NP

DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL
BRIEF FOR DECISION

Deferred

Date	18 November 2013
To	**Attorney-General and Minister for Justice**
From	Strategic Policy
Subject	Increased jurisdiction of *Coroners Act 2003* to investigate stillbirths
Requested by	Attorney-General's office
Decision required by	

RECOMMENDATIONS

That you:

1. **note** the results of consultation on the proposal to expand the jurisdiction of coroners under the *Coroners Act 2003* (the Act) to give coroners the discretion to investigate stillbirths that occur during labour, and that the State Coroner and Minister for Health do not support this proposal (responses at **Attachment 1**);

2. NP_Sch3(2)(1)(b)

3. **sign** the letters to NP_49-Sch4 (**Attachment 2** in response to **Attachments 3** and **4**) and Ms Sarah Atkinson of Maurice Blackburn Lawyers (**Attachment 5** in response to **Attachment 6**) advising that the Government is conducting a comprehensive review of the investigative and reporting regime for stillbirths and the potential future role for the coroner in investigating these deaths.

BACKGROUND SUMMARY

1. On 24 February 2013, you met with [redacted] at the Fraser Coast Community Cabinet meeting who suggested that the Act should be amended to give coroners the discretion to investigate stillbirths where the death of a baby occurs during labour.

2. You instructed the Department of Justice and Attorney-General (DJAG) to investigate the legislative amendments suggested by [redacted] and report back on possible options for reform.

3. Of the 1,954 stillbirths that occurred in 2009–11, 179 occurred during labour and of these 147 were foetuses of less than 28 weeks gestation. Stillbirths that occur during labour are known as 'intrapartum' stillbirths. Professor Michael Murphy, chair of QMPQ Council, estimates that approximately 10 intrapartum stillbirths per annum would warrant coronial investigation. This estimate reflects the number that would 'fit' within the clinically understood concept of intrapartum stillbirth. However, there is a tendency of the health sector to be overly cautious in reporting and the true number potentially subject to investigation could be higher.

4. The current case review framework for stillborn child deaths in Queensland includes audits conducted by local perinatal mortality committees, with oversight provided by QMPQ Council established under the *Health and Hospitals Network Act 2011*. For further information, see **Attachment 7**, the issues paper that you circulated to stakeholders during initial consultation in June 2013.

ISSUES

5. On 20 June 2013, you wrote to Mr Michael Barnes, the then State Coroner; the Honourable Campbell Newman MP, Premier; the Honourable Lawrence Springborg MP, Minister for Health; and the Honourable Jack Dempsey MP, Minister for Police, Fire and Emergency Services, seeking their views as to whether the coronial jurisdiction under the Act should be extended as proposed by NP_49-Sch4 The original briefing note in which you agreed to this course of action is attached (**Attachment 8**).

6. No other Australian state or territory has legislated to allow coronial investigations into stillbirths, although a 2011 report of the South Australian Parliamentary Legislative Review Committee recommended that the *Coroners Act 2003* (SA) be amended to allow for coronial inquests into stillbirths of unexpected, unnatural, unusual, violent or unknown causes. The committee's recommendation is yet to be acted upon.

Results of consultation

7. The State Coroner, Magistrate Terry Ryan and the Minister for Health do not support the expansion of the coronial jurisdiction to allow for the investigation of stillbirths. In feedback provided, the State Coroner noted the likely significant additional costs to the coronial system of expanding the current jurisdiction including:

   - investigation costs, such as independent specialist clinical experts, the cost of the coroner and registry involvement;
   - autopsy costs, such as forensic pathology, toxicology, neuropathy, mortuary, and coronial counsellor costs at a cost for a full internal autopsy with histology and toxicology estimated by the Department of Health at approximately $7,500;
   - conveyance by the government undertaker, because coronial autopsies can only be performed in Brisbane, Nambour, Gold Coast, Rockhampton, Townsville and Cairns, regional or rural stillbirths may need to be conveyed thousands of kilometres from the child's birthplace for autopsy. This is further exacerbated by the fact that not all forensic pathologists who perform coronial autopsies are credentialed to perform infant autopsies; and
   - increased costs for police due to the need to rule out suspicious circumstances, take witness statements, seize medical records, arrange for the government undertaker, and prepare the initial report for the coroner.

8. In his response, the Minister for Police, Fire and Emergency Services also raised concerns about the additional workload and additional specialist training that would be required for frontline police officers.

9. The coronial system has experienced a 26.9 % increase in the number of deaths reported to Queensland coroners since 2007–08, pursuing this approach will negate a significant additional financial burden on an already stretched resource.

10. The Minister for Health recommended consideration should instead be given to improving the current review framework, including changes to the root cause analysis (RCA) legislation, the *Health and Hospitals Network Act 2011* (HHN Act), to mandate this process for intrapartum stillbirths that occur in hospitals. The Minister also supports additional direction and guidance being developed for hospitals reviewing stillbirths, as well as a review of the role, functions and reporting of QMPQ Council, including whether or not hospitals should be required to specifically respond to QMPQ Council recommendations, and those responses be included in QMPQ Council public reports.

11. Allowing QMPQ Council to present findings and recommendations to the public could achieve a number of the intended benefits of NP_49-Sch4 original proposal to expand the jurisdiction of the coroner, including:

    - supporting QMPQ Council in its role to identify statewide and facility specific trends and issues and propose recommendations to effect system wide reforms aimed at reducing perinatal and infant mortality rates;
    - providing the parents of stillborn babies with an explanation as to the cause of death;
    - increasing accountability and transparency across the health system; and
    - providing more information and data in relation to intrapartum stillbirths for research purposes.

12. NP_Sch3(2)(1)(b)

Recommended way forward

13. As supported by the Minister for Health and State Coroner, DJAG recommends no changes be made to the current jurisdiction of the coroner in relation to investigating stillbirths, and recommends that the focus of any reforms should instead be on improvements to existing internal and external investigative and review processes.

14.

15. Focusing on improving current mechanisms in Queensland for investigating perinatal deaths in response to recent community concerns, rather than expanding the coronial jurisdiction will avoid the potential significant costs associated with this option.

16. Exploring enhancements to existing review mechanisms also aligns with the Queensland Government's commitment to reduce red tape, by avoiding potential duplication in the role of the coroner and QMPQ Council, and by supporting better and speedier outcomes for families experiencing this kind of loss.

17. Consultation with the Office of the State Coroner has highlighted that even in the case of deaths of children due to intrapartum complications, like other 'health care related deaths', these investigations "largely duplicate and draw upon current internal and external clinical review mechanisms" rather than contribute significant extrinsic value.

18. One of the clear benefits of the coronial process is that inquests are generally open to the public, and that the findings of both inquests and investigations can be reported on publicly thereby promoting public confidence in the investigative process.

19. As identified at paragraph 11, the same benefits of transparency of the coronial process could potentially be realised, as suggested by the Minister for Health, by requiring hospitals to respond to QMPQ Council recommendations and including those responses in QMPQ Council public reports.

20. Maintaining the current coronial jurisdiction will also avoid any potential public perception that the Queensland Government is inviting debate on 'right to life', foetal development or abortion issues.

21. Should you support the proposed approach, it is recommended that you **sign** the attached letters to [redacted] (**Attachment 2**) and Ms Atkinson (**Attachment 5**) advising that the Government is in the process of reviewing the investigative and reporting regime for stillbirths and the potential future role for the coroner in investigating these deaths.

22. The State Coroner, has further proposed that the Queensland Government consider removing the coroner's jurisdiction to investigate the death of newborn babies resulting from complications during childbirth (approximately six per annum) from the Act. The State Coroner suggests that the circumstances of these deaths mirror intrapartum stillbirths and involve similar investigation processes (such as the RCA) and requirements for technical expertise. For example, a foetus that is stillborn during childbirth is not investigated by the coroner, but a newborn baby that shows signs of life (such as taking a single breath) and then passes away, is investigated by the coroner. DJAG does not recommend this proposal be considered at this time, given community support for expanding (not contracting) the responsibilities of coroners to investigate and report on complications arising during childbirth.

EMPLOYMENT IMPACT

23. Not applicable.

CONSULTATION WITH STAKEHOLDERS

24. You wrote to the Premier, the Minister for Health, the Minister for Police Fire and Emergency Services and the State Coroner. Their consultation feedback was used in the preparation of this brief.

25. The Director of the Office of the State Coroner also provided information and assistance in the preparation of this brief.

26. Initial consultation occurred with the former State Coroner, Mr Michael Barnes. The current State Coroner, Magistrate Terry Ryan, has consulted with his coronial colleagues in consideration of your request for feedback.

27. It was previously recommended that based on feedback from these stakeholders, a new issues paper be developed for the second stage of consultation. In light of the Premier's views, further consultation should not be considered NP_Sch3(2)(1)(b)

FINANCIAL IMPLICATIONS

28. See above at paragraphs 7-9.

POTENTIAL MEDIA

29. NP_49-Sch4

30.

31. On 17 May 2013, the *Courier-Mail* reported that you said you were considering amending the Act as per the proposals put forward by NP_49-Sch4 On the same day, *ABC News* reported that you said you would consider changing laws to allow the coroner to investigate stillbirths.

Deferred

Reference No: 2294882

NOTED or APPROVED / NOT APPROVED
Attorney-General and Minister for Justice
Comments

I believe that if a parent requests it, then it should occur.

Jarrod Bleijie MP Attorney-General and Minister for Justice 17/12/13.	Chief of Staff and Principal Adviser / /	Policy Adviser / /

I support amending the Act to give Coroners a discretion to conduct an inquiry. However, the proposed approach of investigating options with Qld Health as an interim step, is, I think, the appropriate way forward.

29/11.

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Approved by:	Name: Natalie Parker Position: Director Phone: 323 93536 Date: 8 November 2013	Endorsed: John Sosso Director-General	29/11/13

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