INTERIM ORDER PROHIBITING PUBLICATION OF NAME(S) IN ACCORDANCE WITH PARA [87]
PERMANENT ORDER PROHIBITING PUBLICATION OF THE NAME OR ANY OTHER IDENTIFYING PARTICULARS IN ACCORDANCE WITH PARA [89]

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

CIV 2012-404-001684
[2013] NZHC 390

BETWEEN	GARY LANCE GRAVATT Plaintiff
AND	THE CORONER'S COURT AT AUCKLAND First Defendant
AND	AUCKLAND DISTRICT HEALTH BOARD Second Defendant

Hearing: 10 December 2012

Counsel: G Illingworth QC and C R Baird for Appellant
A M Adams and H H Ifwersen for Second Defendant
M McClelland for Estate of Dr Black

Judgment: 4 March 2013

JUDGMENT OF WHATA J

This judgment was delivered by Justice Whata on 4 March 2013
at 4.00 pm pursuant to
r 11.5 of the High Court Rules

Registrar/Deputy Registrar
Date:

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Introduction

[1] On 8 July 2009 Zachary Gravatt died of meningococcal disease – C strain. Coroner Shortland undertook an In Chambers hearing into the circumstances of his death. The Coroner made multiple recommendations under s 57(3) of the Coroners Act 2006, in effect recommending systemic change to the assessment and treatment of patients. The Coroner also resolved, in a separate ruling, that the identities of the health professionals responsible for Zachary's care on 8 July should be prohibited from publication. He said publication of their identities "would effectively be punishing individuals for an overwhelmed and over stressed system". He was satisfied that a permanent suppression order was "in the interests of justice, decency, personal privacy and with an emphasis on public order". The plaintiff, Zachary's father, challenges the decision to suppress the identities. He says that suppression violates freedom of expression and the principle of open justice without proper justification.

The issues

[2] The apparent simplicity of the plaintiff's claim belies its complexity. I must first identify the content and limits of my jurisdiction to examine the decision of the Coroner, having regard to orthodox review principles but also in light of the principle of open justice and the right affirmed by s 14 of the New Zealand Bill of Rights Act 1990 (NZBORA) to impart information.

[3] I must examine the scope of the Coroner's power to suppress information under s 74 of the Coroners Act 2006, which states:

> **74 Coroner may prohibit making public of evidence given at any part of inquiry proceedings**
>
> If satisfied that it is in the interests of justice, decency, public order, or personal privacy to do so, a coroner may prohibit the making public of—
>
> (a) any evidence given or submissions made at or for the purposes of any part of the proceedings of an inquiry (for example, at an inquest); and

(b) the name, and any name or particulars likely to lead to the identification, of any witness or witnesses.

[4] I must then review the content of the decision to suppress and assess whether the conditions prerequisite to the exercise of the power under s 74 were present. If I find a material error, I must determine whether I should confirm, revoke or modify the decision to prohibit publication of the identities of the affected health professionals.

Background

The Coroner's findings

[5] The full context to these proceedings is detailed in the Coroner's findings on the circumstances of Zachary's death. It is necessary to record those findings at length to properly understand the suppression decision and the respective claims of the parties.

[6] The facts are essayed by the Coroner as follows:

> [31] At about 4.00 am on 8 July 2009, Zachary Gravatt awoke in extreme pain in his right groin, with headaches and being feverish.
>
> [32] Zachary was a fourth year medical student and had been in contact with people who had the H1N1 flu virus in the weeks preceding this illness.
>
> [33] Zachary made an appointment to see his general practitioner (GP), Dr Bulmer, at the Herne Bay Medical Centre for 12.00 pm. Dr Bulmer saw Zachary at 12.13 pm.
>
> [34] Dr Bulmer examined Zachary and recorded a presentation of headaches, rigors, with a high fever. His temperature was 39 degrees Celsius. His respiratory rate had increased to something like 28 breaths per minute. He had a soft abdomen with tenderness in the right inguinal region. There was no record of any cough or sore throat.
>
> [35] Important to note there was no rash or sign of meningism.
>
> [36] Dr Bulmer could not find an obvious explanation to the symptoms and considered the H1N1 flu as the most likely cause, given Zachary's exposure to the virus. At the time Auckland had experienced high numbers of people showing similar symptoms at medical clinics and high numbers of hospitalisation, what was described at the time as a pandemic flu virus.

[37] Dr Bulmer also considered a differential diagnosis as possibly pneumonia.

[38] Zachary had taken paracetamol at 11.00 am. At about 12.15 pm intramuscular prochlorperazine was administered. Dr Bulmer placed a phone call to the medical registrar who was not available to take the call. The registrars were very busy because of the winter workload and influenza admissions. Dr Bulmer's call was transferred to Dr Peter Black ("Dr S") at the Auckland City Hospital who advised the registrar of Zachary's presentation. This was followed up by a letter.

[39] An ambulance was called for and transportation was arranged to take Zachary from the Herne Bay Medical Clinic to the Auckland City Hospital. The ambulance arrived at the Emergency Department of Auckland City Hospital at about 1.35 pm.

[40] Zachary continued to complain of an upper abdominal pain and through his lower chest. He continued to have an elevated respiratory rate. Ambulance documentation records: "no rash, headache, no neck stiffness, slight nausea – patient took Maxolon recently, vomiting this a.m. (morning)."

[41] The St John's report shows that Zachary had been in contact with an H1N1 patient.

[42] The physiological data recorded on the ambulance notes confirmed a number of symptoms including an elevated respiratory rate, 28/min with tachycardia rate of 130 beats per minute, a febrile temperature at 39 degrees Celsius and his skin hot to touch. The notes record hypotension (100/50) and a slight dizziness on standing. It showed he had chest pains, headaches, rigors and other body pains. He had vomited that morning and felt unwell and tired. The notes also show there was a failed attempt at obtaining an IV line in transit.

[43] When Zachary arrived at Auckland City Hospital he was assessed in the Emergency Department by the triage nurse using the Australasian College of Emergency Medicine triage scale. At 1.43 pm Zachary was assessed and triaged at "Category 3". This designated score "Category 3" has a priority requiring medical attention within 30 minutes of arrival, as benchmarked by the Australasian College of Emergency Medicine.

[44] The Emergency Department triage nurse in attendance, Nurse Claire Child, ("Nurse T") confirmed she had read the ambulance report and received a verbal handover from ambulance staff. This was in accordance with the normal policy and practices.

[45] She also read the GP's referral and had assessed Zachary's presentation as an influenza-like illness with breathlessness but Zachary's pain level was indicated to be of moderate severity.

[46] Important to note that on this particular date of presentation it was a busy day for the acute services and "Nurse T" had been sharing the duties with one other triage nurse in dealing with a stressful workload including the added workload from the pandemic influenza.

[47] After triage assessment in the Emergency Department, Zachary was able to be transferred directly to the APU as he had been referred by his GP. He was one of four new admissions to the APU at that time.

[48] In the APU, occupancy was about 90% from 8.00 am until 12.00 pm, another 80% from 12.00 pm onwards.

[49] Zachary's presentation coincided with the first season of H1N1 influenza A (referred to as "swine flu") and peak hospital presentations of both seasonal and H1N1 influenza A.

[50] Zachary was placed into a six bedded room (room 3) which was being used for patients with suspected H1N1 influenza. There was a staff nurse present at all times with the six patients.

[51] Emma Hill ("Nurse A") is a nurse educator attached to the APU. Given the APU was so busy that day she came to assist the staff nurse working in room 3 at the time of Zachary's arrival. "Nurse A" performed the initial nursing assessment of Zachary.

[52] At this time there were no signs of rash or evidence of photophobia. She recalls Zachary presenting with flu-like illness, with a high fever and initially very anxious, though he appeared not to be peripherally shut down. He was stripped to his waist (where ambulance staff had removed the clothing from his upper body in order to help reduce his temperature).

[53] "Nurse A" was able to insert an IV line without difficulty, which appeared to lessen his anxiety to some extent.

[54] There was some dialogue between Zachary and the nurse along the lines of he was surprised at how easy the IV line was inserted, that he was nervous at the sight of his own blood which he joked at, given his intended career and desire to be an orthopaedic surgeon.

[55] "Nurse A" in her statement to Dr Roger Reynolds, as filed in his report said she had concerns about Zachary's fever and tachycardia, and wanted him to be seen sooner rather than later, that is, within the 30 minute triage time.

[56] Zachary was able to sit up to allow an easy listening examination on the front and the back of his chest. "Nurse A" administered paracetamol to Zachary and said he did not complain any further of headaches or photophobia, despite feeling awful with generalised abdominal aches.

[57] "Nurse A" followed standard policy and practice by taking basic blood tests for suspected infection and added blood culture samples in view of his high temperature. She had taken sufficient blood samples to add a coagulation screen, noting Zachary's reluctance to have blood taken and to eliminate the necessity of seeking a further blood sample at a later point.

[58] "Nurse A's" assessment commenced at 2.00 pm and was completed and documented at 2.30 pm. The nursing notes confirm that Zachary had flu-like symptoms, abdominal pain and continued anxiety with shortness of breath. His temperature remained high at 39.9 degrees Celsius with pulse of 126. The comment recorded "Alert and Oriented". "Nurse A" left the room

to escort another patient, handing over Zachary's care to room 3 staff nurse. "Nurse A" returned to the door of room 3 to tell Zachary that his mother had called, at which time he appeared relaxed in bed.

[59] ["Dr R"] was one of four medical registrars on that day. He had been told by Dr Peter Black ("Dr S") to look out for Zachary as his admission was a result of a referral from a local GP. "Dr R" clicked onto Zachary's name in the electronic whiteboard system at 1.48 pm, indicating that he was aware Zachary was in the unit at that time.

[60] "Dr R" could not recall exactly what time he attended on Zachary, only to note that it was at the same time Zachary was having bloods taken and an IV line was inserted. The laboratory record shows that bloods were taken at about 2.15 pm.

[61] "Dr R" indicated he would always allow about 30 minutes for an assessment of his patients and then to write up his notes. Irrespective, the notes show a 3.30 pm entry approximately one hour 45 minutes after being triaged a Category 3 score.

[62] In the report provided by Dr Andrew Munro, he says "Dr R" attended on Zachary at 3.30 pm. While "Dr R's" clinical entry was recorded at 3.30 pm, Dr Reynolds concluded that "Dr R's" medical assessment more than likely took place earlier and considered that Zachary was most likely seen between 3.00 pm and 3.30 pm.

[63] What is consistent in both Dr Reynolds' and Dr Munro's reports is that "Dr R's" clinical findings conclude, firstly, he had not received back the blood results, and that his assessment confirmed continued symptoms of high temperature, clammy, sweaty presentation and he looked unwell.

[64] An urgent swab to test for influenza type A was sent at 3.30 pm (this was later reported as negative). "Dr R" recorded Zachary as potentially septic, possibly with a bacterial infection most likely in the chest. He then charted and commenced IV fluids (saline) and glucose between 4.00 pm and 4.15 pm.

[65] There was no other recorded treatment until 4.00 pm. It was suggested a blood pressure reading was taken at 2.30 pm, though not recorded anywhere.

[66] Other than the observations taken during "Dr R's" assessment, there were no other recordings of further observations between 2.30 pm and 4.00 pm.

[67] "Dr R" then contacted Dr Black ("Dr S") out of his concerns, after discussions with Nurse Kevin Gounder, charge nurse ("Nurse B"), he also transferred Zachary to the HDU (High Dependency Unit) area within the APU. "Dr R" thought Zachary was sick enough for him to be admitted to this unit for further consultation with "Dr S". At around 4.00 pm in the HDU "Dr R" recorded tachycardia 130/min; blood pressure systolic 90-100.

[68] Once Zachary was in the HDU the care responsibility still remained with the primary medical team. At the time there was no medical staff

specifically assigned to the HDU area. It still remained a busy day for the service.

[69] "Nurse B" became involved in Zachary's care after speaking with the medical registrar. He was the nurse in charge of the nursing shift in the APU during Zachary's admission. Zachary remained sweaty, clammy and hot to touch.

[70] The initial blood tests confirmed Zachary was clearly not well. "Nurse B" was assessing Zachary when an orderly arrived to take him for a chest X-ray. A request for a chest X-ray had been faxed to the Radiology Department at 3.44 pm and the chest X-ray was taken at around 4.00 pm. Zachary was able to stand for the X-ray. The X-ray showed that Zachary had a clear chest.

[71] "Nurse B" accompanied Zachary throughout that process and followed him back to room 14 in the HDU. On arrival at the HDU, Zachary was attached to a monitor.

[72] Zachary's presentation remained consistent with persistent hypotension and the other indicators showing falling blood pressure.

[73] "Nurse B" also confirmed Zachary was still stripped to the waist. There was no rash or evidence of neck stiffness or photophobia.

[74] Shortly before 5.00 pm, Zachary's father arrived, Dr Lance Gravatt to visit his son and to consult with doctors.

[75] It was a busy day for staff and "Nurse B" was in and out of Zachary's room for the remainder of the day while he was in HDU.

[76] Between 4.15 pm and 5.30 pm there were regular reviews of the vital signs chart, blood tests and test results, observations and consultation amongst members of the treating team. There was the administration of fluids and glucose at about 4.15 pm followed by the administration of Cefuroxime (an antibiotic), Oseltamivir (antiviral for suspected "swine flu") and Fentanyl (pain medication) over a 10 minute period from 4.30 pm.

[77] At about 5.15 pm to 5.30 pm, "Dr S" noted Zachary's presentation to be consistent with influenza illness, myocarditis and disseminated intra-vascular coagulopathy (followed by DIC). He said Zachary should be admitted to the Department of Critical Care Medicine (DCCM), and he suggested a surgical opinion and a CT scan of the abdomen to exclude intra-abdominal sepsis. He also said that Zachary should be given inotropic support (ie medication to raise his blood pressure). He noted one purpuric lesion on Zachary's back.

[78] Given that diagnosis Zachary was prescribed the antibiotic, Gentamicin at about 5.45 pm with the possibility of intra-abdominal sepsis.

[79] At that point it was decided that the intensivist on duty in DCCM should be contacted immediately. Dr Paul Gardner ("Dr I") was the duty consultant at the time. At around 6.00 pm he was advised by telephone of the history and the available results with a clinical suspicion of an influenza virus.

[80] According to Dr Reynolds' report, Dr Paul Gardner ("Dr I") immediately thought the combined information suggested meningococcal disease.

[81] "Nurse B" noted spots were appearing on Zachary's face at the time he was taken to DCCM.

[82] "Dr I" had checked that antibiotics had been administered and while returning to the hospital he called the DCCM, charge nurse, to prepare a bed and ensure that intravenous and arterial access was established. At 6.40 pm, Ceftriaxone was administered when meningococcal infection was recognised as the working diagnosis.

[83] "Dr I" was then advised by his registrar that Zachary was pre-arrest. At that point it was ordered that Zachary be intubated which proved very difficult.

[84] Zachary had gone into arrest with septic shock. This was followed by vomiting and pulmonary oedema. There was ongoing hypotension and despite the attempts to resuscitate Zachary there was no response to the asystolic arrest. Zachary was declared dead at 7.15 pm.

[7] The findings of the Coroner then addressed the post mortem, described the meningococcal disease and identified various issues arising. Reference is made to the Australasian Triage Scale (ATS). The Coroner then states:

[105] The guidelines are clear in saying that patients should be seen well within the recommended maximum times. However there is a recognition and reality that clinical outcomes within Categories 1 to 4 can be affected by delays to assessment and treatment beyond the recommended times.

[106] The facts show that at 1.43 pm Zachary was triaged. According to the ACEM guidelines and policy Zachary should have been treated within that 30 minute period.

[107] In Zachary's case, the expert report writers considered he was appropriately assessed at Category 3 in the circumstances.

[108] At 2.30 pm a further nursing assessment was briefly carried out confirming the same symptoms. Zachary was most likely then seen between 3.00 pm and 3.30 pm by "Dr R".

[8] His report states:

[110] I am of a view that whilst the triage system plays a significant role in assessing and organising emergency treatment in a structured manner, it is never a perfect system despite every effort to manage waiting times as best as possible. The reality is external circumstances like a swine flu epidemic or other unforeseen delays will undermine the best indicators of the triage system.

> [111] I concur with the remarks provided by Dr Reynolds in his report in that there should be a monitoring of patients waiting for assessment and in particular those who are coming to the end of their assigned triage times. That back-up systems be activated when patients are not attended to within the time allocations. That health care provider's [sic] consider appropriate mechanisms when managing delays in treatment. As it was it was an hour and 45 minutes before Zachary had proper treatment.

[9] The Coroner then concludes that the fundamental issue is at what point the diagnosis of the meningococcal septicaemia should have been considered. He said it is accepted that the presentation of Zachary Gravatt to his doctor and then to the Emergency Department was one of flu-like symptoms. He observes that these symptoms and characteristics are similarly found in the diagnosis of meningococcal disease.

[10] The Coroner then records:

> [115] It is important to consider that at the time the medical clinics and hospitals within the Auckland region were under considerable stress in dealing with the peak of the seasonal flu.
>
> [116] Dr Reynolds reports, from April through to July 2009 the number of cases notified per week increased from very low numbers (approximately 10 or less) until the end of May, graduating to approximately 20 in the first week of June, an accelerated increase in subsequent weeks of around 160, 290, 330 and 540 (in the week ending 5 July).
>
> [117] In reality the hospitals were under extreme stress including the Emergency Departments when dealing with the influenza outbreak.

[11] The Coroner observes:

> [119] It was within this context that Zachary was presented to the Emergency Department with similar flu-like symptoms.

[12] And further:

> [132] It was Dr Reynolds' view; the meningococcal infection could have been identified earlier on a differential diagnosis. That would have been more dependent upon regular recording of vital signs particularly the blood pressure. It was likely that a consistent presentation of hypotension would have been observed. This may have alerted the nursing and medical staff to the possibility of the presentation of evolving shock or sepsis well before 4 o'clock.

> [133] In my view the inevitability of identifying this disease would have increased with regular reassessments once the triage time had expired. This must be put in perspective of the environment and workloads of that day.

[13] The Coroner goes on to say:

> [134] In Zachary's case the early symptoms of this disease were confused with the influenza epidemic. This inquiry has illustrated the difficulty in diagnosing meningococcal disease at an early stage. It remains an extremely challenging situation for a doctor to diagnose. ...

[14] The Coroner then identifies the further issue of whether referral to the DCCM was too late. The key finding is as follows:

> [138] In Dr Reynolds' opinion firstly, he believed there were grounds for activating a "code red" as early as 4.00 pm. In his view, regular recording of the blood pressure might have indicated that this "threshold" had been reached before the 3.00 pm mark. Potentially resulting in Zachary receiving more intensive care 2 or 3 hours earlier than the facts have indicated.

[15] He further goes on to state:

> [140] Dr Reynolds felt it was not unreasonable for the treating medical team to interpret the results as being consistent with the viral infection they suspected in the clinical context they were treating Zachary for. If anything, there should have been further consideration for a differential diagnosis concerning consideration of the possibility of bacterial sepsis in the context of reviewing the haemostasis report at 4.57 pm.

[16] He said in summary that Dr Reynolds concluded that the referral to the DCCM should have been made earlier with consideration given to a differential diagnosis. He accepted that view.

[17] There is then a formal finding as follows:

> [142] I am satisfied in the totality of the evidence provided Zachary Gravatt, born 3 July 1987 and 22 years of age at the time of his unfortunate death, has died from Neisseria Meningitidis infection (Meningococcal Septicaemia). Zachary was admitted to the Auckland City Hospital on 8 July 2009. The facts have been outlined in this finding.

[18] The report then makes further comments about media attention, the Northland District Health Board Meningococcal "C" Immunisation campaign and then makes a number of recommendations. Those recommendations focus on

systemic and policy changes needed to properly address the assessment of patients. The following concluding comments reflect the general tenor of the report:

> [168] Lastly, there was acknowledgement of using the lessons of Zachary's case as a teaching tool for DHB's [sic] to facilitate processes for junior doctors and nurses when meeting with families to discuss matters after error or death. The process includes the principles of honesty, compassion and being open with communication.
>
> [169] Despite the importance of the triage system, its effectiveness was undermined by the sheer numbers of patients requiring treatment on that day in the context of the influenza epidemic. Acute areas are often under siege from a combination of pressures. Despite good management they will always be vulnerable to uncontrollable variables.
>
> [170] This has been a life changing event for the Gravatt family. It has been clear to this Court of the effect and emotional impact of their son's death. This Court wishes to record its formal condolences to the Gravatt family. It also must be remembered the impact that this case has had on the medical professionals who dealt with Zachary at the Auckland City Hospital.
>
> [171] It was evident in Dr Reynolds' report of a genuine sorrow and remorse expressed by the medical professionals over Zachary's death.

The prohibition decision

[19] The prohibition decision is essentially divided into three parts, namely the argument, the law, and the reasons for prohibition of publication. The key argument was re-litigated before me and does not need to be repeated in this section of the judgment. As to the law, the Coroner cites *R v Liddell,*[1] and emphasises the importance in a democracy of freedom of speech, open judicial proceedings and the right of the media to report the latter fairly and accurately as surrogates of the public. The observations of the Chief Justice in *Lewis v Wilson & Horton Ltd*[2] are also adopted with the basic point that it is necessary to confront the principle of open justice and on what basis it should yield. He then refers to the following passage from *Fardell v Attorney-General*[3] and quotes:

> [52] ... the approach to suppression issues in the Coroners Court, while informed by the principles of open justice and freedom to receive and impart

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1 *R v Liddell* [1995] 1 NZLR 538 (CA).
2 *Lewis v Wilson & Horton Ltd* [2000] 3 NZLR 546 (CA).
3 *Fardell v Attorney-General* [2007] NZAR 122 (HC).

information guaranteed by s 14 of the Bill of Rights ... ought not to be determined by those considerations alone.

[20] The Coroner then observed further:

> [63] His Honour Heath J went on to comment at paragraph [60] that before making prohibition orders under s 25(2) The Coroners Act 1988 (the predecessor to s 74 of the current Act) Coroners need to consider on a case by case basis, the nature of the evidence sought to be prohibited, any neutralising public policy reasons or the evidence to go into the public domain. His Honour used the example:
>
> > ... If the inquest were to precede criminal proceedings, the possibility of publication causing prejudice to the right to a fair trial must also be considered.

[21] In dealing with personal privacy, the following passage is also cited from *Fardell*:[4]

> [62] ... While it is said disjunctively, it is designed to make more explicit the fact that personal privacy is an element to be considered in determining whether a suppression order is required.

[22] A redundant argument concerning the scope of s 74 is then addressed. Having formed the view that the evidence is within scope, the decision turns to the substantive reasoning. It is observed:

> [93] In this case the central and most important issue in my view was the systemic failure to recognize meningococcal disease and treat it appropriately and in a timely fashion. It is incumbent on me to reiterate this is not about making a decision as to whether Zachary would have lived or died irrespective of receiving timely treatment. That is pure speculation after the fact.
>
> [94] Therefore, it is my clear view, after consideration of all of the submissions and legal arguments, it is the system and not the individuals that require the attention.

[23] And:

> [99] There were difficulties in recognising Zachary's disease and it was not done in a timely fashion. The triage category did not assist the treatment process. In my view they were symptoms of a system under extreme stress. With high workloads and in the context of an influenza epidemic it was going to fall short of [its] purpose.

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4 Ibid, at [62].

[24] There are then the following key observations:

> [100] New Zealand does not have the luxury of having an abundance of health professionals who fill every position required to support a well resourced medical system. Those that work in acute services are constantly under pressure and for the good majority of the time, provide an excellent service making a struggling system look better than what it is. That is not to say there is no room for improvement.
>
> [101] To publish the names and details leading to the identification of those involved in Zachary's case under the guise of true transparency and open justice, in my view, would be a form of punishment and would set an extremely dangerous precedent for future media coverage.
>
> [102] It would serve to discourage good health professionals from seeking employment and experience in the New Zealand Health system. It has the potential to seriously undermine the confidence in the health system as well. The obvious question being who would work in a system that effectively punishes you if you make a genuine mistake. One of the realities of working and treating patients in the health sector is there will be errors and deaths despite the best efforts. For those who are negligent in their professional duties, they can expect sanctions. That wasn't the situation here.

[25] After recognising that the media play an important role in ensuring that users of the health system are served and treated to the highest standards possible, he observes:

> [104] The publication of details leading to the identification of the health professionals in this case would effectively be punishing individuals for an overwhelmed and over stressed system particularly at that time. It is the system and all its issues that need the right media coverage and not the individuals. I accept the arguments of the ADHB with reference to making changes to policy, procedure and the system itself. They have commenced down a path and have made appropriate changes going forward.
>
> [105] I am satisfied in the interests of justice, decency, personal privacy and with an emphasis on public order there should be a permanent order made.
>
> [106] I am confident this order does not impact on the ability of other innocent parties in openly discussing the circumstances of Zachary's case. It will not compromise the interests of transparency, accountability and the work towards the quality improvement that has already been undertaken by the ADHB.

Pleadings

[26] The plaintiff's claim is relatively succinct. Key elements of the claim are:

> 3.3 The decision was based on an error of law in that:

(a) It was inconsistent with the scheme and purpose of the Coroners Act 2006.

(b) It was inconsistent with section 14 of the New Zealand Bill of Rights Act 1990.

3.4 The decision was unreasonable in that:

(a) It was based upon a flawed or fallacious reasoning process.

(b) There was no reasonable or rational basis for the decision.

[27] It is also claimed that various irrelevant considerations were taken into account including:

(a) The health professionals would likely be subject to unfair reporting in the media;

(b) Publication would result in a form of individual punishment and would set an extremely dangerous precedent for future media coverage;

(c) Publication would result in discouraging good health professionals from seeking employment and experience in the New Zealand public health system and has the potential to seriously undermine confidence in the New Zealand public health system;

(d) It would be unfair to name the health professionals;

(e) That prohibition was necessary in the public interest or for the reasons of justice, decency, personal privacy or public order.

[28] The plaintiff also claims that the decision failed to take account of the need to allow free discussion.

[29] The statement of defence rejects the various claims.

Summary of argument

Plaintiff

[30] Mr Illingworth QC elaborated somewhat on the essential claims, reflecting their underlying complexity. He submitted, in short:

(a) The baseline for any exercise of discretion under s 74 is the fundamental principles of open justice and freedom of expression;

(b) The Coroner was not and could not be properly satisfied that prohibition of publication of the names of the health professionals was necessary in the interests of:

(i) Justice;

(ii) Decency;

(iii) Public order; or

(iv) Personal privacy;

(c) The Coroner's approach to the interests of justice was too broad by adopting a generalised concept of fairness to health professionals – rather he should have focussed on whether prohibition was necessary to maintain the administration of justice, for example, a fair trial;

(d) Decency is plainly not an issue – there being no facts, if published, that might ordinarily be objectionable on decency grounds (and this is not challenged);

(e) Personal privacy deals only with confidential information against which there might be a legitimate expectation of privacy;

(f) There is simply no basis for saying that prohibition is necessary in

order to maintain public order – reference to this reason was wrong on its face;

(g) Given that none of the grounds for prohibition apply, the order was unlawful. It was based on an evident logical fallacy, that is, based on conditions that did not and do not exist;

(h) Even if one of those conditions could be said to apply, they were not such as to outweigh the principle of open justice: there is nothing special about the affected medical practitioners that might warrant their exclusion or protection from the orthodox application of fundamental principle;

(i) The decision is not otherwise reasonable in that:

(i) There is no proper basis to say that the publication of the names will "undermine confidence", there being no attribution of blame to them;

(ii) Publication of names will not lead to "a form of punishment" – at most an adverse inference might be improperly drawn, but that has nothing to do with the publication of the names and if so, there may be an effective remedy in defamation;[5]

(iii) The conclusion that publication will serve to discourage good health professionals from taking up work in the medical arena is speculative and illogical given the Coroner's decision;

(j) The decision has set a dangerous precedent, interfering with freedom of speech based on a perceived risk of unfair reportage;

(k) No general privacy interests were engaged given the public context;

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5 Citing *Surrey v Speedy* (1999) 13 PRNZ 397 (HC).

(l) The decision's key conclusion is erroneous on its face;

(i) It is impossible to say that all conditions under s 74 were triggered; and

(ii) Public order plainly not a ground and yet it was a matter of emphasis by the Coroner.

[31] Overall therefore Mr Illingworth submits that the decision proceeds from erroneous definitions of the key qualifying conditions under s 74 and is outside the proper statutory limits of an exception to fundamental principles of open justice and freedom of expression.

[32] Finally, a generalised fear of adverse publicity is hardly a principled basis for prohibition – citing *Re Urlich*.[6]

Auckland District Health Board

[33] Ms Adams for the Auckland District Health Board (ADHB) contends that there was no material error of law or irrelevant consideration. The reference to "with an emphasis on public order" was a slip, but in any event, there was a proper basis to suppress namely to secure fairness to the health professionals, respect for their personal privacy and to avoid the effects of illegitimate adverse publicity on the health system.

[34] Ms Adams helpfully details the background to the decision and sets the frame for her primary contention with the following submissions (in summary):

(a) The interpretation of the proper limits of s 74 must commence with the special purpose and structure of the Coroners Act 2006;

(i) The purpose is two-fold – to prevent deaths and to promote

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[6] *Re Urlich* (Reserved Findings of the Coroner, Coroners Court at Auckland, Decision 90/10, 28 July 2010).

justice;

(ii) The structure is directed to inquests into the cause and circumstances of death, not to attributing blame – there are, for example, no allegations, no accused, no prosecution, no plaintiff or defendant. The process is inquisitorial and recommendatory;[7]

(b) When this purpose and structure is then informed by the immediate context, namely that of health professionals who must routinely on a day-to-day basis deal with death, then the rote application of principles of open justice and freedom of speech is inapposite;

(c) Rather, health professionals are uniquely susceptible to unfair reportage of coronial reports and the significant consequences to them of findings or observations in the reports;

(d) In this case the report identifies systemic causes for the death, rather than any individual act of negligence, carelessness or breach of standards. Nevertheless comments imply individual professional error[8] as illustrated in published articles to date.[9] These and similar suggestions of individual error are unduly highlighted with obvious adverse implications for the professional reputations of the implicated individuals;

(e) This is an obvious adverse impact, without proper foundation, combined with a lack of realistic remedy that makes publication unfair and contrary to the interests of justice and without legitimate public purpose given the substantive findings;

(f) Privacy interests are engaged, as recognised by the developing

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7 Referring also to *Coroner's Court v Newton* [2006] NZAR 312 (CA) at [40].

8 Refer to [101], [111], [112], [132], [137], [138], [139] of the Coroner's findings.

9 Refer to Donna Chisholm "Fighting for Zac" *Metro* (New Zealand, November 2010) at 42-43, and 46.

privacy law dealing with protection of public officials in their employment capacity;[10]

(g) An analogy can be drawn to a review of performance by employers – this is a private matter unless there are good public reasons to publish;

(h) The combination of unfair treatment and privacy considerations and a diluted public interest in knowing who rather than what happened outweigh public justice and freedom of speech factors;

(i) The plaintiffs, by recognising an exception ought to be made for Dr R, acknowledged that principled exceptions are available under s 74.

Affected person

[35] Mr McClelland highlighted, in addition to Ms Adams' submissions, that his client, Dr Black, has passed away with the result that:

(a) He cannot defend himself against any publication; and

(b) There is no issue regarding the protection of the public.[11]

Jurisdiction

[36] The plaintiff proceeds by way of judicial review under the Judicature Amendment Act 1972. That was unnecessary given that s 75 of the Coroners Act 2006 states:

> **75 Review of coroner's decision as to making public of details, evidence, etc**

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[10] See case notes W39127, Office of the Ombudsman, 12 Compendium, 2001, at 105-106; Case Notes W40876, Office of the Ombudsman, 12th Compendium, 2001, at 103; and Case Notes C7668, Office of the Ombudsman, 14th Compendium, 2007, at 104-106.

[11] Citing Laurenson J's decision in *F v Medical Practitioners Disciplinary Tribunal* HC Auckland AP21-SW01, 5 December 2001.

(1) This subsection applies to a person affected by—

(a) ....

(b) a prohibition under section 74.

(2) A person to whom subsection (1) applies may apply to a High Court Judge for a review of the refusal or prohibition.

(3) Until the Judge reaches a decision on the application, the refusal or prohibition concerned continues in effect.

(4) The Judge may (as the case requires), in the Judge's absolute discretion and on any ground the Judge thinks fit,—

(a) confirm the refusal, or revoke it and issue an authority; or

(b) confirm, modify, or revoke the prohibition.

(5) An authority may be issued under subsection (4)(a) unconditionally, or subject to conditions the Judge thinks fit.

[37] The reference to "review" nevertheless invokes the same principles applicable in judicial review proceedings. I must therefore examine whether there was an error of law, regard to an irrelevant consideration, failure to consider a relevant consideration, procedural unfairness or unreasonableness.[12] Ordinarily, the assessments of facts and the overall merits of the decision to prohibit publication must otherwise be left to the discretion of the Coroner. [13]

Freedom of speech and open justice

[38] The review task is however made more complex in this case because the exercise of discretion under review impinges upon the right to impart information affirmed by s 14 of the NZBORA and the constitutional principle of open justice. There is no dispute that the rights affirmed by the NZBORA must be observed by Coroners, except as expressly permitted otherwise by the Coroners Act 2006.[14] Similarly, open justice is a fundament to our system of law and "any departure from

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12 See *Council of Civil Service Unions v Minister for the Civil* Service [1985] AC 374 (HL); *Peters v Davison* [1999] 2 NZLR 164 (CA) at 180.

13 *Rowley v Commissioner of Inland Revenue* [2011] NZSC 76; (2011) 25 NZTC 20-052.

14 cf *Brooker v Police* [2007] 3 NZLR 91 (SC); *Morse v Police* [2012] 2 NZLR 1 (SC).

that principle must depend not on judicial discretion but the demands of justice itself".[15]

[39] It has also been said that closer scrutiny will be given to exercise of statutory powers affecting fundamental rights.[16] I agree that the power to infringe a fundamental right affirmed by the NZBORA must be express, and any condition prerequisite to the exercise of that power must be established, and it is the function of this Court in the exercise of its supervisory jurisdiction to be satisfied that these conditions are substantively fulfilled.[17]

[40] I draw support for this approach from the frame set by Elias CJ in *Morse v Police*.[18] The Chief Justice observed, when dealing with the interpretation of s 4(1)(a) of the Summary Offences Act 1981:

> [12] The meaning of s 4(1)(a) is to be ascertained from its text and purpose (as s 5 of the Interpretation Act 1999 directs), and consistently with the rights and freedoms contained in the New Zealand Bill of Rights Act (as s 6 of that Act requires wherever an enactment can be given such a meaning).

[41] And further:

> [14] ... It is not, I think, proper discharge of the s 6 interpretative obligation to leave the New Zealand Bill of Rights Act protection to be balanced in application. Section 6 does not look to an ambulatory meaning of an enactment according to whether, on the facts of a particular case to which it is to be applied, it limits rights and freedoms. It requires the enactment itself to be given a meaning consistent with the rights, if it can. That is consistent with the purpose of the New Zealand Bill of Rights Act in promoting human rights. Leaving consideration of the New Zealand Bill of Rights Act to application of a provision capable of being interpreted consistently with the rights as expressed in Part 2 also risks dilution of rights, both in the at-large contextual balancing generally and in the inevitable value judgments about the particular exercise of the right. This may be destructive of the s 14 protection of "the freedom to seek, receive, and impart information and opinions *of any kind in any form*".

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15 *Broadcasting Corporation of New Zealand v Attorney-General* [1982] 1 NZLR 120 at 123.

16 For example: Baragwanath J in *Ding v Minister of Immigration* HC Auckland CIV 2005-404-4900, 21 August 2006; See also Philip Joseph *Constitutional and Administrative Law in New Zealand* (3rd ed, Brookers, Wellington, 2007) at 932-933.

17 cf *McGrath v Accident Compensation Corporation* [2011] NZSC 77 at [31].

18 *Morse v Police* [2012] 2 NZLR 1 (SC), with whom Tipping J appeared to broadly agree: [73].

[42] The balancing approach of McGrath J in the same case nevertheless also resonates here:

> [106] It must be borne in mind that under s 5 of the Bill of Rights Act, all rights and freedoms may be made subject to such reasonable limits prescribed by law as can be justified in a free and democratic society. In order to be such a limit on freedom of expression, proscribed offensive behaviour must be confined to sufficiently serious and reprehensible interferences with rights of others. Such conduct is objectively intolerable. The court's analysis must assess the impact of the exercise of the right in the circumstances, as well as the importance of other interests affected. Consideration must also be given to whether there are other methods of addressing the conflict with free speech rights than the offence provision in question or its ordinary meaning.
>
> [107] To this end, a balancing of the conflicting interests must be undertaken by the court as a basis for reaching a reasoned conclusion on whether the summary offence of offensive behaviour is a justified limitation on freedom of speech.

[43] In my view, therefore, the proper observance of freedom of expression (and open justice) demands a three step threshold enquiry. First, there must be express statutory authority to suppress. Second, the authority must be, where possible, interpreted and exercised consistently with freedom of expression. And third, even where those two qualifying conditions exist, any discretionary infringement of that freedom must be justified.[19] The failure to undertake any of these three steps will make the decision to suppress amenable to review.[20]

Coroners Act 2006

Relevant sections

[44] The discretionary power to prohibit publication is set out at s 74, namely:

> **74 Coroner may prohibit making public of evidence given at any part of inquiry proceedings**
>
> If satisfied that it is in the interests of justice, decency, public order, or personal privacy to do so, a coroner may prohibit the making public of-

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19 Consider *Morse v Police* [2012] 2 NZLR 1 (SC) at [14]-[17], [64], [72], [105] and [107]. See also *Brooker v Police* [2007] 3 NZLR 91 (SC) at [59].

20 cf *McGrath v Accident Compensation Corporation* [2011] NZSC 77.

(a) any evidence given or submissions made at or for the purposes of any part of the proceedings of an inquiry (for example, at an inquest); and

(b) the name, and any name or particulars likely to lead to the identification, of any witness or witnesses.

[45] The scope and content of this power is then informed by statutory purpose, function and context.[21]

[46] Section 3 specifies that:

3 Purpose of this Act

(1) The purpose of this Act is to help to prevent deaths and to promote justice through-

(a) investigations, and the identification of the causes and circumstances, of sudden or unexplained deaths, or deaths in special circumstances; and

(b) the making of specified recommendations or comments (as defined in section 9) that, if drawn to public attention, may reduce the chances of the occurrence of other deaths in circumstances similar to those in which those deaths occurred.

...

[47] In terms of the Coroner's role, the following subsections are particularly relevant to the present case:

4 Coroner's role

(1) A coroner's role in relation to a death is-

...

(d) to decide whether to open an inquiry (and, if one is to be conducted, whether an inquest should be held); and

(e) if an inquiry is to be opened and conducted,-

(i) to open and conduct it for the 3 purposes stated in subsection (2) (and in section 57), and not to determine civil, criminal, or disciplinary liability; and

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[21] *Greenpeace New Zealand Inc v Genesis Power Ltd* [2008] NZSC 112 at [51].

(ii) to determine related matters such as whether to prohibit the making public of evidence and whether to authorise the making public of certain particulars of deaths suspected or found to be self-inflicted deaths; and

(iii) on completing it, to complete and sign a certificate of findings in relation to the death; and

...

[48] The purposes of inquiries are set out at s 57 in the following terms:

57 Purposes of inquiries

(1) A coroner opens and conducts an inquiry (including any related inquest) for the 3 purposes stated in this section, and not to determine civil, criminal, or disciplinary liability.

(2) The first purpose is to establish, so far as possible,—

(a) that a person has died; and

(b) the person's identity; and

(c) when and where the person died; and

(d) the causes of the death; and

(e) the circumstances of the death.

...

[49] Pursuant to s 57(3) the Coroner is empowered to make specific recommendations that in his opinion, "may, if drawn to public attention, reduce the chances of the occurrence of other deaths in circumstances similar to those in which the death occurred".

[50] Taken together, the Act expresses the strong public interest in unveiling the circumstances of death, for the purposes of preventing or reducing the chances of death and promoting justice. This is supported by the public nature of inquests affirmed by s 85:

85 Inquests usually to be public

(1) Every inquest must be held in a place that is open to the public.

...

[51] This section is expressly "subject to sections 74, 86, and 87".[22] The phraseology of "subject to" might suggest that a Coroner's powers under those sections are not so much an exception to, but supersede s 85. But given the clear policy of the Act to inform the public of the circumstances of death, I prefer to approach ss 74, 86 and 87 on the basis they are exceptions to the rule.[23]

[52] Further interpretative context is provided by s 58. This section provides that the Coroner may make adverse comments. But before doing so he must: indicate an intention to do so; adjourn the inquiry for at least five working days; notify every member of the person's immediate family who during the adjournment requests the Coroner to do so of the proposed comment; and give such member a reasonable opportunity to be heard in relation to the proposed comment.

[53] The Act also contemplates a procedure if a person is charged with an offence. In such circumstances a Coroner may postpone opening of an inquiry into the death, or open an inquiry and then adjourn it, or adjourn the inquiry already opened into the death.[24]

[54] Section 68(3) then states:

> **68 Procedure if person charged with offence**
>
> ...
>
> (3) A coroner who has under subsection (2) postponed or adjourned an inquiry must not open or proceed with it until criminal proceedings against the person have been finally concluded (as defined in subsection (6)).
>
> ...

[55] Criminal proceedings are finally concluded if no appeal can be made in the course of the proceedings unless the High Court, Court of Appeal or Supreme Court grants an extension of time.[25]

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22 s 85(2).

23 ss 86 and 87 are not germane to this case.

24 s 68(2).

25 s 68(6).

[56] All of this suggests that it is not the function or role of the Coroner to pass judgment on persons associated with the circumstances of death, and some care must be taken by the Coroner to avoid criticism of them. The Coroner therefore has a markedly different role from a Judge in ordinary civil or criminal proceedings, as Heath J observed in *Fardell*.[26]

[57] Coming full circle, under s 74 a Coroner has express but limited jurisdiction to prohibit publication. The Coroner must be satisfied that prohibition is in the interests of justice, decency, public order or personal privacy. These matters are not statutorily defined. Nevertheless satisfaction of those matters by themselves or in combination is a condition of the exercise of any power under s 74. If those conditions do not exist then there is no power to prohibit. Indeed, unlike the medical disciplinary context, there is no general power to prohibit publication in circumstances where it is desirable to do so.[27]

[58] Furthermore, I can see nothing in either the language used in s 74, or the scheme or purpose of the Act that would obviate the duty on the Coroner to observe the affirmed right to impart information and/or the principle of open justice, unless suppression is demonstrably justified in terms of the listed grounds and on those grounds only. Nor is it sufficient to simply identify a basis for suppression under s 74. It must represent an authorised and justified limitation of a fundamental right. This approach to s 74 is, in my view, concordant both with the general purposes of the Act, to help prevent deaths and to promote justice, and also with the specific function of the Coroner in this case, namely to make recommendations which may, if drawn to the public attention, reduce the chances of other deaths.

An error about public order

[59] The Coroner's decision states at [105]:

> [105] I am satisfied in the interests of justice, decency, personal privacy and *with an emphasis on public order* there should be a permanent order

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[26] *Fardell v Attorney-General* [2007] NZAR 122 (HC).

[27] cf Powers of a Disciplinary Tribunal under the Medical Practitioners Act 1995 (now replaced by the Health Practitioners Competence Assurance Act 2003, s 95).

made.
(Emphasis added)

[60] Mr Illingworth said the conclusion reached by the Coroner on public order was illogical and without a proper evidential basis. Ms Adams says that the emphasis on public order was a slip. I do not think that either proposition is a fair characterisation of the Coroner's decision. The Coroner did not define what he meant by public order, but it has been said, I think correctly, to mean "an orderly state of affairs in which people can pursue their normal occupations of life."[28] An efficient and effective health system is, in my view, an aspect of public order or public affairs. Publication of names and unfair media attention may deter health professionals from participation in the health system. They were findings logically available to the Coroner. Nevertheless, I am unable to accept that the general deterrence effect identified is the type of public order impact contemplated by Parliament that might lawfully justify breach of freedom of speech or open justice.

[61] The speech prohibited by the Coroner from publication is the identification of names of affected health professionals without disproportionate criticism of them (if any). The non critical nature of the speech properly reflects the statutory role of the Coroner. I accept that publication of names might be very distressing to those named, especially when combined with wide media coverage of an inherently sensitive subject matter. But a concern or fear held by other health professionals about being named cannot by itself provide a justifiable basis for limiting freedom of speech. More specifically, to the extent that this fear deters participation in the health system by health professionals, it reflects an unreasonable intolerance to free speech that could not possibly have been contemplated by Parliament as a relevant impact on "public order". The position might be different had the speech involved heavy and disputed criticism, or breach of privacy or confidence. But a generalised fear about being named is not a sufficient condition under this head. The Coroner therefore erred when he placed emphasis on this deterrence effect.[29]

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[28] Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (LexisNexis, Wellington, 2005) at 476.

[29] While not directly analogous, the Supreme Court in *Morse v Police* [2012] 2 NZLR 1 examined the threshold test when dealing with allegedly offensive behaviour said to cause public disorder contrary to s 4(1)(a) of the Summary Offences Act 1981. The Court had to determine whether

[62] Notwithstanding this error, Ms Adams properly highlighted that the Coroner's decision must be read as a whole, including the emphasis on the interests of justice and personal privacy. I agree that it must be read in this way. The Coroner's decision carefully links these grounds before concluding that prohibition is appropriate. I therefore turn to examine these aspects of the Coroner's decision in light of the criticisms voiced by the plaintiff.

Interests of justice

[63] The Coroner did not specify the interests of justice affected by publication. However I think it is reasonable to infer that he considered that the potential for unfair media criticism of the affected health professionals triggered interests of justice, as publication infringed both their privacy and reputational interests without obvious remedy. I will proceed on that basis.

[64] I do not accept the plaintiff's contention that the reference to "interests of justice" is solely concerned with the "administration of justice" in the narrow sense of protecting fair trial rights. Plainly fair trials are one very important aspect of the "interests of justice". Nevertheless justice by definition encompasses "the administration of law or equity."[30] In modern parlance, this includes judicial vindication of all justiciable rights, interests and legitimate expectations.[31] Health professionals plainly have legitimate, justiciable and actionable interests in protecting their privacy[32] and reputation.[33] Coroners may therefore weigh them in the mix under s 74 when considering interests of justice. The value attached to those

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flag burning at an ANZAC ceremony was offensive behaviour productive of public disorder. Blanchard J observed at [64] that the proposed action must generate an intolerable level of angst in a reasonable person, affected by the action. Such a reasonable person must be a person who takes a rights sensitive view. Tipping J at [71] similarly said that the effect of the action must be such that it would substantially inhibit the behaviour of those affected persons who are appropriately tolerant of the rights of others. All of this emphasises that there must be a strong objective basis for filtering freedom of expression.

30 *The New Shorter Oxford English Dictionary* (Clarendon Press, Oxford, 1993) vol 1 at 1466.

31 Consider for example the breadth of standing under the Judicature Amendment Act 1972, where it is now orthodox that a statutory power of decision amenable to review includes decisions that affect legitimate expectations that would not otherwise be justiciable.

32 Refer Privacy Act 1993; *Hosking v Runting* [2005] 1 NZLR 1 (CA).

33 Refer *Surrey v Speedy* (1999) 13 PRNZ 397 (HC).

interests is, of course, a matter for the Coroner having regard to all of the circumstances of the case, and is to be weighed against conflicting rights and interests.

[65] I will address privacy considerations when I consider personal privacy. But I do not accept that interests of justice are engaged as a matter of law based on alleged reputational impacts.[34] In the present case, the Coroner's primary concern was that the affected health professionals could be unfairly criticised by others. This concern is strongly voiced in the affidavits of the affected health professionals. I do not doubt the genuineness of these concerns. But the speech subject to prohibition does not, objectively assessed, unfairly impugn the character or reputation of the affected health professionals or otherwise prejudice them in any actionable sense. Indeed the emphasis on systemic failure both in the primary findings[35] and in the prohibition decision[36] strongly mitigates any adverse reputational impact arising out of the narrative of the facts.

[66] This is to be strongly contrasted to the facts in *Ryan v Auckland District Health Board*,[37] where the pleadings included allegations that instruments were not properly sterilised and that failure to diagnose a patient as suffering from Creutzfeldt-Jakob disease resulted from the negligence of a defendant. The matter was discontinued, but the issue of suppression remained to be resolved. The Court in granting suppression was mindful of the harm to reputation caused by the allegations themselves and associated media interest.

[67] Ms Adams also referred to *Newton v Coroner's Court*.[38] In *Newton* the High Court suppressed evidence to prevent unfair publicity flowing from questions posed on an irrelevant issue. There was no opposition to the suppression application. Heath J observed that the "questions asked impinged the rule against attributing blame". In addition Dr Newton had no advance warning that the questions would be

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34 cf *Stubbs v The Health and Disability Commissioner* HC Wellington CIV 2009-485-2146, 3 March 2010.

35 See [110], [134], [169].

36 See [93], [99].

37 *Ryan v Auckland District Health Board* HC Auckland CIV 2007-404-006177, 5 December 2008.

38 *Newton v Coroner's Court* [2005] NZAR 118 (HC) at [25].

asked. The unfairness therefore arose not from the publication per se, but from the combination of the irrelevant questions, attribution of blame and procedural irregularity. The facts therefore of that case are somewhat removed from the present.

[68] The remaining latent potential for unfair media criticism is simply too opaque a basis to derogate from freedom of speech on interest of justice grounds. Quite the reverse; in a context where the Coroner's findings do not unfairly impugn any of the health professionals, interests of justice favour affirming freedom of expression.

[69] Accordingly, subject to what I have to say about personal privacy, the potential for unfair criticism does not by itself invoke interests of justice.

Personal privacy

[70] The concept of personal privacy is not defined in the Coroners Act 2006, but I think it is logical to assume that Parliament would seek to maintain consistency with extant privacy law in terms of what is meant by "personal", "privacy" and the relationship of those concepts to freedom of speech, open justice and public interest considerations. "Personal information" is defined in the Privacy Act 1993 as "information about an identifiable individual."[39] It is not limited to sensitive or private information.[40] The use and dissemination of this information is then subject to specified privacy principles under the Privacy Act, including (in short) protection from dissemination without consent unless it is necessary in the public interest.[41]

[71] Recognition of privacy interests is also gaining momentum under the auspices of s 21 of the NZBORA – the right to be secure against unreasonable search and seizure.[42] Overlaying this, the scope of "personal privacy" as a ground for suppression must be interpreted consistently with, as far as possible, the right to free

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39 Privacy Act 1993, s 2; cf Official Information Act 1982, s 2, which defines "personal information" as "any official information held about an identifiable person".

40 Stephen Penk "The Privacy Act 1993" in Stephen Penk and Rosemary Tobin (eds) *Privacy Law in New Zealand* (Brookers, Wellington, 2010) 49 at [3.5.1].

41 Privacy Act 1993, Principle 11, s 6; see also Broadcasting Standards Authority Privacy Principle 8, issued under Broadcasting Act 1989, s 21(1)(f); Privacy Act 1993, ss 28, 43, 44, 54, 95, 98; New Zealand Bill of Rights Act 1990, s 5; Evidence Act 2006, s 30.

42 *R v Williams* [2007] NZCA 52; cf *Lange v Atkinson* [2000] 3 NZLR 385 (CA) at 396.

speech and the principle of open justice.[43] It cannot be right that the potential dissemination of any personal information triggers the power to suppress. Rather, an evident theme throughout the various authorities dealing with protection of privacy is that there must be facts in respect of which there is a reasonable expectation of privacy.[44] Further, there are various gradations of privacy expectations, with the greatest protection afforded to intimate activity, space or affairs.[45] Even where the facts are particularly intimate, a genuine public interest in those facts may nevertheless demand publication.[46] Illustrative of the application of privacy values, minor interference that does not cause harm will not attract a remedy under the auspices of privacy legislation.[47]

[72] In light of this general frame, I am of the view that personal privacy in this context refers to personal facts in respect of which there is a reasonable expectation of privacy. A general claim to privacy will not be sufficient; but the more intimate the facts, the more compelling the case will be for limits to be placed on freedom of speech and open justice principles. Balanced against this, a genuine public interest or concern in those facts may outweigh even a strong privacy interest. In the final analysis, a Coroner must be satisfied that the infringement of freedom of speech and open justice is justified on personal privacy grounds.

[73] Turning then to the personal privacy claim in this case. The Coroner refers to, but does not explain, what aspects of personal privacy are affected by publication. The ADHB however says that the work place of health professionals is a private sphere and performance of their duties is personal information, over which they have a reasonable expectation of privacy. Ms Adams cited observations of the Ombudsman dealing with the privacy entitlements and rights of public officials. Those decisions are helpful because they provide insight into the balancing of public interest and privacy considerations. As Ms Adams says, performance of employment

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43 *Brooker v Police* [2007] 3 NZLR 91 (SC).

44 *Hosking v Runting* [2005] 1 NZLR 1 (CA); *Hamed v R* [2011] NZSC 101.

45 *R v Williams* [2007] NZCA 52.

46 *Hosking v Runting* [2005] 1 NZLR (CA) at [134].

47 Stephen Penk "The Privacy Act 1993" in Stephen Penk and Rosemary Tobin (eds) *Privacy Law in New Zealand* (Brookers, Wellington, 2010) at [3.5.5].

duties by public officials is personal information not automatically available for public consideration, unless there is a genuine and legitimate public interest in that performance.[48] This logically applies to health professionals who must maintain, among other things, the confidence of their patients.

[74] The plaintiff contends that health professionals work in the public domain and cannot reasonably expect that their names and work performance will remain private. Mr Illingworth referred to the leading privacy case, *Hosking v Runting*.[49] In that case, shopping in Newmarket did not attract a reasonable expectation of privacy. It is not factually analogous. I think it preferable to approach the question of personal privacy with a finer grain examination of the facts in this case.

[75] Hospitals are by dint of their function, public places. But the medical treatment of patients is a deeply personal matter for the patient, attracting a high expectation of privacy. There is also a reasonable expectation that employers will keep private information about the performance of health professionals, and indeed such personal information is subject to Privacy Act principles. Accordingly, to the extent that the relevant work place information is not already in the public domain, it is a matter of personal privacy.[50]

[76] A feature of the present case is that the information contained in the Coroner's report is the product of an authorised intrusion into the personal privacy of affected health professionals and unveils personal information about the involvement of the relevant professionals in Zachary's care. It includes information that might not otherwise be readily available to the public or to the patient. It is the combination of this material and the identification of the health professionals that is most concerning to them. I am satisfied that to the extent that revealing the names of the health professionals exposes facts about their professional conduct, not otherwise in the public domain, then prohibition of the publication of those identifiers may be justified on personal privacy grounds.

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48 Case Notes W40876, Office of the Ombudsman, 12th Compendium, 2001, at 103; and Case Notes C7668, Office of the Ombudsman, 14th Compendium 2007, at 104-106.

49 *Hosking v Runting* [2005] 1 NZLR 1 (CA).

50 Consider also the approach taken in *Andrews v Television New Zealand Ltd* [2009] 1 NZLR 220 at [65].

[77] I am also mindful that the Coroner identified that the cause of death was systemic failure to recognise meningococcal disease and treat it appropriately and in a timely fashion, and that it is the system and not the individuals that require attention. This suggests that any ongoing public interest should relate to the system not the individuals, and the apparent utility in naming the individual health professionals is small.

[78] Against those observations, the privacy interest sought to be protected is not, in my view, in the highest category. Health professionals, like other professionals, must expect that their conduct may be assessed by disciplinary or other regulatory bodies and may be subject to public scrutiny from time to time. As noted by Mr McClelland there is a general presumption that health professionals subject to disciplinary proceedings will be named.[51] Furthermore, some of the work related information cannot be characterised as intimate, as it will likely be known in part at least to patients and/or to colleagues.[52]

[79] In this regard, I have found the recent opinion of Ombudsman, David McGee, helpful in understanding the approach taken to privacy values and health professionals under the auspices of the Official Information Act 1982. He was responding to a request for the names of PHARMAC staff involved in allocation of funds.[53] I am not concerned with the detailed features of the facts in that case. Indeed, as Ms Adams noted,[54] this decision dealt with policy making, rather than frontline primary health care. Nevertheless the Ombudsman observed:

> 17. ... The names of officials should, in principle, be made available when requested. All such information normally discloses is the fact of an individual's employment and what they are doing in that role.

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51 Though some care is needed as the threshold test is different: *ABC v Complaints Assessment Committee* [2012] NZHC 1901.

52 cf *Stubbs v The Health and Disability Commissioner* HC Wellington CIV 2009-485-2146, 3 March 2010.

53 Ombudsman's opinion under the Official Information Act, reference 230402, 14 December 2012.

54 The decision postdated the hearing but counsel helpfully filed submissions dealing with the decision.

> Anonymity may be justified if a real likelihood of harm can be identified but it is normally reserved for special circumstances such as where safety concerns arise.
>
> ...

[80] Returning then to the key question: is suppression of the names of the health professionals justified on personal privacy grounds? I am unable to agree with Ms Adams that the work place information unveiled by the Coroner is sufficiently private to outweigh the value that attaches to free speech. While I yield to the Coroner's assessment of the general public interest in the specific information sought to be disclosed, the inherent value of freedom of speech must also be carefully weighed. It is also about the importance of enabling ongoing public debate on a matter of legitimate and genuine concern to a parent of the deceased.

[81] For completeness, I am not suggesting that work place privacy cannot provide a basis for suppression on personal privacy grounds. But there must be some aspect of that information that justifies suppression; for example, personal details or work place criticism altogether unrelated to the matters before the Coroner that if revealed could cause embarrassment to the affected person. A real prospect of improper pressure or harassment might also qualify as a legitimate reason to prohibit publication. But a general fear of criticism does not meet the necessary threshold.

Overall assessment of decision

[82] The Coroner raises legitimate matters of concern. But the Coroner's reasons for suppression are too generalised, illustrated by the lack of definition given to what was meant by interests of justice, public order and personal privacy. As the Coroner's decision in *Re Urlich*[55] illustrates, suppression is not a matter that can be approached in a broad brush way. The relevant factors weighing for and against publication must be assessed on a fine grained basis, so that there is surety that the statutory grounds for suppression are present, and that the principles applicable have been applied appropriately and the proper balancing exercise undertaken. Bearing in

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55 *Re Urlich* (Reserved Findings of the Coroner, Coroner's Court at Auckland, Decision 90/10, 28 July 2010).

mind that the right to impart information is a fundamental right affirmed by statute, the Coroner was required to clearly state how the considerations stated at s 74 apply and then justify the impairment of that right by specific reference to the relevant statutory grounds, properly defined. In short, the Coroner had to demonstrate through his reasons why he was satisfied that the interests of justice and/or matters of personal privacy outweigh principles of open justice and freedom of expression in each case. For the reasons already given, I do not consider that the Coroner correctly engaged in this exercise.

Result

[83] The Coroner erred in law. On the information available to me, none of the statutory grounds for prohibition under s 74 are triggered. In my view also, had any of the qualifying conditions been present, they did not justify by themselves or in combination, derogation of the right to impart information.

[84] But in terms of relief, my preference would have been to refer this matter back to the Coroner for reconsideration in light of my judgment. Plainly Parliament contemplated that the Coroner would undertake the careful weighing exercise against the full backdrop of fact. However none of the parties sought that course, and it appears from s 75 that a one step review process is contemplated.

[85] In terms of Dr Black, I am not persuaded that suppression is justified on the basis that as he has passed away, he has no remedy available to him. As I have said, the Coroner's report does not by itself criticise any of the health professionals and I am not satisfied that suppression is justified on interests of justice grounds. Any potential criticism arising might or might not give rise to a justiciable claim and remedy. But that is speculation on both counts. That being the case, it would be unfair to the other health professionals and to their families to afford a cloak of protection to Dr Black's family, but not to them. Furthermore, while Dr Black's family raise a legitimate matter of concern to them, I consider that any unfairness arising to them is outweighed by the value attached to freedom of speech.

[86] I am mindful that this course will cause real angst to the affected health professionals. I hope that they can take solace from the fact that, in my view, there is no finding by the Coroner that would remotely warrant negative publicity about them. Quite the opposite, the Coroner found: "it is the system not the individuals that require the attention."

[87] Accordingly, there shall be an order revoking the prohibition on publication. However, that order shall lie in this Court for ten working days to afford counsel the opportunity to:

(a) Signal whether an appeal is contemplated; and/or

(b) Identify any specific information which might be properly suppressed; and/or

(c) Recommend any conditions that might attach to my order.

[88] If an appeal is to be lodged, or specific request made, I will consider whether any further interim order for suppression is required.

Permanent Suppression

[89] By consent, there shall be an order that the name of [redacted] ("Dr R") and any identifying particulars shall be suppressed. In this judgment [redacted] name has been anonymised save in relation to this paragraph. Publishers will need to remove [redacted] name from this paragraph prior to publication.

Costs

[90] My preliminary view is that costs should follow the event in the ordinary way, though Dr Black's case largely (and appropriately) followed the ADHB. However, this case has raised a matter of public importance. Accordingly, if counsel cannot agree on costs then leave is granted to file submissions.

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