NSW GOVERNMENT | Communities & Justice

Responses to Questions from the Select Committee on the coronial jurisdiction in New South Wales

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Introduction

Questions unable to be answered by the Department of Communities and Justice (DCJ)

The following questions will not be answered by DCJ in this response, as they relate to:

- Matters of opinion, or
- Matters relating to functions and/or responsibilities of other persons or agencies in the coronial process that are not within the functions or responsibilities of DCJ.

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Data

Wherever possible, data provided in the responses is that which is publicly available and has been subject to a rigorous validation process to ensure its reliability.

Other data has also been provided. The Committee should note that this data has been extracted from the JusticeLink case management system used by the Department of Communities and Justice for the collection of courts data. It should be noted that being a

case management system, it is not purpose built for data extraction or analysis. For instance:

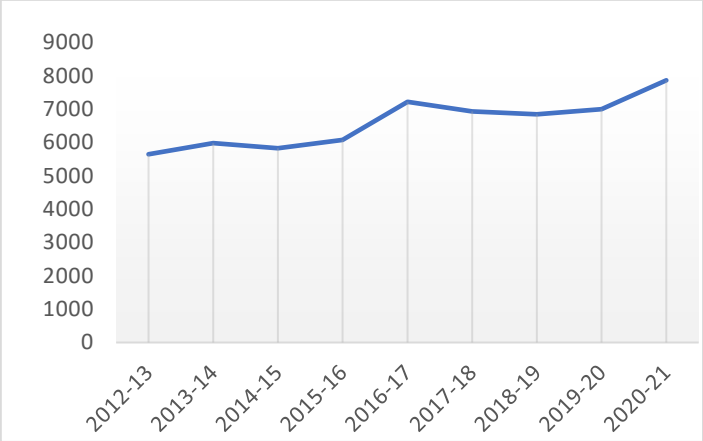
- Data is drawn from information that must be manually entered into JusticeLink by court registry staff and consequently may be affected by factors including the timeliness of entry into the system and accuracy of information about the event.
- In coronial proceedings, the hard copy court file constitutes 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 the case management system 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.

As part of its commitment to the ongoing work of the Coronial Processes 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 from JusticeLink 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. 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.

Funding, workload and resources

1. Please outline how much funding the Coroners Court has received each year, over the last ten years?

Real net recurrent expenditure $'000	
2012-13	5 648
2013-14	5 986
2014-15	5 830
2015-16	6 077
2016-17	7 219
2017-18	6 929
2018-19	6 848
2019-20	7 005
2020-21	7 867



Source: Report on Government Services 2022 (part C, section 7), Table 7A.15.

The above NSW RoGS data covers a period of 9 years since 2012-13. It indicates that funding to the Coroners Court of NSW (**Coroners Court**) has increased by almost 40% in that period.

These figures are for the State Coroners Court only, and do not take into account judicial and staff resources at regional Local Court locations where coronial work is also performed, for example, by the 200 Assistant Coroners undertaking functions across NSW. Assistant Coroners are court staff who, after having successfully completed the "Assistant Coroner Course" are appointed by the Attorney General to undertake administrative functions on behalf of a Coroner, including the issue of burial and post mortem examination orders.

These figure also do not include the recent allocation of additional funding for:

- Two Aboriginal Coronial Information and Support Officers
- Seven additional roles in the Coronial Case Management Unit and the Registry
- An additional Coroner to enable the continuation of centralised case management of initial coronial directions, and
- An additional Coroner assigned to the end of September 2022 to accommodate large inquests due to be heard by the State Coroner.

2. Can you also please provide a breakdown of funding by division/service in the coronial jurisdiction over the last ten years?

It is not possible to provide this comparative analysis as the mix of services and divisions has changed a number of times during this period.

3. What is the caseload of the coronial jurisdiction by year for the last ten years? Can you provide a breakdown for each year by type, including the number of deaths reported, investigations and inquests, even with a breakdown by location if possible.

Coronial statistics are reported in the Local Court Annual Review. Below are the figures since 2011. The figures provide a breakdown by:

- Number of deaths reported to the State Coroners Court/regional
- Investigations finalised
- Inquests, and
- Fires reported (available for 2020 only).

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Deaths reported										
State Coroners Court	3128	2864	2807	2901	2989	3109	3550	3423	3470	3540
Other statewide	2566	2505	2533	2709	2777	2851	3052	2841	3203	2834
Total	**5694**	**5369**	**5340**	**5610**	**5766**	**5960**	**6602**	**6264**	**6673**	**6374**
Investigations finalised										
State Coroners Court	3805	2185	2305	3169	2950	3031	3508	3240	3834	3829
Other statewide	2134	1989	2209	2185	3426	2700	2942	2647	2369	3211
Total	**5939**	**4174**	**4514**	**5354**	**6376**	**5731**	**6450**	**5887**	**6203**	**7040**
Inquests-inquiries										
State Coroners Court	215	111	98	103	87	92	57	74	77	94
Other statewide	75	37	44	37	63	28	27	37	36	18
Total	**290**	**148**	**142**	**140**	**150**	**120**	**84**	**111**	**113**	**112**
Fires reported										
State Coroners Court	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	148
Other statewide	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	54
Total	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**202**

Source: Local Court of New South Wales Annual Review 2020

4. Could you please provide an organisational chart of the NSW Coroners Court.

See Attachment 1. Please note, the Organisational Chart sets out the various roles in the NSW Coroners Court only, and does not take into account judicial and staff resources at regional Local Court locations where coronial work is also performed, for example, 200 Assistant Coroners. It also does not include the recent allocation of judicial resources to the NSW Coroners Court.

5. Data from the Productivity Commission's findings in 2019 show the New South Wales recurrent expenditure on coronial services was $6.9 million, compared with $21.5 million in Victoria.

a. What is your response to this difference?

The tables below provide a resource comparison between NSW and Victoria using Productivity Commission data in the Report on Government Services (**RoGs**). However:

- Structural and operational differences between the coronial system in NSW and Victoria means that funding differences between jurisdictions are not directly comparable. For instance, Victoria operates a fully centralised coronial system whereas the system in NSW is only partially centralised.
- The RoGS indicates that data for Victoria includes additional expenditure on:

  > "the full costs of government assisted burials/cremations, legal fees incurred in briefing counsel assisting for inquests and costs of preparing matters for inquest, including the costs of obtaining independent expert reports".

  These costs are not included in data reported by New South Wales.
- As above, data on funding for NSW is for the Coroners Court only, and does not take into account judicial and staff resources at regional Local Court locations where coronial work is performed.
- Data for NSW does not include recent additional funding noted in response to Q1 above.

FTE comparison to Victoria

*Source: Report on Government Services 2022 (part C, section 7), Tables 7A.29 & 7A.30 (**RoGS**)*

Headcount per 1,000 finalisations				
	Judicial officers		Staff	
	NSW	VIC	NSW	VIC
2012-13	0.8	1.7	7.3	15.3
2013-14	0.8	1.2	6.8	10.4
2014-15	0.8	1.3	7.2	11.2
2015-16	0.8	1.4	6	11.3
2016-17	0.9	1.4	7.1	12.6
2017-18	0.9	1.5	5.9	14.5
2018-19	0.8	1.6	5.2	17.6
2019-20	0.8	1.4	4.7	16
2020-21	0.9	1.6	5.9	17.5

b. What impact does this reduced funding have on your capacity to conduct coronial inquiries and inquests?

Structural and operational differences between the coronial system in NSW and other jurisdictions mean that funding differences between NSW and other jurisdictions are not directly comparable.

6. The NSW Government's submission noted that there are 5.3 full-time equivalent judicial resources allocated to the NSW Coroners Court. Could you please advise if this is sufficient to undertake the work effectively of the NSW Coroners Court?

Over the past 10 years, the number of full time equivalent (**FTE**) judicial officer (Coroner) resources per 1,000 finalisations has remained relatively steady.

The FTE comparison between NSW and Victoria utilising RoGS data (see response to Q5) suggests that judicial resources between these jurisdictions are similar, taking into account that this data does not include the additional staff and Coroner recently allocated to the NSW Coroners Court (see Q1).

7. The Report on Government Services suggests that the New South Wales spend is $990 per finalised case as against the national average of $2,195.

a. Why is the amount significantly lower compared to the national average?

See response to Q1. As a result of structural and operational differences between the coronial system in NSW and other jurisdictions, the difference in spend per case finalised between NSW and the national average is not directly comparable.

b. Is the resourcing of the Coroners Court adequate?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

8. Should the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroners Court can effectively undertake its role in investigating deaths in a timely manner?

Additional resources have been provided, as outlined in responses to Q1 and Q24.

Timeliness of decisions

9. How many Section 23 mandatory inquests are currently before the NSW Coroners court?

As at 24 November 2021, the pending caseload of the coronial jurisdiction includes:

Section 23 Mandatory Inquests	
Death in a police operation	39
Death in custody	102
Total	**141**

Source: JusticeLink case management system. Data is drawn from information manually entered into the JusticeLink case management system that operates in conjunction with paper records. The system owner employs business processes to govern the quality and timeliness of data entered into JusticeLink; however, there may be data quality issues that impact the accuracy of this data

a. How many are undertaken per year?

b. Can you provide figures for the last ten years?

Statistics on the number of mandatory inquests held per year are published in the Local Court Annual Review.

The State Coroner also provides an annual report to the Attorney General that is tabled in Parliament under section 37 of the *Coroners Act 2009*, which provides details of the number of section 23 deaths reported and inquests into section 23 deaths held in any given year.

Figures for the annual number of section 23 inquests held in the last 10 years are as follows:

	2011	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Inquests into s 23 deaths	30	39	36	30	36	23	26	34	37	45

10. What is the current wait time for a post mortem report to be finalised and presented to the Coroner?

NSW Health advises that:

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.

11. What is the average timeframe from a decision to list an inquest to the commencement of an inquest in court?

DCJ Data and Analytics Unit has advised that it is not presently possible to extract this information from JusticeLink.

12. What is the average timeframe for a brief of evidence to be presented to the Coroner?

Data as to the average time taken to finalise a brief of evidence is a matter for the NSW Police Force. This is highly variable, depending on factors including the nature and complexity of the case.

13. What is the average timeframe between the date of death to the handing down of inquest findings? Can you provide this figure for the last ten years.

An average timeframe is not available.

The majority of matters in which an inquest is held take longer than 12 months from the date of report of death to finalisation. However, only a small minority of matters (generally, less than 2%) proceed to an inquest. 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 for 100 percent 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

14. In your view what is a reasonable/expected timeframe for investigations and inquests?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

15. What is the average length of a coronial inquest in Regional NSW?

DCJ Data and Analytics Unit has advised that it is not presently possible to extract this information from JusticeLink. Data on inquest length is not presently recorded.

16. What is the average length of a coronial inquest in Metropolitan NSW?

DCJ Data and Analytics Unit has advised that it is not presently possible to extract this information from JusticeLink. Data on inquest length is not presently recorded.

17. What strategies are being considered /implemented to reduce current timeframes?

The Coronial Processes Taskforce, comprising senior representatives from the government agencies involved in coronial processes (DCJ, NSW Health, NSW Police Force) and judicial members (State Coroner, Chief Magistrate), has recently prepared a Report outlining work being done to identify and implement strategies to address objectives including to reduce delays in the release of deceased persons, and reduce delays in finalising post-mortem reports. A copy of the Taskforce's Report has been provided to the Committee.

As part of its commitment to the ongoing work of the Coronial Processes Taskforce, DCJ is currently developing capacity to extract and report regularly to the Coronial Services Committee on a range of coronial data to enable monitoring over time of the impact of initiatives, including centralised initial coronial directions (see Q24 response below). Development of the data extract and validation process is in progress.

DCJ has undertaken to report on the following dataset:

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

1	Release of deceased for funeral
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

18. When and how frequently are families and kinship updated regarding the coronial process? a. What information is provided at each stage?

The Senior Next of Kin (**SNOK**) is contacted by a DCJ Coronial Information and Support Program (**CISP**) Officer or Forensic Medicine Social Work at the earliest opportunity within 24 hours of a deceased person arriving into the care of Lidcombe Forensic Medicine's mortuary.

- **An initial contact phone call** is made to relay admission information, including that the family's loved one has arrived into the care of the mortuary. Any available and relevant information is provided, including that a CT scan and medical history review is being conducted, and possible examination of the body is flagged. Objection to post mortem examination and any care or treatment concerns of which the family wish the Coroner to be aware are also canvassed.
- **A second phone call** is made to relay the Recommended Coronial Direction (**RCD**) provided by the forensic pathologist for the Coroner's consideration. CISP's role is to discuss any Coroners certificate recommendation or objection to post mortem when an examination is recommended. CISP discusses the recommendation with the SNOK and seeks their acceptance or non-acceptance of the recommended outcome. This can include a number of discussions and review by the Coroner once the family's views and decisions are canvassed.

CISP contact with the SNOK continues throughout the coronial process and timeline as decisions are made by the Coroner and family are kept updated.

19. How are coronial inquest delays communicated/explained to the deceased persons family and kinship?

The Registry's administrative functions include notifying family members about inquest dates and coronial documents being received.

In practice, many family enquiries to the Registry relate to delays in the finalisation of proceedings or provision of specific documents such as the post mortem report. In order to provide realistic information to families about the timeframe for the coronial process, an initial letter is sent that indicates the receipt of the post mortem report will usually take at least several months.

The Lidcombe Registry also uses a Priority Request process to enable families to request that provision of the post mortem report be expedited. Reasons for the request are required. A request is forwarded to the responsible NSW Health forensic pathologist, and is subject to that individual's capacity to accommodate it. On average, the Registry processes one to two Priority Requests per week.

In addition to the Registry, CISP Officers have a role in providing of information and support to family members, which includes management of expectations around the coronial process and transparency as to the possibility of uncertainty of timeframes due to factors beyond the Coroner's control. CISP Officers may also assist advocating on families' behalf for the priority of information release.

20. What are the primary causes leading to delays in coronial investigations and inquests?

There are many possible causes of delay. In cases that cannot be finalised by acceptance of a medical certificate of cause of death or Coroners certificate and proceed to investigation, the Coroner's decision as to whether an inquest should be held or dispensed with depends on the availability of the final post mortem report (completed by the forensic pathologist) and/or brief of evidence (completed by police). Coronial proceedings cannot be finalised without this information.

21. Is there risk that delaying an inquest can impact on the reliability of witness evidence?

This is a subjective issue for the individual witness. A witness' capacity to recall detail can reduce over time. This is a recognised issue in any court proceeding that is not unique to coronial proceedings.

The Coroners Court seeks to minimise delays to reduce trauma for families and to help ensure witnesses can give their best evidence, including through provision of support by CISP Officers at the inquest if this is sought by the witness.

In addition, statements are often taken from witnesses in the course of preparing the brief of evidence, well before an inquest commences.

22. Has the COVID-19 pandemic contributed to delays in the timing of inquests?

a. If so, are their systems or reforms in place to address this backlog?

No inquests were conducted between 23 March 2020 and 19 June 2020.

While some inquests were delayed during periods of lockdown, there was no overall impact on the number of inquests held in 2020 compared with previous years (data below).

Since May 2020, arrangements for the management of coronial proceedings have been put in place and adapted in response to the evolving COVID-19 pandemic. State Coroners Memorandum No. 6 sets out current arrangements to 25 February 2022 for matters listed at Lidcombe Forensic Medicine and Coroners Court Complex, including:

- Masks required to be worn in the building and distancing and density limits to be maintained.
- All parties, legal representatives and family members to appear via audio visual link (**AVL**) or audio link unless exceptional circumstances exist.
- Counsel assisting permitted to attend in person if they wish to.
- Arrangements to be made for media to receive an audio link if requested, and

- Arrangements are in place for formal inquest findings to be delivered in court using technology to enable appearances, with findings to be published online on the Coroners Court website and sent to parties electronically or by mail.

Impact on inquests held

	2016	2017	2018	2019	2020
State Coroners Court	92	57	74	77	94
Other statewide	28	27	37	36	18
Total	**120**	**84**	**111**	**117**	**112**

Source: Local Court of NSW Annual Reviews

23. What process is held to decide which inquiries will be subject to an inquest?

The decision to hold or dispense with an inquest is made by the Coroner upon review and assessment of all material obtained in the course of the coronial investigation, including the brief of evidence and/or post mortem report.

The SNOK should also be consulted for their views.

The Coroner has a discretion to dispense with an inquest unless it is mandatory (section 25, *Coroners Act 2009*). The Coronial Matters chapter of the *Local Court Bench Book* provides guidance on the matters that the Coroner will generally consider, which include:

- Whether the deceased's identity is known and the date and place of death are satisfactorily disclosed.
- Whether the cause and manner of death are satisfactorily disclosed on the evidence.
- Whether the deceased's family requests an inquest and provides a cogent reason(s) for doing so.
- Whether the case raises issues of public health or safety, and
- If so, whether an inquest is likely to lead to recommendations that will assist with the prevention of future deaths of a similar kind.

An inquest must be conducted:

- For suspected homicides, not including suicides (section 27(1)(a)).
- For deaths in custody or in the course of police operations (sections 23, 27(1)(b)).
- Where the evidence does not sufficiently disclose whether a person has died; the identity of the deceased; or the date, place, cause or manner of death (section 27(1)(c),(d)), and
- If directed by the Attorney General or State Coroner (sections 28, 29).

a. Who is involved in this decision?

This is the Coroner's decision, as above. If a Police investigation is conducted, the Officer in Charge is responsible for obtaining the SNOK's views as to whether or not an inquest is requested. The standard practice is for this to be filed as a notice with the brief of evidence.

Notwithstanding the SNOK's views, the Coroner may still form the preliminary view that it is appropriate to dispense with an inquest in circumstances where:

- The evidence satisfactorily discloses the answers to their statutory jurisdiction to determine identity, date, place, cause and manner of death, and
- There do not appear to be any particular public interest issues which should be investigated.

If the deceased's family has sought an inquest in these circumstances, a letter is sent to the next of kin (or their lawyer) requesting a reply within 30 days, which outlines the Coroner's reasons for proposing to dispense with an inquest. Any submission(s) received in response will be considered by the Coroner in making a final decision whether or not to dispense with an inquest.

24. Are clearance rates a true indicator of the performance of the NSW Coroners Court? Please outline any other reforms or measures being implemented to address the timeliness of coronial investigations and inquests.

Clearance rates:

Clearance rates are one indicator of court performance. Clearance rates are an indication of the timeframe within which matters are finalised, which are measured by dividing the number of finalisations in the reporting period by the number of lodgements in the same period. In conjunction with other measures, such as backlog and pending caseload, they provide an indicator as to whether a jurisdiction is managing its overall caseload in a timely manner.

Case clearance rate is a recognised international measure of court performance (for instance, under the International Framework for Court Excellence). However, clearance rates are not an indication of the complexity or work involved in determining a matter.

Measures to address timeliness of coronial investigations and inquests:

Over the last four years, a number of initiatives have been put in place to improve the timeliness of the coronial process. These are outlined in the Report of the Coronial Processes Taskforce provided to the Committee and include legislation aimed at reducing the number of natural cause deaths reported the Coroner, and the establishment in 2017 of the Coronial Case Management Unit (**CCMU**) under the then State Coroner, Michael Barnes.

The CCMU comprises cross-agency staff, including a Coroner, forensic pathologist, clinical nurse consultant, social worker, registry staff and police, co-located at Lidcombe who meet twice daily to present medical, family and other relevant information so that the Coroner can either dispense with a matter or make a direction for the next steps of the investigation, including whether an autopsy or other forensic examination/s need to be performed. The CCMU triages all deaths referred from the greater Sydney metropolitan area.

The CCMU model supports the Coroner to make more timely, consistent and appropriate coronial decisions at the early stages of the coronial process and achieve outcomes consistent with the legislative intent of establishing the cause of death by the least invasive means.

A more recent initiative is the introduction of centralised initial coronial directions. In March 2020, in response to the COVID-19 pandemic, the State Coroner directed that all reported deaths in NSW (greater Sydney metropolitan area and all regional and rural areas) be reported to the Duty Coroner at Lidcombe Forensic Medicine and Coroners Court Complex for the making of initial coronial directions.

This effectively fast-tracked the Taskforce's work in identifying options aimed at streamlining and centralising 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 continue. Additional resources have also been provided to the CCMU at Lidcombe to address its state-wide role. Development of data for regular reporting to the Coronial Services Committee will allow the monitoring of this process, with early indications showing a positive impact on regional cases, 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 and
    - 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.

Provision of information to stakeholders

25. Many submissions highlighted that bereaved families and their legal representatives are waiting weeks, months or even years to be provided with information about the death of their loved ones.

a. Could you please comment on why this is the case?

b. What are the current timeframes for providing information to bereaved families?

Timeframes for the provision of information are highly variable, depending on the nature of the information sought and whether the Coroner's approval is required.

Timeframes may be lengthy for several reasons:

- In some cases, the Coroner must approve release of documentation before it is provided to family on a case by case basis.
- The availability of the forensic pathologist in completing the post mortem report, the availability of Coroners and registry staff workload can impact the response time for the family, and
- The multi-disciplinary coronial process involves coordinating with other parties and organisation to ensure information is able to be provided to family members.

In addition, family members must make a specific request for copies of documents including the post mortem report through the Registry. This is due to the distressing nature of the information and that some family members do not wish to receive it.

DCJ would be happy to respond to any specific examples.

26. What is the timeframe and process for providing a brief of evidence (including medical records, transcripts of interviews, statements, and reports) to family and next of kin?

a. When would family and next of kin expect to receive this information?

The current estimated timeframe provided by Forensic Medicine for completion of post mortem reports is in the range of 6 to 12 months. However, depending on the extent of the examination performed (for instance, where organ retention is required), this report can take over 12 months to be completed and ready for release to family.

The Police brief of evidence can take several months to be completed and provided to the court registry, depending on the nature and extent of the brief requested by the Coroner. Once the brief has been submitted, it can often be released quickly to the SNOK on their request. However, in some cases this requires the Coroner's approval prior to release due to the sensitive and/or distressing nature of the contents.

b. Submissions to this inquiry have mentioned long delays in getting these materials despite multiple requests. Do you have comments on these concerns.

Timeframes are variable due to a range of factors that are often outside of the court Registry's control, including time taken to receive the documents from police or Forensic Medicine.

CISP Officers, who assist families with enquiries, aim to act on telephone enquiries on the same day. Registry staff aim to action requests as soon as possible, depending on the nature of the enquiry. However, there can be delays if a request requires review by a Coroner prior to the release of information or consideration by another agency in the coronial process.

27. Is there a feedback and/or complaints process for people involved in the coronial process?

a. How is it accessed?

Complaints and feedback can be submitted through the Coroners Court public website, via the Contact us section. Complaints and feedback can also be provided verbally or in writing to any staff member employed at the court for appropriate action by a relevant manager.

b. Is it available in plain English?

Yes.

c. What reporting is provided in relation to complaints?

Depending on the nature of the complaint, it may be referred for action to the Registrar, Manager of Coronial Services, CISP Coordinator or State Coroner.

Generally, neither the State Coroner nor the Chief Magistrate is able to address concerns about the correctness of a decision made by a Coroner, and these concerns can only be determined via a formal appeal process.

Under section 29 of the *Coroners Act 2009*, the State Coroner is able to review a Coroner's reasons for dispensing with an inquest and direct that an inquest be held if of the opinion that an inquest should be held.

Complaints about the conduct of a Coroner may be made to the Judicial Commission of New South Wales.

Amendments to the *Coroners Act 2009*

28. Many stakeholders participating in this inquiry have called for a complete overhaul of the Coroners Act.

a. Do you think there is a need to review the Coroners Act?

The legislation is subject to a statutory review required by section 109 of the *Coroners Act 2009*. This review is currently ongoing.

b. What structural or other reforms do you think would be beneficial to the Coroners Court?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

c. Should elements of the Victorian Act be applied to improve the New South Wales Act? If so, which ones?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

29. Have you been involved in the 2017 statutory review of the Coroners Act? And if so, could you please provide an update on where this review is up to, and outline what steps or consultative process has been undertaken in relation to the review?

As noted in the Government Submission #18 to this Select Committee inquiry, the work of the Improving the Timeliness of Coronial Procedures Taskforce bears on the question of whether the policy objectives of the *Coroners Act 2009* 'remain valid' and its terms 'remain appropriate for securing those objectives' (see s 109(1), *Coroners Act 2009*). The statutory review of the *Coroners Act 2009* was on hold to allow the Taskforce to complete its work. The Taskforce finalised a report on its work and was disbanded in October 2021. Work on the statutory review has recommenced.

30. Does the existing legislative and system effectively accommodate cultural needs and considerations?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

31. Do you support the Coroners Act 2009 to be amended to expand the definition of 'relative' and 'senior next of kin' to recognise the deceased persons extended familial or kinship structures?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

32. Should section 24 of the Act be expanded to cover residents in aged care facilities?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

33. Section 78 of the Coroners Act 2009 requires a Coroner to forward to the Director of Public Prosecutions the deposition taken at an inquest or inquiry if a Coroner forms the opinion that *"(i) the evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and (ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence"*.

a. How often does this occur?

b. Can you provide figures for each year for the past ten years.

The suspension of coronial proceedings and referral of a case to the Director of Public Prosecutions (**DPP**) occurs relatively infrequently.

Data is only available from 2013 onwards, following the migration of the coronial jurisdiction to the JusticeLink case management system.

	2013	2014	2015	2016	2017	2018	2019	2020	2021*	Total
Case suspended - referral to DPP	3	2	3	0	1	2	1	5	1	**18**

Source: JusticeLink case management system. Data is drawn from information manually entered into the JusticeLink case management system that operates in conjunction with paper records. The system owner employs business processes to govern the quality and timeliness of data entered into JusticeLink; however, there may be data quality issues that impact the accuracy of this data.

c. What challenges exist in relation to the wording of this provision?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

d. Should this provision be amended/strengthened? If so, in what way?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

Examining systemic issues

34. To what extent does a Coroner consider the quality of care, treatment and supervision of the deceased before their death, and investigate the wider systemic circumstances?

Coroners have powers to examine systemic issues and make recommendations under the *Coroners Act 2009*. Section 3(e) of the *Coroners Act 2009* sets out the coronial jurisdiction's preventative role, which enables Coroners to:

> "make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)".

Coroners regularly use this power to make recommendations for system-wide improvements.

The State Coroner's report into First Nations People's Deaths in Custody noted that coronial recommendations addressed a range of systemic issues, including the need for improved mental health treatment and medical care, additional training, Aboriginal staffing levels and custody notifications.

35. Should the Act be amended to include an express statutory function on the Coroner to undertake systemic research and reviews of deaths in custody, including maintaining a public register of deaths and tracking trends and identifying systemic issues?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

a. What issues or implications would you see with this proposal?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

36. Do you support the Coroners Act 2009 to be amended to provide the Coroner with powers to make recommendations in relation to the impact of systemic issues (including racism) on First Nations people and how it contributed to their deaths? Please explain your answer.

This is a policy question for government.

Accountability of Coroners recommendations

37. In NSW, the 2009 Premiers Memorandum encourages state agencies and ministers to respond to recommendations 'within six months of receiving a coronial recommendation'.

a. Do state agencies and ministers routinely respond to recommendations within the six month timeframe?

b. How are the responses provided, and what happens from there?

Ministers and NSW government agencies follow the processes outlined in the Department of Premier and Cabinet (**DPC**) Memorandum 2009-12 (**the Memorandum**) to provide acknowledgment to the State Coroner of receipt of a recommendation. This acknowledgement is kept on the court file when received. The Memorandum also requires Ministers to:

- implement recommendations unless a recommendation is impracticable due to cost or other factors or the outcome can be achieved in another way, and
- respond to the State Coroner within 3 months with further 3-monthly progress reports if required.

Responses received are sent to DCJ Legal, which compiles and publishes a table of responses to coronial recommendations.

c. Should this requirement be included in the Coroners Act?

As indicated in the NSW Government's response to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, a recommendation of this kind (Recommendation 32 of the Select Committee's report) will be considered in the context of the statutory review of the *Coroners Act 2009*.

d. Would you support the NSW State Coroner being afforded power to require any government agency to provide a response to recommendations within a fixed time, and for the State Coroner to report to Parliament if an inadequate response is received?

This is a policy question for government.

38. How does the NSW Coronial Jurisdiction monitor government agencies implementation of recommendations made by the Coroners Court?

NSW Government responses to coronial recommendations made pursuant to section 82 of the *Coroners Act 2009* are forwarded to DCJ Legal, which publishes the responses on the Department's website.

a. What reporting happens in this regard?

Agencies and Ministers are required to report to the Attorney General, within six months of receiving a coronial recommendation, outlining any action to be taken to implement the recommendation.

b. Would you support the publication of progress reports on the Coroners Court or other relevant agencies websites?

This is a policy question for government.

39. Should New South Wales Coroners be given the power to make findings on every matter, not only matters that go to inquests, with all findings published? Please explain your response.

This is a policy question for government.

For information: In practice, a large majority of deaths do not require an inquest, because, on the available evidence-

- the statutory objects of the Coroner's investigation (determination of the identity of the deceased person, the times and dates of their death, and the manner and cause of their death) are satisfactorily addressed, and
- no systemic issues are raised.

When dispensing with an inquest, the State Coroner has directed that in all cases the Coroner must provide written reasons addressing the statutory objects of the Coroner's investigation that are placed on the coronial file. A single page form is used. A copy is made available to the SNOK on request to the Registry.

40. Should New South Wales adopt a similar provision in the Act to Victoria, where it stipulates that recommendations may be made to 'any entity on any matter connected with a death' (s 72(2) of Vic Legislation)?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

41. Do you support the establishment of a Coroners Prevention Unit (similar to Victoria) to identify systemic issues, provide a robust evidentiary base to assist Coroners in writing more meaningful recommendations, provide expertise to follow up on coronial recommendations and promote adherence by government agencies? How would this work in NSW?

This is a policy question for government.

Training of Coroners

42. Could you please outline the training that is provided to new Coroners as they commence in their role?

Prior to commencing their required period of country service, newly appointed magistrates are provided with the opportunity to complete a short rotation at the Lidcombe State Coroners Court to gain experience in coronial proceedings while working alongside senior Coroners.

a. What additional training should be provided to new Coroners?

b. Should there be a focus on providing ongoing training to regional Coroners?

c. Could a professional development syllabus be developed in New South Wales for Coroners?

d. Has any similar proposal been looked at before?

Ongoing education and training of Coroners (magistrates) is developed and delivered by the Judicial Commission of New South Wales, working with the Local Court.

43. How should Coroners be appointed to ensure that the skills and expertise are appropriate?

The NSW Government is responsible for appointing magistrates.

44. What ongoing performance and development process in in place for Coroners?

This question should be referred to the Judicial Commission of New South Wales.

Structure of the NSW coronial jurisdiction

Questions 45-57 cannot be answered by DCJ as they seek opinion evidence.

Meeting the needs of bereaved families

58. Submissions to the inquiry have commented that the current coronial process can be traumatising and confusing for families. Could you please comment on what the court can do to:

a. streamline and simplify the various processes for bereaved families?

b. make information more clear and accessible?

c. ensure it is more inclusive and respectful of the families involved, including personalised and relevant support to individual circumstances?

d. provide information to bereaved families on the expectations and practicalities of going to court during the inquests, including their role in the process?

CISP practice is informed by grief and loss research, which has found that, when a person has died suddenly and unexpectedly, at the initial stage, family need clear and simplified information to assist them to understand coronial processes. This can include:

- Having one contact person throughout the process.
- Limiting unnecessary contact made to family by phone or email, and
- Using simple language and asking questions to canvas family's knowledge and ability to take in information at that time.

59. Some submissions to the inquiry have commented on offensive behaviour of solicitors, advocates, and witnesses at the Coroners Court outside of formal hearings, including horseplay, jokes, disparaging remarks about the deceased and the deceased's family.

a. How much oversight does the Coroner have over these behaviours?

b. What is being done to mitigate these behaviours?

The State Coroners Court is not aware of any such behaviours.

60. What considerations and support are given to the financial and logistical practicalities for family members when participating in coronial inquests?

CISP and Registry staff assist in identifying what supports family may require throughout the process. Examples include allocating a separate room near the courts for family during the inquest, and enquiring if accommodation could be provided.

c. Are you aware of any financial support to assist families to travel to and from coronial inquest hearings (particularly for those in remote and regional communities who may face significant transport and accommodation costs)?

On a case by case basis, the court may assess if transport or accommodation costs could be covered by DCJ or through other agencies.

b. Are bereaved families provided their own room within the Coroners Court to use in between proceedings?

Yes, upon request and availability of these spaces.

c. Does the Coroners Court provide other forms of financial assistance and support to bereaved families attending the court for an inquest, for example, food allowances?

Yes, on a case by case basis depending on request and availability.

d. Are witnesses provided support and counselling on the day of the inquest?

Yes, the CISP is available to assist upon request.

61. What is the current process for connecting bereaved families with legal assistance?

This will vary depending on the type of matter, and if the death falls within a particular provision of the *Coroners Act 2009*.

- Most cases that proceed to inquest do not fall under section 23 or 24 of the Act, and family do not meet requirements for Legal Aid. Family are required to choose their own legal representation, if any. The CISP is able to suggest options, but cannot give legal advice.
- Section 23 deaths of First Nations persons require the Crown Solicitor's Office (**CSO**) or DCJ Legal to be instructed to assist in relation to the conduct of the coronial proceedings within 48 hours. An Aboriginal Coronial Information and Support Program Officer is also assigned as a liaison point for the SNOK (and other family members of the deceased person as appropriate in the circumstances) within 48 hours.

A What are the timeframes for bereaved families accessing legal assistance?

This is a matter for the family. By the time a matter proceeds to inquest, those families who wish to be legally represented will have obtained legal representation, either through specialist units at Legal Aid NSW or the Aboriginal Legal Service (NSW/ACT) Limited, or the family's other choice of legal representative.

b. Are you aware of any financial support to assist families to obtain legal representation?

This occurs on a case by case assessment. However, in most matters family must make their own arrangements to connect with legal representation of their choice.

c. Should the Coroners Court be required to connect bereaved families with legal assistance early on in the process?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

62. Who is the primary contact for bereaved families throughout the coronial inquest?

Depending on the needs and preferences of the family, this maybe their chosen legal representation or CISP.

a. How much contact and support is provided to bereaved families?

The CISP facilitates contact and support based on the needs and preferences of each individual family. For example, this could be sitting in person at court every day of the inquest, or a phone call prior to the inquest.

b. Does the primary contact provide practical and logistical support to bereaved families on the inquest process?

Yes, a CISP Officer may assist with this and/or coordinate with counsel assisting the Coroner and the court.

63. What information is provided to families when a post mortem examination is required? a. Are the views of the family considered when determining whether or not to order a post mortem examination?

The CISP speaks to the SNOK when an objection to examination is noted. The Coroner considers the views of family in the recommended coronial direction and aims to consider their wishes as much as possible. However, this may not be possible in matters that are considered suspicious or when a potential homicide has occurred.

The general information provided to the SNOK is as follows:

1. Explain why the body is with the Coroner.
2. Ask for permission to do the examination required/ordered (CT, External and Toxicology Examination, External and Rapid Toxicology Examination, Coronial Post Mortem) and provide information about the different types of examinations.
3. Explain the timeframe for an examination. Generally, physical examination of the body takes a few hours from when it begins in the morning. It is usually finished by lunchtime and, provided no further testing is required, the body is usually ready for release to the funeral by the end of the day.
4. Explain the process for maintaining the objection. Broadly, this requires the SNOK to provide a written objection that is reviewed by the Coroner to consider amendment of the order; and if the Coroner does not amend the order, the SNOK has two days to make an application to the Supreme Court to request that it overrule the Coroner's decision.
5. Explain the timeframe for an application to the Supreme Court.

64. Could you please provide an update on the revised practice note for guidelines for senior Coroners for case management of deaths in custody.

a. When will this be finalised?

Coronial Practice Note 3 of 2021: Case Management of Mandatory Inquests Involving Section 23 Deaths commenced on 24 September 2021. This Practice Note sets out case management arrangements for all deaths which fall within the scope of section 23 of the *Coroners Act 2009* that occur on or after this date.

b. What consultation on the guidelines has taken place?

c. What stakeholders were involved in the consultation?

In accordance with the Court's usual processes, key stakeholders from the coronial jurisdiction were consulted in relation to the development and drafting of this Practice Note, including:

- NSW Police Force
- Corrective Services NSW
- Legal Aid NSW
- Crown Solicitor's Office
- DCJ Legal
- Aboriginal Legal Service (NSW/ACT)
- Law Society of New South Wales
- New South Wales Bar Association
- NSW Health
- DCJ Court Services

65. Would you support having the discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request? It has been stated that this would enable families to achieve some level of closure after a long investigatory process that mirrors a coronial inquest.

This question seeks an answer based on opinion. It is not appropriate to answer this question.

Meeting the needs of First Nations families and communities

66. Do the staff at the NSW Coroner's Court have adequate training in relation to First Nation cultural awareness and cultural competency? (Specifically regarding death and bereavement protocols).

DCJ's Aboriginal Employment Strategy, which will be rolled out in early 2022, includes a number of strategies to build the cultural capability of staff, each year and ongoing, bespoke to the operating context of courts.

a. Would you support a cultural safety framework being developed?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

b. Are forensic pathologists trained in First Nations peoples cultural practices, and how to respect those practices?

This is a matter for NSW Health.

67. Do you permit cultural customs such as smoking ceremonies, dances, changing hearing dates to accommodate sorry business, inclusion of objects of cultural, familial, and personal significance?

Yes. See response to Q68 below for more information.

68. What other measures is the court implementing to provide a more culturally appropriate service and space for First Nations peoples?

Aboriginal Coronial Information and Support Program Officers assist to ensure the coronial process is as culturally sensitive and appropriate as possible and adheres to any cultural considerations raised by family. As outlined in the draft First Nations Protocol, this includes:

- The name the family wish to use for the deceased throughout the duration of the hearing(s) and appropriate warnings about use of those names, including in hearings convened via audio link or AVL.
- Whether it is appropriate to hear all or part of the inquest on nominated Country of the deceased.
- Performance of an Acknowledgement of Country, Welcome to Country, and/or a smoking ceremony, and
- Display and use in court of symbols and artefacts of cultural significance to the deceased and the deceased's family.

69. The committee notes the two newly appointed First Nations Information and Support Officers in the Court.

a. Does the NSW Coronial Jurisdiction have a workforce plan to increase First Nations staff numbers?

Work is underway as part of DCJ's Aboriginal Employment Strategy to progress a range of strategies specific to Court Services to increase the number of Aboriginal people employed in courts, including the coronial jurisdiction and to improve the cultural competency of non-Aboriginal staff.

This strategy includes the appointment in 2021 of two Aboriginal Coronial Information and Support Officers.

b. Do you think other First Nations specific roles are needed in the Coroners court to assist with cultural competency?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

70. Could the Coroners Court employ one or more First Nations Coroners and First Nations commissioners to sit on all inquiries relating to the death of a First Nations person? What issues would need to be considered with this proposal.

This question should be referred to the NSW Government, which appoints judicial officers.

71. Does the NSW Coronial Jurisdiction have a database of First Nations people to serve as expert witnesses and/or other support during a Coronial Inquest? If so, how and when is this used?

There is no established database, however, First Nations witnesses are called upon when required.

72. Does the NSW Coronial Jurisdiction regularly consult with First Nations people and/or Peak Bodies on the effectiveness of its services?

a. If so, how?

b. Could this consultation process be improved?

As a result of recent changes to operations and practice in the coronial jurisdiction, including the appointment of two Aboriginal Coronial Information and Support Officers and the development of a First Nations Protocol, strategies for improving consultation with First Nations people and peak bodies have been put in place and will continue to be improved.

73. Has the Coronial Jurisdiction implemented recommendations from the Royal Commission into Aboriginal Deaths in Custody?

a. What progress has been made to implement these recommendations?

Recommendations relevant to the coronial jurisdiction are contained in the section on Post-Death Investigations, Recommendations 6 to 40 of the Recommendations from the Royal Commission into Aboriginal Deaths in Custody National Report.

All those recommendations for which the State Coroner has responsibility have been implemented, except for the Protocol in Recommendations 38 and 39 which is currently being finalised.

74. Could you please provide an update on the protocol for the case management of inquests under section 23 involving First Nations people?

A consultation draft of the Protocol was circulated to key stakeholders for written comment in August 2021, with responses due by 19 November 2021. The State Coroner is currently considering all feedback received.

a. When will this be finalised?

The commencement date for the Protocol will be subject to the outcome of the consultation process.

b. What consultation on the guidelines has taken place?

See above.

c. What stakeholders were involved in the consultation?

The draft Protocol was circulated to, and useful feedback was received from, a number of key legal and First Nations stakeholders and the two Aboriginal CISP Officers.

75. Could you please provide an update on the establishment of the Koori Engagement Unit (similar to Victoria) in the New South Wales Coroners Court?

The State Coroners Court has recently employed two Aboriginal Coronial Information and Support (CISP) Officers, who commenced in September and October 2021.

The Role Description for these roles was developed in consultation with Troy Williamson, Manager of the Koori Engagement Unit in Victoria, and DCJ's Aboriginal Services Unit.

Since commencing in the role, the Aboriginal CISP Officers have been providing support to two Aboriginal families whose loved ones have recently died in custody and have reviewed the list of reported deaths for 2021 and identified additional persons whose Aboriginal status had not been recorded.

Meeting the needs of culturally and linguistically diverse families and communities

76. How do you accommodate cultural and religious protocols related to the treatment of deceased bodies? Provide examples.

The Coroners Court recognises the importance of faith and culture in families' experiences of grieving the sudden and unexpected death of a loved one. It is acknowledged that processes including the carrying out of post mortem examinations and whole organ retention can conflict with religious beliefs and/or cultural practices of families interacting with the coronial system.

The Coroner is required to balance the needs and requirements of the family with the requirements upon a Coroner to properly investigate a death which may be sudden or unexpected and possibly suspicious. When determining family objections to a post mortem examination, the *Coroners Act 2009* does not expressly require the Coroner to have regard to religious beliefs and/or cultural practices, but requires that the Coroner have regard to the dignity of the deceased person and order the least invasive procedure to allow the determination of the cause of death (section 88). In practice, when making the initial coronial direction the Coroner will take religious beliefs and cultural practices into account when determining whether it is "necessary or is desirable" in the public interest to conduct an examination, and if so, will adhere to the requirement to order the least invasive procedure appropriate in the circumstances.

There may be circumstances where the Forensic Pathologist wishes to retain whole body organs that are required for further examination. Organ retention is in direct opposition to the religious practices of some faith communities who may wish for burial or cremation of their loved one within a short period of time, or wish to ensure the body is 'intact' or all organs returned for a funeral practice as per their religious or cultural beliefs. This is only to occur where the Forensic Pathologist believes that retention will assist determination as to the medical cause of death (section 90(5)).

Examples of operations and practices to support the needs of culturally and linguistically diverse families and communities include:

- P79A Police Report of death to the Coroner form includes provision for early notification that the SNOK objects to a post mortem examination.
- Coronial Information and Support Program Officers, who are trained social workers, act to liaise with the Coroner and SNOK throughout the coronial process, including to provide information and support to families in relation to objections to the post mortem process and whole organ retention. CISP Officers (although they are based at the Lidcombe Forensic Medicine and Coroners Court Complex) are available to provide support in coronial matters across the state and regularly engage with multifaith and culturally and linguistically diverse clients and their communities.

- The Coronial Case Management Unit triages deaths reported to the Coroner at Lidcombe, and regularly works with the Coroner to expedite cases on cultural religious grounds when expressed by the deceased's family or community, particularly to facilitate priority release of the deceased for burial.
- Multifaith room: the Lidcombe Forensic Medicine and Coroners Court Complex has a dedicated multifaith room or prayer room that clients can utilise when attending the facility.
- Consultation with Muslim and Jewish religious leaders: The State Coroner's Office has engaged in consultation with religious leaders of Australian National Imams Council and Chevra Kadish to develop a form which is used to indicate:
  - Any objection to post mortem examination, including whether the objection relates to full (invasive) post mortem examination and/or external (non-invasive) examination of the deceased, and
  - Request for priority release consideration.

77. Do senior next of kin have an opportunity to choose the gender of the pathologist when there is relevant cultural consideration? Why or why not?

This is a matter for NSW Health.

78. What support is offered to culturally and linguistically diverse families and communities who are in contact with the Coroners Court?

See response to Q76 above.

79. What engagement have you had with culturally and linguistically diverse families and communities in relation to the ways in which the Coroners Court can meet the needs of these communities?

See response to Q76 above.

Intersection between the coronial jurisdiction and work, health and safety laws

80. Could you please comment on the intersection between the coronial jurisdiction and work, health and safety laws, particularly in terms of work-related fatalities.

In August 2020, a Protocol for Cooperation between NSW Government agencies and the State Coroner in relation to Workplace Incidents was signed between the State Coroner, NSW Police Force, SafeWork NSW and the Resources Regulator.

The Protocol sets out the roles and responsibilities of each agency in relation to the investigation and prosecution of workplace incidents.

81. Can you provide any figures related to how many workplace fatalities are dealt with in the coronial jurisdiction?

DCJ does not hold this information. The Committee may wish to consider seeking this data from the National Coronial Information System.

82. How many matters did you refer to SafeWork NSW in the last ten years?

None. This is a matter for the NSW Police Force.

83. Does a memorandum of understanding exist between you and SafeWork NSW?

See response to Q80 above.

Comparison of other Australian state and territory jurisdictions

84. What learnings have been applied from other jurisdictions in New South Wales?

The two Aboriginal CISP Officer roles recently established at the State Coroners Court are based upon Koori Engagement Unit roles in the Coroners Court of Victoria and were developed in consultation with the Manager of the Victorian unit.

DCJ and the State Coroner have been involved in establishing the Suicide Monitoring System, an interagency collaboration with NSW Health and Police. The System was launched in November 2020, and provides monthly data on suspected and confirmed suicides in NSW, similar to the review work undertaken by the Suicide Register maintained by the Coroners Prevention Unit in Victoria. Public reports are available on the NSW Health website. A Technical Experts Reference Group, which includes analysts from suicide registers in other jurisdictions, meets quarterly to share expertise as work continues to develop the System's data collection and reporting capabilities.

85. What further reforms or learnings from other states and territories could improve the New South Wales coronial jurisdiction?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

86. How often is there communication/engagement between coronial jurisdictions to share learnings?

Australian State and Territory Chief Coroners meet twice a year to discuss issues and share learnings between jurisdictions. Meetings are hosted by the Chief Coroner of the State/Territory that has agreed to host the annual Asia Pacific Coroners Conference that year. Agenda items for the conference are also discussed.

Coroners from the Asia Pacific region meet at the annual Asia Pacific Coroners Conference, established in 2002 to promote the advancement, best practice and education of coronial law and practice. Membership is open to all Coroners and to anyone involved in, or associated with, the coronial jurisdiction, such as pathologists, forensic scientists, police investigators, lawyers, and grief counsellors. Members of the Society are located in Australia, New Zealand, and various nations in the Asia Pacific region.

The next conference is due to be held in Queensland in November 2022.

Medical advice and input into Coronial inquests

87. What is the coronial reporting process when an unexpected death occurs at a health facility?

The relevant medical practitioner will determine whether the death is reportable. Once that determination is made, they will contact the NSW Police Force, which attends the scene and assess whether the death is reportable. If so, police make the appropriate arrangements to report the death to the Coroner and transfer the deceased to the mortuary.

a. Would the medical practitioner involved in the unexpected death also be involved in the decision as to whether the death is reported to the Coroner?

Yes. The practitioner needs to make a determination as to whether the death was an unexpected outcome.

b. Would you support creating a qualified independent position to determine whether a health related death is reported to the Coroner?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

88. Submissions received from medical practitioners have indicated there is a 'doubling up' of recommendations between the 'Root Cause Analysis' process within NSW Health, which is used to review/analyses incidents of clinical unexpected death within a health facility, and recommendations made in the coronial inquest.

Under section 23 of the *Health Administration Act 1982*, Root Cause Analysis reports are not admissible in any proceedings, including coronial proceedings.

a. Do you receive Root Cause Analysis results prior to a Coronial inquest?

This is a matter for the Coroner.

It is understood that the Coroner may request a Root Cause Analysis report but cannot require it to be produced nor refer to it in any findings should the matter proceed to an inquest. If provided, the Root Cause Analysis report can be useful in indicating whether relevant systemic failures were identified by a hospital, and whether recommendations were made and if so implemented.

b. Is there is adequate input from relevant medical clinicians in Coronial inquests?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

c. When making recommendations do you consider the costs involved in implementing recommendations, including new equipment and developing new systems?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

Bushfires

89. Bushfires are an annual occurrence in New South Wales, however findings from coronial inquests into bushfires regularly take over two years to be released after the bushfire event. Community groups and firefighters have called for the NSW Coroners Court to release findings and recommendations in a timely manner so that lessons can be acted upon before the next bushfire season.

a. What is the average timeframe for a Bushfire investigation and inquest?

There is no average timeframe. As the circumstances surrounding each bushfire are different (in terms of their cause, origin, extent of property damage, any deaths involved), each inquiry will be different.

b. Is it possible with current resourcing to expedite inquest findings and recommendations so that lessons can be identified and acted upon within a 12 month timeframe?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

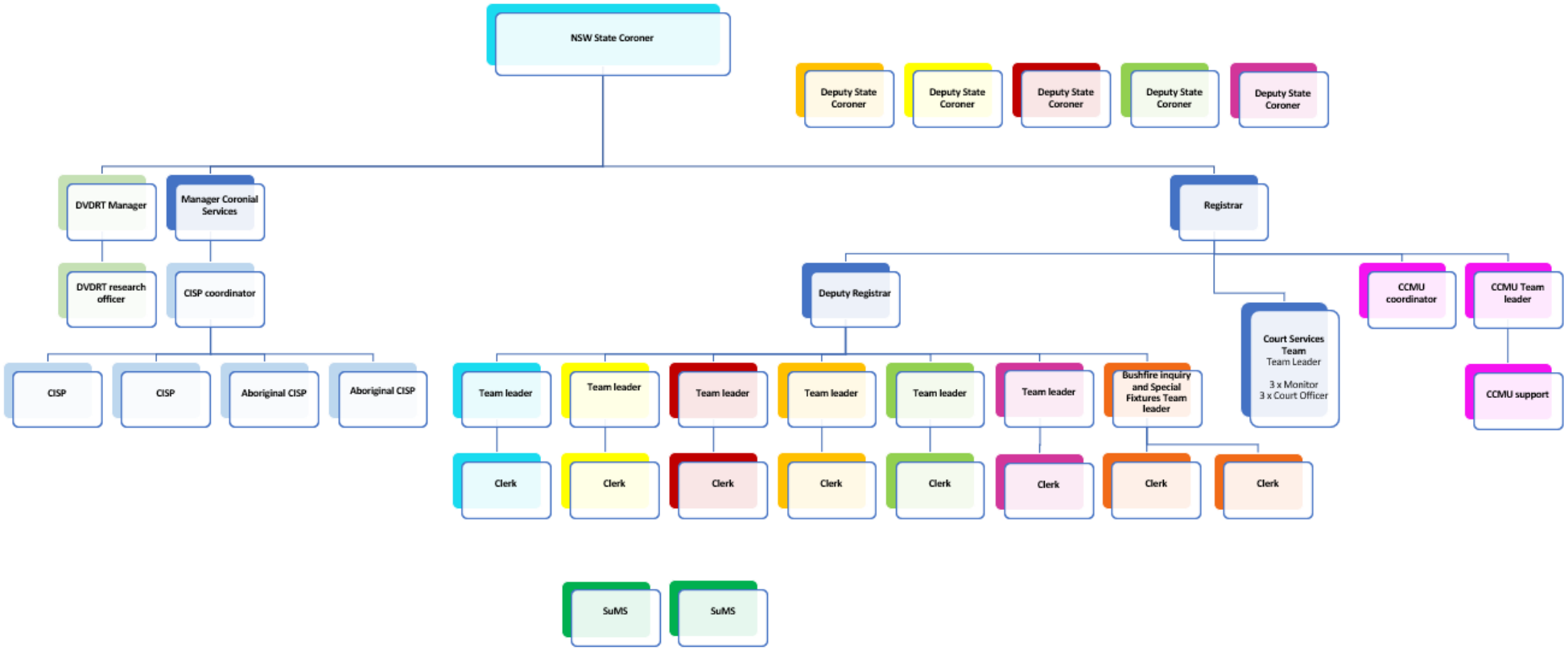
c. Would you support releasing relevant evidence, information, and documents (which may help prevent similar bushfires) to the public before the completion of a coronial investigation?

This question seeks an answer based on opinion. It is not appropriate to answer this question.

d. Would the introduction of 'standard templates', which detail essential information between fire agencies and the Coroner, help accelerate the coronial process for bushfire investigations and inquests?

The NSW Police Force, in consultation with the State Coroner, developed a template for the collection of evidence from witnesses for the investigation of the 2019-20 bushfires.

NSW State Coroners Court Organisational Structure



as at 2 December 2021