Response to Question on Notice from the Select Committee on the Coronial Jurisdiction in NSW

Agency: Department of Communities and Justice

Hearing date: 30 November 2021

QON #: 1

Question summary: Modelling for additional coroner (p45)

Question:

Mr DAVID SHOEBRIDGE: Rather than asking you a subjective question about whether 6.2 coroners are enough, what will the impact be, in reducing the delay, of going from 5.2 coroners to 6.2 coroners? What will that mean in reduced delay?

Mr McLENNAN: I expect that you will see a reduction in delays. Are you talking about the delays in finalisation of matters?

Mr DAVID SHOEBRIDGE: Correct, the delay in finalisations.

Mr McLENNAN: I cannot put an exact figure on it now, but I would expect there would be a delay.

The CHAIR: Presumably there is modelling. Can you provide us on notice with any modelling?

Mr McLENNAN: I can take that on notice.

Mr FOLLETT: We can take that on notice.

Response:

The Department is unable to provide this information as it would reveal Cabinet in Confidence information.

Response to Question on Notice from the Select Committee on the Coronial Jurisdiction in NSW

Agency: Department of Communities and Justice

Hearing date: 30 November 2021

QON #: 2

Question summary: Data on requests for inquests from families and responses (p50)

Question:

The Hon. PENNY SHARPE: Yes, okay. Sorry, I do not want to take a lot of the time of the Committee. I am very interested in this issue though, because it seems to me pretty fundamental given the distress of families, particularly if they have asked for an inquest and that is not being undertaken. I am not suggesting that there are bad reasons for that. Are you able to take on notice for us, maybe for the last three years—given we have had two years of COVID—what was the number of requests from families, and the number of 30-day letters, and who actually provided those letters to the families?

Mr McLENNAN: I can take that on notice.

Response:

Data as to the number of requests by families that an inquest be held:

This is not available. Generally, this will be a notation made by the NSW Police Force (**NSWPF**) Officer in Charge (**OIC**) on the last page of the hard copy Brief Order Document. This is not recorded in the JusticeLink case management system, and would require manual extraction from the hard copy file.

It should be noted that, in practice, it is not unusual for the court to receive an indication at this early stage that the family wishes for an inquest to be held, a position which is often not maintained once the post mortem report and/or brief of evidence is available to provide answers about their loved one's manner and cause of death.

Data as to the number of '30-day letters' sent:

This is not currently available.

The Department of Communities and Justice (**DCJ**) is investigating whether it is possible to determine this from information recorded in JusticeLink. It should be noted that a letter proposing to dispense with an inquest (a '**30-day letter**') may not be sent on behalf of the coroner in all cases. Generally, the coroner may not require such a letter to be sent prior to dispensing with an inquest if the family has already indicated that they do not wish for an inquest to be held.

Who provides these letters to families:

Letters are sent on behalf of the coroner at his or her direction. Letters are prepared and sent by Assistant Coroners or other Registry staff at the court location where the death has been reported to the coroner.

Response to Question on Notice from the Select Committee on the Coronial Jurisdiction in NSW

Agency: Department of Communities and Justice

Hearing date: 30 November 2021

QON #: 3

Question summary: Data on post-mortem investigations; timeliness data used by Taskforce; data on length of delay between death and the provision of a post-mortem report (pp 57-58)

Question:

Mr DAVID SHOEBRIDGE: You say in your report the lengthiest phase of the coronial process is the port-mortem investigation. What is the data on that? What is the median time frame for a post-mortem investigation? How many are waiting?

Mr FOLLETT: I do not have that to hand, Mr Shoebridge. If that data is available—which I suspect it is—we can provide that. I can take that one on notice.

…

Mr DAVID SHOEBRIDGE: You must have a dataset for this task force. You must have a dataset.

Mr FOLLETT: Yes. We do, Mr Shoebridge. We do.

Mr DAVID SHOEBRIDGE: Can you provide that dataset to the Committee?

Mr FOLLETT: Obviously, I would not provide the committee's workings, because a lot of that is different agencies' documents. But if there are particular datasets that you are after in terms of timeliness, we could provide those.

Mr DAVID SHOEBRIDGE: You must have data on timeliness.

…

The CHAIR: Committee members should address the Chair and not each other. Please frame a question.

Mr DAVID SHOEBRIDGE: What is the average length of delay between death and the provision of a post-mortem report?

Mr FOLLETT: I do not know that offhand, Mr Shoebridge. But we can provide on notice data on timeliness that backs up some of the report's findings if that is going to be helpful to the Committee.

…

The CHAIR: We have received a fair bit of evidence that says it can take a number of years from death to final coronial decision or recommendations. It can take five or six years. We all agree that is far too long. I guess what we really want to know is: How much will the reforms that you have implemented reduce that backlog of time? What is being done to tackle the rest of the delay? A significant amount of delay seems to be, frankly, the lack of judicial officers to process the work. What have you done so far and how much will that reduce the time delay?

Mr FOLLETT: That is a fair question, Chair. The taskforce really focused on four discrete areas—

The CHAIR: I understand that. We are not being critical of the task force. We are now just trying to look at the other parts of the process that we have received evidence on.

Mr FOLLETT: I understand. Yes. On notice, we can provide data behind timeliness.

The CHAIR: Any data you have on timeliness and measures to improve it, and projections about what has been achieved and what is, hopefully, to be achieved from those measures would be very useful in our deliberations.

Mr FOLLETT: Yes. Absolutely.

Response:

As part of its commitment to the ongoing work of the Coronial Processes Taskforce (**Taskforce**), which is being assumed by the Coronial Services Committee (chaired by the State Coroner), DCJ is currently developing its capacity to extract and report on a range of coronial data relating to key family centred milestones identified by the Taskforce, including timeliness in the release of the deceased for funeral and the finalisation of coronial proceedings.

This data is not currently publicly available. Development of the first data extract and validation process is in progress, and it is anticipated that the first dataset will be presented to the Coronial Services Committee at its first quarterly meeting in April 2022.

The Select Committee should note that this data is being extracted from JusticeLink, the case management system used by DCJ for the collection of courts data. It should also be noted that, being a case management system, JusticeLink is not purpose built for data extraction or analysis. The extraction and validation process therefore requires DCJ's Data and Analytics Unit to address a range of limitations that may affect the accuracy of data obtained from JusticeLink, including the following:

Data is drawn from information that must be manually entered into JusticeLink by court registry staff and, consequently, may be affected by factors including the timeliness of entry into the system and accuracy of information about the event.

In coronial proceedings, the hard copy court file constitutes the primary record of the proceeding. Not all information in the hard copy court file is able to be entered into JusticeLink, due to constraints including a reliance on manual processing and system limits (e.g., there is no data field in JusticeLink for a specific coronial event).

JusticeLink is used across NSW courts for a range of different proceedings. It is not purpose built for coronial proceedings, and does not capture various information and processes that are unique to the coronial jurisdiction's inquisitorial nature.

Data on the length of post mortem investigations:

- *What is the median time frame for a post-mortem investigation?*
  Pages 13 and 14 of the Improving the Timeliness of Coronial Procedures Taskforce Report state:
  A post-mortem examination is typically completed within three to five days of admission; however, post-mortem reports can take several months depending on the nature of the death and tests required.

For November 2021, the median timeframe for a post mortem examination (from admission to Forensic Medicine to completion of the post mortem examination) was 3 days. This has improved from a median timeframe of 4 days in 2019.

For November 2021, the median timeframe for provision of the post mortem report (from admission to Forensic Medicine to completion of the post report) was 160 days. This has improved from 221 days in 2019.

- *How many are waiting?*

NSW Health advises:

At the end of November 2021, there were 258 reports waiting to be finalised for longer than 6 months.

- *What is the average length of delay between death and the provision of a post-mortem report?*

NSW Health advises:

For November 2021, the median timeframe for provision of the post mortem report (from admission to Forensic Medicine to completion of the post report) was 160 days. This has improved from 221 days in 2019.

Data on timeliness:

- *Any data you have on timeliness*

The data below from the Report on Government Services (**RoGS**) shows that NSW finalises the majority of cases within 24 months, noting that the national benchmark target for RoGS is 100% of cases to be completed within 24 months.

	% finalised within 12 months	% finalised within 24 months
2016-17	89.9	98.0
2017-18	89.4	97.5
2018-19	86.2	96.5
2019-20	83.6	97.0
2020-21	87.5	96.6

Source: Report on Government Services 2022 (part C, section 7), Table 7A.23

These timeframes are affected by factors including readiness for hearing (requiring completion of investigations by the NSW Police Force and/or NSW Health) and the availability of court listing dates (depending on the likely lengthy and complexity of the matter).

DCJ is currently developing capacity to extract and report to the Coronial Services Committee on the following timeliness measures (on a statewide, metropolitan and regional basis) using data from the JusticeLink case management system that relates to key family centred milestones identified by the Taskforce.

1	**Release of deceased for funeral**
1.1	Number of deaths reported
1.2	Number of medical certificates filed
1.3	Number of coronial certificates issued
1.4	Number of post mortem examination orders made

1.5	Average number of days from report of death to medical certificate filed
1.6	Average number of days from report of death to coronial certificate issued
1.7	Average number of days from report of death to order authorising disposal of human remains (for cases where coronial certificate issued only)
1.8	Average number of days from report of death to order authorising disposal of human remains (for cases where post mortem examination order made only)
2	**Closure of the coronial case**
2.1	Number of death cases completed
2.2	Time period between report of death and case closed: percentage completed within 0-3 months, 3-6 months, 6-9 months, 9-12 months, 12-18 months, 18-24 months, >24 months
2.3	Time period between report of death and case closed (cases with no order for brief of evidence only): percentage completed within 0-3 months, 3-9 months, >9 months
2.4	Time period between report of death and case closed (cases where brief of evidence order made only): percentage completed within 0-6 months, 6-9 months, >9 months
2.5	Number of death cases completed that proceeded to inquest (cases with hearing listing, including cases where inquest suspended, referred to DPP)
2.6	Time period between report of death and case closed (cases where inquest held only): percentage completed within 0-12 months, >12 months

Data on measures to improve timeliness:

- *Projections about what has been achieved and what is, hopefully, to be achieved from those measures*

DCJ's ultimate aim is to improve the experiences of families going through the coronial process. Key issues for families are improved communication and information provision, increased timeliness of outcomes (especially the return of their loved one for the funeral), and improved confidence and trust in the process.

DCJ-led initiatives of the Taskforce have included the measures outlined below, where initial data suggests an improvement. However, it should be noted that this is based on preliminary observation over a relatively short period of time to date. Ongoing formal monitoring over a longer period of time is required, and will be undertaken to assess whether apparent improvements are sustained over a longer-term basis.

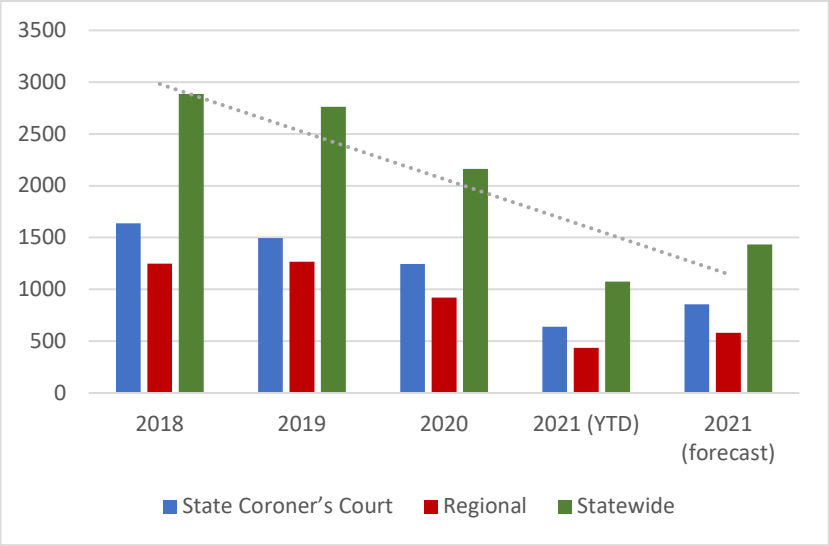
1. Coroners Act 2009 *amendments: impact on reporting of natural cause deaths*

In January 2020, the *Coroners Act 2009* was amended to remove the requirement to report a death to the Coroner if the deceased person had not seen a medical practitioner in the six months prior to their death.

Data provided by the National Coronial Information System (**NCIS**) indicates that, between 2018 and 2020, there has been a reduction in the number of natural causes deaths being reported and in the number of cases closed by the coronial jurisdiction where the death was reported to be from natural causes. This trend appears to have continued in 2021.

Year	State Coroner's Court	Regional	Statewide	• **Data for closed cases:** - **by year of notification to the NSW coroner (1/1/18 – 30/9/21)**
2018	1637	1249	**2886**	

2019	1494	1267	**2761**	- **where case type on completion = death due to natural causes.** • **2021 data available to 30 September 2021** - **italics represent projected numbers based on year to date data.**
2020	1244	920	**2164**	
2021 (YTD)	641	435	**1076**	
2021 (forecast)	*855*	*580*	***1435***	



Data indicates a decrease in reported natural causes deaths:

- From 2018 to 2020 – 24.4%
- From 2018 to 2021 (forecast) - 49.9%, based on projected data to year end
- However, note that the **actual decrease is likely to be less** as 2021 open cases are closed and added to 2021 closed cases.

2. Centralised Initial Coronial Directions

Once reported to the Duty Coroner at Lidcombe Forensic Medicine and Coroners Court Complex (**FMCCC**), a death is triaged by cross-agency staff (NSW Health, DCJ and the NSW Police Force). Medical, family and other relevant information is gathered to enable the Coroner to make directions for the next steps of the investigation, including whether an autopsy or other forensic examination/s need to be performed. The initial coronial direction may involve:

- Any orders for investigation of a death, including any post mortem examination and preparation of a brief of evidence;
- An order to dispense with a post mortem examination and issue a Coroners Certificate to finalise the proceeding, for certain deaths by unknown natural causes where the family does not wish for an examination to be conducted; or
- A 'no jurisdiction' order where, as a result of the triage process, a Medical Certificate of Cause of Death is signed by a doctor and accepted by the coroner.

The centralised coronial decision-making process has been in place since 2017, when the Coronial Case Management Unit (**CCMU**) was established by the then State Coroner, Michael Barnes, to improve the management of all deaths reported from the greater metropolitan Sydney area.

In March 2020, in response to the COVID-19 pandemic, the process was expanded state-wide by the State Coroner. All reportable NSW deaths (greater metropolitan Sydney area, regional and rural) are to be reported to the Duty Coroner at Lidcombe FMCCC for the making of initial coronial directions. This effectively fast-tracked work being done by the Taskforce to identify options to streamline and centralise triaging processes across NSW.

The 2021-22 State Budget included funding for an additional magistrate to be assigned exclusively to the coronial jurisdiction, to enable centralised case management to become business as usual. Additional resources have also been provided to the CCMU at Lidcombe, which co-ordinates the initial coronial direction process.

a. Impact on orders

Early indications suggest the process, which anecdotally has had a positive impact on the management of greater metropolitan Sydney matters, has, since its expansion, been having a positive impact on the management of regional matters, including:

- Coronial decisions (e.g. the issue of a Medical Certificate of Cause of Death, Coroners Certificate or post mortem examination) are being made more quickly, efficiently and consistently with flow-on effects to families including:
    - more timely and informed communications
    - improved capacity to address family concerns
    - faster return of the deceased to their family (in the case of regional deceased requiring a post-mortem examination the median time from admission to release has decreased by 25%, down from 8 days to 6 days)
    - quicker access to death certificates
    - reduced distress.
- A higher number of coronial investigations are finalised at an earlier stage through the issue of a Medical Certificate of Cause of Death or Coroners Certificate, resulting in fewer deceased persons being transferred to a forensic medicine facility for examination (90 fewer in the regions) as well as a reduction in associated costs.

b. Impact on timeliness of released of the deceased

Development of data for regular reporting to the Coronial Services Committee will allow the formal monitoring of this process, with early indications showing a positive impact on regional cases since March 2020 including:

- An increase in the number of cases in which a medical certificate is accepted or a Coroners certificate is issued, and a decrease in the number of post mortem examinations ordered; and
- Faster return of the deceased to their family (in the case of regional deceased requiring a post-mortem examination the median time from admission to release has decreased by 25%, down from 8 days to 6 days).