



Neil MacLean

Chief Coroner
Auckland

Confessions of a Coroner - Concurrent Workshop Repeated

Friday, 21 June 2013

Start 4:30pm

Start 5:35pm

Duration: 55mins

Duration: 55mins

Sovereign

Sovereign



The logo for Rotorua GP CME 2013. It features a stylized blue 'f' shape to the left of the text 'Rotorua GP CME 2013'. To the right of this is the NZMA logo, which includes the text 'NZMA' and 'New Zealand Medical Association'.

General Practice Conference & Medical Exhibition

20-23 June 2013 | Energy Events Centre | Rotorua



CORONIAL SERVICES
OF NEW ZEALAND

Purongo O te Ao Kakarauri

Confessions of a Coroner

Chief Coroner of New Zealand, Judge MacLean

**NZMA General Practice Conference and Medical Exhibition
Rotorua, June 2013**

Overview:

- Recent Review of Coroner's decisions
 - Carroll v Coroners Court
 - Gravatt v Coroners Court
- The Ministerial Review of the Coroners Act 2006
- Publication of suicide information
- Postvention initiatives

Carroll v The Coroners Court

- ▶ Recent High Court decision of Justice Winkelmann (29 April 2013).
- ▶ Successful judicial review of Coroner's 'Finding' that "good Samaritans" decision not to contact police was contributing factor in death
- ▶ Examined whether decision was without proper evidential foundation and unreasonable – whether finding amounted to adverse comment (under s15(2)(b) Coroners Act 1988) – and if so – the failure to comply with notice requirements and principles of natural justice.
- ▶ The relevant Finding was quashed.

Held:

- ▶ The Coroner's Finding was unreasonable and based upon speculation as to what might have happened if the applicants had called the police.
- ▶ The Coroner's finding was in breach of natural justice because he failed to tell them their conduct was likely to be called into question during the inquest.
- ▶ They were also not given reasonable opportunity to comment on their conduct.

Gravatt and Name Suppression

- ▶ Recent High Court decision of Justice Whata (4 March 2013).
- ▶ Successful application for judicial review of a Coroner's order made under section 74, prohibiting the making public of the names of some health professionals involved in a deceased's care.

Coroners have the power to prohibit publication of names or particulars identifying witnesses

74 Coroner may prohibit making public of evidence given at any part of inquiry proceedings

If satisfied that it is in the interests of justice, decency, public order, or personal privacy to do so, a coroner may prohibit the making public of--

(a) any evidence given or submissions made at or for the purposes of any part of the proceedings of an inquiry (for example, at an inquest); and

(b) the name, and any name or particulars likely to lead to the identification, of any witness or witnesses.

Justice Whata revoked the prohibition order

- ▶ The Coroner had in effect established that the circumstances of death were to do with systemic issues and his recommendations were directed to the system needing attention and not the individuals. If it had not been so and the recommendations were directed to individuals Justice Whata states name suppression may have been warranted.

Not enough information given

- ▶ The Coroner erred in law by not demonstrating why he was satisfied that the interests of justice and/or matters of personal privacy outweighed the principles of open justice and freedom of expression in the case of each individual.
- ▶ Suppression is not a matter that can be applied in a broad brush way...the relevant facts weighing for and against publication must be assessed on a fine grained basis..."
- ▶ The Coroners Act must like any other enactment be given a meaning consistent with the rights and freedoms including open justice set out in the NZBORA.

A 3-stage enquiry

1. There must be express statutory authority to suppress.
2. The authority must be where possible interpreted and exercise consistently with freedom of expression.
3. Even where the above 2 qualifying conditions exist any discretionary infringement of that freedom must be justified.

The failure to undertake any of these steps will make the decision to suppress reviewable

S 74 not triggered in this case

- ▶ His honour stated that it is not the role of the Coroner to pass judgments on persons associated with the circumstances of death and some care must be taken by the Coroner to avoid criticism of them, but that in this case none of the statutory grounds in s 74 for prohibition were triggered and had they been present they did not justify by themselves or in combination derogation of the right to impart information.

From now on:

- ▶ Any medical professionals, or Counsel acting on behalf of them, seeking prohibition orders, must now provide very detailed submissions setting out their reasoning using the three stage structure set out by Justice Whata, it is quite clear that something more than harm must be relied on when seeking name suppression.

How to interpret s 74

– Public Order

- ▶ A concern or fear held by a health professional about being named cannot by itself provide a justifiable basis for limiting freedom of speech.
- ▶ “the position might have been different had the speech involved heavy and disputed criticism or breach of privacy or confidence.”

How to interpret s 74

– Interests of justice

- ▶ Justice Whata was not convinced by the argument that the ground is engaged purely based on alleged “reputational impacts”.
- ▶ This is particularly so in the Gravatt case because the Coroner’s decision did not as stated at paragraph 68 “unfairly impugn the character or reputation of the affected health professionals”.

How to interpret s 74

– Personal Privacy

- ▶ “A real prospect of improper pressure or harassment might...qualify as a legitimate reason to prohibit publication. But a general fear of criticism does not meet the necessary threshold”.

Ramifications

- ▶ It may be that this is now a harder test to satisfy, and it does have big ramifications with even the Health and the Disability Commission slowly moving towards greater disclosure, whether this approach is considered right or wrong however, it is more in line with what is occurring overseas such as in the UK, Canada and Australia.

Minister Announces Review –

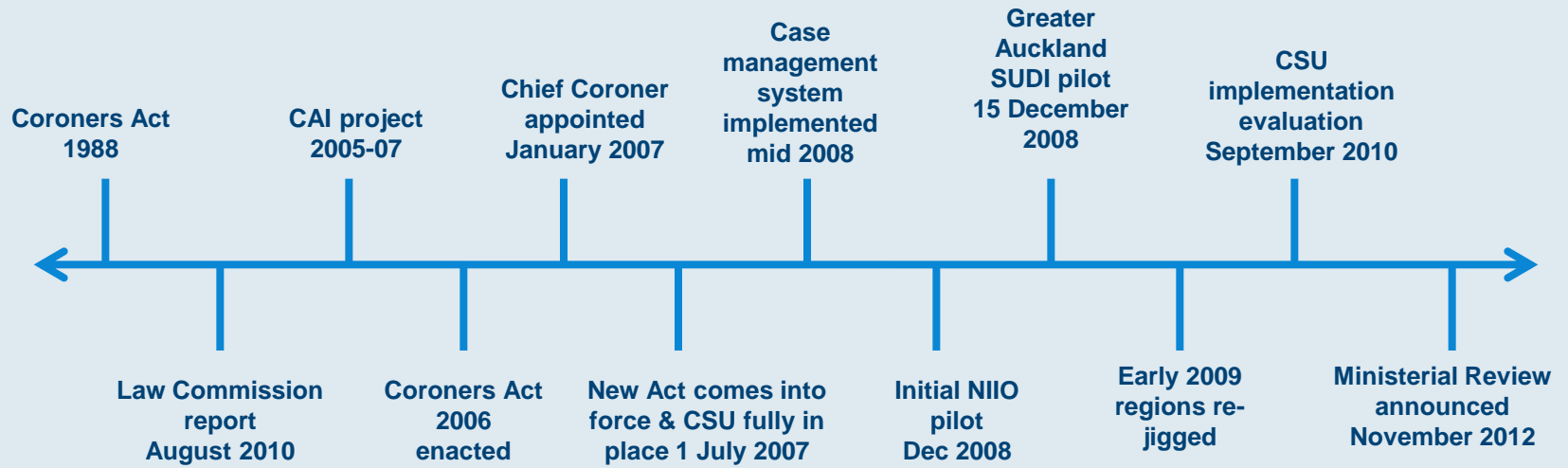
Aims of the review will be to:

- Better balance the needs of grieving families (including the cultural needs of Māori whānau) with the public interest in understanding the causes and circumstances of deaths
- Improve the quality, consistency and timeliness of coronial investigations and decision making

Minister Announces Review –

Aims of the review will be to:

- Clarify the role of coroners and reduce duplication between them and other authorities
- Clarify the role coroners have in making recommendations and the relationship to agencies that have policy and operational responsibility in those areas, and
- Ensure resources are used effectively.



Possible Changes

- (1) Specifying and clarifying reporting of Health-care related deaths?
 - Broad discretion provided to medical professionals in New Zealand's legislation on what deaths to be reported
 - In Australian jurisdictions, legislative reforms have sought to specify and clarify when deaths occurring in a medical setting should be reported to a Coroner
 - Could clarify the circumstances when a death from a health-care related procedure should be reported to a Coroner, and may encourage greater compliance in reporting by Doctors.

Possible Changes

(2) Mandatory responses to recommendations?

- Currently no provision in our Act which makes it mandatory for agencies or organisations to respond to Coroner's recommendations
- Many other jurisdictions require mandatory responses to recommendations. In England and Wales 'Rule 43' requires that a person who receives a Coroner's report must send the Coroner a written response within 56 days.
- In Victoria anyone receiving a recommendation from a Coroner must respond in writing within three months stating what action, if any, has or will be taken.

Possible Changes

(3) Suicide Reporting and Media Guidelines

- Suicides average around 540 annually
- All suicides must be reported to the Coroner
- Coroners Act 2006 restrictions re: publication
- Section 71 aims to reduce risk of copycat suicide, to protect the privacy of the deceased person and to minimise the impact on their family balanced against the public interest
- Media guidelines for the reporting of suicide developed in 2011 through collaboration with media, mental health professions and government agencies.



Reporting Suicide

A resource for the media

Developed by the media Roundtable and
adopted by the Media Freedom
Committee and the Newspaper
Publishers' Association
December 2011

Statutory constraints on the reporting of suicide.

- ▶ Before a Coroner's inquiry is completed no one may make public any particulars of a death without a Coroner's permission, including that it may be self-inflicted.
- ▶ If a Coroner has found a death to be self-inflicted the only details that may be made public without a Coroner's permission is the name, address and occupation of the deceased, and the fact that the death has been found to be self-inflicted.

Section 71 – Coroners Act 2006

- ▶ Section 71 – ‘Restrictions on making public of details of self-inflicted deaths’ states:
 - 1) **No person may, without a coroner's authority, make public any particular relating to the manner in which a death occurred if—**
 - (a) the death occurred in New Zealand after the commencement of this section; and
 - (b) there is reasonable cause to believe the death was self-inflicted; and
 - (c) no inquiry into the death has been completed.
 - (2) **If a coroner has found a death to be self-inflicted, no person may, without a coroner's authority or permission under section 72, make public a particular of the death other than—**
 - (a) the name, address, and occupation of the person concerned; and
 - (b) the fact that the coroner has found the death to be self-inflicted.
 - (3) **The only grounds on which a coroner may under this section authorise the making public of particulars of the death (other than those specified in subsection (2)(a) and (b)) are that the making public of particulars of that kind is unlikely to be detrimental to public safety.**

'Opening up' of Suicide Reporting

- I have advocated a gentle opening up of suicide reporting in NZ to encourage more open discussion and accurate information about suicide (this mirrors what is happening in parts of South Australia)
- Suicide statistics are now released annually to provide a clearer, earlier and accurate picture of the extent of suicide in New Zealand. The most recent release of suicide statistics showed some concerning trends, including a significant jump in teenage (15–19 year olds) suicide numbers and the continued rise of Maori suicides, in particular young Maori.
- 'Opening up' has been strongly opposed by a small number of vocal academics

Postvention initiatives

–SUDI and recently extended to the area of Suicide

- ▶ The “postvention” phase relating to sudden deaths.
- ▶ Started with Infant deaths, specifically deaths falling within the definition of “SUDI”, from birth to 1 year old.
- ▶ A health trained investigator works with the Coroner’s office to improve information collection for SUDI deaths and to provide support to families that have suffered a SUDI death.

SUDI Referral Advisors

- ▶ The role commenced at the end of 2008 in Auckland and Northland and grew from there. Feedback has shown it is a great success for increasing the information available on SUDI deaths and for its support to families whanau and communities
- ▶ The main objectives of the Referral Advisor:
 - To co-ordinate a collaborative response to SUDI that maintains the integrity of the coronial process;
 - To collate sufficient and accurate information for the coronial database to identify how SUDI can be prevented.

Key role & responsibility of the SUDI Referral Advisor:

- ▶ Comprehensive collection of information
- ▶ Meet with whānau and co-ordinate support for them;
- ▶ Deliver SUDI workshops/facilitate training;
- ▶ Provide info/advice to professionals;
- ▶ Be a source of knowledge on SUDI, processes after death, legislation and rights of whānau/families;
- ▶ liaise with relevant people/organisations to:
inform of the death; arrange support and referrals;
and ensure ongoing support is provided to whānau.

Appropriate urgent postvention response to suicide

- ▶ Auckland Pilot – Particular focus on youth.
- ▶ Aim to avoid a sudden, uncoordinated postvention response.
- ▶ Seeking answers to questions such as: What's happening? What should happen? How?
- ▶ Cases such as *David Gaynor* show just how many agencies can be involved following the suicide of someone in a school environment, this leads to concerns about agencies with the best of intentions getting in one another's way.

Questions?