25 August 2014

Avant mutual group

Avant Mutual Group Limited
ABN 58 123 154 898

Registered Office
Level 28 HSBC Centre
580 George Street Sydney NSW 2000

PO Box 746 Queen Victoria Building
Sydney NSW 1230

DX 11583 Sydney Downtown

www.avant.org.au

Telephone 02 9260 9000 Fax 02 9261 2921
Freecall 1800 128 268 Freefax 1800 228 268

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

Avant welcomes the opportunity to provide input into the Attorney-General's review of the Coroners Act 2009.

Avant is a medical indemnity organisation representing over 60,000 medical and allied health practitioners and students in Australia. We have offices throughout Australia. Avant frequently assists members in preparing statements for and appearing as witnesses in coronial inquests in all states and territories around Australia.

It is from this perspective that we provide the comments below.

Amendment to sections 81(3) and 82(3) of the Coroners Act to include civil liability

Based on our experience of assisting members in NSW and in other states and territories, we submit that amendments should be made to sections 81(3) and 82(3) to include a reference to civil liability and unprofessional conduct.

At present the *Coroners Act* 2009 (NSW) does not prevent a coroner from indicating or suggesting in a finding or recommendation that a person is civilly liable or should be subject to disciplinary action.

The role of the coroner is to investigate manner and cause of death. Coronial inquests are inquisitorial in nature and it is not the function of the coroner to determine negligence or unprofessional conduct.

This view was emphasised by the then State Coroner Derek Hand in the Thredbo Landslide Inquest were he commented that:

> *"The inquest plays an important function as a fact finding exercise, essential to investigate and answer the relatives' and public's need to know the cause of death free from the constraints of inter partes litigation. It does not apportion guilt. Although not expressly prohibited by the Act, it is not the function of the inquest to determine any question of civil, let alone, criminal liability*[1].

Legal practitioners are reminded of this before the commencement of most inquests in NSW, when coroners provide the legal representatives of witnesses with "Procedural Directions".

[1] Inquest into the Thredbo Landslide, State Coroner Derek Hand, 19 June 2000, p 10, unreported. See also *Keown v Khan* [1999] 1 VR 69 at 75-6 per Callaway JA and *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1 at 15, and the statement of the then Hon Mr Merton (Minister for Justice & Emergency services) in the second reading speech of the Coroners (Amendment) Bill in 1993 [the predecessor legislation to the current act]: see Hansard Legislative Assembly second reading on 21 April 1993 at 1381

These directions outline the general principles and procedures to be adopted by the coroner conducting the inquest, and typically include the following:

> *"It is important to emphasise that their (proceedings) purpose is not to decide criminal or civil liability of any person but to determine the circumstances of the death".*

Despite directions of this nature and the position at common law, we have been involved in or are aware of a number of recent coronial inquests that have focused on medical practitioner's standard of care and have resulted in findings commenting on the "appropriateness of the care and treatment" provided by medical practitioners. Although witnesses have the protection of a s61 Certificate afforded to them by the Act for self-incrimination against their own evidence, s61 does not protect witnesses from other evidence such as expert opinions and reports commissioned by a coroner which may comment on standard of care and professional conduct issues.

We accept that a coroner is entitled to make comments about the role of a person in a death, and that family members of the deceased (or anyone else) can make a claim or complaint based on information obtained from coronial proceedings. However we have been involved in matters where the jurisdictional boundaries are blurred. We have seen an increasingly adversarial approach being taken in inquests with lines of questioning more akin to a civil or disciplinary proceeding than an inquisitorial matter seeking to investigate manner and cause of death. We have also seen reports obtained for the purpose of an inquest being relied upon in civil and disciplinary matters.

In some cases there may be overlaps between the coronial jurisdiction and disciplinary or negligence claim proceedings. However the coronial jurisdiction is not intended to be adversarial, it has no parties and the rules of evidence do not apply, so comments relating to civil liability can often deprive the witness of procedural fairness and natural justice in future proceedings. This raises the potential for coroners' findings to be challenged. In our view, these decisions should be left to the appropriate courts and professional and regulatory bodies.

In our view, this position should be enshrined in legislation. Equivalent legislation in other states (Queensland[2], South Australia[3] and Western Australia[4]) prevents coroners from indicating or suggesting in their findings and recommendations that a person is civilly liable. It will ensure all participants in the coronial process are aware of the limits of the coronial jurisdiction, and will assist in reinforcing the boundaries of the coronial Jurisdiction to ensure fair, cost efficient and time efficient coronial proceedings.

Suggested amendments

We recommend that the sections be amended as follows:

81 Findings of coroner or jury verdict to be recorded

(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and
(b) the date and place of the person's death, and
(c) in the case of an inquest that is being concluded—the manner and cause of the person's death.

[2] S46(3)(b) *Coroners Act 2003* (QLD)
[3] S25(3) *Coroners Act 2003* (SA)
[4] S25(5) *Coroners Act 1996* (WA)

(2) *The coroner holding an inquiry concerning a fire or explosion must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict:*
   (a) *as to the date and place of the fire or explosion, and*
   (b) *in the case of an inquiry that is being concluded—as to the circumstances of the fire or explosion.*

(3) *Any record made under subsection (1) or (2) must not indicate or in any way suggest that:*
   (a) *an offence has been committed by any person;*
   (b) *a person is civilly liable; or*
   (c) *a person has breached professional etiquette or ethics or departed from accepted standards of professional conduct.*

82 Coroner or jury may make recommendations

(1) *A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.*

(2) *Without limiting subsection (1), the following are matters that can be the subject of a recommendation*

   (a) *public health and safety,*
   (b) *that a matter be investigated or reviewed by a specified person or body.*

(3) *The record made under section 81 is to include any recommendations made by the coroner or jury. The record must not indicate or in any way suggest that:*
   (a) *an offence has been committed by any person;*
   (b) *a person is civilly liable; or*
   (c) *a person has breached professional etiquette or ethics or departed from accepted standards of professional conduct.*

(4) *The coroner is to ensure that a copy of a record that includes recommendations made under this section is provided, as soon as is reasonably practicable, to:*

   (a) *the State Coroner (unless the coroner is the State Coroner), and*
   (b) *any person or body to which a recommendation included in the record is directed, and*
   (c) *the Minister, and*
   (d) *any other Minister (if any) that administers legislation, or who is responsible for the person or body, to which a recommendation in the record relates.*

Please contact us on the details below if you require any further information or clarification of the matters raised in this letter.

Yours sincerely

Georgie Haysom
Head of Advocacy

Direct: (02) 9260 9185

Email: georgie.haysom@avant.org.au

John Kamaras
Special Counsel - Coronial

Direct: (02) 9260 9071

Email: john.kamaras@avant.org.au

About Avant

Avant Mutual Group Limited ("Avant") offers a range of insurance products and expert medico-legal advice and assistance to over 60,000 medical and allied health practitioners and students in Australia. Our insurance products include professional indemnity insurance for individuals and practices, as well as private health insurance, which is offered through our subsidiary The Doctors' Health Fund Pty Limited.

Our members have access to medico-legal assistance via our Medico Legal Advisory Service. We have offices throughout Australia, and provide extensive risk advisory and education services to our members with the aim of reducing medico-legal risk.