Options for implementing reporting of firearm injuries to New Zealand Police by health professionals

Discussion Paper

22 March 2022

This discussion paper seeks input into mandatory reporting by health professionals of firearm injuries in New Zealand, and includes:

- An overview of the current situation and available data
- Proposed options for reporting
- Implementation information

NEW ZEALAND POLICE
Ngā Pirihimana o Aotearoa

MINISTRY OF HEALTH
MANATŪ HAUORA

Contents

Part 1: Introduction

1.1 Purpose of this discussion paper

New Zealand Police Ngā Pirihimana o Aotearoa (Police) is seeking your views on options for reporting of firearm injuries to Police by health professionals.

In New Zealand it is not mandatory for health professionals to report to Police if an individual presents with an injury caused by a firearm. This means important information may not come to the attention of Police. Such information may indicate a person is not fit and proper to have access to firearms, or that a person has been involved in a crime. Police is therefore not always able to assess the level of ongoing risk to the individual and the public, and to take action accordingly.

The Royal Commission of Inquiry into the terrorist attacks on Christchurch masjidain (RCOI) recommended the Government introduce mandatory reporting of firearms injuries to Police by health professionals.

The Government agreed in principle, noting more work is required to establish how best to achieve this recommendation.

Police and the Ministry of Health Manatū Hauora (Ministry of Health) want your feedback on how best to implement the intent of this recommendation.

1.2 How this discussion paper is organised

This discussion paper starts with an introduction to the topic (Part 1), followed by the current context (Part 2), which seeks your feedback on the existing reporting framework for health professionals and what we know about firearms injuries. The purpose of any changes, and the proposed options are then canvassed in Part 3. This Part seeks your feedback on proposed options for change. The options contain varying degrees of legal requirements. Part 3 of the discussion paper also seeks feedback on which groups of health professionals should be subject to any requirements. Part 4 covers off some of the implementation issues. We are keen to understand the impact of any proposed changes on health professionals.

Part 5 contains a summary of consultation questions, and in Part 6 you will find the consultation submission form.

1.3 How to have your say

The closing date for submissions is Friday 6 May 2022.

We encourage you to give your views on the questions set out in this discussion paper, and to provide any other comments you may have about the matters discussed.

Some questions may not apply to you. You do not have to answer all the questions.

To assist you with your response, a submission form accompanies this discussion paper. We recommend you read the discussion paper in full before completing the submission form. You do not have to use this form to make a submission.

Please include your name, contact details, and organisation (if you are making a submission on behalf of your organisation) and field of work in your submission.

You can submit by:

- Sending your submission to consultation@police.govt.nz
- Posting your submission to Firearms Policy Team, Level 13, New Zealand Police National Headquarters, 180 Molesworth Street, Thorndon, Wellington, 6011
- Using the online submission form, located **here**

1.4 Privacy

Your feedback may be made available by Police and the Ministry of Health to members of the public who request copies of submissions. Please indicate clearly if your identity or comments are provided in confidence, or if there is some other reason they should not be disclosed.

Any request for non-disclosure will be considered in terms of the Official Information Act 1982. Your feedback may be edited for publication to anonymise it or remove sensitive information.

1.5 Next steps

Your feedback and responses to the questions in this paper are an important part of informing further development on options for change. Police and the Ministry of Health will consider the results of this engagement before providing advice to Government. This will inform whether legislative change is required and, if so, there will be a further opportunity to provide submissions at the Select Committee stage of the legislation.

Part 2: Context

2.1 Background to the proposals

The report of the RCOI recommended the Government introduce mandatory reporting of firearm injuries to Police by health professionals.

The RCOI's report stated that a firearm injury may say something about the fitness of a person to hold a firearms licence, particularly if there is a history of similar incidents. The RCOI report also noted that without a reporting requirement or practice, this important information will often not come to the attention of Police.

The RCOI report identified that the individual responsible for the terrorist attacks on Christchurch masjidain sought health advice after injuring himself with a firearm in the period leading up to the attacks. This injury was not reported to Police. The situation demonstrated that, at present, an accidental firearm injury involving a firearms licence holder is unlikely to meet the current threshold for disclosure by health practitioners in the Health Information Privacy Code 2020 (the HIPC Code). The HIPC Code enables disclosure of health information where it is necessary to prevent or lessen a serious threat to public safety or the life or health of an individual.

In December 2020, the Government agreed in principle to this recommendation, noting that further work was required to establish how best to achieve it.

2.2 Current framework for reporting firearm injuries

A firearm injury results from either a criminal act or inappropriate use, storage, carriage, or maintenance of a firearm. The injury may be intentional or accidental, and caused by someone illegally possessing the firearm or airgun or by a firearms licence holder. The injury may also be caused in various ways, such as through the discharge of a firearm or a blunt force injury. All of these situations may pose an ongoing risk to public safety or the safety of the individual.

The RCOI report does not define what a 'firearm injury' is. We seek your views on whether the definition should be limited to an injury caused by the discharge of a firearm[1] or airgun,[2] or cover any injury caused by a firearm (such as a blunt force injury).

Currently, when a health professional is aware that a person presenting to them has been injured by a firearm, they are not required to report it to Police. Any reports they may make

[1] Under the Arms Act 1983, a firearm means anything from which any shot, bullet, missile, or other projectile can be discharged by force of explosive and, by virtue of this definition, a firearm includes pistols, restricted weapons and any specially dangerous airguns. A full definition of a firearm is provided in section 2 of the Arms Act 1983.

[2] An airgun includes any air rifle, any air pistol, and any weapon from which, by the use of gas or compressed air (and not by force of explosive), any shot, bullet, missile, or other projectile can be discharged.

to Police are therefore done on a voluntary basis and must comply with the legal provisions regarding disclosure of personal health information.

Existing provisions enable disclosure of personal health information to Police in certain circumstances, although these do not specifically cover reporting of accidental firearm injuries. Existing provisions include:

- Rule 11(2)(d) of the Health Information Privacy Code 2020 (HIPC Code) enables disclosure of health information where it is necessary to prevent or lessen a serious threat to public safety or the life or health of an individual. Rule 11(2)(j)(i) HIPC Code enables disclosure where it is necessary to avoid prejudice to the maintenance of the law by any public sector agency, including prejudice to the prevention, detection, investigation, prosecution, and punishment of offences.

- Section 22C of the Health Act 1956 enables health practitioners to disclose health information for certain purposes, including to any constable for the purposes of exercising or performing their duties or functions.

- As of 24 December 2020, section 92 of the Arms Act 1983 requires that health practitioners 'must consider' reporting to Police if they believe a firearms licence holder should be limited or prohibited from using a firearm due to a physical or mental health condition.

  A key objective of the Arms Act 1983 is to deliver on the safe use and control of firearms. Section 92 does not include incidents related to non-licence holders, nor is it mandatory. It also requires the health practitioner to know or reasonably believe that their patient is a licence holder, and is focused on the relevance of the health condition on their patient's fitness to hold a licence rather than on any wider concerns arising from a firearm injury.

- Section 58 of the Arms Act 1983 requires every person who has caused bodily injury to or the death of any person using a firearm or airgun to report the incident in person to Police. Failure to report to Police is an offence for which there is a penalty of up to three months' imprisonment or a fine of up to $1000.

We are seeking your views on whether you think the current legislative framework, as outlined above, is sufficient or whether additional measures need to be taken to enable the reporting of important information to Police.

2.2.1 What are other countries doing?

The United Kingdom and States across Australia, Canada and the United States have mechanisms for reporting firearm injuries ranging from voluntary reporting to mandatory reporting.

There is no current consensus on the most effective way to implement reporting of firearm injuries, although there is evidence that effective reporting must be well supported by

guidance material, awareness of obligations and pathways for reporting, and easy-to-use reporting mechanisms. Both voluntary and mandatory reporting regimes are enabled differently by different jurisdictions. Some have introduced mandatory reporting through Memoranda of Understanding rather than legislation, and others support voluntary reporting through greater protection for health professionals from legal action being taken against them in legislation. Below are two examples.

An example of mandatory reporting
Under British Columbia's Gunshot and Stab Wound Disclosure Act 2010, a health care facility or emergency medical assistant who treats a person for a gunshot wound must report to police the injured person's name, the fact they are being treated for a gunshot and details of the facility and medical assistant that treated them.

An example of voluntary reporting
Under Western Australia's Firearms Act 1973, if a health professional believes a person presenting has an injury inflicted by a firearm or ammunition, nothing prevents them in good faith from informing the Commissioner of Police. A health professional acting in good faith is protected from any criminal or civil action.

We are seeking your input on the definition of 'firearm injury' and your feedback on the current legislative framework.

What do you think?
1. Do you think that a 'firearm injury' should be defined as an injury expected to have been caused by the discharge of a firearm or airgun, or more broadly as any injury expected to have been caused by a firearm or airgun, for example including blunt force injury? Please explain. 2. Are there any adverse impacts or unintended consequences that could result from your preferred approach to the definition? 3. Are you familiar with the information disclosure provisions set out in section 2.2 above, and do you think they are sufficient to enable sharing relevant firearms injury information with Police? Please explain.

2.3 Available data on firearm injuries in New Zealand

We do not currently have a complete data picture to help us understand how often firearm injuries occur in New Zealand. Police receives data on firearm injuries from three main sources - hospitals, the Accident Compensation Corporation (ACC) and Police's own records.

The number of publicly funded hospital discharges coded with a first cause of 'injury by firearm' remained relatively constant from 2013 to 2018, with an average of 154

hospitalisations per year. Of these injuries, 50% were accidental, 24% were assault, 12% were intentional self-harm and 12% were from an undetermined intent.[3] This information is likely to be an undercount, as it only captures firearm incidents resulting in more than a three-hour hospital visit. It also includes duplicates from re-admissions.

Data from ACC have also remained consistent, with an average of 260 new claims involving reference to firearms over the ten-year period 2010/11 to 2019/20. These data are not a comprehensive picture, as it only captures incidents with an ACC claim and there are likely to be some duplicate incidents. However, ACC data are likely more indicative of the extent of firearm injuries than District Health Board (DHB) data as they also capture incidents that do not require hospitalisations (for example, those treated by a General Practitioner).

For the injury reports it receives, Police does not record the number of firearm injuries specifically, but rather the number of incidents and offences that resulted in an injury where the weapon was a firearm (noting that this does not necessarily mean the injury was caused by the firing of the firearm). One 'occurrence' (for example, a single instance of homicide) may result in many offences (for example, if there were multiple victims, offenders, or multiple different offences within the same occurrence). Some offences within each occurrence could result in an injury, while others do not.

Between 1 January 2019 and 20 June 2021, there were 769 occurrences where an injury was recorded, and the weapon was a firearm. Of course, not all firearms injuries are reported to Police.

We are seeking your views on the data sources available as well as how your workplace or organisation records or collates any information relating to firearm injuries. We are also interested in whether you think there are any benefits of having a better knowledge base of firearm injuries.

What do you think?
4. Are you aware of any additional information sources or data on firearm injuries in New Zealand? If so, what are these sources? 5. Does your workplace/organisation treat firearm injuries? If so, what data are recorded or collated on these injuries? 6. In your opinion, what are the potential benefits of knowing how often firearms injuries occur?

[3] Data extracted from the National Minimum Dataset (NMDS). NMDS events containing a clinical code related to firearm usage/discharge**.** Data extracted on 10 June 2020. https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/publicly-funded-hospital-discharges-series/publicly-funded-hospital-discharges-series/publicly-funded-hospital-discharges-series

2.4 The current reporting of firearm injuries could work better

Police currently receives voluntary reports of firearm injuries via 111 emergency calls or 105 crime reporting line reports.

Police is most likely to receive reports of firearm injuries when they are involved in an emergency response, or when they are notified by hospitals, medical centres, General Practices, and other frontline staff who request Police assistance, such as ambulance paramedics. The data that are available suggest the majority of these reports involve injuries inflicted by or suffered by non-licence holders. However, firearm injuries are likely to be under-reported to Police.

Police is also aware of a small number of cases where licence holders themselves have reported near misses or unsafe discharges of a firearm. However, self-reporting to Police by individuals who have inflicted injuries by firearms is low.

The current reporting of firearm injuries means important information may not come to the attention of Police, which may indicate a person is not fit and proper to have access to firearms, or that a person has been involved in a crime. Police is therefore not always able to assess the level of ongoing risk to the individual and the public and to take action accordingly.

We are seeking further information from you relating to experiences you may have had reporting firearm injuries to Police, particularly when care is provided by multiple practitioners.

What do you think?
7. As a health practitioner, have you reported any firearm injuries to Police? If so, how did you report the injury/ies? (for example through your manager, or telephone or email to Police?) 8. In your experience as a health practitioner, when care is provided by multiple practitioners, how is a decision to report made, and who makes it? 9. If you are not a health practitioner, have you reported any firearms injuries to Police? If so, what was your experience?

2.5 Other forms of reporting in our health system

In general, laws and principles surrounding patient-client confidentiality prohibit the sharing of health information beyond this relationship. Core reasons for this include to:

- promote open and honest disclosure of information by patients to health practitioners; and

- avoid deterring people from seeking healthcare out of fear for undesired or unconsented consequences.

There are examples where this duty of confidentiality is superseded to enable or compel the sharing of information. In addition to provisions in the HIPC Code and the Health Act 1956 discussed at page 6 above, and the mandatory consideration required by the recent amendment to the Arms Act 1983, relevant reporting frameworks in New Zealand include:

- *Reports of intimate partner violence concerns in DHB settings are underpinned by a non-legislative framework between the Ministry of Health and Police.* Trialled in three DHBs and being rolled out nationally, reports of intimate partner violence to Police occur through a five tier 'graduated response' underpinned by effective interagency collaboration. This framework guides clinicians to complete a risk assessment, balance competing considerations, involve the patient's wishes if possible, and escalate concerns to Police in appropriate circumstances and ways. Reports of family violence in primary care settings are not legally mandatory but are enabled through the HIPC Code where it is necessary to prevent or lesson a serious threat to public safety or the life or health of an individual.

- *Informing Waka Kotahi - NZ Transport Agency of a patient's fitness to drive.* Section 18 of the Land Transport Act 1998 requires health practitioners to advise the Director-General of Health, who in practice then advises Waka Kohtahi, of any individual who poses a danger to public safety by continuing to drive when advised not to.

- *Health practitioners must consider certain factors and consult with another qualified health practitioner when providing an abortion after 20 weeks of gestation under the Abortion Legislation Act 2020.* Before providing an abortion, a qualified health practitioner is legally required to consider the person's physical and mental health and wellbeing, consider all relevant legal and professional standards, and consult with another qualified health practitioner. The requirement to consider these factors intends to guide and inform the health practitioner's reasoning and judgment.

- *Health professionals must notify their local Medical Officer of Health of a suspected or diagnosed notifiable disease.* Under the Health Act 1956 and the Tuberculosis Act 1948, health professionals are required to inform their local medical officer of certain notifiable diseases. The requirement acts as a safeguard to support a collective decision and path forward. The Institute of Environmental Science and Research may then be advised and can provide epidemiological information to the Ministry of Health, who will activate control measures as necessary.

We are seeking your input on experience you may have on reporting health information in other contexts, such as family violence or driver licensing.

What do you think?

10. As a health practitioner, what is your experience of reporting health information in other contexts, such as family violence or driver licensing?
    a. What kind of health information do you report?
    b. Who do you report this information to?
    c. Do you find this process easy or difficult?
    d. Do you know what happens with the data you report?
    e. Are you aware of any unintended consequences arising from reporting this information?

Part 3: Purpose of proposals

While treating a firearm injury, health professionals may come across important information about the cause, type, and severity of the injury as well as the patient's recollection of events.

Such an injury can be indicative of carelessness, incompetency and mishandling; reporting of such injuries may therefore be used by Police to consider (on its own or alongside other information Police holds or may discover) whether a licence holder should continue to retain that licence.[4] As is currently the case with reports of firearm injuries, the information reported by health professionals to Police may also be used for criminal investigation purposes and may be used for prosecution purposes among other evidence collected, recognising that many firearms injuries do not involve licence holders.

It is very likely that current reporting of firearm injuries to Police does not represent all instances of firearm injuries and that the legal and operational frameworks for reporting may not be widely known or applied consistently.

As noted in the Introduction of this paper, the intent of these proposals is to ensure relevant information comes to the attention of Police, where appropriate, to enable Police to investigate and determine any ongoing safety risk to the individual and the public and mitigate the potential for future harm.

There are also risks associated with reporting confidential information obtained through the provision of healthcare, which are being considered in tandem. These include the potential for reporting of injuries to deter people from seeking timely healthcare. However, Police notes that firearm injuries will often constitute an emergency and require healthcare to be sought either by the individual, or their friend or relative. There may also be a conflict with patient confidentiality potentially impacting trust and honesty, and the risk of an incursion on privacy. However, some of risks associated with reporting confidential information may be considered acceptable if public safety is improved.

3.1 Key outcomes

The Government agreed in principle to the RCOI's recommendation that there be mandatory reporting of firearm injuries to Police by health professionals, noting further policy work was required. To respond to the RCOI's recommendation, the key outcomes we are seeking from this work are to:

- Improve public safety by encouraging reports of injuries which may indicate a risk to the person and/or the public
- Reduce harm to the public and individuals by promoting safe possession and use of firearms

[4] Under section 24 and section 24A of the Arms Act 1983, a person must be deemed to be a fit and proper person to be in possession of a firearm before they are issued with a firearms licence. A person can take possession of a firearm without a licence if they are under the supervision of a licence holder. However a licence holder's licence can be revoked if access to their firearm is obtained by a person who is not fit and proper to be in possession of a firearm.

- Enable consistent reporting of firearm injuries by health practitioners and ensure health practitioners understand and fulfil any obligations
- Minimise trade-offs to public health objectives, such as deterring healthcare being sought and received
- Retain appropriate privacy and confidentiality
- Prevent inequity, prejudice and inconsistency in the application and outcomes of these proposals
- Provide Police with the information it needs to make decisions about a person's fitness to possess a firearm or hold a licence, and/or to enable investigation of circumstances in which the injury occurred and whether any legal action is required, and to assess the effectiveness of the Arms Act 1983 in reducing the illegal possession of firearms.

We are seeking your input on the benefits and risks of the sharing of information to Police. We are also seeking your feedback on the key outcomes, as outlined above.

What do you think?
11. What do you consider to be the key benefits of sharing a client's or patient's personal information about firearm injuries with Police? 12. What do you consider to be the key risks of sharing a client's or patient's personal information about firearm injuries with Police, and how could these be mitigated? 13. Do you believe if a client or patient knows that this information would be shared with Police it could deter them from seeking healthcare, or compromise trust and honesty when doing so? 14. Do you agree with the key outcomes outlined above? Do you think any of the outcomes need to be amended or added? Please explain.

3.2 Preliminary options for discussion

Four broad options have been identified for implementing reporting of firearms injuries by health professionals:

- Option 1: mandatory reporting in legislation
- Option 2: mandatory reporting in legislation, with exceptions
- Option 3: mandatory consideration of the need to report in legislation; and
- Option 4: reporting encouraged through non-legislative mechanisms.

These initial options recognise there is a range of approaches to achieve the key outcomes that we have outlined above. In outlining the four options, we have provided some additional information about how the option may or may not meet key outcomes. We seek your

feedback on the four options outlined above and encourage you to review each option against the key outcomes, as listed at Part 3.1 of the document.

The options have been informed by overseas reporting regimes and existing reporting frameworks in New Zealand. Under each of the options, Police will use the information reported on firearms injuries as it is currently used, for follow-up investigation and to decide whether further action is needed.

Option 1: Mandatory reporting in legislation

Health practitioners must report firearm injuries to Police in all instances. A very narrow range of injuries would be excluded, for example degenerative hearing loss caused over a long period of firearms use.

This option contains very little health practitioner discretion. It would result in a wide range of injuries being reported to Police. Option 1 could assist in meeting the key outcome of consistent reporting, but the wide mandatory reach may deter people from seeking healthcare. Patients' privacy and confidentiality would be affected by this option.

Option 2: Mandatory reporting in legislation, with exceptions

Health practitioners must report firearm injuries in most instances to Police and retain discretion to report in others. Compared to Option 1, this option would have more areas where a health professional could exercise their discretion. A possible area of discretion could be when reporting is covered by an existing framework and processes (for example, the processes referred to on page 6, 9 and 10 of this discussion paper). There may be other possible exceptions from the mandatory requirement (which we seek your feedback on), which may justify a distinct approach with discretion to determine an appropriate and tailored response, while still providing an opportunity to restrict access to firearms as a default.

While Option 1 refines the type of injuries that occur, Option 2 seeks to retain flexibility for health practitioners in certain situations and contexts to account for the complexity or sensitivity of the issue. However, this discretion creates the possibility that Police does not become aware of some relevant injuries, which could impact on public safety.

Option 3: Mandatory consideration of the need to report in legislation

Under this option, health professionals 'must consider' reporting firearm injuries to Police. While consideration of reporting would be required by the law, the reporting of the injury itself would be discretionary.

When deciding whether to report a firearm injury to Police, health practitioners would be guided to consider certain factors, such as the nature and cause of the injury, and other factors which may guide them to a more objective assessment of the risk posed to the individual and public from not reporting. The law could include the requirement to consult with another qualified health practitioner when deciding whether to report. This option could also provide an explicit authority to disclose information and a protection when doing so.

Option 3 allows health professionals to decide what to report to Police. It relies on the ability of health practitioners to conduct a thorough and objective analysis of the situation. It may avoid deterring people from seeking health care, but it could lead to inconsistent practice. Option 3 could be framed in the same way as s 92 of the Arms Act 1983, as mentioned on page 6 of this discussion paper.

Option 4: Reporting encouraged through non-legislative mechanisms

Guidance for and encouragement to report would be implemented through non-legislative mechanisms, such as a Memorandum of Understanding, or through professional standards and best-practice clinical guidance. If non-mandatory reporting is enabled by these levers, the disclosure of this information is already covered in the existing HIPC Code where it is necessary to prevent or lessen a serious threat to public safety or the life or health of an individual (but not otherwise). This option does not require any change to the law. It relies heavily on the exercise of discretion by health professsionals. Increased awareness is likely to encourage more reporting, which is a key outcome of the proposal. However, it may not provide Police with as much information as the other options, with a potential flow on effect for public safety.

What do you think?

15. Please rank the above options (1) to (4) from your MOST preferred to LEAST preferred option and explain your reasoning.

16. As a health practitioner, how confident would you be in identifying an injury as being caused by a firearm or airgun?

17. Is it appropriate and reasonable to place responsibility on the health practitioner to identify a likely cause of an injury? For example, any mandatory requirement to report could be 'where the injury could reasonably be determined to be caused by the discharge of a firearm'.

18. At option 1 (mandatory reporting in legislation), which types of injuries are suitable for exclusion?

19. At option 2 (mandatory reporting in legislation, with exceptions), is it appropriate to provide for exceptions from mandatory reporting of firearm injuries in certain situations? If so, which situations?

20. At option 3 (mandatory consideration of the need to report in legislation), what specific factors do you think should be considered in guidance?

21. At option 4 (reporting encouraged through non-legislative mechanisms), how do you think awareness within the health sector could be raised to encourage reporting?

22. What do you consider the consequence should be when a health practitioner fails to meet a mandatory reporting obligation?

3.3 Which health-based workforces should be included in a reporting framework?

The RCOI Report did not define health professional. There are multiple aims when defining which workforces to include in the proposal:

- Capturing all workforces likely to treat a firearm injury
- Only placing duties on workforces likely to treat or respond to a firearm injury
- Accounting for variation in how care is accessed and who provides it
- Not unduly compromising patient privacy and confidentiality

One option is to include within scope all health practitioners registered under the Health Practitioners Competence Assurance Act 2003 (HPCA Act)[5].

Professions regulated under the HPCA Act are:

- Chiropractic
- Dentistry, dental hygiene, clinical dental technology, dental technology, dental therapy, and oral health therapy
- Dietetics
- Medical Laboratory Science, Anaesthetic Technology
- Medical Imaging and Radiation Therapy
- Medicine
- Midwifery
- Nursing
- Occupational Therapy
- Optometry and optical dispensing
- Osteopathy
- Paramedics
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Psychotherapy

If an obligation to report was placed on the above professions, this would encompass many workforces and situations, but would place obligations on some workforces regulated under the HPCA Act who may never treat firearm injuries. However, defining health practitioner in this way would still be inherently restricted, as only those treating a firearm injury would be captured.

Alternatively, individual workforces within the HPCA Act (through the responsible authority under the Health Providers Index) could be selected to meet any reporting requirements, based on their likelihood of treating a firearm injury, such as Paramedics, Nurse Practitioners, General Practitioners, and others. This narrower selection would better protect patient confidentiality in cases where there is no reason to compromise it. It would also be possible to capture the professions most likely to respond to injuries in the first place, who may then refer to other workforces. However, this may not include all instances of firearms injuries, and is less likely to be enduring and comprehensive as the roles of workforces change over time, in which case a mechanism would be required to allow for this list of workforces to be updated.

[5] This full list of HPCA Act regulated workforces is available at: https://www.health.govt.nz/our-work/regulation-health-and-disability-system/health-practitioners-competence-assurance-act/responsible-authorities-under-act

We are seeking your views on which professions should be captured by a reporting requirement.

What do you think?
23. Which workforces are most likely to treat a firearm injury in the context you work in? Are they best placed to report the incident, or someone else on their behalf? 24. Do you have an opinion on how broadly or narrowly health workforces should be defined, and on which specific workforces should be in or out of scope? 25. Do you consider there may be other groups or organisations, in addition to health professionals, that may come across information indicative of misuse of a firearm or airgun that should come within a reporting framework? If so, who?

Part 4: Implementation

Any successful reporting regime depends on other considerations and effective implementation of this initiative. We seek your input on the following issues in particular.

4.1 Guidance

Effective, practical, consistent, and widely communicated guidance to support health practitioners to determine when to report, how to report, and the legal protections and obligations for reporting, is critical. Following the development of these options, guidance for reporting will be developed in consultation with the health practitioners implicated by the regime.

4.2 How reports are made

As is currently occurring, reports to Police can continue to be made via the non-emergency 105 phoneline and the emergency 111 phoneline. These are 24/7 services. We would like to know your preferred mechanism for reporting and ask at question 29 below to specify whether this would be via 105/11 or submitting a report online.

We are proposing that the information Police would require includes:

- Name of the individual concerned
- Contact details
- A brief statement about the nature and severity of the injury and any relevant background to the injury if known (for example, other relevant health needs).

We are interested in your views on what information the report should require a health professional to provide, including additional information to what is listed above.

Reported information would be recorded in Police systems for follow-up action. This may involve Police making follow-up enquiries with the health professional/s who were involved in treating the individual. Being informed about the circumstances of the injury and any relevant health needs will enable Police to tailor its response accordingly and provide an appropriate wraparound response, as is current practice.

4.3 How is the information used, and what happens following a report?

Police currently has a dedicated compliance team responsible for all compliance decisions relating to existing licence holders. To support this team a graduated response model is applied when assessing whether an individual who has come to the attention of Police needs their fit and proper status reviewed to determine their suitability to retain their firearms licence. Current licence holders may come to the attention of the Police by being entered into the Police system as a victim, offender, suspect, someone reporting a crime, self-harm event, Land Transport Act 1998 medical event notification of driver's licence suspension, or other circumstance.

When a licence holder does come to the attention of Police a variety of options and regulatory tools can be used, including taking no further action, issuing a warning, issuing an improvement notice or issuing an intention to revoke the firearms licence and an accompanying licence suspension notice. This approach recognises that each individual's circumstances must be assessed on a case-by-case basis and that Police's subsequent intervention must reflect these circumstances.[6]

If the intervention involves serving an intention to revoke the firearms licence, the notice provides the licence holder with the information that Police believes is relevant to the licence holder's fit and proper status. On reciept of the notice, the licence holder has the opportunity to provide reasons why the licence should not be revoked. Police will consider all available information and may decide not to revoke the licence. If the licence is revoked, the former licence holder can appeal the decision. If the revocation decision is appealed, a commissioned officer of Police, that was not involved in the original decision, must then review all information, and decide to support the original revocation decision or decide that the licence should be returned. If the licence remains revoked the former licence holder can appeal to the District Court for a review of the decision by Police.

Similarly, Police's response to a health professional's report of a firearm injury would differ depending on the set of circumstances, the level of risk involved and whether the individual holds a firearms licence. For example, it may result in a conversation with the individual, further engagement with the health professional and, where it relates to a licence holder, the determination that further advice is required. In other situations, it may include assessing the individual's fitness to hold a firearms licence.

The information provided by health professionals could also be used for criminal investigation purposes, as is currently the case.

The data captured will also be used to gain a better understanding of the prevalence of firearm injuries in New Zealand; that is, the level of harm occurring as a result of firearms misuse. In time, this information will inform the effectiveness of the implementation of the Arms Act 1983 and other measures aimed at ensuring a reduction in the misuse and illegal use of firearms.

We are seeking further information on any internal guidance or policies your organisation has for reporting firearm injuries. We are also seeking your input as to what information health professionals should provide to Police and how reports should be made.

[6] Further information on Police's Graduated Response can be found here: https://www.police.govt.nz/advice-services/firearms-and-safety/new-firearms-laws-and-what-they-mean/24-december-2020/graduated-response

What do you think?
26. If you work for an organisation, does it currently have internal policies, protocols and/or guidance for reporting of firearms injuries? If so, please describe these. 27. What key elements would you like to see included in guidance to support reporting of firearms injuries by health professionals to Police? What else would be required to effectively implement this reporting in your healthcare setting? 28. What information do you think should and should not be provided when a health professional is making a report to Police? 29. If you are a health professional, when making a report, is your preference to do so: a. On the phone, via Police's 111 or 105 phonelines, or b. By submitting a report online. 30. What impact would reporting firearm injuries to Police have on your organisation? For example, time commitment, additional costs, or new processes required. How could these impacts be mitigated to enable more effective and efficient reporting? 31. Do you consider that the benefits of increased reporting outweigh the costs of doing so?

4.4 What is the broader response to the injured person?

Through these proposals there is also an opportunity to provide additional support to those injured and to further improve public safety.

This may be a tailored health and therapeutic response following an injury, an intensive cross-agency approach if there is an indication of future violence, or additional training on the safe storage and use of firearms for licence holders for those with accidental injuries (noting that this would likely be to a very small group, as the data Police holds suggests the majority of gun-shot injuries involve non-firearms licence holders).

What do you think?
32. Do you have any comment on Police's proposed use of information relating to firearm injuries?

Any other comments?
33. Do you have any additional comments about any matters raised in this discussion paper?

Part 5: Summary of questions for engagement

What do you think?
1. Do you think that a 'firearm injury' should be defined as an injury expected to have been caused by the discharge of a firearm or airgun, or more broadly as any injury expected to have been caused by a firearm or airgun, for example including blunt force injury? Please explain. 2. Are there any adverse impacts or unintended consequences that could result from your preferred approach to the definition? 3. Are you familiar with the information disclosure provisions set out in section 2.2 above, and do you think they are sufficient to enable sharing relevant firearms injury information with Police? Please explain. 4. Are you aware of any additional information sources or data on firearm injuries in New Zealand? If so, what are these sources? 5. Does your workplace/organisation treat firearm injuries? If so, what data are recorded or collated on these injuries? 6. In your opinion, what are the potential benefits of knowing how often firearms injuries occur? 7. As a health practitioner, have you reported any firearm injuries to Police? If so, how did you report the injury/ies? (for example through your manager, or telephone or email to Police?) 8. In your experience as a health practitioner, when care is provided by multiple practitioners, how is a decision to report made, and who makes it? 9. If you are not a health practitioner, have you reported any firearms injuries to Police? If so, what was your experience? 10. As a health practitioner, what is your experience of reporting health information in other contexts, such as family violence or driver licensing? a. What kind of health information do you report? b. Who do you report this information to? c. Do you find this process easy or difficult? d. Do you know what happens with the data you report? e. Are you aware of any unintended consequences arising from reporting this information?

11. What do you consider to be the key benefits of sharing a client's or patient's personal information about firearm injuries with Police?

12. What do you consider to be the key risks of sharing a client's or patient's personal information about firearm injuries with Police, and how could these be mitigated?

13. Do you believe if a client or patient knows that this information would be shared with Police it could deter them from seeking healthcare, or compromise trust and honesty when doing so?

14. Do you agree with the key outcomes outlined above? Do you think any of the outcomes need to be amended or added? Please explain.

15. Please rank the above options (1) to (4) from your MOST preferred to LEAST preferred option and explain your reasoning.

16. As a health practitioner, how confident would you be in identifying an injury as being caused by a firearm or airgun? Very confident, confident, somewhat confident, not confident at all?

17. Is it appropriate and reasonable to place responsibility on the health practitioner to identify a likely cause of an injury? For example, any mandatory requirement to report could be 'where the injury could reasonably be determined to be caused by the discharge of a firearm'.

18. At option 1 (mandatory reporting in legislation), which types of injuries are suitable for exclusion?

19. At option 2 (mandatory reporting in legislation, with exceptions), is it appropriate to provide for exceptions from mandatory reporting of firearm injuries in certain situations? If so, which situations?

20. At option 3 (mandatory consideration of the need to report in legislation), what specific factors do you think should be considered in guidance?

21. At option 4 (reporting encouraged through non-legislative mechanisms), how do you think awareness within the health sector could be raised to encourage reporting?

22. What do you consider the consequence should be when a health practitioner fails to meet a mandatory reporting obligation?

23. Which workforces are most likely to treat a firearm injury in the context you work in? Are they best placed to report the incident, or someone else on their behalf?

24. Do you have an opinion on how broadly or narrowly health workforces should be defined, and on which specific workforces should be in or out of scope?

25. Do you consider there may be other groups or organisations, in addition to health professionals, that may come across information indicative of misuse of a firearm or airgun that should come within a reporting framework? If so, who?

26. If you work for an organisation, does it currently have internal policies, protocols and/or guidance for reporting of firearms injuries? If so, please describe these.

27. What key elements would you like to see included in guidance to support reporting of firearms injuries by health professionals to Police? What else would be required to effectively implement this reporting in your healthcare setting?

28. What information do you think should and should not be provided when a health professional is making a report to Police?

29. If you are a health professional, when making a report, is your preference to do so:
    a. On the phone, via Police's 111 or 105 phonelines, or
    b. By submitting a report online.

30. What impact would reporting firearm injuries to Police have on your organisation? For example, time commitment, additional costs, or new processes required. How could these impacts be mitigated to enable more effective and efficient reporting?

31. Do you consider that the benefits of increased reporting outweigh the costs of doing so?

32. Do you have any comment on Police's proposed use of information relating to firearm injuries?

33. Do you have any additional comments about any matters raised in this discussion paper?

SUBMISSION FORM FOR CONSULTATION ON REPORTING OF FIREARM INJURIES TO NEW ZEALAND POLICE BY HEALTH PROFESSIONALS

The closing date for submissions is **6 May 2022**.

We recommend that this Submission Form is completed after you have read the Discussion Paper *Initial Options on Reporting of Firearm Injuries* in full.

You can submit this form by emailing it to ***consultation@police.govt.nz*** or posting your submission to ***Firearms Policy and Partnerships Team, Level 13, Police National Headquarters, 180 Molesworth Street, Thorndon, Wellington***

Privacy

Your feedback may be made available by Police and the Ministry of Health to members of the public who request copies of submissions. Please indicate clearly in the space below if your identity or comments are provided in confidence, or if there is some other reason they should not be disclosed.

Any request for non-disclosure will be considered in terms of the Official Information Act 1982. Your feedback may be edited for publication to anonymise it or remove sensitive information.

This submission was completed by:

Name

Address

Email

Are you submitting this:

☐ As an individual?

☐ On behalf of a group or organisation? (please specify)

☐ Other? (please specify)

Would you like this information to be provided in-confidence? If yes, what information would you like to be withheld?

If you are submitting an individual, we would find it useful if you could indicate the following, but this is optional

Age

Gender

Ethnicity

Questions

1. Do you think that a 'firearm injury' should be defined as an injury expected to have been caused by the discharge of a firearm or airgun, or more broadly as any injury expected to have been caused by a firearm or airgun, for example including blunt force injury? Please explain.

2. Are there any adverse impacts or unintended consequences that could result from your preferred approach to the definition?

3. Are you familiar with the information disclosure provisions set out in section 2.2 of the Discussion Paper, and do you think they are sufficient to enable sharing relevant firearms injury information with Police? Please explain.

4. Are you aware of any additional information sources or data on firearm injuries in New Zealand? If so, what are these sources?

5. Does your workplace/organisation treat firearm injuries? If so, what data are recorded or collated on these injuries?

6. In your opinion, what are the potential benefits of knowing how often firearms injuries occur?

7. As a health practitioner, have you reported any firearm injuries to Police? If so, how did you report the injury/ies? (for example through your manager, or telephone or email to Police?)

8. In your experience as a health practitioner, when care is provided by multiple practitioners, how is a decision to report made, and who makes it?

9. If you are not a health practitioner, have you reported any firearms injuries to Police? If so, what was your experience?

10. As a health practitioner, what is your experience of reporting health information in other contexts, such as family violence or driver licensing?

    a. What kind of health information do you report?

    b. Who do you report this information to?

    c. Do you find this process easy or difficult?

    d. Do you know what happens with the data you report?

    e. Are you aware of any unintended consequences arising from reporting this information?

11. What do you consider to be the key benefits of sharing a client's or patient's personal information about firearm injuries with Police?

12. What do you consider to be the key risks of sharing a client's or patient's personal information about firearm injuries with Police, and how could these be mitigated?

13. Do you believe if a client or patient knows that this information would be shared with Police it could deter them from seeking healthcare, or compromise trust and honesty when doing so?

14. Do you agree with the key outcomes outlined on page 13 and 14 of the Discussion Paper? Do you think any of the outcomes need to be amended or added? Please explain.

15. Please rank the above options (1) to (4) from your MOST preferred to LEAST preferred option and explain your reasoning.

Option 1: mandatory reporting in legislation

Option 2: mandatory reporting in legislation, with exceptions

Option 3: mandatory consideration of the need to report in legislation

Option 4: reporting encouraged through non-legislative mechanisms.

16. As a health practitioner, how confident would you be in identifying an injury as being caused by a firearm or airgun?

Not confident at all

17. Is it appropriate and reasonable to place responsibility on the health practitioner to identify a likely cause of an injury? For example, any mandatory requirement to report could be ‘where the injury could reasonably be determined to be caused by the discharge of a firearm’.

18. At option 1 (mandatory reporting in legislation), which types of injuries are suitable for exclusion?

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20. At option 3 (mandatory consideration of the need to report in legislation), what specific factors do you think should be considered in guidance?

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24. Do you have an opinion on how broadly or narrowly health workforces should be defined, and on which specific workforces should be in or out of scope?

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    a. On the phone, via Police's 111 or 105 phonelines, or
    b. By submitting a report online.

30. What impact would reporting firearm injuries to Police have on your organisation? For example, time commitment, additional costs, or new processes required. How could these impacts be mitigated to enable more effective and efficient reporting?

31. Do you consider that the benefits of increased reporting outweigh the costs of doing so?

32. Do you have any comment on Police's proposed use of information relating to firearm injuries?

33. Do you have any additional comments about any matters raised in this discussion paper?

Please use this space for any additional comments