Second Reading

The Hon. JOHN HATZISTERGOS (Attorney General, and Minister for Industrial Relations) [5.34 p.m.]: I move:

That this bill be now read a second time.

I am pleased to introduce the Coroners Bill 2009. Coroners perform a unique and vital role within the legal system. They are responsible for ensuring that deaths arising in suspicious, violent, unnatural and unknown circumstances are properly investigated. They also have authority to investigate the cause and origins of fires and explosions. Unlike most other judicial proceedings, which are adversarial in nature, coroners conduct inquisitorial proceedings in which they are responsible for directing medical and police investigations and gathering evidence. In relation to deaths, the objective of coronial investigations is to reveal the circumstances surrounding the death, including the identity of the deceased, the time and date of death, and the cause and manner of death.

Coronial inquests and inquiries can uncover evidence of criminal conduct and can result in coronial recommendations and improved public health and safety. Coroners assist grieving families by providing them with an understanding of the circumstances in which a loved one died. The office of coroner has a history that dates back to the twelfth century in England. The office was inherited as part of the common law of the colony of New South Wales. Legislation was passed in New South Wales to consolidate the powers of coroners in 1912. This Act was superseded by a new Act in 1960 and this, in turn, was replaced by the current Act, which came into being in 1980. Over the past 29 years the current Act has been the subject of numerous developments, including the creation of the office of State Coroner in 1988 and assistant coroners. It is timely then to take the opportunity to rewrite the Act and provide a modern and cohesive legislative framework to support coroners.

The new bill also contains a number of reforms that will improve the efficiency and effectiveness of the coronial jurisdiction. These reforms emanate from a review undertaken by the Attorney General's Department in consultation with the State Coroner and the Chief Magistrate. I would like to take this opportunity to thank both the State Coroner and the Chief Magistrate for their assistance in developing this bill and the reforms contained within it. Consultation was also undertaken with the following stakeholders: the Royal College of Forensic Pathologists of Australasia, the Australian and New Zealand College of Anaesthetists, the New South Wales Bar Association, the Law Society of New South Wales, the Legal Aid Commission of New South Wales, the New South Wales Police Force, NSW Health, the Department of Ageing, Disability and Home Care, the New South Wales Council on the Ageing, the Funeral Directors Association of New South Wales, the New South Wales Society of Jewish Jurists and Lawyers, the Aboriginal Justice Advisory Council, the Australian Federation of Islamic Councils, the New South Wales Council for Pacific Communities, the Nan Tien Temple, the Buddhist Council of New South Wales and the Homicide Victims Support Group.

I would like to thank all those groups for the feedback and assistance they have provided in helping the Government to develop this bill. In particular, I would like to extend my thanks to Dr Tamsin Waterhouse and Dr Joe Duflou who met with me on several occasions on behalf of the Royal College of Pathologists to discuss the bill. Pathologists are at the front line of delivering coronial services in this State and they perform their difficult and important work with passion and dedication. Through my discussions with Dr Waterhouse and Dr Duflou we were able to make several important changes to the bill to strike an appropriate balance in ensuring that deaths reported to the Coroner are investigated both thoroughly and in a timely matter. However, I appreciate that some reforms in this bill represent a change in the way that deaths are reported to and investigated by the Coroner.

I would like to thank the college for its openness in accepting these reforms and for its willingness to work with the State Coroner to ensure that these reforms do not unnecessarily impact on the quality of coronial services in this State. I again extend to the college, as I have already done in our meetings, an open invitation to bring concerns or issues that may arise in the implementation of the Coroners Act to my attention. The reforms in this bill broadly deal with four areas of coronial law: governance structure of the coronial jurisdiction; the categories of death that are within the jurisdiction of coroners; the conduct of post-mortems; and the case management of coronial proceedings.

I will deal with the first of these changes to the governance structure. The most significant change in this area is that clause 12 provides that only magistrates and Australian lawyers will be eligible for appointment as coroners under the new Act. The role of the coroner is complex and demanding. Coroners are required to oversee investigations and assess whether evidence might be sufficient to warrant the referral of a matter to the Director of Public Prosecutions for serious criminal charges to be laid. Coroners review the conduct of individuals, companies and government agencies to ensure that there are no systemic failures that contributed to a person's death.

Magistrates and lawyers have the legal skill and knowledge to assess these evidentiary issues. Historically, registrars of the Local Court in country areas were appointed as coroners. Registrars may not necessarily have

legal qualifications or the capacity to deal with more complex cases in conjunction with their normal duties. In recent years inquests and inquiries have been conducted almost exclusively by magistrates and registrar coroners have dealt with less complex matters where an inquest or inquiry is dispensed with. Accordingly, the change in eligibility for appointment will not substantially affect the workloads of magistrates. The reform will enhance the role of coroner and ensure that only legally trained officers with the requisite professional skill are called upon to perform the role.

Under the savings provisions registrar coroners who are not Australian lawyers will be reappointed as assistant coroners. This change to the eligibility for appointment is consistent with coronial practice in other States and territories and will promote a professional and high-quality coronial service. The hierarchy of the coronial jurisdiction also has been amended. At present, the State Coroner is supported by a Senior Deputy State Coroner, up to four Deputy State Coroners, as well as coroners and assistant coroners. The coronial jurisdiction operates within the framework of the Local Court and is overseen by the Chief Magistrate. This complex structure has been streamlined by abolishing the position of Senior Deputy State Coroner. Currently no magistrate is appointed to this position.

The State Coroner will be supported by Deputy State Coroners and one of the Deputy State Coroners may be appointed to relieve the State Coroner during any period of temporary leave or vacancy. The structure has been made more flexible also by removing the restriction on the number of Deputy State Coroners that may be appointed. The Act originally allowed for two Deputy State Coroners and subsequently this was increased by legislative amendment to three and then four. Although there is no plan to appoint additional Deputy State Coroners at this time, it is cumbersome and unnecessary to continually require legislative amendment to alter the number of Deputy State Coroners that may be appointed. The process is not conducive to responsive coronial services. The number of Deputy State Coroners should be determined by reference to workloads. I have undertaken to consult with the Minister for Police about any proposal to increase the number of appointments that might impact on coronial support services provided by police.

Clause 7 makes it clear that the State Coroner operates under the supervision of the Chief Magistrate and is deemed to have the status of a Deputy Chief Magistrate. The State Coroner is a magistrate of the Local Court. It is incongruous that the State Coroner potentially could give directions to coroners, including to the Chief Magistrate in his capacity as a coroner, when the State Coroner is subordinate to the Chief Magistrate. The second area of reform relates to the jurisdiction of coroners. The Coroners Act 1980 provides that coroners have jurisdiction to investigate violent, sudden or unnatural deaths, or deaths where the cause appears to be unknown. Currently the coroner has jurisdiction to investigate deaths that occur either during or within 24 hours of the administration of an anaesthetic, or if a death occurs within a year and a day of an accident. The State Coroner and Deputy State Coroners also have exclusive jurisdiction to investigate deaths occurring in custody or during police operations, deaths of children possibly subject to abuse or neglect, or deaths of disabled persons in care within the meaning of the Disability Services Act 1993.

The jurisdiction of the coroner generally captures deaths that are either suspicious or where the circumstances surrounding the death are unclear. An examination of the categories of reportable deaths identified areas where the jurisdiction needed refinement to ensure that matters were not reported to the coroner unless there were unresolved issues that needed investigation. Close to 95 per cent of all deaths in New South Wales are from natural causes. Every year around 6,000 deaths are reported to the coroner. Based on information available from the National Coronial Information System, typically more than half these deaths are due to natural causes. It is the Government's view that in most cases grieving families should not have to await the outcome of coronial processes where the cause of their loved one's death is known or apparent. At the very least, those family members should be able to have a greater say, in appropriate circumstances, as to whether or not the precise cause of death needs to be ascertained where it is apparent that a person died from natural causes.

Furthermore, coroners and medical investigators should be able to focus their attention on cases where a person dies of unknown causes or in suspicious or violent circumstances. Therefore, the bill includes a number of changes to prevent non-suspicious natural deaths from being unnecessarily reported to coroners. A number of these reforms also bring New South Wales into line with other jurisdictions in Australia. Chapter 3 of the bill outlines the jurisdiction of coroners. It largely restates the current jurisdictional requirements with some modification. Coroners have jurisdiction to investigate reportable deaths that are defined in clause 6 of the bill. It is worth noting that clause 20 now makes it clear that the jurisdiction of coroners is not dependent on the death being formally reported to the coroner and jurisdiction may be seized whenever the coroner becomes aware of a reportable death. The requirement to report a death that occurs during or within 24 hours of the administration of an anaesthetic has been replaced with a more general category of health-related deaths.

The New South Wales Regional Committee of the Australian and New Zealand College of Anaesthetists suggested this change due to concerns that the current reporting criteria causes confusion when a sedative is used instead of an anaesthetic. The requirement to report anaesthetic-related deaths to the coroner also may lead to confusion when anaesthesia is not a contributory factor to the cause of death. The arbitrary time frame of 24 hours means that the decision to report a death to a coroner often is based on the timing of death rather than any concerns regarding the medical treatment provided. In view of these concerns, the category of reportable deaths has been changed to require deaths to be reported to a coroner if the death is not the reasonably

expected outcome of a health-related procedure. This category more accurately identifies deaths arising from medical misadventure.

The term "health-related procedure" has been defined to mean a medical, surgical, dental or other health-related procedure including the administration of an anaesthetic, sedative or other drug. The definition also expressly excludes, by regulation, certain health procedures that are undertaken in response to impending death, for example, cardiac resuscitation and palliative care measures, to ensure that matters are not unnecessarily reported to the coroner. The category of health-related procedure deaths is consistent with the approach taken in the coronial jurisdictions of Victoria, Queensland, South Australia and the Australian Capital Territory. Section 14C of the Coroners Act 1980 provides that an inquest must be held if a death occurs during or within 24 hours of the administration of an anaesthetic and an interested person requests, within 28 days of the death, that an inquest hearing be held. No other State mandates inquest hearings in relation to anaesthetic or health-related deaths.

In the majority of cases the decision to hold an inquest hearing will be determined by the coroner after the conclusion of the investigation and having regard to the information available and the wishes of the family. It is unnecessary and inappropriate to mandate the holding of an inquest in these cases, particularly when there may be no concerns regarding the medical treatment that was provided. The new bill omits the reference to mandatory inquests in these circumstances and allows a coroner to determine whether or not an inquest is desirable. Medical practitioners may issue death certificates if a death is not reportable to a coroner and they are satisfied that the cause of death is known. Currently a death certificate may be issued only if the medical practitioner has attended the person during the previous three months prior to the death.

The current three-month period is restrictive where a medical practitioner may have been treating the person for a known health problem and may have an opinion on the cause of death. New South Wales is currently one of only two jurisdictions that still mandates a coroner referral where a medical practitioner had not attended the deceased in the three months prior to death. The underlying principle of the Coroners Bill is that coroners and investigating medical officers should be able to focus their attention on those cases where a person dies of unknown causes or in suspicious or violent circumstances. The current restriction means deaths are reported to the coroner where the person died from known and non-suspicious natural causes. This provides no tangible benefit to the family of the deceased or to the wider community.

New South Wales Health has advised that the majority of prescriptions for chronic, managed conditions such as diabetes, cardiovascular disease and pulmonary disease, are written for a six-month period, and a patient may not need to consult their medical practitioner between prescriptions. Six months is therefore a more logical period in which a medical practitioner must have seen a deceased person prior to their death in order to issue a death certificate. It also better reflects current medical practice. Clause 6 of the bill therefore extends the period in which the medical practitioner attended the person from three to six months.

The bill omits the requirement in the current Coroners Act 1980 that a death be reported to a coroner if the person died within a year and a day after the date of any accident to which the cause of death is attributed. This provision was based on an antiquated legal rule that a person could be held responsible for the death of a person only if the death occurred within a year and a day of the incident. The rule has its origin at the beginning of the last century in response to limitations in medical science in identifying a connection between the medical cause of death and an event occurring at a much earlier time. The rule was abolished as part of the criminal law in 1991 by section 17A of the Crimes Act 1900.

The bill makes it clear that the Coroner has jurisdiction to investigate deaths caused by accidents or criminal conduct, no matter when death actually occurs. This approach is consistent with coronial law in all other States and territories. Clause 38 relates to the exception to the requirement to report deaths to the coroner when an elderly person dies as a result of an accidental fall, which is an accident attributable to the age of that person and not due to an act or omission by another person. One of the underlying principles of this bill is that Coroners and investigating medical officers should be able to focus their attention on those cases in which a person dies of unknown causes or in suspicious or violent circumstances.

It is an unfortunate reality that accidental falls are common among older people and often result in fractures or other serious injuries that require hospitalisation. In many instances an accidental fall may result in complications, such as pneumonia. It is estimated that each year in Australia more than 1,000 people over the age of 65 die from complications caused by a fall. The current Coroners Act provides that these deaths need not be reported to a coroner if the person was aged more than 65 years and died after sustaining an injury from an accident, which was an accident that was attributable to the age of that person, contributed substantially to the death of the person, and was not caused by an act or omission by any other person. There is currently an exception to this provision if the person died in a hospital or nursing home.

The requirement to report a death to a coroner in such circumstances and when there are no apparent concerns unnecessarily can cause further distress to family members who may not understand why the death needs to be reported and who may assume that something of which they were not aware previously is suspicious and requires the death to be reported to the coroner. The bill therefore alters the requirement to provide that such

deaths need not be reported to a coroner, unless a relative objects to a medical practitioner issuing a death certificate. If an objection is raised, the medical practitioner will be obliged to report the death to a coroner. This will ensure that if the family of the deceased person has any concerns that the accidental fall should have been prevented, or that it was caused by the act or omission of another person, a coroner will be able to investigate those concerns. The bill increases the age group to which this exception applies from 65 years or more to 72 years or more to reflect the improved health standards since the introduction of this provision.

It is important to note once again that the Government has consulted widely in developing this bill, including consultation with the New South Wales Council on the Ageing, COTA, which is the peak body for older persons in New South Wales and draws its membership from seniors clubs and groups, service providers, and older individuals. COTA's legal response group has examined in detail the provisions of this bill. They have indicated their support for the various reforms it provides, including the changes in clause 38.

I will now turn to reforms relating to the conduct of post-mortem examinations. As I indicated earlier, typically more than half of the deaths reported to Coroners prove to be due to natural causes. Each year Coroners in New South Wales order post-mortems to be conducted in approximately 5,000 cases. The caseloads of Coroners have a direct impact on the workloads of forensic pathologists. While post-mortems are often necessary, they can also often be a source of distress to families as they may offend religious, cultural and personal beliefs or cause delay in finalising investigations. The bill therefore includes a number of reforms to protect the dignity of deceased persons, involve family members in decisions about post-mortem investigations and ensure that such investigations are completed in a timely manner.

One of the objectives of the reforms in this bill is to ensure that post-mortems are not undertaken unless it is necessary to establish the identity, time of death, or cause and manner of death. This is consistent with the principle enshrined in clause 88—that the dignity of the deceased person is to be respected. Under section 48 of the current Act coroners are not obliged to make orders for a full post-mortem. The discretionary power is such that they may make an order for the purpose of identifying the deceased, date and place of death, and cause and manner of death. I am advised that at Glebe post-mortems are ordered in approximately three-quarters of the cases that are admitted into the morgue. I understand that for the remainder the State Coroner and Deputy State Coroners at Glebe already adopt the approach of examining any available medical records and considering whether the cause of death can be determined without the need for a post-mortem examination. The new bill will give a legislative basis for coroners taking this approach.

Clause 88 of the bill introduces an obligation on medical officers carrying out post-mortem examinations to establish the cause and manner of death by using the least invasive procedure that is appropriate in the circumstances. Prior to making an order for an invasive post-mortem examination the coroner should consider whether it is possible to sufficiently establish the cause of death through non-invasive investigative means, such as arranging a review of medical records and consulting with treating doctors. On occasions, it will be sufficient to establish the cause of death through limited examinations, such as external examination, taking samples for toxicology or partial internal examinations. Clause 88 of the bill expressly refers to these more limited examinations.

The benefits of this approach are two-fold. Firstly, it will ensure that forensic pathologists are not required to overservice by conducting post-mortems where they are not necessary, or by conducting full post-mortem examinations when a more limited examination would suffice. This will ensure that forensic pathologists are not overburdened. Removing unnecessary demands also will enable forensic pathologists to expedite post-mortem investigations in relation to homicides and other suspicious deaths so that criminal proceedings relating to a death are not delayed. To this extent, I note that Martha Jabour from the Homicide Victims Support Group has given her endorsement to the reforms provided in this bill.

As honourable members would be aware, Ms Jabour does a tremendous amount of good work supporting the families of persons who have died as a result of homicide. Through this work, she is constantly in contact with the coronial jurisdiction. A perhaps lesser known fact is that Martha worked as part of a team in the grief counselling section at the Glebe morgue. Therefore she has a great understanding of how the coronial jurisdiction operates in this State.

Coronial inquiries and investigations sometimes uncover evidence that leads to the prosecution of an offender. At the very least, coronial investigations are a necessary part of any broader investigation into a homicide death. Accordingly, it is important that the coronial jurisdiction operates effectively and swiftly when it comes to homicide deaths. This is not just to ensure that offenders are quickly brought to justice, but also so that victims' families may obtain closure and will be able to commence the difficult task of getting their lives back together again. I therefore place on the record the support that Martha Jabour from the Homicide Victims Support Group has given to this bill, particularly the provisions which enable coroners and medical investigators to focus their attention on those deaths that warrant detailed and forensic investigation including, most notably, homicide-related deaths.

The second benefit of this approach to conducting post-mortem examinations is that it is consistent with community expectations that deceased persons are to be treated with dignity. Relatives expect that tests and

examinations will not be carried out unnecessarily on their loved one. The bill makes it clear that examinations are carried out only to the extent necessary to establish the cause, manner and other circumstances surrounding death. As I noted earlier, in developing this bill the Government has consulted with the Funeral Directors Association of New South Wales, which represents the hundreds of funeral practitioners across this State and whose members help families through the grieving process. I place on the record what Mr Ken Chapman, the executive secretary of the New South Wales Funeral Directors Association, stated in a letter to me dated 24 April 2009 in relation to the reforms in this bill:

> authorising the coroner to direct certain medical investigators to conduct a review of the medical records of a deceased person and report to the coroner on the cause of death based on such a review will greatly shorten the time currently taken for the conduct of post mortems. Presently, long delays occur and funeral directors are frustrated in their attempts to facilitate funerals to meet the requirements of the deceased's family.

Clause 89 (6) of the bill introduces a new provision which allows the coroner the discretion to dispense with a post-mortem if, after obtaining advice from police officers and medical practitioners, he is satisfied that the person died from natural causes and the senior next of kin indicates that the family does not wish to have a post-mortem conducted to ascertain the precise cause of the person's death. Clause 25 (2) allows the coroner to dispense with an inquest in circumstances where he has not directed a post-mortem examination on a person who has died from natural causes and where he has obtained advice from police, medical practitioners and the deceased person's family.

The conduct of a post-mortem examination when the death is due to unsuspicious natural causes has little public benefit. The real benefit of conducting a post-mortem would be for family members who may wish to obtain information on how their relative died. The post-mortem can provide information on co-existing conditions, including inheritable conditions where early detection may be advantageous for the future treatment of a family member. Families should therefore have a greater involvement in the decision of whether to have a post-mortem examination when a relative dies of natural causes, and the only purpose of the post-mortem is to distinguish between more than one possible natural cause of death.

In some instances the conduct of a post-mortem will provide family members with certainty, closure and peace of mind. In other instances families will feel that the death of a sick relative should not require a full post-mortem examination. The bill recognises that greater weight should be given to the views of the family on the issue of conducting post-mortems. The coronial process should not be a source of greater distress to the families of people who have died. Giving a greater role to families in the decision-making process in these circumstances will ensure that coroners act in a manner that is sensitive to the needs of grieving families. I will provide the House with a real life example of how this new provision could benefit people who have lost a relative or loved one.

Earlier this year the member for Newcastle, the Hon. Jodi McKay, MP, wrote to me on behalf of a constituent, Mr Allan Charlesworth. Sadly, Mr Charlesworth's mother, Joyce, had died at the age of 86 years. She had not been in good health and it was apparent that she had died from natural causes. Accordingly, Mr Charlesworth did not want his mother's remains to be the subject of a post-mortem examination. He, like everyone, knew that Joyce passed away due to natural causes and her old age. However, under current law the coroner felt obliged to order an autopsy to establish the exact cause of death. The autopsy revealed that Ms Charlesworth had indeed died from natural causes. It turned out that her death was, to be precise, caused by aspiration in the lungs related to chronic pulmonary heart disease.

Mr Charlesworth was forced to delay his mother's funeral for several weeks, causing additional distress and uncertainty for family and friends, who were confused that a death notice had appeared in the paper with no details of the funeral. The delay in holding the funeral also made it more difficult for everyone to grieve and to deal with Joyce's death. Under new clause 89 in the bill, it will be clear that the coroner could decline to order an autopsy as it was apparent that Mrs Charlesworth had died from natural causes and her son did not desire a post-mortem examination. Clause 90 of the bill deals with the sensitive issue of organ retention. This clause provides that a direction for a post-mortem examination does not permit the retention of whole organs without further order of the coroner. In addition, a new right is created in clause 96 to allow a relative to object to an order permitting retention of a whole organ.

There are occasions when retention of body organs is necessary following a post-mortem in order to allow a detailed microscopic examination to be carried out to ascertain the cause of death. Microscopic examination of soft tissue such as the brain requires the organ to be fixed in formulin before it can be properly examined. This process may take several weeks. Organ retention is a sensitive issue. Relatives expect that when the body of a deceased is returned to them the whole body will be returned. Since the Walker report into post-mortem practices in 1993 it has been the practice of coroners to inform relatives if organ retention is necessary. Relatives may then elect to have the body returned without an organ for funeral arrangements or delay funeral arrangements until the body can be returned with the organ.

One concern about the current process is that unless an objection was made to the conduct of the post-mortem

examination by relatives, there is no provision to allow a relative to object to the retention of organs following a post-mortem examination. A number of families may wish to object to organ retention on the basis of cultural, religious or other personal beliefs. The bill will allow those objections to be raised with the coroner, and if the matter is not satisfactorily resolved the objection can be made to the Supreme Court. The bill increases the rights of relatives and empowers them to interact with coroners on issues that affect them.

I will now outline changes in the new bill that relate to case management of coronial cases. Case management is a well-established practice that allows courts to control the preliminary stages of proceedings to ensure that cases are determined quickly and with minimal cost. A number of reforms will enhance the case management powers of coroners to assist them meeting national time standards. Clause 52 allows the State Coroner to issue practice notes and give guidance to coroners generally on the appropriate manner for dealing with cases. This bill will promote consistent and best practice by all coroners. Clause 46 introduces the concept of coronial proceedings. The Coroners Act 1980 does not permit a coroner to hold a hearing in open court unless he commences an inquest or inquiry. Clause 46 introduces the concept of coronial proceedings. Coronial proceedings include the holding of an inquest or inquiry, conducting proceedings to determine whether or not to hold or to continue to hold an inquest or inquiry, or proceedings of an interlocutory or similar nature, including proceedings to deal with evidential matters or case management issues.

The effect of clause 46 is to confer on coroners the power to hold preliminary hearings in open court for the purposes of assisting their investigations or preparing the matter for inquest or inquiry. At present there is no provision allowing the coroner to conduct a preliminary hearing with the parties to determine issues such as the likely length of an inquest or inquiry, who will be appearing in the proceedings and the number of witnesses who are required to attend. The new provision will allow the coroner the option to determine any preliminary questions in open court, such as whether they have jurisdiction to deal with a particular death or whether or not an inquest or inquiry is necessary or desirable.

Clause 46 does not expand the powers of coroners. However, it will enable them to exercise their powers in open court instead of having to make preliminary decisions in chambers without the opportunity for interested parties to make submissions. The provision promotes the principle of open justice and has the potential to reduce the length of investigations and inquests and inquiries by identifying the scope of the matters to be investigated or limiting the need for witnesses to attend inquests and inquiries if their evidence is uncontested. Several coroners have indicated that they have been frustrated with limitations in the current Act that allow a witness to decline to provide any information to a coroner prior to an inquest or inquiry. The only way the information may be obtained is by commencing an inquest or inquiry and compelling the witness to give evidence.

If this information was available to the coroner prior to the inquest or inquiry, it might avoid the necessity of conducting an inquest or inquiry or might have provided information that could lead to further investigations. Clause 46 will allow a coroner to conduct coronial proceedings for the purposes of obtaining information from a witness prior to an inquest or inquiry. Clause 61 provides the coroner with the power to deal with claims of self-incrimination. If a witness declines to give evidence based on a claim of privilege against self-incrimination, the coroner may assess whether it is in the interests of justice that the evidence be given. If a person is compelled to give evidence the coroner shall provide a certificate indemnifying the use of the evidence in other proceedings.

The new provision allows a coroner to issue a certificate to protect against evidence given in coronial proceedings being used in other proceedings. Clause 61 increases the scope of protection from the current Act. A certificate issued under section 33AA of the Coroners Act 1980 prohibits the use of evidence in proceedings before any other proceedings before a New South Wales court. Clause 61 extends the protection afforded by a certificate so that it prohibits the use of evidence in proceedings before a New South Wales court, as well as any other proceedings where a person is empowered to take evidence.

The bill also restricts the availability of a coronial inquest or inquiry to be held before a jury. Clause 48 provides that a coronial inquest or inquiry may only be conducted with a jury if the State Coroner decides that a jury is required and that an inquest or inquiry before a jury may only be conducted by the State Coroner. Since 1960 coronial juries have been used on only a handful of occasions. The use of coronial juries can add a layer of cost and complexity to coronial proceedings. Notwithstanding this, there are limited circumstances in which the retention of a coronial jury may be useful. Clause 48 of the bill provides that a jury may be used for an inquest or inquiry only if the State Coroner directs it. The State Coroner will be able to give such a direction only if the State Coroner is to act as the coroner for the inquest or inquiry. Juries will not be permissible in any other coronial proceedings.

Clause 51 deals with the power of coroners to give directions to police officers in relation to coronial investigations. Clause 51 replaces sections 17B and 17C of the current Act. Although coroners oversee the conduct of investigations, police officers are the coroner's agents in the field gathering evidence on behalf of coroners. Where a death is suspicious or the circumstances surrounding the death are unclear, the coroner will direct the police officer in charge of the investigation to prepare a brief of evidence. Concerns have been raised by the New South Wales Police Force that the power to direct police officers can include directions to engage private experts which may involve significant costs. Clause 51 will allow the Commissioner of Police and the

Director General of the Attorney General's Department to enter into a memorandum of understanding to regulate these costs.

Clause 82 of the bill deals with the power of coroners to make recommendations. The capacity to make recommendations is one of the most significant powers conferred on coroners. The importance of this power is highlighted in clause 3, which, for the first time, identifies the power of coroners to make recommendations in connection with an inquest or inquiry as one of the main objects of the bill. The power to make recommendations provides coroners with the opportunity to identify any systemic failures in the health, law enforcement or other services to prevent similar deaths occurring in the future. The role of the coroner is not only to review the circumstances surrounding death; it is also to protect the living.

The power to make recommendations means nothing unless governments and agencies give careful and serious consideration to their implementation. That is not to say that all coronial recommendations should be implemented, and there may be substantial reasons why it is not appropriate to implement particular recommendations. However, there must be an appropriate framework to ensure that all recommendations are brought to the attention of the appropriate Minister or public official so that they are given proper consideration. At present the Coroners Act 1980 does not contain any guidance on the communication of recommendations. Clause 82 now provides that a coroner making a recommendation shall, as soon as practicable, forward a copy of the recommendation to the State Coroner, to any person or body to which the recommendation is directed, and to the Minister who administers legislation or who is responsible for the person or body to which a recommendation in the record relates.

Clause 82 addresses concerns that were recently raised in a report published in the Australian Indigenous Law Review titled, "Coronial Recommendations and the Prevention of Indigenous Death", by Ray Watterson, Penny Brown and John McKenzie. That report concluded that based on a sample of recommendations made in 2004 only 48 per cent had been implemented. In a number of instances it was clear that recommendations were not effectively communicated to the bodies to whom they were directed. Clause 82 will ensure that copies of coronial recommendations are forwarded by the State Coroner. The State Coroner has primary responsibility under the Act to oversee coronial services in the State. That function will include the monitoring of coronial recommendations and ensuring that agencies respond to recommendations. Clause 82 will ensure that copies of coronial recommendations are also forwarded to the Minister responsible for the legislation or agencies to whom the recommendation is directed.

It is consistent with principles of ministerial responsibility that Ministers ensure that recommendations affecting their portfolio are given serious consideration and that a response is provided to the coroner. In line with this new provision, and as per a commitment made by the Government in March, the Premier has this week issued a memorandum to all Ministers and agencies setting out a new process for responding to coronial recommendations. Under the memorandum, Ministers and agencies who receive recommendations are required to advise the Attorney General within six months whether they will be adopted. Summaries of coroners' recommendations and responses from Ministers and public officials will then be posted on the website of the Attorney General's Department, which will be updated and track progressed every six months.

It should be remembered that recommendations from coroners are not directives. Any system which enabled a coroner, who is a judicial officer, to direct or determine government policy would not only be a serious breach of the separation of powers, but would also be contrary to the principles of democratic governance. However, coroners do have an important and historic role to play in making recommendations to government to help prevent fires and deaths. The Government values and respects this role and is committed to giving recommendations appropriate consideration and, where appropriate, implementing them. Coronial recommendations are sometimes not implemented, or only partly implemented. This may be because action has already been taken, or because it is not possible to implement the recommendation in the way that is suggested.

When the Government determines its response to coronial recommendations it is accountable for that decision. The Government's new open and transparent system for monitoring and reporting on recommendations will ensure the Government not only informs coroners of those decisions but also informs the community on a continuing basis. This matter will be discussed at the forthcoming meeting of the Standing Committee of Attorneys-General in August, and the Government will consider any further proposals that flow from that meeting. Coroners have an important role to play in preventing future deaths through coronial recommendations. Coronial recommendations can bring important changes to health and safety regulation.

By way of example, coronial recommendations have led to regulations being introduced that require the compulsory wearing of life jackets in small recreational boats. Design changes to the making of window blinds to remove looped cords that can create hazards to children were a result of coronial recommendations. The requirement to fence swimming pools was a direct result of coronial recommendations relating to children drowning in backyard swimming pools. Clause 82 of the bill provides an effective framework for Government Ministers and agencies and others to respond to coronial recommendations. The State Coroner and the Attorney General will be able to monitor recommendations as well as the responses.

Coroners play a unique and important role in the judicial system. They focus on the circumstances surrounding

death so that we can understand why and how a person died. Coroners investigate death so that they can protect the living. The investigations undertaken by coroners can detect hidden homicides and reveal evidence that can bring people responsible to justice. The capacity for coroners to identify the reasons why somebody died can lead to important changes that can prevent those circumstances from recurring. The way in which coroners achieve these ends must be sensitive to the needs of families and friends of the deceased. Coroners must seek the truth surrounding deaths in a way that acknowledges the cultural and religious beliefs surrounding death and deals with grieving family and friends in a way that demonstrates compassion and understanding.

The Coroners Bill 2009 represents important reform by providing a modern framework within which coroners may achieve these altruistic goals. It refines the jurisdiction of coroners by ensuring that unsuspicious deaths are not unnecessarily reported to coroners, and it enhances the investigative powers of coroners and allows coroners to case manage proceedings so that the circumstances surrounding death can be revealed as quickly as possible. The bill will ensure that the conduct of post-mortems will be managed with sensitivity and regard for the dignity of deceased persons.

In developing this legislation the Government has worked closely with the State Coroner and Chief Magistrate as well as a number of key stakeholders, both inside and outside of the Government, including most notably the Royal College of Pathologists of Australasia. As a result, in addition to the government agencies that work in and with the coronial jurisdiction each day this bill has been endorsed by various external organisations representing a diversity of interests, including the New South Wales Law Society, the Homicide Victims Support Group, the New South Wales Council on the Ageing and the Funeral Directors Association of New South Wales. Coroners undertake an important role on behalf of the community investigating deaths, fires and explosions. The bill will ensure that they are able to investigate these matters effectively, sensitively and in a timely manner. I commend the bill to the House.