From the President's Office

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13 July 2021

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SUBMISSIONS FOR THE INQUIRY INTO THE CORONIAL JURISDICTION IN NSW

The AMA(NSW) welcomes the opportunity to make a submission to the Upper House Select Committee for the Inquiry into the Coronial Jurisdiction in NSW. In order to prepare this submission, we have consulted members of AMA(NSW) as well as members of NSW Public Hospital Medical Staff Councils who have experience with the Coronial Jurisdiction.

As the peak representative body for medical practitioners in NSW, AMA(NSW)'s submission focuses upon the Coronial Jurisdiction from the perspective of the medical profession and addresses those areas of the Coronial Jurisdiction where the processes and procedures may be improved from that viewpoint.

The AMA(NSW) appreciates the Coronial Jurisdiction touches the lives of many in NSW, and requires co-operation from many individuals, professional groups and industries across the State. Our submission therefore is restricted to only those aspects of the Coronial Jurisdiction where we believe we can provide meaningful input.

The AMA(NSW) wishes to express it appreciation for the work of the Coroner's Court of NSW. We are cognisant of the fact the Court works tirelessly to improve systems and processes in NSW with the ultimate aim of protecting the community.

The Terms of Reference

1. That a select committee be established to inquire into and report on the coronial jurisdiction in New South Wales, and in particular:

(a) the law, practice and operation of the Coroner's Court of NSW, including:

(i) the scope and limits of its jurisdiction,

(ii) the adequacy of its resources,

(iii) the timeliness of its decisions,

(iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,

(v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,

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

(b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary,

(c) the most appropriate institutional arrangements for the coronial jurisdiction New South Wales, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement, and

(d) any other related matter.

The AMA(NSW)'s submission focuses on Terms of Reference 1(a)(iv) and (d).

The relevant Legislation – The Coroners Act (2009) (NSW) (the Act)

The Act provides the Coroner with the power to make recommendations.[1] Specifically, in accordance with Section 81:

> *The coroner must investigate sudden, unexpected, and unnatural deaths to determine the identity, date, place, circumstances, and medical cause of death.*

Relevantly, particularly with respect to this submission on behalf of our members we note Section 82, ss 1 & 2 which provide that the Coroner or the jury have the power to make recommendations as they consider necessary, following an inquest to **improve public health and safety** and prevent future deaths/incidents, or that a matter is to be investigated by a specified body/person.

Root Cause Analysis (RCA) process in NSW Health

Incidents in Public Hospital Settings, that are reported to the Coroner, are almost always investigated. The NSW Ministry of Health is made aware of issues that are relevant to patient safety from a number of sources[2].

Root Cause Analysis (RCA) reports are used to review/analyse incidents by identifying the root causes and factors that contributed to an incident. RCA reports often provide recommendations that arise out of an investigation and those recommendations are implemented in health facilities as required. For incidents that correspond with a Harm Score 1(a corporate/clinical unexpected death), a report is due to the Ministry of Health within 60 calendar days of the incident notification. To do this staff are encouraged to use a number of templates including the Recommendations Report template.[3]

[1] Coroners Act 2009, Sections: 3(a); 81, 82, 101F(1)(c), 101J.
[2] https://www.health.nsw.gov.au/policies/manuals/Documents/pmm-12.pdf
[3] https://www.cec.health.nsw.gov.au/Review-incidents/incident-management-policy-resources

The Ministry advises that care should be taken when reporting, so that it does not prejudice a Police or Coronial investigation. Further, any review by the Health Service is to be limited to whether there were any systems issues that may have contributed to the incident, as determined by the Chief Executive.

The endorsed model of RCA is root cause analysis and action (RCA2), developed by the National Patient Safety Foundation,[4] to ensure that there is a focus on the actions needed to reduce harm and improve safety. In terms of actually implementing RCA2 recommendations, incident data is monitored and analysed to detect trends and determine whether system-wide improvements are needed. Feedback on the outcome of investigations and implementation changes to policy and procedure/practice is provided to the RCA team, and staff.[5] Noting that this is to be done in a "timely manner".

Coronial Recommendations

The AMA(NSW) is of the view delays in the Coronial Jurisdiction must be addressed, not just to better the delivery of health care to the public, but first and foremost to reduce suffering for families who find themselves in the Jurisdiction.

At this point in time, the results of RCAs are not routinely released to the Coroner. Our members have indicated that it is not unusual for the Coroner to make recommendations similar to those made during the RCA process. Further, by the time a Coronial investigation is complete, a hearing is convened, time is taken to deliver a decision, often the recommendations made following an RCA have already been implemented.

> *"I have seen policies and guidelines change after inquests and I find it very common that practice has changed by the time that the recommendations filter down."*[6]

Recommendations formed following the RCA process are broadly applied, and may include education of Public Hospital Staff and changes to processes and procedures within individual departments or across Hospitals, Local Health District and State wide.

AMA(NSW) members have expressed that this 'doubling up' of recommendations to be an unnecessary use to the Coroner's resources, and providing the RCA Recommendations (not necessarily the report), at the initiation of an Coronial Investigation may provide the Coroner with the comfort that certain matters, relevant to the Public Health System, and which impact upon medical professionals, have already been addressed.

> *"I find most clinical practice changes come from RCAs and are either made by the LHD or by the Agency for Clinical Innovation, such as the recent change to oxygen prescribing on PCA charts. No doubt the Coroner may have made the same recommendation, but the Coroner's*

[4] https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx
[5] https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2020_047.pdf

[6] AMA(NSW) Hospital Practice Committee member

process takes a long time, and the RCA process is more agile and results in practice changes more rapidly."[7]

Following consultation with Medical Staff Councils, the overwhelming concern was a lack, or at least a perceived lack, of relevant clinician input into Coronial recommendations. It was suggested that the Coroner ensure those recommendation which impact upon the delivery of medicine be the subject of a consultation process involving those practitioners who will be providing services. It is thought that this will ensure best practice, practical implementation and ensure system improvement rather than disruption.

Resourcing and Implementation of Recommendations

We have also received feedback regarding resourcing and the implementation of Coronial Recommendations. It has been noted that recommendations are made without reference to the costs involved in implementing those recommendations. When recommendations are made with respect to use of equipment or developing new systems, especially those requiring IT development for sharing records, such as, between agencies, like NETS, NSW Health and NSW Ambulance, these changes involve significant monetary costs and as well as the costs associated with having clinicians needing to have time away from work for education and training.

For those medical professionals outside of the Public Hospital System and working in private practices, consideration should also be given to the costs associated with the implementation of recommendations that might impact private practices.

In noting the desirability of having regard to the costs associated with implementing changes AMA(NSW), and those with whom it has consulted, do not wish to detract from or diminish the importance of change to protect the health and safety of the public including the prevention or minimisation of harm, but submits there is a need for recognition of the costs as a part of the process.

We trust our submission provides valuable insight to the practical impacts associated with a Coroner's recommendations and the delivery of healthcare in NSW. We again thank you for the opportunity to provide a submission to assist the Council's review of the law, practice and operation of the Coroner's Court of NSW.

Yours sincerely,

Dr. Danielle McMullen

President, AMA (NSW)

[7] AMA(NSW) Hospital Practice Committee member