Study finds "systemic" problems and under-resourcing in NZ coronial system

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A ground-breaking University of Otago study of more than 600 findings by coroners in New Zealand has identified serious failings that constrain the ability of coroners to act preventively and stop further loss of life.

The Law Foundation-funded study of 607 coronial inquiries during the five years from July 2007 to June 2012 was published in the *New Zealand Medical Journal* today.

The main finding of the research, which also included 123 interviews with coroners, and public and private organisations sent coroners' recommendations, was that the preventive and patient safety potential of coroners' recommendations is not being maximised due to serious systemic issues and under-resourcing.

The study identified poor information-sharing systems, an under-resourced coronial system, a lack of training for coroners to make health and safety assessments, a shortage of available outside expertise, insufficient targeting of important coronial recommendations – some went to no-one in particular – and that some coroners felt their recommendations had no effect.

This was noticeable in the high number of repeated and identical recommendations, particularly in drowning and sudden unexplained infant deaths.

The report's author, University of Otago Faculty of Law Acting Director

of the Legal Issues Centre Dr Jennifer Moore, says of concern, the study found that 72 recommendations did not go to an identifiable organisation. For example, a recommendation was directed to "all white-baiters" and another to "any person reading…this decision."

"Australian research has demonstrated that vaguely directed recommendations receive poor or no responses and have little or no preventive impact," notes Dr Moore.

An analysis also found 324 identical repeated recommendations out of the 1644 total recommendations made by coroners – with 201 of these made in cases of drowning; 47 in sudden unexplained death in infants (SUDI); 58 in transport-related accidents, eight in intentional self-harm deaths and a further eight in serious falls.

"Some organisations (61 out of 79) reported that the cumulative effect of repeated recommendations may aid the uptake of coronial recommendations. However, coroners themselves felt that their repeated recommendations are 'falling on deaf ears' and not being implemented," says Dr Moore.

The study also found that in 72 of the 607 coroners' findings studied, previous coronial findings had not been taken into account.

Furthermore, Dr Moore notes, there is no system of providing easy access to full coronial findings so that they are accessible and educational. She adds that such a system could improve the quality of decision-making, enhance the educative role of coroners and reduce the frequency of adverse events.

"Study participants stated that the inaccessibility of full coronial findings means that there are fewer opportunities to learn from deaths, to improve patient safety and quality of care, and that coroners' decision-

making is inconsistent." Hence, "coroners' ability to fulfil their statutory preventive function is undermined."

Some coronial data is shared, but the inaccessibility of full coronial findings prevents their "prophylactic potential", she writes.

This is the first major study of New Zealand's coronial findings. It looked at 607 findings into people's deaths, resulting in 1644 preventive recommendations that were sent to 309 individuals and organisations since the New Zealand Coroners Act came into force in 2007.

Of the 607 coronial inquiries, transport accidents (187), drowning (81), intentional self-harm (76) and complications of medical or surgical care (58) were the four main underlying causes of death categories investigated by coroners. Government organisations received the highest proportion of recommendations (121), followed by not-for-profit organisations (67), for profit organisations (44) and individuals (5).

Dr Moore says the New Zealand public deserves a highly-performing coronial service to highlight avoidable deaths and recommend prevention measures.

The Ministry of Justice is currently reviewing the coronial service and expects to introduce an amendment bill in the coming months. Dr Moore's research findings support further resources for the coronial services to improve the preventive impact of recommendations. The research findings also support the introduction of a mandatory response regime which would require organisations that are sent recommendations to write a formal response to say what, if anything, they intend to do.

There are approximately 29,000 deaths in New Zealand each year, of which about 20 percent are reported to Coroners. The Dean of Otago's Law Faculty Professor Mark Henaghan was co-researcher on the

project, which was funded by the New Zealand Law Foundation.

Provided by University of Otago

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