

# THE CORONIAL REPORTING OF MEDICAL-SETTING DEATHS: A LEGAL ANALYSIS OF THE VARIATION IN AUSTRALIAN JURISDICTIONS

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*This article examines the issue of when a medical-setting death is reportable to the Coroner in Australia. It compares and contrasts the various definitions of medical-setting reportable deaths in the state and territory Coroners Acts, demonstrating great variability in approach. We argue in favour of the adoption by all jurisdictions of a definition, such as that in the Queensland Act, which encompasses 'health care' generally and includes purported health care and omissions in the provision of health care. The article goes on to examine the offences and penalties that attach to a failure to comply with coronial reporting obligations. This analysis reveals a lack of consistent approach from jurisdiction to jurisdiction, both as to the nature and elements of the offences and the seriousness of the penalties attached. We argue that states and territories should adopt a two-tier approach consisting of a strict liability offence with a low financial penalty and a more serious offence requiring intent and carrying a harsher penalty. Finally, we advocate for Coroner's Guidelines to be issued in all jurisdictions to assist Australian health practitioners in better understanding their reporting obligations.*

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## I INTRODUCTION

In November 2005, the Queensland Public Hospital Commission of Inquiry handed down the ‘Davies Report’ which examined complaints about Dr Jayant Patel at Bundaberg Base Hospital.<sup>1</sup> It identified 13 patient deaths in which an unacceptable level of care by Dr Patel contributed to the outcome. In only two cases, the deaths were reported to the Coroner, although all 13 were likely reportable under the relevant state legislation.<sup>2</sup> Earlier in 2003, a United Kingdom inquiry into the activities of serial killer Dr Harold Shipman found that during his career as a general practitioner he probably murdered no fewer than 215 of his patients by morphine overdose, avoiding detection by falsifying the death certificates.<sup>3</sup> Although Shipman and Patel may have been rogue elements in their profession,<sup>4</sup> both cases highlight the weaknesses of a coronial system that relies on the treating doctor to determine whether a case should be reported to the coroner. That doctor, whilst best placed to make the assessment, ‘is also usually the person whose performance will be scrutinised if a coroner investigates the death’.<sup>5</sup>

In the wake of the Shipman and Patel scandals, the problem of the under-reporting of medical-setting deaths to the coroner in Australia has received

<sup>1</sup> Geoffrey Davies, ‘Queensland Public Hospitals Commission of Inquiry’ (Report, Queensland Public Hospitals Commission of Inquiry, November 2005).

<sup>2</sup> *Ibid* 17.

<sup>3</sup> Dame Janet Smith, ‘The Shipman Inquiry: Death Certification and the Investigation of Deaths by Coroners’ (Report No 3, 2003) (‘Third Shipman Report’).

<sup>4</sup> Cf Herbert G Kinnell, ‘Serial Homicide by Doctors: Shipman in Perspective’ (2000) 321 *British Medical Journal* 1594.

<sup>5</sup> Davies, above n 1, 524.

considerable attention.<sup>6</sup> Indeed, several states have amended or replaced their Coroners Act provisions to provide clearer definitions of when a medical-setting death is reportable.<sup>7</sup> Yet despite the emergence of medical-setting deaths as a separate and discrete category of reportable death, not all jurisdictions have followed suit, and those that have made amendments have opted for individualised definitions. This, combined with the widely varying penalties for noncompliance with reporting obligations, has led to a fragmented approach.

This article examines the current Australian law on the circumstances in which a medical-setting death is reportable to the coroner and the penalties that apply when a reportable death is not reported. Part II explains the legal obligations of doctors when a patient dies and summarises what is known about the problem of underreporting of deaths to the coroner. Part III compares and contrasts the current state and territory definitions of medical-setting reportable deaths. This analysis is undertaken by grouping jurisdictions together based on common key features in how they define a medical-setting reportable death. In Tasmania, Western Australia and the Northern Territory, for a medical-setting death to be reportable, it must be related to an anaesthetic. In South Australia and the Australian Capital Territory, the focus is on whether death was caused by or temporally associated with an operation or procedure. In Queensland, New South Wales and Victoria, a medical-setting death will be reportable if it is an unexpected outcome of a health-related operation or procedure. Part IV examines the offences and penalties that attach to a failure to comply with coronial reporting obligations from jurisdiction to jurisdiction, again identifying varying approaches and penalties.

The article highlights the need for further reform, arguing that the current definitions of medical-setting deaths in Tasmania, Western Australia and the Northern Territory are antiquated. Similarly, existing definitions that do not encompass *purported* health care or *omissions* in the provision of health care also need amendment. With respect to penalties, a two-tier approach is recommended consisting of a strict liability offence with a low penalty and an offence requiring intent with a higher penalty. Even with these reforms, differences between the jurisdictions are likely to remain. In this regard, the

<sup>6</sup> Law Reform Commission of Western Australia ('LRCWA'), *Review of Coronial Practice in Western Australia: Final Report*, Project No 100 (2012); *Law Reform Committee: Coroners Act 1985*, Parl Paper No 229 (2006).

<sup>7</sup> See *Coroners Act 2009* (NSW) s 6; *Coroners Act 2003* (Qld) s 8; *Coroners Act 2008* (Vic) s 4.

article advocates for the issuance of guidelines by coroners in all jurisdictions to assist Australian health professionals in understanding their obligations.

It should be noted that this article is limited to a legal analysis of the coronial reporting requirements for medical-setting deaths. Its purpose is to critically examine this discrete area of law and make suggestions for its improvement. The article does not explore the broader issue of whether the death certification process itself should be overhauled.<sup>8</sup> Notably, Australian legislatures have shown little interest in making changes to the death certification process, instead focussing on reform of the criteria for the reporting of medical-setting deaths.<sup>9</sup> Furthermore, whilst there is limited capacity for Coroners Courts around the country to deal with any increase in medical-setting reportable deaths, the current funding and resourcing deficits for some Coroners Courts<sup>10</sup> do not deflect from the need for appropriate reporting criteria; to suggest otherwise is a case of the proverbial ‘tail wagging the dog’. Equally, although there are other ways of preventing medical-setting deaths,<sup>11</sup> the coronial system remains an important and independent avenue for such investigation. Importantly, it is empowered to make recommendations with respect to public health or safety and the prevention of deaths in the health care system.<sup>12</sup> Research into the continued improvement of this process, as one of the ways to prevent avoidable injury and death in the health care system, is warranted.

## II DOCTORS, ‘REPORTABLE DEATHS’ AND THE CORONER

In all Australian states and territories, a doctor responsible for a deceased person’s medical care immediately before death or who examined the deceased’s body must issue a cause of death certificate to the Births, Deaths and

<sup>8</sup> For discussion of this issue, see Davies, above n 1, 528–30.

<sup>9</sup> Even if death certification reform were to take place, the need for criteria for the reporting of medical-setting deaths would, on most mooted models for reform, still exist. An exception would be a model such as that proposed by the Third Shipman Report, above n 3, 501–2 [19.55], in which all medical-setting deaths are referred to the coroner.

<sup>10</sup> See, eg, South Australian Coroners Court, *Annual Report of the State Coroner: Financial Year 2011–2012* (31 October 2012) 14; Coroners Court of Victoria, *Annual Report 2011–2012* (18 February 2013) 49–50; ABC News, *Coroners Court Records \$1.2m Loss* (9 May 2013) <<http://www.abc.net.au/news/2013-05-09/coroners-court-records-2412m-loss/4680372>>.

<sup>11</sup> See David Ranson, ‘How Effective? How Efficient?’ (1998) 23 *Alternative Law Journal* 284.

<sup>12</sup> *Coroners Act 1997* (ACT) s 3BA(1)(d); *Coroners Act 2009* (NSW) s 3(e); *Coroners Act* (NT) s 34(2); *Coroners Act 2003* (Qld) s 3(d); *Coroners Act 2003* (SA) s 25(2); *Coroners Act 1995* (Tas) ss 28(2)–(3); *Coroners Act 2008* (Vic) s 1(c); *Coroners Act 1996* (WA) s 25(2).

Marriages Registry within 48 hours of the death or its discovery.<sup>13</sup> However, a doctor must not issue a certificate if the death falls into a 'reportable' death category under the relevant Coroners Act.<sup>14</sup> In these cases, the death must be reported to the coroner and failure to do so constitutes a statutory offence.<sup>15</sup> Once reported, it is for the coroner to determine the cause of death.<sup>16</sup> In most cases, this will be determined following an investigation. In a small minority of cases an inquest or public hearing will be held.<sup>17</sup> Once cause of death is established it is for the coroner to notify the Registrar of Births, Deaths and

<sup>13</sup> *Births, Deaths and Marriages Registration Act 1997 (ACT)* s 35(1); *Births, Deaths and Marriages Registration Act 1995 (NSW)* s 39(1); *Births, Deaths and Marriages Registration Act (NT)* s 34(1); *Births, Deaths and Marriages Registration Act 1996 (SA)* s 36(1); *Births, Deaths and Marriages Registration Act 1999 (Tas)* s 35(1); *Births, Deaths and Marriages Registration Act 1996 (Vic)* s 37(1); *Births, Deaths and Marriages Registration Act 1998 (WA)* s 44(1). In New South Wales, a doctor may give 'notice' of the death if it is 'impractical' or 'undesirable' to give a cause of death within the 48 hour time frame: *Births, Deaths and Marriages Registration Act 1995 (NSW)* s 39(1)(b). In Queensland, a cause of death certificate must be issued within two working days of the death or its discovery, rather than 48 hours: *Births, Deaths and Marriages Registration Act 2003 (Qld)* s 30(4).

<sup>14</sup> *Births, Deaths and Marriages Registration Act 1997 (ACT)* s 35(3); *Coroners Act 1997 (ACT)* s 77; *Births, Deaths and Marriages Registration Act 1995 (NSW)* s 39(2); *Coroners Act 2009 (NSW)* s 38(1)(a); *Births, Deaths and Marriages Registration Act (NT)* s 34(2); *Coroners Act (NT)* s 12 (definition of 'reportable death'); *Births, Deaths and Marriages Registration Act 2003 (Qld)* s 30(2); *Coroners Act 2003 (Qld)* s 26(5)(a); *Births, Deaths and Marriages Registration Act 1996 (SA)* s 36(2); *Coroners Act 2003 (SA)* s 28; *Births, Deaths and Marriages Registration Act 1999 (Tas)* s 35(2)(b); *Coroners Act 1995 (Tas)* s 19 (note that s 19 says that a doctor 'need not' give notice, rather than 'must not' give notice); *Births, Deaths and Marriages Registration Act 1996 (Vic)* s 37(4); *Coroners Act 2008 (Vic)* s 4; *Births, Deaths and Marriages Registration Act 1998 (WA)* s 44(5); *Coroners Act 1996 (WA)* s 17. Under the same provisions, there is no requirement to provide a cause of death certificate if another doctor has done so. It should be noted that the *Coroners Act 1997 (ACT)* does not actually employ the term 'reportable death': see below nn 68, 142.

<sup>15</sup> *Coroners Act 1997 (ACT)* s 77(1); *Coroners Act 2009 (NSW)* ss 35(1)–(2); *Coroners Act (NT)* ss 12(3)–(4); *Coroners Act 2003 (Qld)* s 7(3); *Coroners Act 2003 (SA)* s 28(1); *Coroners Act 1995 (Tas)* s 19; *Coroners Act 2008 (Vic)* s 10(1); *Coroners Act 1996 (WA)* s 17. In New South Wales, the death can also be reported to an 'assistant coroner': *Coroners Act 2009 (NSW)* s 35(2), and in Victoria to the Victorian Institute of Forensic Medicine: *Coroners Act 2008 (Vic)* s 10(1). In the Australian Capital Territory, New South Wales, Queensland, South Australia, Tasmania and Western Australia, the death may also be reported to a police officer. Pursuant to the same legislative provisions, the death need not be reported if the person has a reasonable belief the death has been reported.

<sup>16</sup> See generally Ian Freckleton and David Ranson, *Death Investigation and the Coroner's Inquest* (Oxford University Press, 2006) ch 4.

<sup>17</sup> See, eg, Coroners Court of Victoria, above n 10, 54; Michael Barnes, 'Annual Report 2011–2012' (Report, Office of the State Coroner, 29 October 2012) 15, 31–44.

Marriages of the finding.<sup>18</sup> Whilst a coroner is a judicial officer responsible for the independent investigation of reportable deaths, the role does not include making determinations of liability or guilt.<sup>19</sup> However, the coroner's role is not limited to fact-finding. Rather, much of the operation of the modern coroner in Australia centres on 'injury and death prevention, with the coroner empowered to make recommendations on matters of public health and safety and judicial administration'.<sup>20</sup> Put simply, the modern coroner 'speak[s] for the dead to protect the living'.<sup>21</sup>

The categories of 'reportable death' in the Coroners Acts differ widely from jurisdiction to jurisdiction, especially when it comes to specific kinds of deaths including, for example, death by drowning,<sup>22</sup> death in the course of a police operation,<sup>23</sup> or the sudden death of a child under the age of one.<sup>24</sup> Even where all the Acts possess the same category, there is often little, if any, consistency in the wording and thus the precise scope of the provision. Medical-setting deaths provide no exception.<sup>25</sup> The more general (non-situational) categories of reportable death also differ. In the Northern Territory, Tasmania, Victoria and Western Australia, a death is reportable if it appears to be 'unexpected, unnatural or violent or to have resulted directly or indirectly from an accident or injury'.<sup>26</sup> In New South Wales and Queensland

<sup>18</sup> *Coroners Act 1997* (ACT) s 56(2)(b)(ii); *Coroners Act 2009* (NSW) s 34; *Coroners Act* (NT) s 34(4); *Coroners Act 2003* (Qld) s 97; *Births, Deaths and Marriages Registration Act 1996* (SA) ss 35, 37(2); *Births, Deaths and Marriages Registration Act 1999* (Tas) s 36(2); *Coroners Act 2008* (Vic) s 49(2); *Coroners Act 1996* (WA) s 28.

<sup>19</sup> See *Coroners Act 2009* (NSW) s 34(3); *Coroners Act* (NT) s 34(3); *Coroners Act 2003* (Qld) s 45(5); *Coroners Act 2003* (SA) s 25(3); *Coroners Act 1995* (Tas) s 28(4); *Coroners Act 2008* (Vic) s 69(1); *Coroners Act 1996* (WA) s 25(5). Cf *Coroners Act 1997* (ACT) s 55.

<sup>20</sup> Victorian Institute of Forensic Medicine, *The Role of the Coroner* (2014) <<http://www.vifm.org/forensics/medico-legal-death-investigation/the-role-of-the-corer/>>. See also the sources cited in above n 12. See generally Tatum Hands, 'Coronial Law Reform: Watch This Space' (2012) 37 *Alternative Law Journal* 139.

<sup>21</sup> James Young, 'Speaking for the Dead to Protect the Living: The Role of the Coroner and the Shipman Inquiry' (2004) 54 *British Journal of General Practice* 162.

<sup>22</sup> *Coroners Act 1997* (ACT) s 13. See below n 142.

<sup>23</sup> *Coroners Act 2003* (Qld) s 8(3)(h).

<sup>24</sup> *Coroners Act 1995* (Tas) s 3 (definition of 'reportable death' para (a)(viii)).

<sup>25</sup> See below Part III.

<sup>26</sup> *Coroners Act* (NT) s 12(1) (definition of 'reportable death' para (a)(iv)); *Coroners Act 1995* (Tas) s 3 (definition of 'reportable death' para (a)(iv)); *Coroners Act 2008* (Vic) s 4(2)(a); *Coroners Act 1996* (WA) s 3 (definition of 'reportable death' para (a)) (but this definition does not include 'accident').

the death would need to be 'violent', 'unnatural' or 'suspicious',<sup>27</sup> in South Australia it could be 'unexpected, unnatural, unusual' or 'violent',<sup>28</sup> and in the Australian Capital Territory it would need to be 'suspicious'.<sup>29</sup>

The various categories of reportable deaths have come under scrutiny over the past decade.<sup>30</sup> With respect to medical-setting deaths, the criticisms have been threefold. First, some coronial legislation still contain provisions that are a 'legacy of history' and do 'not necessarily catch the types of medical adverse events that should be investigated by Coroners'.<sup>31</sup> Second, some more modern formulations employ ambiguous and inexact wording, making it difficult for doctors to know when a case is reportable.<sup>32</sup> Third, there is emerging evidence, both published and anecdotal, suggesting the under-reporting of medical-setting deaths to the coroner both in Australia<sup>33</sup> and elsewhere.<sup>34</sup> A study, published in 2007, of the medical records of 229 deceased patients from two Melbourne hospitals revealed 58 reportable deaths of which only 22

<sup>27</sup> *Coroners Act 2009* (NSW) ss 6(1)(a), (c) ('unusual' is also included in s 6(1)(c)); *Coroners Act 2003* (Qld) ss 8(3)(b)–(c).

<sup>28</sup> *Coroners Act 2003* (SA) s 3 (definition of 'reportable death' para (a)).

<sup>29</sup> *Coroners Act 1997* (ACT) s 13(1)(d).

<sup>30</sup> See, eg, David Ranson, 'Reportable Deaths' (1998) 5 *Journal of Law and Medicine* 320.

<sup>31</sup> Australian Medical Association, Submission No 29 to LRCWA, *Review of Coronial Practice in Western Australia*, 25 August 2011, quoted in LRCWA, *Final Report*, above n 6, 31.

<sup>32</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity ('VCCAMM'), Submission No 22 to Law Reform Committee, Parliament of Victoria, *Coroners Act 1985*, 14 July 2005, 1; Austin Health, Submission No 45 to Victorian Law Reform Committee, *Coroners Act 1985*, 15 July 2005, 1; Victoria, *Law Reform Committee: Coroners Act 1985*, above n 6, 53–5; LRCWA, *Final Report*, above n 6, 35; Freckelton and Ranson, above n 16, 162–9.

<sup>33</sup> See below nn 35–6 and accompanying text. See also Stephen M Cordner, 'Doctors, Death Certificates and Reporting to Coroners — Room for Improvement' (2013) 199 *Medical Journal of Australia* 379; Jacinta Heffey, Submission No 33 to Law Reform Committee, Parliament of Victoria, *Coroners Act 1985*, 13 July 2005, 1; Australian Council for Safety and Quality in Health Care, Submission No 51 to Law Reform Committee, Parliament of Victoria, *Coroners Act 1985*, 25 July 2005, 2–4; VCCAMM, above n 32, 3.

<sup>34</sup> See, eg, Mid Staffordshire NHS Foundation Trust, 'Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Volume 2: Analysis of Evidence and Lessons Learned (Part 2)' (Report, February 2013) ch 14; Tom Luce (Chair) et al, 'Death Certification and Investigation in England, Wales and Northern Ireland' (Report, June 2003); S A Booth et al, 'Who to Report to the Coroner? A Survey of Intensive Care Unit Directors and Her Majesty's Coroners in England and Wales' (2003) 58 *Anaesthesia* 1204; Tsung-Hsueh Lu et al, 'Non-Referral of Unnatural Deaths to Coroners and Non-Reporting of Unnatural Deaths on Death Certificates in Taiwan: Implications of Using Mortality Data to Monitor Quality and Safety in Healthcare' (2008) 20 *International Journal for Quality in Health Care* 200; R D Start et al, 'General Practitioners' Knowledge of When to Refer Deaths to a Coroner' (1995) 45 *British Journal of General Practice* 191; R D Start et al, 'Clinicians and the Coronial System: Ability of Clinicians to Recognise Reportable Deaths' (1993) 306 *British Medical Journal* 1038.

(37.9 per cent) had been reported.<sup>35</sup> Another study of non-metropolitan hospitals in Victoria found that between 10 to 40 per cent of surveyed doctors are willing to consider altering a cause of death certificate to avoid coronial involvement.<sup>36</sup> More recent research published in the *Medical Journal of Australia* identified 320 unreported deaths between July 2010 and June 2011 in Victoria.<sup>37</sup> These deaths, of which 219 occurred in hospitals, constituted only 'a proportion of the unquantified pool of non-reported deaths'.<sup>38</sup> Despite the obvious potential for under-reporting to conceal cases of medical negligence or criminal activities,<sup>39</sup> it would seem that there are also other factors at play and that a lack of understanding by doctors of their reporting obligations is central to the problem.<sup>40</sup> It is also recognised that doctors may choose not to report a case to the coroner out of a desire to spare the deceased's family from the trauma of an autopsy and the associated delay in the release of the body for burial or cremation.<sup>41</sup> Institutional pressures and loyalty to colleagues are also thought to contribute to a culture of general under-reporting in the medical practice.<sup>42</sup>

Legislative changes in Victoria, Queensland and New South Wales since 2008 have sought to provide clearer, and in some cases broader, definitions of when a medical-setting death is reportable.<sup>43</sup> Importantly, this avoids the need

<sup>35</sup> Amanda Charles et al, 'Under-Reporting of Deaths to the Coroner by Doctors: A Retrospective Review of Deaths in Two Hospitals in Melbourne, Australia' (2007) 19 *International Journal for Quality in Health Care* 232.

<sup>36</sup> David James Brumley, *Death Certification by Doctors in Non-Metropolitan Victoria* (MSC (Primary Health Care) Thesis, Flinders University of South Australia, 1995) 81–2. See also Hedley G Peach and David J Brumley, 'Death Certification by Doctors in Non-Metropolitan Victoria' (1998) 27 *Australian Family Physician* 178. Similar results were obtained from a study of general practitioners in the United Kingdom: Gillian Maudsley and E M I Williams, 'Death Certification by House Officers and General Practitioners — Practice and Performance' (1993) 15 *Journal of Public Health Medicine* 192.

<sup>37</sup> Sandra L Neate et al, 'Non-Reporting of Reportable Deaths to the Coroner: When in Doubt, Report' (2013) 199 *Medical Journal of Australia* 402, 403.

<sup>38</sup> *Ibid* 402.

<sup>39</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 51–3; Davies, above n 1, 524.

<sup>40</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 53; LRCWA, *Final Report*, above n 6, 35.

<sup>41</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 57–9.

<sup>42</sup> Jenny Firth-Cozens, Robert A Firth and Sue Booth, 'Attitudes to and Experiences of Reporting Poor Care' (2003) 8 *Clinical Governance: An International Journal* 331.

<sup>43</sup> See *Coroners Act 2009* (NSW) s 6; *Coroners Act 2003* (Qld) s 8 (amended by *Coroners and Other Acts Amendment Act 2009* (Qld)); *Coroners Act 2008* (Vic) s 4. The NSW legislation repealed the *Coroners Act 1980* (NSW). The Victorian legislation repealed the provisions of

to rely on more general categories of reportable death (eg, 'violent' or 'unnatural' death).<sup>44</sup> However, despite the emergence of medical-setting deaths as a separate and discrete category of reportable death in most jurisdictions, there remains great variation in both the wording used and the penalties for noncompliance. These matters are explored more fully in Parts III and IV of this article respectively.

### III CURRENT LEGISLATIVE APPROACHES TO MEDICAL-SETTING DEATHS IN AUSTRALIA

Each state and territory Coroners Act defines a reportable medical-setting death in its own terms. However, analysis of the various definitions reveals three different overall approaches, namely:

- 1 whether the death was related to anaesthesia;
- 2 whether the death was caused by or temporally associated with an operation or procedure; or
- 3 whether the death was not a reasonably expected outcome of health care.

Each of the individual state and territory definitions can be located within one (and only one) of these overall approaches (see Table 1). These approaches are discussed below. They are summarised in Table 1 which follows the discussion.

#### *A Approach 1: Anaesthetic-Related Death*

In the Northern Territory and Western Australia, a death is reportable when it occurs 'during an anaesthetic' or 'as a result of an anaesthetic and is not due to natural causes'.<sup>45</sup> The Tasmanian provision refers to 'anaesthesia or sedation'.<sup>46</sup> The terms 'anaesthetic', 'anaesthesia' and 'sedation' are not defined.

This lack of definition has led to criticism on the basis that what falls within the ambit of 'anaesthesia' is open to debate.<sup>47</sup> As the Victorian Consultative

the *Coroners Act 1985* (Vic) which related to coroners and renamed that Act the *Victorian Institute of Forensic Medicine Act 1985* (Vic).

<sup>44</sup> See Ranson, above n 30.

<sup>45</sup> *Coroners Act* (NT) s 12(1) (definition of 'reportable death' paras (a)(v)–(vi)); *Coroners Act 1996* (WA) s 3 (definition of 'reportable death' paras (b),(c)).

<sup>46</sup> *Coroners Act 1995* (Tas) s 3 (definition of 'reportable death' paras (a)(v)–(vi)).

<sup>47</sup> Freckelton and Ranson, above n 16, 172.

Council on Anaesthetic Mortality and Morbidity points out, 'anaesthesia is no longer restricted to operative surgery, but is involved in an expanding range of complex interventional procedures performed outside the operating theatre'.<sup>48</sup> This can make it difficult for doctors to know whether certain deaths are reportable or not.<sup>49</sup>

Doctors may also have difficulty in determining whether a patient died 'as a result of' an anaesthetic.<sup>50</sup> Freckelton and Ranson explain the difficulties of establishing causation in this context:

Often ... it is not the anaesthetic that has caused the death but patient management between anaesthetists and surgeons and between the surgical anaesthetists and intensive care practitioners. However, the lines of professional responsibility and medical causation are frequently blurred in the multidisciplinary environment found in intensive care and high-dependency units in hospitals.<sup>51</sup>

This anaesthetic category of reportable death can also lead to anomalous results; for example, in the Northern Territory and Western Australia, a death during a dental procedure where a local anaesthetic has been injected into the gum for a filling would be reportable, but not the in-hospital death of a heavily sedated patient undergoing an invasive procedure.<sup>52</sup> As such it has been described as a

hangover from a time when this was the most dangerous aspect of surgery and fails to take into account the numerous other medical complications, failings or oversights which may contribute to a preventable death occurring in a hospital.<sup>53</sup>

It is important to remember that a medical-setting death that does not come within the 'anaesthetic' category will only be reportable if it falls into another more general category of reportable death in the relevant Coroners

<sup>48</sup> Victorian Consultative Council on Anaesthetic Mortality and Morbidity, 'Eighth Report of the Victorian Consultative Council on Anaesthetic Mortality and Morbidity' (Report No 8, April 2004) 8. See also *Law Reform Committee: Coroners Act 1985*, above n 6, 108–9.

<sup>49</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 108.

<sup>50</sup> See LRCWA, *Review of Coronial Practice in Western Australia: Discussion Paper*, Project No 100 (2011) 46.

<sup>51</sup> Freckelton and Ranson, above n 16, 173.

<sup>52</sup> See *Ibid* 172.

<sup>53</sup> Michael Barnes, 'Review of the *Coroners Act 1996 WA*' (Report, August 2008) 22, cited in LRCWA, *Discussion Paper*, above n 50, 46.

Act. Unfortunately, these other categories (for example, ‘unexpected’ or ‘unnatural’ deaths) can present difficulties.<sup>54</sup> Is a death from asbestos-related mesothelioma natural or unnatural? Does the term ‘unnatural’ include omissions or deaths where there has been a failure to treat or diagnose a medical condition?<sup>55</sup> When is a medical-setting death ‘unexpected’? Whose expectation is relevant: the family’s, the general practitioner’s or a specialist’s? Is the expectation objective or subjective? And at what point in time must the expectation be held? As Freckelton and Ranson observe, ‘there have been few judicial decisions or published court practice guidelines to help in construing the meaning behind the legislative terms’.<sup>56</sup>

In light of these problems, it is not surprising that the other jurisdictions have replaced the ‘traditional’<sup>57</sup> anaesthesia-related death category with a broader category encompassing medical procedure or health care-related deaths. The Australian Capital Territory was the first jurisdiction to do so in 1990,<sup>58</sup> followed by Queensland<sup>59</sup> and South Australia<sup>60</sup> in 2003 and then Victoria and New South Wales in 2008<sup>61</sup> and 2009<sup>62</sup> respectively. These

<sup>54</sup> See for discussion, *Law Reform Committee: Coroners Act 1985*, above n 6, 91–100; Ranson, above n 30, 322; Freckelton and Ranson, above n 16, 162–9. See also Heffey, above n 33, 1–4.

<sup>55</sup> See *R v Poplar Coroner; Ex parte Thomas* [1993] QB 610; *R (Touche) v Inner North London Coroner* [2001] QB 1206.

<sup>56</sup> Freckelton and Ranson, above n 16, 162.

<sup>57</sup> For the history of why anaesthesia deaths held special legislative status, see D Fenwick, ‘The History of Anaesthetic Mortality Reporting’ (2007) 35(3)(Supplement) *Anaesthesia and Intensive Care Journal* 21.

<sup>58</sup> *Coroners (Amendment) Ordinance 1990* (ACT) s 5(a) amended s 11(e) of the *Coroners Ordinance 1956* (ACT). Section 5(a) replaced the words ‘dies while under, or as a result of the administration of, an anaesthetic administered in the course of a medical, surgical, or dental operation or operation of a like nature’ with the current provision: see below Part IV.

<sup>59</sup> The *Coroners Act 2003* (Qld) replaced the *Coroners Act 1958* (Qld), under which s 7(1)(a)(v) said a death was reportable where it appeared a person had ‘died while under an anaesthetic in the course of a medical, surgical, or dental operation or operation of a like nature’.

<sup>60</sup> The *Coroners Act 2003* (SA) replaced the *Coroners Act 1975* (SA), which contained no reference to medical-setting deaths, anaesthetic-related or otherwise. The *Coroners Act 2003* (SA) s 3 (definition of ‘reportable death’ paras (d)(i)–(ii)) introduced a category of reportable death related to surgical, invasive medical or diagnostic procedures and anaesthetics: see below Part III.

<sup>61</sup> The *Coroners Act 2008* (Vic) replaced the *Coroners Act 1985* (Vic) s 3 (definition of ‘reportable death’ paras (f)–(g)), which said a death was reportable ‘that occurs during an anaesthetic’ or ‘that occurs as a result of an anaesthetic and is not due to natural causes’.

<sup>62</sup> The *Coroners Act 2009* (NSW) replaced the *Coroners Act 1980* (NSW) s 12B(1)(e), which said a death was reportable where

the person died while under, or as a result of, or within 24 hours after the administration of, an anaesthetic administered in the course of a medical, surgical or dental operation or

jurisdictions all rejected the alternative of retaining the anaesthetic category and providing a much more comprehensive definition of ‘anaesthesia’.<sup>63</sup> As the Victorian Parliament Law Reform Committee explained, ‘anaesthesia related deaths should be considered to be simply a particular category of a range of medical processes which if associated with a patient’s death needed to be reviewed by the coroner’.<sup>64</sup> Freckelton and Ranson agree, arguing that ‘the complex interplay between surgery, anaesthesia, and preoperative medical care requires a more thorough and multidisciplinary review of operative deaths than would be achieved by looking at anaesthesia alone’.<sup>65</sup> Notably, the Law Reform Commission of Western Australia has recently made a recommendation to this effect in its review of coronial practice in Western Australia.<sup>66</sup> The Commission noted ‘full support’ in the submissions received for replacing the current anaesthesia-based provision with one encompassing a wider range of medical-setting deaths.<sup>67</sup> Based on the discussion above, it would appear that there is a clear imperative for the Western Australian Government to give effect to this recommendation, and for the Tasmanian and Northern Territory Governments to follow suit. The shape that this reform might take is considered below.

*B Approach 2: Death During, Caused by, or Temporally  
Associated with Operations or Procedures*

In the Australian Capital Territory, a coroner must hold an inquest into the death of a person who dies during or within 72 hours after, or as a result of:

- (i) an operation of a medical, surgical, dental or like nature; or
- (ii) an invasive medical or diagnostic procedure;

other than an operation or procedure prescribed by regulation to be an operation or procedure to which this paragraph does not apply; ...<sup>68</sup>

procedure or an operation or procedure of a like nature, other than a local anaesthetic administered solely for the purpose of facilitating a procedure of resuscitation from apparent or impending death.

<sup>63</sup> For discussion, see *Law Reform Committee: Coroners Act 1985*, above n 6, 110–13.

<sup>64</sup> *Ibid* 112, quoting David Leo Ranson, Submission No 19, to Law Reform Committee, Parliament of Victoria, *Coroners Act 1985*, 14 July 2005, 17.

<sup>65</sup> Freckelton and Ranson, above n 16, 173.

<sup>66</sup> LRCWA, *Final Report*, above n 6, 31.

<sup>67</sup> *Ibid*.

<sup>68</sup> *Coroners Act 1997 (ACT)* s 13(1)(e).

Here, the focus is on deaths related to *operations* and *invasive procedures*. A causal relationship between the operation or procedure and the death (at any time) invokes the coroner's jurisdiction. However, notably, the relationship need only be temporal; if the death occurs during, or within 72 hours of, the operation or procedure it is *automatically* reportable. The advantage of this temporal aspect is that these deaths are easily identifiable as reportable by an objective standard and do not rely on an individual doctor's subjective assessment of whether the operation or procedure caused the death.

South Australia similarly makes a death reportable that occurs during or as a result, or within 24 hours, of

- (i) the carrying out of a surgical procedure or an invasive medical or diagnostic procedure; or
- (ii) the administration of an anaesthetic for the purposes of carrying out such a procedure,

not being a procedure specified by the regulations to be a procedure to which this paragraph does not apply; ...<sup>69</sup>

In both jurisdictions, the procedures excluded by the regulations (thereby avoiding unnecessary referrals to the coroner) include the giving of an intravenous injection, the giving of an intramuscular injection, intravenous therapy, the insertion of a line or cannula, artificial ventilation, cardiac resuscitation, and urethral catheterisation.<sup>70</sup>

In South Australia, a death is also reportable that occurs:

at a place other than a hospital but within 24 hours of

- (i) the person having been discharged from a hospital after being an inpatient of the hospital; or
- (ii) the person having sought emergency treatment at a hospital ...<sup>71</sup>.

There is little information in the public domain to explain the reasoning behind the introduction of these provisions into the Australian Capital Territory and South Australian Coroners Acts. However, presumably the temporal aspect of these definitions is based on the supposition that where

<sup>69</sup> *Coroners Act 2003* (SA) s 3(1) (definition of 'reportable death' para (d)). 'Anaesthetic' is defined as 'a local or general anaesthetic, and includes the administration of a sedative or analgesic': s 3(1) (definition of 'anaesthetic').

<sup>70</sup> *Coroners Regulation 1994* (ACT) reg 5(2)(a)–(g); *Coroners Regulations 2005* (SA) reg 4(2)(a)–(g).

<sup>71</sup> *Coroners Act 2003* (SA) s 3(1) (definition of 'reportable death' para (e)).

death is proximate in time to an operation or procedure (in the case of the Australian Capital Territory), or to a procedure, anaesthetic, or discharge from hospital (in the case of South Australia), there may have been factors at play, other than natural causes, that caused or contributed to the patient's death. However, the degree to which the time periods (72 hours and 24 hours respectively) are a suitable window for the detection of preventable deaths is debatable.<sup>72</sup> As Ranson explains, 'whilst the period of time is easy to assess it is arguable whether the death of all individuals within 72 hours of surgery is a sufficient discriminator of deaths that need to be reported to a coroner'.<sup>73</sup>

Relevant in this context are the findings of *The Quality in Australian Health Care Study*.<sup>74</sup> This study reviewed the medical records of over 14 000 admissions to 28 hospitals in New South Wales and South Australia during 1992, looking at admissions associated with adverse events. In 4.9 per cent of cases involving an adverse event the patient died,<sup>75</sup> with the average number of bed-stays attributable to the adverse event being 8.2 (approximately 197 hours).<sup>76</sup> A comparative study of adverse events in 13 New Zealand public hospitals during 1998 found that 4.5 per cent of patients died from an adverse event with the attributable bed-stays being, on average, 11.5 days (with a median of 4 days).<sup>77</sup> These figures show that not all deaths arising from an adverse event occur within the first 24 hours, or indeed the first 72 hours. Thus, these studies cast doubt on the utility of the Australian Capital Territory and South Australian temporal provisions in actually picking up all relevant cases.

It is pertinent to note that the Davies Report (published by the Davies Inquiry),<sup>78</sup> recommended the introduction of a provision into the *Coroners Act 2003* (Qld) making a death occurring within 30 days of an 'elective health procedure' automatically reportable.<sup>79</sup> An 'elective health procedure' was

<sup>72</sup> See VCCAMM, above n 32, 2.

<sup>73</sup> Ranson, above n 64, 14.

<sup>74</sup> Ross McL Wilson et al, 'The Quality in Australian Health Care Study' (1995) 163 *Medical Journal of Australia* 458.

<sup>75</sup> *Ibid* 459.

<sup>76</sup> *Ibid* 466.

<sup>77</sup> Peter Davis et al, 'Adverse Events in New Zealand Public Hospitals I: Occurrence and Impact' (2002) 115(1167) *New Zealand Medical Journal* 1. See also Peter Davis et al, 'Adverse Events in New Zealand Public Hospitals: Principal Findings from a National Survey' (Occasional Paper No 3, Ministry of Health, December 2001) 23.

<sup>78</sup> Davies, above n 1.

<sup>79</sup> *Ibid* 535-6.

defined as ‘a health procedure that can be delayed for a period of 24 hours without death being a likely outcome’.<sup>80</sup> The adoption of the perioperative period of 30 days is notable. This period of time was selected as an accepted yardstick of surgical performance, although the Davies Inquiry did concede that a shorter time period might also be reasonable to adopt.<sup>81</sup> The reality is that we lack empirical data to know the optimal timeframe for the detection of preventable deaths. This has led to claims that the 24 and 72 hour timeframes are ‘arbitrary’ and ‘too simplistic’.<sup>82</sup> The difficulty, however, with extending the time period is that, whilst it may increase the provision’s sensitivity to the detection of preventable deaths, it would also reduce the test’s specificity; all deaths following an operation or procedure within the timeframe would be reportable. Coroners Courts around the country have little, if any, capacity to absorb the much greater number of reportable deaths that such a provision would generate. This is a problem with any reform aimed at addressing the current problem of under-reporting, but where the specificity of the test is low, resulting in cases being referred to the coroner unnecessarily, it is unlikely to gain acceptance as a reform option. Not surprisingly, the Queensland Government chose not to implement the recommendation of the Davies Inquiry but opted to focus on whether death was not the reasonably expected outcome of health care.<sup>83</sup>

### C Approach 3: Death Not A Reasonably Expected Outcome

Over the summer of 2009/2010, amendments to the Victorian, Queensland and New South Wales definitions of medical-setting reportable deaths came into operation. The Victorian changes took effect from 1 November 2009 with the commencement of the *Coroners Act 2008* (Vic). The Queensland reforms came into operation the very next day,<sup>84</sup> and the New South Wales reforms commenced on 1 January 2010.<sup>85</sup> Each of these jurisdictions based its new definition of a medical-setting reportable death around the criterion that *death was not a reasonably expected outcome*. For the purposes of the follow-

<sup>80</sup> Ibid 536.

<sup>81</sup> Ibid 533.

<sup>82</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 113.

<sup>83</sup> Explanatory Notes, *Coroners and Other Acts Amendment Bill 2008* (Qld) 2.

<sup>84</sup> *Coroners and Other Acts Amendment Act 2009* (Qld).

<sup>85</sup> *Coroners Act 2009* (NSW).

ing analysis, the New South Wales definition is examined first, followed by the Victorian and then Queensland definitions.

### 1 *New South Wales*

In New South Wales, a person's death is reportable if it 'was not the reasonably expected outcome of a health-related procedure carried out in relation to the person'.<sup>86</sup>

This encompasses deaths arising out of 'a medical, surgical, dental or other health-related procedure (including the administration of an anaesthetic, sedative or other drug)<sup>87</sup> but not any procedure excluded by the regulations.<sup>88</sup> The New South Wales definition focuses only on the *unexpectedness* of the death, and not *when* the death occurred or *why*. Unlike the definitions in other Australian states and territories, it does not mandate the presence of a *temporal* or *causal* link between death and the procedure in question.

This category of reportable death, introduced by the *Coroners Act 2009* (NSW), replaced the former provision which required the reporting of a death that occurred during, or as a result of, or within 24 hours of the administration of an anaesthetic administered in the course of a medical, surgical or dental or like operation or procedure.<sup>89</sup> This former provision was thought to have generated confusion when a sedative was used rather than an anaesthetic, as well as when anaesthesia was not a contributory factor to the cause of death.<sup>90</sup> It was also felt that the 24 hour timeframe was 'arbitrary' and meant that 'the decision to report a death to a coroner often [was] based on the timing of death rather than any concerns regarding the medical treatment provided'.<sup>91</sup> Indeed, one of the aims of the new Act was to 'refine the jurisdiction of coroners by ensuring that unsuspecting deaths are not unnecessarily reported to Coroners'.<sup>92</sup>

<sup>86</sup> Ibid s 6(1)(e).

<sup>87</sup> Ibid s 6(3).

<sup>88</sup> Ibid. The *Coroners Regulation 2010* (NSW) reg 5 preserves the exclusions contained in the now repealed *Coroners Regulation 2005* (NSW) reg 3A. These include intravenous and intramuscular injections, the insertion of a line or cannula, artificial ventilation, urethral catheterisation, the insertion of a naso-gastric tube, and cardio-pulmonary resuscitation.

<sup>89</sup> *Coroners Act 1980* (NSW) s 12B(1)(e) (see above n 62 for the precise wording).

<sup>90</sup> New South Wales, *Parliamentary Debates*, Legislative Council, 4 June 2009, 15783 (John Hatzistergos, Attorney-General).

<sup>91</sup> Ibid.

<sup>92</sup> Legislation Review Committee, Parliament of New South Wales, *Legislation Review Digest*, No 8 of 2009, 15 June 2009, 11.

Despite optimism that this new category would more accurately identify deaths arising from medical misadventure,<sup>93</sup> a number of problems have been identified with this formulation. In its examination of the former equivalent Queensland provision,<sup>94</sup> the Davies Inquiry pointed to difficulties with the meaning of ‘reasonably expected’: *whose* expectation is relevant and what *degree of certainty* is required for a death to be reasonably expected?<sup>95</sup> The Commission also drew attention to problems with causation noting the potential for ‘difference of opinion and debate about whether or not the *health procedure* was the cause of the death, rather than the *underlying condition* that made it necessary’.<sup>96</sup> Despite the Queensland Government amending the Queensland legislation to help resolve these ambiguities and uncertainties, the New South Wales definition remains unaltered.

## 2 Victoria

In Victoria, a death is reportable

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>97</sup>

A ‘medical procedure’ is 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>98</sup>

The Victorian definition is similar to the New South Wales definition in that it looks at whether the death was not reasonably expected. Unlike the

<sup>93</sup> New South Wales, *Parliamentary Debates*, Legislative Council, 4 June 2009, 15783 (John Hatzistergos, Attorney-General).

<sup>94</sup> Pursuant to this now repealed provision, a death was a ‘reportable death’ if ‘the death was not reasonably expected to be the outcome of a health procedure’: *Coroners Act 2003* (Qld) s 8(3)(d). A health procedure was defined to mean ‘a dental, medical, surgical or other health related procedure, including for example the administration of an anaesthetic, analgesic, sedative or other drug’: *Coroners Act 2003* (Qld) sch 2 (definition of ‘health procedure’), later amended by *Coroners and Other Acts Amendment Act 2009* (Qld).

<sup>95</sup> Davies, above n 1, 526.

<sup>96</sup> *Ibid* (emphasis added).

<sup>97</sup> *Coroners Act 2008* (Vic) s 4(2)(b).

<sup>98</sup> *Ibid* s 3(1) (definition of ‘medical procedure’).

New South Wales definition, however, it specifies when the expectation must be held (namely, *immediately before the procedure*) and that the expectation of a *registered medical practitioner* is the relevant standard. Furthermore, the Victorian provision concerns only 'medical procedures', thus excluding other procedures that might fall within the ambit of the New South Wales provision, including dental procedures. It is also limited to procedures 'performed by or under the supervision of a registered medical practitioner', thereby excluding procedures performed by, for example, unregistered medical practitioners, nurse practitioners and medical students.

In looking at the history behind the introduction of this provision, the Victorian Government appears (ultimately)<sup>99</sup> to have accepted the view of the Victorian Parliament Law Reform Committee that the new Victorian definition should be modelled on the Queensland provision (as it stood at the time).<sup>100</sup> It may seem curious that the Committee recommended a definition in the medical-setting context based on *whether the death was not reasonably expected*, when at the same time it recommended that the general category of 'unexpected' death be removed from the definition of 'reportable death' owing to the many ambiguities and problems it gave rise to.<sup>101</sup> However, the Committee was clearly impressed by the Queensland provisions when viewed in conjunction with the State Coroner guidelines for medical practitioners.<sup>102</sup> The Committee explained:

In conjunction with the guidelines, the ... focus is on establishing, through a series of questions, whether the health procedure caused the death and whether the death was the unexpected outcome of the procedure. The series of questions in the guidelines turns a doctor's mind to a more detailed and structured consideration of these complex issues.<sup>103</sup>

In enacting the current definition of a medical-setting reportable death, the Victorian Government provided further definition around the phrase

<sup>99</sup> See Victorian Government, 'Government Response to the Victorian Parliament Law Reform Committee's *Coroners Act 1985*' (Report, tabled in Parliament 13 March 2007) 4–5. The Government appreciated the Committee's view that there was a need to clarify which kinds of health procedure-related deaths should be reported to the coroner and stated it would 'work with health stakeholders to make this clearer in the development of the new Act': at 4–5.

<sup>100</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 113–14. For the former Queensland provision, see above n 94.

<sup>101</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 93.

<sup>102</sup> Queensland, *State Coroner's Guidelines* (December 2003) <[http://www.courts.qld.gov.au/\\_data/assets/pdf\\_file/0004/84919/state-coroners-guidelines.pdf](http://www.courts.qld.gov.au/_data/assets/pdf_file/0004/84919/state-coroners-guidelines.pdf)>.

<sup>103</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 113–14. Cf Davies, above n 1, 523–8.

‘not ... reasonably expected’ and the Victorian Coroners Court subsequently produced its own *Information for Health Practitioners* brochure.<sup>104</sup>

The Victorian Parliament Law Reform Committee had considered that the ‘important issue ... of medical omissions’ needed to be addressed, citing the example of a death that occurs as a result of premature discharge from hospital or a failure to treat.<sup>105</sup> It recommended that the new Victorian definition should include deaths ‘where the death from the particular cause was potentially avoidable or preventable had the clinical management been different’.<sup>106</sup> It is not clear why the Victorian Government chose not to include this provision, or indeed any other provision incorporating omissions. This is now an aspect of the Victorian provisions (and all other provisions throughout the states and territories, apart from Queensland) that is open to criticism.

### 3 Queensland

In Queensland, ‘health care related deaths’ must be reported to the Coroner.<sup>107</sup> A person’s death is ‘health care related’ if

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.<sup>108</sup>

A person’s death is also a ‘health care related death’ if

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—

<sup>104</sup> Coroners Court of Victoria, *Information for Health Professionals* (2011) <<http://www.coronerscourt.vic.gov.au/find/publications/information+for+health+professionals>>.

<sup>105</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 114.

<sup>106</sup> *Ibid.*

<sup>107</sup> *Coroners Act 2003* (Qld) ss 7–8.

<sup>108</sup> *Ibid* s 10AA(1).

- (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.<sup>109</sup>

This definition is noteworthy for several reasons. First, 'health care' includes 'any health procedure' or 'any care, treatment, advice, service or goods provided for or purportedly for the benefit of human health'.<sup>110</sup> The definition is the widest employed throughout the various state and territory Acts. It covers alternative therapies, and the provision of goods as well as services.

Second, the health care need only have *contributed* to death and, as such, this definition avoids the more absolute causal connection required in some of the other Acts.<sup>111</sup> The provision specifies that *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'<sup>112</sup> and that *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'.<sup>113</sup>

Third, the legislation specifies whose expectation is relevant in determining whether death was not reasonably expected: an 'independent person' is one 'appropriately qualified in the relevant area ... of health care who has had regard to all relevant matters'.<sup>114</sup> Relevant matters include:

- (a) the deceased person's state of health as it was thought to be when the health care started or was sought;
- (b) the clinically accepted range of risk associated with the health care;
- (c) the circumstances in which the health care was provided or sought.<sup>115</sup>

<sup>109</sup> Ibid s 10AA(2).

<sup>110</sup> Ibid s 10AA(5) (definition of 'health care' paras (a)–(b)).

<sup>111</sup> See, eg, *Coroners Act 1995* (Tas) s 3 (definition of 'reportable death').

<sup>112</sup> *Coroners Act 2003* (Qld) s 10AA(3)(a).

<sup>113</sup> Ibid s 10AA(3)(b).

<sup>114</sup> Ibid s 10AA(4).

<sup>115</sup> Ibid.

The provision also pinpoints the time at which the expectation must be held, namely immediately before the health care was received or when the health care was sought.<sup>116</sup>

Fourth, the provisions continue to operate in conjunction with coronial guidelines for medical practitioners, the value of which has been applauded by law reform bodies and commentators alike.<sup>117</sup>

Finally, but importantly, no other jurisdiction expressly includes omissions in the provision of health care when determining whether a death is reportable.<sup>118</sup> Omissions would include, for example, deaths occurring consequent upon premature discharge from hospital, deaths due to misdiagnosis, or failure to administer appropriate therapy, and deaths resulting from a failure to respond in a timely fashion.<sup>119</sup> It is clear that preventable deaths in hospitals are generated by both commission and omission; the Quality in Australian Health Care Study found that 52 per cent of the adverse events (of which 4.9 per cent resulted in death) were associated with 'acts of omission', which were defined as 'failure to diagnose or treat'.<sup>120</sup> The failure to include omissions in the definition of medical-setting reportable deaths constitutes a major shortfall in other Australian states and territories.

Arguably, the current Queensland model is the 'best and most comprehensive formulation'<sup>121</sup> for the reporting of medical-setting deaths. This was certainly the view taken by the Law Reform Commission of Western Australia in its *Review into Coronial Practice in Western Australia*.<sup>122</sup> In considering the appropriate replacement for the current anaesthetic-based approach, the

<sup>116</sup> Ibid ss 10AA(1)(b), (2)(b).

<sup>117</sup> See *Law Reform Committee: Coroners Act 1985*, above n 6, 113–14; VCCAMM, above n 32, 2; LRCWA, *Final Report*, above n 6, 35.

<sup>118</sup> Interestingly, the Davies Report did not expressly address the issue of omissions, although it cautioned that '[r]eforms need to be broad enough and robust enough to capture all cases of medical errors, neglect and misconduct leading to death by health service practitioners': above n 1, 530. The amendments ultimately introduced reflect this intention as well as work done by the Department of Justice and Attorney-General as part of an internal departmental review of the Act. This review, and the policy position it adopted, was most likely informed by the 2006 Parliament of Victoria Law Reform Committee Report into the *Coroners Act 1985* (see above n 6, 114) which advocated the need for omissions to be included in the definition of medical-setting reportable deaths: email from Natalie Parker, Queensland Department of Justice and Attorney-General, to Sarah Middleton, 28 March 2013 (copies of which are held by the author).

<sup>119</sup> Heffey, above n 33, 5.

<sup>120</sup> Wilson et al, above n 74, 461.

<sup>121</sup> LRCWA, *Discussion Paper*, above n 50, 48.

<sup>122</sup> LRCWA, *Final Report*, above n 6.

Commission was impressed with the clarity of the Queensland provision, the likelihood that it would encourage greater compliance in reporting of health care related deaths, and the fact that it explicitly covers deaths resulting from a failure to treat.<sup>123</sup> Notwithstanding this view, the Commission ultimately adopted a compromise position after the Department of Health raised concerns about the Queensland provisions being too broad and complex, giving rise to the potential for medical practitioners to over-report deaths.<sup>124</sup> Although the Queensland State Coroner, Michael Barnes, provided the Commission with evidence that the Queensland provisions were working well, with no signs of ‘defensive practices’,<sup>125</sup> the Commission ultimately — and for pragmatic reasons — recommended the introduction of a new reportable category of ‘healthcare or purported healthcare-related death’<sup>126</sup> defined in these terms:

the death of a person after receiving or seeking healthcare or purported healthcare in circumstances where—

- (a) immediately before receiving the healthcare or purported healthcare the person’s death was not the reasonably expected outcome; or
- (b) the person might not have died at the time of the person’s death if the person had received the healthcare which could be reasonably expected to have been provided to them.<sup>127</sup>

<sup>123</sup> Ibid 31. See also LRCWA, *Discussion Paper*, above n 50, 48.

<sup>124</sup> Department of Health, Submission No 11 to LRCWA, *Review of Coronial Practice in Western Australia*, 17 August 2011, cited in LRCWA, *Final Report*, above n 6, 32. The Department’s alternative proposal for reform was more closely aligned with the current New South Wales approach but also incorporated failures to provide health care. Difficulties with the Department’s formulation, including the fact that it did not cover purported health care and did not apply to non-registered health practitioners, led the State Coroner to provide a modified version of the Department proposal. This version formed the basis for the Commission’s final recommendation: LRCWA, *Final Report*, above n 6, 34–5.

<sup>125</sup> LRCWA, *Final Report*, above n 6, 34.

<sup>126</sup> Ibid 35.

<sup>127</sup> Ibid. Recommendation 18 defines ‘healthcare’ to mean ‘assessment, examination, diagnostic test, treatment or a medical, surgical, dental or other health related procedure (including the administration of an anaesthetic, sedative or other drug or substance)’. ‘Purported healthcare’ includes all cases of purported ‘healthcare’ whether or not it has scientific efficacy. ‘Reasonably expected’ means expected by an objective person appropriately qualified in the relevant area of healthcare.

With these and other changes recommended to the *Coroners Act 1996* (WA), the Commission also recommended that the State Coroner

produce comprehensive guidelines explaining the role of the coroner, detailing the categories of reportable deaths under the *Coroners Act*, interpreting key provisions or terms of the *Coroners Act* and providing examples of types of deaths that may fall into each of the categories of reportable death under the *Coroners Act*.<sup>128</sup>

If these recommendations are implemented, Western Australia will become the fourth Australian jurisdiction to adopt a definition based on whether *death was not reasonably expected* and to provide coroner's guidelines for medical practitioners explaining their reporting obligations,<sup>129</sup> but only the second jurisdiction to include a failure to provide health care in that definition.

<sup>128</sup> LRCWA, *Final Report*, above n 6, 36 (recommendation 19).

<sup>129</sup> Coroner's guidelines are discussed below in Part V. It should be noted that some guidance is already available to doctors in Western Australia: see Robert Turnbull, *The Coronial Process in Western Australia: A Handbook for Medical Practitioners and Medical Students* (June 2010) <[http://www.coronerscourt.wa.gov.au/\\_files/Handbook\\_for\\_Doctors.pdf](http://www.coronerscourt.wa.gov.au/_files/Handbook_for_Doctors.pdf)>.

Table 1: Criteria for a Reportable Medical-Setting Death

Relationship Between Medical Event and Death Indicated by shading and connector words						
Overall approach	Juris-diction	Medical Event	Death during	Death within a certain time after	Death following as a result of*	Death not reasonably expected
<b>Approach 1: Anaesthetic-related death</b>	NT	Anaesthetic	OR			
	TAS	Anaesthesia or sedation	OR			
	WA	Anaesthetic	OR			
<b>Approach 2: Causal or temporal association with death</b>	ACT	Operation or procedure	OR	72 hrs	OR	
	SA	Procedure or anaesthetic	OR	24 hrs	OR	
		Inpatient discharge or seeking of emergency treatment (non-hospital death)		24hrs		

Relationship Between Medical Event and Death Indicated by shading and connector words						
Overall approach	Jurisdiction	Medical Event	Death during	Death within a certain time after	Death following as a result of*	Death not reasonably expected
<b>Approach 3: Death not a reasonably expected outcome</b>	NSW	Health-related procedure				
	QLD	Health care or failure to provide health care			AND	
	WA	Medical procedures	OR		AND	

\* In NT, TAS, WA, ACT and SA there must be a clear causal connection ('as a result of'). In QLD, there must be a clear or 'likely' causal connection. In VIC, the causal connection need only be possible ('the death is or may be causally related')

#### IV FAILURE TO COMPLY WITH REPORTING OBLIGATIONS

In Australia, a doctor who fails to report a reportable medical-setting death may be guilty of a statutory offence. The offence and the applicable penalty for each state and territory are contained in the respective Coroners Acts. As with the definitions of reportable medical-setting deaths, the penalties for failures to comply with coronial reporting obligations vary greatly between jurisdictions. There are also differences in the nature and elements of the offences themselves.

##### A *The Offences*

The Northern Territory, Victorian and Western Australian Coroners Acts impose obligations specifically on medical practitioners to report certain deaths to a Coroner.<sup>130</sup> A doctor who is present at or after the death of a person<sup>131</sup> will be guilty of a statutory offence if he or she fails to report a reportable death within the prescribed timeframe.<sup>132</sup> In the Northern Territory, the duty to report also arises if the doctor does not view the body or is unable to establish cause of death.<sup>133</sup> In Western Australia, the duty to report extends to situations where the death ‘may be’ reportable, where cause of death cannot be determined, or where the death occurred under suspicious circumstances.<sup>134</sup> There is no obligation to report a death if it has already been reported by another doctor.<sup>135</sup>

In these jurisdictions, there coexists a general duty to report deaths. In the Northern Territory and Victoria, ‘a person who has reasonable grounds to believe that a reportable death has not been reported’ must report the death, ‘as soon as possible’ or ‘without delay’ respectively.<sup>136</sup> In Western Australia, a person must report ‘a death that is or may be ... reportable’ immediately after becoming aware of the death, unless he or she ‘has reasonable grounds to

<sup>130</sup> *Coroners Act* (NT) s 12(3); *Coroners Act 2008* (Vic) s 10(1); *Coroners Act 1996* (WA) s 17(3). In Victoria, the death may be reported to the Institute and in Western Australia to a member of the police force.

<sup>131</sup> The wording in the *Coroners Act 1996* (WA) s 17(3) is ‘at or soon after’.

<sup>132</sup> In the Northern Territory ‘as soon as possible’, in Victoria ‘without delay’, and in Western Australia ‘immediately’.

<sup>133</sup> *Coroners Act* (NT) s 12(3)(b)–(c).

<sup>134</sup> *Coroners Act 1996* (WA) s 17(3).

<sup>135</sup> *Coroners Act* (NT) s 12(4); *Coroners Act 2008* (Vic) s 10(2); *Coroners Act 1996* (WA) s 17(4).

<sup>136</sup> *Coroners Act* (NT) s 12(2); *Coroners Act 2008* (Vic) s 12(1).

believe that the death has already been reported.<sup>137</sup> In each jurisdiction doctors and persons are liable for the same penalties, although the penalties as between jurisdictions differ.<sup>138</sup>

In the remaining states and territories, a doctor's duty to report deaths is subsumed within the duty owed by 'persons' generally. All of the provisions are worded differently, but in summary:

- In Queensland and South Australia, a person who is aware of a death that is or may be reportable,<sup>139</sup> and who does not reasonably believe that the death has been reported,<sup>140</sup> must report the death immediately;<sup>141</sup>
- In the Australian Capital Territory and New South Wales, a person who has reasonable grounds to believe both that a death is reportable,<sup>142</sup> and that it has not been reported, must report the death in the prescribed time;<sup>143</sup> and
- In Tasmania, a person with reasonable grounds to believe that a reportable death has not been reported must report the death 'as soon as possible'.<sup>144</sup>

With respect to medical-setting deaths, two key observations can be made. The first is that in most jurisdictions, doctors are not expressly singled out as having reporting obligations discrete from those owed by persons generally. This subsumption of doctors' reporting obligations within those owed by the public at large can be criticised when viewed against a backdrop of evidence that doctors' lack of understanding of their coronial reporting obligations is predominantly to blame for the widespread under-reporting of medical-setting deaths.<sup>145</sup> The second observation, which follows from the first, is that

<sup>137</sup> *Coroners Act 1996* (WA) s 17(1).

<sup>138</sup> See below nn 152–8 and accompanying text.

<sup>139</sup> The Queensland provision refers to a death 'that appears to be' reportable: *Coroners Act 2003* (Qld) s 7(1)(a).

<sup>140</sup> The *Coroners Act 2003* (SA) s 28(1) refers to 'reasonable grounds'.

<sup>141</sup> *Coroners Act 2003* (Qld) ss 7(1), (3); *Coroners Act 2003* (SA) s 28(1).

<sup>142</sup> The *Coroners Act 1997* (ACT) does not actually employ the term 'reportable death': see above n 68. The precise wording of the provision is 'reasonable grounds to believe that ... a coroner would have jurisdiction to hold an inquest in relation to the death': s 77(1)(b)(i).

<sup>143</sup> *Coroners Act 1997* (ACT) s 77(1)(c): 'as soon as practicable' after becoming aware of the death and having the reasonable grounds referred to in s 77(1)(b); *Coroners Act 2009* (NSW) s 35(2): 'as soon as possible' after becoming aware of the grounds referred to in s 35(1).

<sup>144</sup> *Coroners Act 1995* (Tas) s 19(1). Section 19(3) provides that '[i]f more than one medical practitioner is present at or after a death and one of them reports it ... the other medical practitioners need not report the death'.

<sup>145</sup> See above Part III.

doctors in these jurisdictions have no coronial reporting duties above and beyond a general member of the community. Given that doctors are the professionals entrusted with determining cause of death and completing post-death documentation, it is surprising that no higher standard is required of them, except to the extent that their 'reasonable' beliefs might be determined according to a reasonable doctor (as opposed to person) standard.

Looking at the situation from a national perspective, it becomes apparent that doctors in the Australian Capital Territory, New South Wales, Queensland, South Australia and Tasmania are subject to less stringent reporting requirements than their counterparts in the remaining jurisdictions. The relevant offences require a physical act (the failure to report) as well as a mental element (reasonable *knowledge* or *belief* that a death is or may be reportable and has not been reported). Conversely, in Victoria, the Northern Territory and Western Australia, there is no express reference to any mental element; rather the provisions are simply directed towards whether the doctor failed to report a death in the circumstances prescribed (outlined above). Apart from expressly setting out a doctor's obligations, these latter provisions have the advantage of being less complex and thereby more easily understood by doctors. In particular, they do not involve consideration (at least on the face of the legislation) of the doctor's reasonable knowledge or beliefs about the death. Having said that, the substantive differences between these doctor-specific offences and those applying to the public at large may be more apparent than real. This depends, in particular, upon the availability of the defence of mistake of fact.<sup>146</sup> It would seem that the defence would apply in both the Code jurisdictions of the Northern Territory<sup>147</sup> and Western Australia,<sup>148</sup> but the position is less clear in Victoria.<sup>149</sup> Where this defence applies, a

<sup>146</sup> See generally Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Thomson Reuters, 3<sup>rd</sup> ed, 2010) 218–24; David Lanham et al, *Criminal Laws in Australia* (Federation Press, 2006) 385–8.

<sup>147</sup> In the Northern Territory, the relevant offence (namely, *Coroners Act* (NT) s 12(3)) is a 'simple' one, contains no express mental element, and is not one of 'strict' or 'absolute' liability: see generally *Criminal Code* (NT) ss 3(4), 43AN–43AO. As such, the Code provides that the conduct in question (the failure to report) must be intentional, in the sense that it is voluntary (*Criminal Code* (NT) ss 43AI(1), 43AM(1)), and that the various defences contained in pt II div 4 of the Code apply. This includes the defence of mistake of fact: *Criminal Code* (NT) s 32.

<sup>148</sup> In Western Australia, the absence of an express mental element in the provision creating the offence. Namely, *Coroners Act 1996* (WA) s 17(3) means that the various defences in ch v of the *Criminal Code* (WA) apply: *Criminal Code* (WA) sch s 36. This includes the defence of mistake of fact: *Criminal Code* (WA) sch s 24.

doctor who fails to report a death based on an honest and reasonable mistaken belief which — if true — would have made the death not reportable, will be acquitted of that offence.<sup>150</sup> This defence could be raised where failure to report is based on a doctor's erroneous opinion on the patient's cause of death or his or her belief that the death had already been reported. Notably, although the issue of mistake is raised by way of defence, the onus falls upon the prosecution to prove beyond reasonable doubt that a mistake was not made.<sup>151</sup>

### B The Penalties

In addition to variation in the elements of the offences relating to a failure to report, there is also variation in the penalties for a breach of reporting obligations.

First, in all jurisdictions a financial penalty attaches — in the form of a fine — to noncompliance with coronial reporting obligations.<sup>152</sup> However, as seen in two jurisdictions, a term of imprisonment may also be imposed. South Australia takes the most stringent approach nationally with a maximum penalty of \$10 000 or two years imprisonment. In the Australian Capital Territory the penalty is \$7000, being 50 penalty units ('p/u'), and/or 6 months imprisonment.<sup>153</sup>

Second, there is little parity in the quantum of the fine across the remaining jurisdictions. It ranges from \$1000 in Western Australia through to

<sup>149</sup> In Victoria, where a statutory offence is silent as to the mental element, there is a rebuttable common law presumption that a guilty intent (*mens rea*) is still required. If the presumption can be displaced, the offence will be one of either 'strict liability' or 'absolute liability'. Both kinds of offences require only a physical act (*actus reus*) but, whilst the former is open to the defence of honest and reasonable mistake of fact, the latter is not. Ultimately, the classification of an offence is a matter of statutory construction.

<sup>150</sup> In both the Northern Territory and Western Australia, a person who successfully raises the defence of mistake may still be convicted of a lesser offence: *Criminal Code* (NT) s 32; *Criminal Code* (WA) sch s 24. However, there would appear to be no lesser offence applicable to this particular situation.

<sup>151</sup> *He Kaw Teh v The Queen* (1985) 157 CLR 523. See for discussion, Bronitt and McSherry, above n 146, 223; Lanham, above n 146, 388.

<sup>152</sup> *Coroners Act 1997* (ACT) s 77; *Coroners Act 2009* (NSW) s 35(2); *Coroners Act* (NT) s 12(3); *Coroners Act 2003* (Qld) s 7(3); *Coroners Act 2003* (SA) s 28(1); *Coroners Act 1995* (Tas) s 19(1); *Coroners Act 2008* (Vic) s 10(1); *Coroners Act 1996* (WA) s 17(1). In South Australia and Western Australia, the fine is set out as a maximum monetary figure, whereas in the other jurisdictions the penalty is expressed in penalty units.

<sup>153</sup> The current value of a penalty unit in the Australian Capital Territory is \$140: *Legislation Act 2001* (ACT) s 133.

\$5760 (40 p/u) in the Northern Territory.<sup>154</sup> In New South Wales, Victoria, Tasmania and Queensland, the maximum penalties are \$1100 (10 p/u),<sup>155</sup> \$2887.20 (20 p/u),<sup>156</sup> \$1300 (10 p/u)<sup>157</sup> and \$2750 (25 p/u)<sup>158</sup> respectively (see Table 2).

Third, in three jurisdictions there is an additional offence if a doctor issues a cause of death certificate to the Births, Deaths and Marriages Registry for a reportable death. In Queensland, a doctor committing this offence is liable for a maximum penalty of \$11 000 (100 p/u).<sup>159</sup> In Victoria, the penalty is \$1732.32 (12 p/u)<sup>160</sup> and in South Australia it is \$1250.<sup>161</sup> Doctors committing these offences may also be liable for failing to report the death to the coroner and will thus be potentially liable, all up, for \$12 500 in Queensland,<sup>162</sup> \$4619.52 in Victoria<sup>163</sup> and \$11 250 in South Australia.<sup>164</sup>

### C Reform

Despite the recent reforms to the definition of medical-setting reportable deaths in Queensland, New South Wales and Victoria, there has been comparatively little change to the penalties associated with failure to comply with reporting obligations. In both Queensland and Victoria, the offence for issuing a cause of death certificate for a reportable death and the existing

<sup>154</sup> The current value of a penalty unit in the Northern Territory is \$144: *Penalty Unit Regulations* (NT) reg 2; *Penalty Units Act* (NT).

<sup>155</sup> The current value of a penalty unit in New South Wales is \$110: *Crimes (Sentencing Procedure) Act 1999* (NSW) s 17.

<sup>156</sup> The current value of a penalty unit in Victoria is \$144.36: *Monetary Units Act 2004* (Vic) ss 5-6; Treasurer (Vic), 'Monetary Units Act 2004 (Vic) — Notice Under Section 6, Fixing the Value of a Fee Unit and a Penalty Unit' in Victoria, *Victoria Government Gazette*, No G 16, 18 April 2013, 793, 812.

<sup>157</sup> The current value of a penalty unit in Tasmania is \$130: *Penalty Units and Other Penalties Act 1987* (Tas) ss 4-4A; Tasmania, *Tasmanian Government Gazette*, No 21 341, 19 June 2013, 966.

<sup>158</sup> The current value of a penalty unit in Queensland is \$110: *Penalties and Sentences Act 1992* (Qld) s 5.

<sup>159</sup> *Coroners Act 2003* (Qld) s 26(5).

<sup>160</sup> *Births, Deaths and Marriages Registration Act 1996* (Vic) s 37(4).

<sup>161</sup> *Births, Deaths and Marriages Registration Act 1996* (SA) s 36(2).

<sup>162</sup> *Coroners Act 2003* (Qld) ss 7(3), 26(5).

<sup>163</sup> *Coroners Act 2008* (Vic) s 10(1); *Births, Deaths and Marriages Registration Act 1996* (Vic) s 37(4).

<sup>164</sup> *Coroners Act 2003* (SA) s 28(1); *Births, Deaths and Marriages Registration Act 1996* (SA) s 36(2).

penalties predate the 2009 coronial reforms.<sup>165</sup> Similarly, neither Queensland nor New South Wales increased the penalty for failure to report a reportable death as part of their recent coronial reforms.<sup>166</sup> Victoria did increase its fine from 10 to 20 p/u<sup>167</sup> but rejected the recommendation of the Victorian Parliament Law Reform Committee to increase the penalty to 600 p/u<sup>168</sup> or 5 years' imprisonment to make it commensurate with the penalty for making a false statement on a certificate authorising cremation.<sup>169</sup> The Government's response to the Committee Report noted that there were already penalties in place for failures to report and that noncompliance could also constitute professional misconduct.<sup>170</sup> The Government went on to say that it would 'examine ways to hold doctors who ignore the law more accountable' but was 'not convinced that the Committee's particular recommendations would be effective ...'.<sup>171</sup>

Rather than increasing penalties, the New South Wales, Victorian and Queensland legislatures have sought to combat the problem of under-reporting by providing better definition around when medical-setting deaths are reportable and by promoting better education for doctors about their reporting obligations.<sup>172</sup> There are certainly sound arguments in favour of this stance. First, most unreported deaths go undetected. So, if the objective of reform is to make sure that relevant deaths come to the coroner's notice, it is important that doctors feel comfortable reporting such deaths. The application of substantial fines including prison terms may actually work against this objective. Equally, a serious penalty might lead to defensive practices with

<sup>165</sup> See *Coroners Act 2003* (Qld) s 26(5), as originally enacted: *Births, Deaths and Marriages Registration Act 1996* (Vic) s 37(4). For discussion, see *Law Reform Committee: Coroners Act 1985*, above n 6, 33.

<sup>166</sup> *Coroners Act 2003* (Qld) s 7(2). As originally enacted: *Coroners Act 1980* (NSW) s 12A(1).

<sup>167</sup> At that time, the value of a penalty unit was \$107.43, making the fine \$2148.60: Treasurer (Vic), 'Monetary Units Act 2004 (Vic) — Notice Under Section 6 Fixing the Value of a Fee Unit and a Penalty Unit' in Victoria, *Victoria Government Gazette*, No G 14, 6 April 2006, 651, 680.

<sup>168</sup> At that time, 600 p/u was equivalent to \$64 458.

<sup>169</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 38. *Cemeteries and Crematoria Act 2003* (Vic) s 140, imposes a maximum penalty of 600 p/u and/or five years' imprisonment for doctors making false statements on a certificate authorising cremation.

<sup>170</sup> Victorian Government, 'Government Response', above n 99, 3.

<sup>171</sup> *Ibid.*

<sup>172</sup> Explanatory Notes, *Coroners and Other Acts Amendment Bill 2009* (Qld) 1–2. See generally Victorian Government, 'Government Response' above n 99.

doctors over-reporting cases in order to ensure they are not inadvertently breaking the law.

Second, doctors' lack of understanding of the criteria for the reporting of medical-setting deaths is thought to contribute significantly to the problem of under-reporting. As such, increasing the penalties will not necessarily bring about change, other than potentially making more doctors liable for higher penalties. It might be better to try and bring about cultural change by way of education and redefining reportable deaths in terms that are clear, unambiguous and easily understood, as the Victorian Government has done. Having provisions that set out the reporting obligations of doctors — as distinct from those of the public at large — also assists in this objective.

Third, prosecutions of doctors for failures to report deaths would appear to be rare, verging on unknown.<sup>173</sup> Many of these failures never come to the attention of the police (nor indeed any other agency). The few that do may involve doctors who were genuinely unaware of their legal wrongdoing. Although these doctors technically may still be guilty of the relevant offence, their lack of guilty intent (for example, based on a misunderstanding of their reporting obligations) and other factors in their favour may lead to leniency in sentencing, in particular the suspension of any applicable prison term. To do otherwise might lead the law into disrepute.

Fourth, where a doctor fails to report a reportable death to the coroner, a court lacks the power to place conditions on a doctor's practice. Yet, the threat of loss of registration or conditions on practice, and the associated stigma and loss of income that this brings, may be a more effective deterrent than hefty criminal sanctions that are rarely, if ever, enforced. In this sense, reprimanding the conduct via regulatory processes may be preferable.<sup>174</sup>

In spite of the arguments above, the Law Reform Commission of Western Australia has taken a different view. In its review of coronial law in that State, the Commission cited anecdotal evidence that the \$1000 fine in Western Australia discourages police from prosecuting even blatant breaches of the reporting provisions.<sup>175</sup> The Commission has recommended that the fine be

<sup>173</sup> At present, there appears to be no empirical research in the public domain that examines the frequency and outcomes of prosecutions for failure to comply with coronial reporting obligations. The supposition that prosecutions are rare is based on a search of AustLII databases and anecdotal evidence.

<sup>174</sup> There appears to be no published research into whether failures to report deaths to the coroner are matters that have been dealt with in this forum (either the Australian Practitioners Health Regulation Agency, or the previously existing State and Territory Medical Practitioners Boards).

<sup>175</sup> LRCWA, *Discussion Paper*, above n 50, 43.

increased to \$12 000 or 12 months' imprisonment to highlight the seriousness of breaching offences that impact upon coronial investigation of deaths.<sup>176</sup> In arriving at this position, the Commission looked at the heavier penalties applicable in other jurisdictions (most notably South Australia) as well as penalties attaching to other breaches of the *Coroners Act 1996* (WA), which go as high as \$100 000<sup>177</sup> and demonstrate Parliament's intention that coronial offences warrant serious penalties.<sup>178</sup>

Such a large fine and/or prison sentence is intended to send a strong signal about the seriousness of failing to report a reportable death. It places emphasis on the public protection role of coroners who, by their findings, comments and recommendations, contribute to a reduction in the incidence of preventable deaths and injury.<sup>179</sup> The Commission also recommended that measures be developed to ensure that doctors are informed about their obligations under the legislation,<sup>180</sup> and that coronial guidelines be produced to assist medical professionals and others in better understanding their reporting obligations under the proposed reforms.<sup>181</sup> Arguably, these recommendations work together to ameliorate the seemingly inherent 'unfairness' of an offence which applies heavy penalties to doctors who may have been unaware of their own legal wrongdoing. The rationale is that where the law is clear, and doctors have the opportunity to understand the law, the public interest in the accurate reporting of medical-setting deaths justifies a serious penalty for transgressions. It remains to be seen, however, whether an increase in penalty will actually bring about more prosecutions.

So the question remains as to what is the best approach? There are problems with all the existing approaches. On the one hand, a low penalty like that in Victoria is not much of a deterrent to deliberate under-reporting to cover-up errors or omissions, although it operates more fairly for doctors who inadvertently breach the provisions. On the other hand, a high penalty, like that proposed for Western Australia, may incorporate doctors who were

<sup>176</sup> LRCWA, *Final Report*, above n 6, 30.

<sup>177</sup> *Coroners Act 1996* (WA) s 46A.

<sup>178</sup> LRCWA, *Discussion Paper*, above n 50, 44.

<sup>179</sup> See sources cited in above n 12.

<sup>180</sup> LRCWA, *Final Report*, above n 6, 36 (proposal 20). Proposal 20 suggests

that the Office of the State Coroner work together with relevant agencies and professional bodies ... to develop ways of appropriately delivering to Western Australian medical practitioners information about any relevant changes to their obligations under the *Coroners Act*.

<sup>181</sup> *Ibid* 36 (proposal 19).

unaware of their legal wrongdoing. Even if the offence is framed to include a mental element<sup>182</sup> with a large fine, as in South Australia, it becomes difficult to prosecute anything other than blatant breaches of reporting obligations, potentially undermining the regulatory nature of the provisions.

One solution to this dilemma would be to create two separate offences for doctors. The first would be an offence that does not contain a mental element but which is open to the defence of honest and reasonable mistake of fact. This provision, to which a small financial penalty would attach, would exist primarily to encourage accurate reporting of medical-setting deaths in the public interest. The second offence would include a mental element and impose a significantly larger penalty. It would be intended for cases where a doctor has flagrantly failed to report medical-setting deaths and would operate as a deterrent to under-reporting associated with a cover-up of criminal activity, medical error or negligence.

Table 2: *Maximum Penalties for Non-Compliance With Reporting Obligations*

Jurisdiction	<i>Failure to Report a Reportable Death</i>			<i>Issuing a Cause of Death Certificate for a Reportable Death</i>	
	Monetary Sum	Penalty Units	Prison Term	Monetary Sum	Penalty Units
ACT	\$7000	50	6 months	–	–
NSW	\$1100	10	–	–	–
NT	\$5760	40	–	–	–
QLD	\$2750	25	–	\$11 000	100
SA	\$10 000	n/a	2 years	\$1250	n/a
TAS	\$1300	10	–	–	–
VIC	\$2887.20	20	–	\$1732.32	12
WA	\$1000	n/a	–	–	–

<sup>182</sup> See above Part IV(A).

## V CONCLUSION

This article has demonstrated the wide variation that exists throughout Australia in relation to the laws governing medical-setting reportable deaths. It has argued that Tasmania, the Northern Territory and Western Australia should replace their current anaesthetic-based definitions of reportable medical-setting deaths with a more modern and expansive definition, ideally modelled on the Queensland provisions. It has also argued that other jurisdictions should follow Queensland's lead by including omissions in the provision of health care in the definition of medical-setting reportable death. With respect to penalties for failure to report, Part IV proposed the introduction of two separate offences: one, a strict liability offence with a low penalty attached, and the other an offence requiring mens rea with a more severe penalty attached. While these reforms would go a long way toward creating greater consistency between the various jurisdictions, differences would, in all likelihood, still remain in the exact wording and therefore scope of the provisions.

These jurisdictional differences are part and parcel of our federal system of government.<sup>183</sup> Indeed, they are the expression of one of the fundamental attributes of a federal system: that states are free to legislate on matters within their legislative competence in the manner that they see fit.<sup>184</sup> There are, of course, ways of bringing about a nationally consistent approach to areas of state law. The states may agree on uniform laws or make a referral of powers to the Commonwealth.<sup>185</sup> The passage of the *Australian Health Practitioner Regulation National Law*,<sup>186</sup> which established a single national scheme for the registration and regulation of all health practitioners,<sup>187</sup> serves as a recent example.

In relation to the reporting of medical-setting deaths, a nationally consistent approach would offer advantages. Confusion is thought to be prominent amongst doctors about reporting requirements even within their own jurisdiction,<sup>188</sup> which is likely to be exacerbated in the case of doctors moving

<sup>183</sup> See generally Sarah Joseph and Melissa Castan, *Federal Constitutional Law: A Contemporary View* (Thomson Reuters, 3<sup>rd</sup> ed, 2010).

<sup>184</sup> Australian Constitution s 107.

<sup>185</sup> *Ibid* s 51(xxxvii).

<sup>186</sup> See *Health Practitioner Regulation National Law Act 2009* (Qld) sch.

<sup>187</sup> Ian Freckelton, 'Regulation of Health Practitioners: National Reform in Australia' (2010) 18 *Journal of Law and Medicine* 207.

<sup>188</sup> See VCCAMM, above n 32.

jurisdiction or practising in more than one jurisdiction. A uniform approach would allow for the creation of a best practice model, ensuring that in all jurisdictions omissions and purported health care are included in the definition of medical-setting death. It would also allow for the creation of one comprehensive national set of guidelines for the reporting of medical-setting deaths, as well as the opportunity for the collection of more meaningful coronial data pertaining to preventable deaths in the health care system.

Despite these potential advantages, the prospect of a nationally consistent approach now or in the future seems remote. A doctor's duty to report a reportable death is only one of a number of obligations imposed by the Coroners Acts and indeed other state Acts.<sup>189</sup> Thus, it may be difficult to sustain an argument in favour of a referral of powers to the Commonwealth on this singular, discrete issue. Nor is there likely to be support for such; notably, there has been no suggestion in favour of a nationally consistent approach in any of the literature cited in this article. Agreement between the various jurisdictions on a uniform approach is also unlikely bearing in mind that those jurisdictions to have replaced their anaesthetic-based approach have each adopted their own unique definition.

To the extent that jurisdictional differences remain, each individual state and territory should develop their own coroner's guidelines for medical practitioners and other health care professionals. These guidelines should: be appropriate for a medical audience; be available in print as well as online; and go above and beyond the general information commonly found on Coroners Court webpages.<sup>190</sup> Ideally, they should describe the role of the coroner, explain the categories of reportable death, interpret key provisions or terms of the legislation, and provide examples of reportable deaths according to each category of reportable death.<sup>191</sup> Such guidelines already exist in New South

<sup>189</sup> In the Victorian context, for instance, examples would include: *Human Tissue Act 1982* (Vic); *Assisted Reproductive Treatment Act 2008* (Vic); *Medical Treatment Act 1988* (Vic); *Guardianship and Administration Act 1986* (Vic).

<sup>190</sup> See, eg, Northern Territory Government, *Coroner's Office* (23 October 2012) Department of the Attorney-General and Justice <<http://www.nt.gov.au/justice/courtsupp/coroner/>>; Courts Administration Authority of South Australia, *The Coronial Process* (2012) <<http://www.courts.sa.gov.au/OurCourts/CoronersCourt/Pages/The-Coronial-Process.aspx>>; ACT Magistrates Court, *Coroner's Court* (23 January 2013) <[http://www.courts.act.gov.au/magistrates/courts/coroners\\_court](http://www.courts.act.gov.au/magistrates/courts/coroners_court)>; Magistrates Court of Tasmania, *The Coronial Process* (25 July 2013) <[http://www.magistratescourt.tas.gov.au/divisions/coronial/coronial\\_process](http://www.magistratescourt.tas.gov.au/divisions/coronial/coronial_process)>.

<sup>191</sup> LRCWA, *Final Report*, above n 6, 36.

Wales,<sup>192</sup> Queensland,<sup>193</sup> and Victoria.<sup>194</sup> The Queensland guidelines in particular have been applauded for their 'focus ... on establishing, through a series of questions, whether the health procedure caused the death and whether the death was the unexpected outcome of the procedure.'<sup>195</sup> In doing so, they '[turn] a doctor's mind to a more detailed and structured consideration of these complex issues'.<sup>196</sup>

<sup>192</sup> Coroners Court of New South Wales, *For Healthcare Professionals* (1 May 2012) <[http://www.coroners.lawlink.nsw.gov.au/coroners/for\\_health\\_professionals.html](http://www.coroners.lawlink.nsw.gov.au/coroners/for_health_professionals.html)>.

<sup>193</sup> Office of the State Coroner Queensland, *Information for Health Professionals* (9 October 2013) <[http://www.courts.qld.gov.au/\\_\\_data/assets/pdf\\_file/0006/92868/m-osc-fs-information-for-health-professionals.pdf](http://www.courts.qld.gov.au/__data/assets/pdf_file/0006/92868/m-osc-fs-information-for-health-professionals.pdf)>.

<sup>194</sup> Coroners Court of Victoria, *Information for Health Professionals* (2011) <<http://www.coronerscourt.vic.gov.au/find/publications/information+for+health+professionals>>. Unlike New South Wales, Queensland and Victoria, the Western Australian guidelines were not generated by the State's Coroners office, but instead by a medical adviser to the Coroner: Turnbull, above n 129.

<sup>195</sup> *Law Reform Committee: Coroners Act 1985*, above n 6, 113.

<sup>196</sup> *Ibid* 113.