner chooses to take jurisdiction. A medical member of the council expressed concern that he is aware of cases where an inquiry has appeared necessary, but where the Coroner has declined to intervene citing that this might cause distress to the family. He also stated that he is aware of situations where a Coroner has asked a general practitioner to sign a death certificate because hospital doctors have refused to do so. The Council believes that greater clarity and consistency is required in terms of Coroner's jurisdiction.<sup>42</sup>

Another common theme was that there is currently “confusion”<sup>43</sup> about reportable health care-related deaths. For example, the Ministry of Justice explained that:

Doctors sometimes appear to have difficulty determining whether or not to report certain deaths to the coroner as 39.5% of cases referred to the coroner in 2009/10 resulted in the coroner advising the doctor to sign the certificate. There is also correspondence on file indicating that this has been an issue for coroners in the past ... Doctors will be able to advise whether access to other resources would help them to determine whether or not a death should be reported.<sup>44</sup>

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<sup>35</sup> Coroners, Submission, 7 June 2011, 2.

<sup>36</sup> Police, Submission, 1 July 2011, 3.

<sup>37</sup> Palmerston North Women's Health Collective, Submission, 11 August 2011, 3.

<sup>38</sup> The following submissions mention inconsistency: Mortality Collective, College of Intensive Care Medicine, Medical Council, Critical Care Medicine. Inconsistency is a common theme across several of the 30 questions.

<sup>39</sup> Freckelton and Ranson, n 11, 162.

<sup>40</sup> College of Intensive Care Medicine, Submission, 21 July 2011, 2.

<sup>41</sup> Mortality Collection, Submission, July 2011, 4.

<sup>42</sup> Medical Council of New Zealand, Submission, 17 June 2011, 2.

<sup>43</sup> Regional Public Health, Submission, 27 July 2011, 1. The literature also discusses the “confusion”. For example, see David Ranson, “How Effective? How Efficient? The Coroner's Role in Medical Treatment Related Deaths” (1998) 23 Alt LJ 284, 285; Freckelton and Ranson, n 11, 162; Christopher Dorries, *Coroners' Courts: A Guide to Law and Practice* (Oxford University Press, Oxford, 2014) 48, where the author describes doctors' “confusion” about reportable deaths and contends that a “prime reason ... is the lack of clear statutory guidelines”.

<sup>44</sup> Ministry of Justice, Submission, July 2011, 4.

The “confusion” and “difficulty” that doctors experience when determining whether a health care-related death is reportable were highlighted when Coroner Ian Smith presented on the subject at the University of Otago Medical Faculty in 2010. The majority of questions from the audience were about reportable health care-related deaths and completion of the Medical Certificate of Cause of Death. Despite the definition of a reportable death causing confusion, there have been few judicial decisions or published court practice guidelines to help in construing the meaning behind the legislative phrases.<sup>45</sup>

Dr Sage commented that his understanding “from Judge MacLean [is] that the Ministry has expressed some resistance to amending the Act in the foreseeable future”.<sup>46</sup> This does not accord with Ministry of Justice’s endorsement of amending s 13 of the Act. They may be resistant to amendment of other provisions, as illustrated by their responses to other questions.

Various suggestions were made about how to improve decision-making and consistency concerning reportable health care-related deaths:

- Include the legislative provisions and explanations in guidelines in training.<sup>47</sup>
- Include the legislative provisions in a published public version of a Bench Book.<sup>48</sup>
- “Incorporation of an intermediate set of criteria that require referral to the Medical Examiner should such a position be entertained.”<sup>49</sup>
- The criteria for referral should be expressed in simple terms on a plastic card, credit card sized for easy reference. They should include contact information for the medical advisor and Coroner.<sup>50</sup>
- The revised Medical Certificate of Cause of Death should contain “all the appropriate triggers for referral to the Coroner. One additional trigger should be when the doctor is aware of ‘any person expressing concern as to cause of death’”.<sup>51</sup>

In addition to reflecting on these suggestions for reform, it is important to consider why doctors experience difficulty in determining whether to report health care-related deaths. There is both under- and over-reporting of deaths to the coroner.<sup>52</sup> When deaths that should have been reported are not, what is the explanation? Commentators have questioned whether it is lack of clarity in the legislative definitions and/or doctors’ ignorance of the legal triggers and/or doctors having “something to hide”<sup>53</sup> and/or other factors such as the culture of medicine.

There is “little direct evidence of doctors deliberately concealing deaths from the coroner”.<sup>54</sup> Moreover, given that multidisciplinary teams are involved in the care of patients, “deliberately concealing a reportable death from a coroner would involve an extremely complex conspiracy of silence”.<sup>55</sup> These observations should not suggest that safeguards are unimportant, but they highlight that any legal and policy reforms in this area should not overreach given that Dr Shipman cases are rare.<sup>56</sup>

Research demonstrates (and the submissions confirmed) that the wording of the legislation is (even if only partly) contributing to the problem. There are too many different interpretations of the

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<sup>45</sup> Freckelton and Ranson, n 11, 162.

<sup>46</sup> Dr Sage, Submission, 3.

<sup>47</sup> New Zealand Medical Association, Submission, 23 June 2011, 3.

<sup>48</sup> Dr Sage, Submission, 3.

<sup>49</sup> Dr Mapelsden, Submission, 18 June 2011, 2.

<sup>50</sup> Dr Sijnja, Submission, 29 June 2011, 3.

<sup>51</sup> Medical Council of New Zealand, Submission, 17 June 2011, 2.

<sup>52</sup> New Zealand Law Commission, n 27, 13, 15, 17.

<sup>53</sup> Freckelton and Ranson, n 2, 302.

<sup>54</sup> Freckelton and Ranson, n 2, 302.

<sup>55</sup> Freckelton and Ranson, n 2, 302.

<sup>56</sup> Richard Baker, *Harold Shipman’s Clinical Practice 1974-1998: A Clinical Audit Commissioned by the Chief Medical Officer* (Department of Health, London, 2001).



legislation and some doctors find this confusing and/or lack understanding of the legal requirements.<sup>57</sup> The lack of clarity in the words used in the legislation to define reportable deaths means that doctors are “likely to find it difficult to identify many reportable deaths”.<sup>58</sup>

Amendment of s 13 ought to define “unexpected deaths” carefully.<sup>59</sup> The meaning of the phrase is far from clear.<sup>60</sup> Do we mean that the death was medically considered to be preventable? If so, how ought this approach be defined? One definition of this might be: if the patient had received ideal management s/he would have had a very significant chance of survival (greater than 75% chance of survival). However, quantification may be difficult. Also, for whom was the death “unexpected”: doctors, coroners, families?

Additional definitions to consider are:

- what constitutes a “procedure”;
- what constitutes “anaesthetic deaths”; and
- is death as a direct result (“unexpected”) of administration of medication, as opposed to death as a result of medication error, caught by the Law Commission’s category of death as a direct result of medical intervention?<sup>61</sup>

The Dunedin hospital clinicians who were consulted indicated that they define a “procedure”<sup>62</sup> as a “practice where written consent is required”. Examples of this could include blood transfusion, insertion of central catheters, hip replacements, appendectomies.

In conclusion, the Law Commission’s 2011 review of submissions revealed that apart from the coroners, there was overwhelming support for amendment to s 13 of the *Coroners Act 2006*. The government’s subsequent review of the coronial jurisdiction reached the same conclusion.

## THE NEW ZEALAND GOVERNMENT’S 2012-2014 REVIEW OF THE CORONIAL JURISDICTION

New Zealand’s coronial jurisdiction is currently undergoing further reform. On 31 July 2012, the Courts Minister announced a targeted review of the Coronial Services of New Zealand (CSNZ).<sup>63</sup> A principal catalyst for the government review was the Law Commission’s finding, during its review of the *Burial and Cremation Act 1964* (NZ), that there is potential duplication between the CSNZ and other investigation bodies, and that clarification for reportable deaths is needed.<sup>64</sup> The ministerial review’s first Cabinet Paper reported that the Ministry of Justice wrote to 168 stakeholders seeking feedback about the coronial system. Forty-nine submissions were received.<sup>65</sup>

On 26 June 2013, the Courts Minister announced proposals to reform the CSNZ.<sup>66</sup> Health care-related reportable deaths were identified as an area requiring reform. Moore has analysed the government’s review of the coronial jurisdiction elsewhere.<sup>67</sup>

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<sup>57</sup> Christopher Dorries, *Coroners’ Courts: Guide to Law and Practice* (Oxford University Press, Oxford) 48.

<sup>58</sup> Freckleton and Ranson, n 11, 164.

<sup>59</sup> New Zealand Law Commission, *Referral of Deaths to Coroners*, Discussion Document (October 2011) 3.

<sup>60</sup> See the discussions in Freckleton and Ranson, n 11, 163; Ranson, n 43, 285.

<sup>61</sup> Email from Margaret Barnett-Davidson (New Zealand Nurses Organisation lawyer and registered nurse) to Jennifer Moore, October 2011.

<sup>62</sup> Email from Dr Jill Wolfgang to Dr Jennifer Moore, October 2011.

<sup>63</sup> Chester Borrows, “Changes to Coroner’s Court Signalled” (Press Release, 26 June 2013); Moore, n 19.

<sup>64</sup> In 2011 and 2012, one of the authors of this article (Moore) worked at the Law Commission on the review of the *Burial and Cremation Act 1964*. That review is ongoing: see <<http://www.lawcom.govt.nz/project/review-burial-and-cremation-act-1964>>. The *Burial and Cremation Act 1964* intersects with the *Coroners Act 2006*.

<sup>65</sup> A summary of submissions can be found at the Ministry of Justice <<http://www.justice.govt.nz/courts/coroners-court/media-centre/news/summaryofsubmissions>>.

<sup>66</sup> Borrows, n 63.

<sup>67</sup> Moore, n 19.

## THE CORONERS AMENDMENT BILL 2014

On 31 July 2014, the *Coroners Amendment Bill 2014* was introduced to Parliament.<sup>68</sup> The Bill underwent its first reading on 19 February 2015.<sup>69</sup> The Bill is currently at the Select Committee stage. Submissions are due on 26 March 2015 and the report is due on 19 August 2015.<sup>70</sup> At the time of the publication of this article, the Bill had undergone its second reading. The Select Committee report and the Bill's second reading did not propose changes to the original formulations of the clauses that we discuss in this article.

Overall, the changes proposed in the Bill are welcome and timely. According to the Bill's explanatory note, the focus of the reforms is:

Providing greater certainty for families and the general public, and enhancing the role of coroners as independent judicial officers.<sup>71</sup>

The "key changes" are "strengthening coroners' recommendations", "improving processes in the coronial system", and "better defining which cases need to be reported to the coroner and go to inquest".<sup>72</sup>

According to the Honourable Amy Adams (Minister for Courts), reform to health care-related reportable deaths was necessary because:

Medical deaths can pose a particular difficulty in deciding whether a death should be reported, and some of the terms used in the Act such as "operation", "procedure", and "treatment" can be broad and difficult to define. The bill will reduce uncertainty by requiring deaths to be reported only where the death would not have been expected before the operation, procedure, or treatment commenced.<sup>73</sup>

Clause 9 of the *Coroners Amendment Bill 2014* amends ss 13 and 14 of the *Coroners Act 2006* and the circumstances in which deaths must be reported to the coroner. The Bill states:

The kinds of deaths referred to in subsection (1) are ...

- (b) a death –
  - (i) that occurred during, or appears to have been the result of, a medical procedure; and
  - (ii) that, immediately before the procedure was undertaken, a reasonable health practitioner would not have expected;
- (c) a death –
  - (i) that occurred while the person concerned was affected by an anaesthetic; and
  - (ii) that, immediately before the anaesthetic was administered, a reasonable health practitioner would not have expected.

Pursuant to the Bill's cl 7 interpretation section, "medical procedure" means:

- (a) a medical, surgical, or dental treatment or operation, or any procedure of a similar kind; and
- (b) includes the administration of a medicine (as defined in section 3 of the *Medicines Act 1981*) or an anaesthetic.

From a clinical perspective, the introduction of the requirement that the death is one "a reasonable health practitioner would not have expected" is a significant clarification. The previous clauses were based on a presumption of death by a single cause (such as a "procedure"), whereas the proposed clause avoids this presumption and focuses on the core issue of whether it was an unexpected death. There are also precedents for the use of "a reasonable person". The use of this phrase in the *Code of Patient Rights* has been clarified by common law judgments and the findings of reports by the New Zealand Health and Disability Commissioner.

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<sup>68</sup> New Zealand Parliamentary Library, *Coroners Amendment Bill 2014: Bills Digest No 2161*, 7 August 2014 <<http://www.parliament.nz/enz/pb/legislation/bills/digests/50PLLaw21611/coroners-amendment-bill-2014-bills-digestno-2161>>.

<sup>69</sup> New Zealand Parliamentary Library, n 68.

<sup>70</sup> New Zealand Parliamentary Library, n 68.

<sup>71</sup> Explanatory Note, *Coroners Amendment Bill 2014* (NZ) General Policy Statement, 1.

<sup>72</sup> Explanatory Note, *Coroners Amendment Bill 2014* (NZ) General Policy Statement, 1-2.

<sup>73</sup> New Zealand, *Parliamentary Debates*, House of Representatives, 19 February 2015, 703 NZPD 1775 (Hon Amy Adams, Minister for Courts).



The challenge will be in operationalising this definition in a rigorous and transparent manner; otherwise the statutory test of whether a reasonable health practitioner would have expected a death to occur in the particular circumstances introduces further uncertainty in what is already a complex area. There are a number of ways this could be achieved. For example, a working definition of “reasonable” could be developed by clinicians informed by feedback from the coronial office and/or the coronial office could publish guidelines of the sorts of cases that they expect to have reported. Given the challenges here it will be important that such a change is the subject of robust evaluation.

### **Should New Zealand adopt the equivalent Queensland or Victorian provisions?**

As we outlined in the earlier section about the Law Commission’s review of death certification, most stakeholders agreed that the definition of s 13 of the *Coroners Act 2006* needed revision. However, differing views emerged regarding the form of the revision. Several submitters recommended the adoption of the equivalent Australian (Victorian or Queensland) legislative provisions.<sup>74</sup> For example, the Health Quality and Safety Commission (HQSC):

Strongly supports an expansion of the definition of reportable deaths under s 13(1)(c) of the *Coroners Act 2006* to include “health care related deaths”, using the Queensland legislation definition of this phrase or similar. In addition, the Perioperative Mortality Review Committee recommends consideration of additional definitions in relation to medical or surgical procedures and anaesthesia. The Committee recommends replacing section 13(1)(c)(iii) of the *Coroners Act 2006* with the following two subsections, (c)(iii) and (c)(iv) set out below in bold ...

- (iii) **that occurred before a person was discharged from hospital following an operation or procedure; or**
- (iv) **that occurred within 30 days of an operation or procedure of that kind.**

The Perinatal and Maternal Mortality Review Committee recommends consideration of additional definition in relation to intrapartum deaths. The Committee’s concern in relation to intrapartum deaths is that stillbirths are currently excluded from the Coroner’s jurisdiction. The Committee considers it is appropriate for the Coroner to have the power to investigate intrapartum deaths, including both maternal and fetal deaths (stillbirth). The Committee’s recommended revision of 13(1)(d) is set out below in bold:

- (d) any death **of a woman or fetus, where the death** occurred while the woman concerned was giving birth, or that appears to have been a result of that woman being pregnant or giving birth, **or where the fetus was stillborn.**<sup>75</sup>

The clauses (iii and iv) proposed by the HQSC in bold, above, focus on a death happening after a procedure, on the presumption that we expect people to live after every procedure. Although clinical outcomes have improved, historically if someone survived an emergency repair of an aortic aneurysm this was the exception rather than the rule. It would not have made sense to report those patients who died after an attempt at rescue surgery and to not report a patient for whom surgery was not attempted. Death after some interventions may be expected (for example, hip fracture surgery in the frail elderly.) This procedure is always done because, without operation, the prolonged bed rest required for the hip to heal without internal fixation is almost inevitably fatal. For some patients it may not be unexpected that they die following the procedure, but the more important cause of death was the original fracture, not the operation. It would be a judgment of a “reasonable health practitioner” as to which patient deaths after a hip fracture surgery were unexpected. Like the HQSC, the Department of Critical Care also recommended adoption of the Queensland provisions and reiterated the familiar theme of inconsistency:

We think that there is *not enough consistency*. There seem to be different answers from different coroners to the same type of question. We have heard of an instance where the night coroner said “no” to the question of accepting *jurisdiction* but the coroner next day said “yes”. Family arrangements had to stop and the body brought back. On another occasion there was discussion before death indicating that referral after death would not be necessary “but check with the on-call coroner when the patient

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<sup>74</sup> Health Quality and Safety Commission, Dr Searle, Critical Care Medicine.

<sup>75</sup> Health Quality and Safety Commission, Submission, 8 July 2011, 4-5.

actually dies". When the patient died the on-call coroner did want to accept jurisdiction. If coroners were prepared to make prospective decisions before death, during working hours, it would be helpful to all parties concerned, including the on-call coroners themselves because it would reduce the number of after hours calls. All we would then need to do in the middle of the night would be notify the police in the old fashioned way. However, this arrangement would not work if the coroners are unable to abide by each others' decisions. We believe that there is also *inconsistency amongst doctors about who is referred, but part of the reason for this is that the "rules for referral" are too open to interpretation*. For example if someone has an emergency operation for a ruptured abdominal aortic aneurysm and dies in the operating room or subsequently in the ICU, should this be referred or not? Death would certainly be "during or after" a medical or surgical procedure but the natural history of this disease is to die. If an operation was withheld the patient would just die and this could be put down as natural causes. Should the fact that an emergency operation to try to save life change this? We think that *doctors and coroners appear to be inconsistent in their approach to this question*. A similar example is subarachnoid haemorrhage from a ruptured cerebral artery aneurysm, for which the patient has an operation to clip the aneurysm, and subsequently develops symptomatic vasospasm which may turn out to be fatal. The natural history of this disease without an operation would likely be to either die from the effects of the first bleed, die from a second bleed from the same aneurysm, or die from vasospasm. Does the fact that the patient had an operation change this? *Doctors and coroners both appear to be inconsistent in their approach to this situation ... We think that the Vic and Qld definitions do seem to be more precise and preferable. However, none of the definitions available really deal with the issue of death while under medical care. The words "appear to be" are too vague and don't specify in whose eyes the appearance should be.*<sup>76</sup>

Commentators highlight that legislative phrases such as "appear to be" and "unexpected" do not specify for whom the death was unexpected and that this creates problems in reporting health care-related deaths.<sup>77</sup> Clarity could be achieved by requiring all deaths in particular categories to be reported. This approach may lead to unnecessary coronial inquiries. However, the approach may lead to fewer debates among clinicians about whether the legislation is being properly applied. If the criteria are clearly based on judgment (by an "independent" and/or reasonable health practitioner) then it may be less contentious for practitioners to hold differing judgments. If there is pretence that the provisions are absolutely clear, more debate among practitioners may be generated.

Like HQSC and Critical Care Medicine, Dr Searle also recommended adopting the equivalent provisions from the Victorian *Coroners Act*:

When a death is "without known cause" clearly should be referred to the coroner who should take jurisdiction. Junior doctors need education to reassure that where death is clearly a natural process and consequent upon a number of different pathologies, the importance of which is hard to weigh in the final outcome, and then they are fully justified in making their "best guess". Although in these circumstances a hospital post mortem may be considered.

Those that have close temporal relationship with and which may have been contributed to by surgical procedures should be referred to the coroner and a judgement on this issue should be made by a junior doctor with the help of advice from his consultant and an expert third party such as a member of the Mortality Review Committee. Certainly the Bundaberg experience would not support the value of a 24 hour rule. The issue of deaths occurring during periods of medical treatment is much more difficult and statements such as those appearing in the Victorian legislation should be considered.<sup>78</sup>

Commentators have also complained that investigations of health care-related deaths are delayed.<sup>79</sup> This problem may also be addressed by amending the legislative definition of "medical-related" or "health care-related" deaths. The current New Zealand definition could, arguably, encompass referral of almost every health care-related death. This approach is unnecessary and does not reflect cases where death is highly likely due to terminal illness, multiple chronic conditions or

<sup>76</sup> Department of Critical Care Medicine, Submission, 17 June 2011, 1-2 (emphasis added).

<sup>77</sup> Freckelton and Ranson, n 11, 163.

<sup>78</sup> Dr Searle, Submission, 2.

<sup>79</sup> For example, see Ministry of Justice, *Coroners Act Review: Proposals for Reform – Paper 1* (26 June 2013); Elena Mok, "Harnessing the Full Potential of Coroners' Recommendations" (2014) 45 VUWLR 321, 336.

incidents involving emergency surgery. As a result, medical practitioners often consult the coroner to discuss whether the coroner should take jurisdiction of the death.

In Queensland and Victoria, coroners have jurisdiction to investigate health care-related deaths where a medical practitioner would not have expected the relevant health care to contribute to the death.<sup>80</sup> All the circumstances relating to the death, such as whether the deceased suffered from an underlying condition or injury, may be examined.<sup>81</sup>

The Queensland *Coroners Act 2003* “health care related death” provisions are as follows:

- (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.<sup>82</sup>

<sup>80</sup> *Coroners Act 2008* (Vic) s 4(2)(b); *Coroners Act 2003* (Qld) s 10AA(2)(b).

<sup>81</sup> *Coroners Act 2003* (Qld) s 10AA(4).

<sup>82</sup> *Coroners Act 2003* (Qld) s 10AA.

The Victorian *Coroners Act 2008* health care-related reportable deaths provisions are as follows:

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.<sup>83</sup>

The Victorian legislation defines “medical procedure” as:

a procedure performed on a person by or under the general supervision of a registered medical practitioner and includes imaging, internal examination and surgical procedure.<sup>84</sup>

Refining the definition of “health care-related deaths” in the New Zealand *Coroners Act 2006* in a similar fashion to the Victorian or Queensland provisions may ensure the coronial process is focused on cases that warrant investigation by a judicial officer.

Any rewording of the definition should carefully consider five issues in particular. First, who must “not have reasonably expected” that the health care would cause or contribute to the patient’s death – the treating doctor, any health practitioner who was involved in the patient’s care, an independent doctor? The authors prefer the Queensland statutory approach because it specifies that an “independent person” must not have reasonably expected the death and s 10AA(4) defines “independent person,” as outlined above.

Secondly, what does “reasonably expected” mean? The legislation is silent. The Queensland Act defines “reasonably believes” as “believes on reasonable grounds”. Therefore, it could be inferred that “reasonably expected” means that the health practitioner would not have expected on reasonable grounds that the health care would cause or contribute to the patient’s death. What should the health practitioner consider when making such an assessment? As we explained above, such assessment could be informed by guidelines produced by the CSNZ.

Thirdly, should the statute provide an operational timeframe? For example, the HQSC’s submission (outlined at the beginning of this section) suggested that s 13(1)(c)(iv) should be redrafted as follows: “That occurred within 30 days of an operation or procedure of that kind.”

This provision may not provide clarity. The essence of the process required in the provision is a judgment about whether the death was expected. If the death happens 31 days after the procedure, our view is that the judgment remains the same. A person suffering from anoxia during a surgical procedure could be kept alive on machines for 29 days and need to be reported, but if s/he died after 31 days s/he would not be reported.

Fourthly, who will undertake the assessment required by the Victorian provision that “the death is or may be causally related to the medical procedure”? What level of causation is required? We prefer the “independent person” test.

Finally, how should practitioners interpret the following Queensland provision: “health care contributes to the 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”? This provision should be interpreted in light of what the independent practitioner would reasonably have expected. For example, an elderly and frail patient undergoing a hip replacement may die earlier from the surgery than if s/he had remained in a hospital bed. However, such a death may be classified by a reasonable independent practitioner as reasonably expected.

Overall, from a clinical perspective, the Queensland provisions are preferable because they are more comprehensive and less open to broad interpretation by clinicians. The current New Zealand legislation focuses on particular circumstances on a presumption that those circumstances are (or might be) *the* cause of death. This is out of step with the modern understanding of death that has been

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<sup>83</sup> *Coroners Act 2008* (Vic) s 4(2)(b).

<sup>84</sup> *Coroners Act 2008* (Vic) s 3(1).

developed with the focus on patient safety. It is understood that the “cause” of an adverse outcome is almost always multifactorial, and simplifying this down to “a cause” risks missing opportunities of modifying contributory factors that may not have been major contributory factors, but are amenable to modification.

The amendment needs to focus on the fact that there is a judgment to be made as to whether a particular death was unexpected. Clarity is required as to what is meant by “unexpected” and the Queensland clauses do this well. Clarity is also required on who is making the judgment. The Queensland approach is again adequate. It outlines the types of practitioners who could be considered an “independent person”.

A shared understanding of what might be included in unexpected deaths, as judged by a reasonable person, could be developed. This would be aided by coronial guidance based on particular cases that could be added to over time, based on further examples either of under-reporting or over reporting. A mandatory list of particular procedures is potentially problematic because of changes in practice. Acute aortic aneurysm repair used to be successful rarely, but the success rate has risen significantly in the last 20 years.<sup>85</sup> While it is true that some procedures will always be risky because of the nature of the underlying condition, a group of reasonable people are likely to be in high agreement as to which these procedures are. By contrast, some guidelines of procedures that might usually not require reporting would be helpful and open to debate and amendment as ability to treat changed. As the field of health quality and safety develops, attention will need to be paid to the overlap between inquiry instigated by the coroner and inquiry instigated under the reporting clauses of the HQSC's National Reportable Events Policy. Both deal with unexpected events and both exist to try to improve quality of service provision. Nevertheless, we recognise that the roles of these agencies differ. Coroners are independent judicial officers who may hold public investigations. Doing these investigations well is very resource intensive and appropriate collaboration would be desirable to avoid unhelpful duplication.

### Implementation of the legislation

What systems are required to maximise consistency in decision-making and interpretation of the Act? In addition to amendment of ss 13 and 14, solving the problems concerning reportable health care-related deaths will require other interventions. For example, guidelines as to what “unexpected” means could be drafted. The Queensland State Coroner has issued guidelines with explanations of the categories of unnatural deaths.<sup>86</sup> The Victorian Institute of Forensic Medicine has issued a statement on death certificates and reportable deaths.<sup>87</sup>

Some of the difficulties in reportable health care-related deaths “have been resolved by providing specific lists of diseases, conditions, and death circumstances that are unequivocally reportable”.<sup>88</sup> Scholars have cautioned that prescriptive reporting directions may “decrease coroners’ roles by narrowing the range of deaths that are reported to them”.<sup>89</sup> However, the evaluation conducted by the Clinical Liaison Service (CLS) in Victoria, shows that there has been an increase in reports of health care-related deaths to the coroner since the establishment of CLS. It is arguable that in New Zealand currently there may be some unnecessary referrals. The Victorian evaluation suggests that tighter legislative criteria contribute to a rise in reporting. Also, it is highly unlikely that a perfect system will ever be devised and, arguably, the introduction of prescriptive legislative provisions and/or guidelines to encourage consistency is preferable to the current state of confusion.

Any new system/process introduced by the current reforms needs to be implemented correctly among both junior and senior clinicians so that it becomes part of routine clinical practice in due

<sup>85</sup> Rossella Fattori et al, “Interdisciplinary Expert Consensus Document on Management of Type B Aortic Dissection” (2013) 61 J Am Coll Cardiol 1661.

<sup>86</sup> Queensland State Coroner <<http://www.justic.qld.gov.au/courts/coroner/pdfs/guidelines.pdf>>.

<sup>87</sup> Victorian Institute of Forensic Medicine, Statement on Death Certificates and Reportable Deaths <<http://www.coronerscourt.vic.gov.au/home/>>.

<sup>88</sup> Freckelton and Ranson, n 11, 183.

<sup>89</sup> Freckelton and Ranson, n 11, 183.

course. There is an extensive medical literature on interventions which can improve clinicians' adherence to best practice recommendations. These include educational initiatives, the use of decision support/decision aids and the need to audit practice.<sup>90</sup> For example, a pre-coded/formatted electronic Medical Certificate of Cause of Death, which includes decision support tools on reportable deaths, could assist new generation/junior doctors with this problem. Regional Public Health suggested that an "on-line tool which guides doctors to select the appropriate deaths for reporting to coroners"<sup>91</sup> could be introduced.

## CONCLUSION

It is well recognised by researchers and practitioners that health care-related deaths present particular problems. Apart from coroners, there is overwhelming support for the amendment to the 2006 Act provisions concerning health care-related deaths. The key issue is how to redraft the legislative provisions so that uncertainty is minimised.

While the proposed amendments in the *Coroners Amendment Bill 2014* are an improvement on the current legislative drafting, doubt remains about whether they will solve the challenges presented by health care-related reportable deaths. The Ministry of Justice recommended that the definition of health care-related deaths should be drafted in consultation with health sector officials.<sup>92</sup> Therefore, debate about the *Coroners Amendment Bill 2014* provisions that concern health care-related deaths should give serious consideration to the submissions received by the Law Commission that expressed the view that the Queensland or Victorian legislation should be used as models. The more prescriptive approach in the Queensland legislation may reduce uncertainty for health practitioners making decisions about health care reportable deaths to the coroner. A range of interventions (such as guidelines, and decision aids) will be required to ensure that practitioners change their reporting practices based on the legal amendments.

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<sup>90</sup> Jeremy Grimshaw et al, "Changing Provider Behavior: An Overview of Systematic Reviews of Interventions" (2001) 39(8 Suppl 2) *Med Care* 112.

<sup>91</sup> Regional Public Health, Submission, 27 July 2011, 1.

<sup>92</sup> Ministry of Justice, n 79, 83.