The Hon. Brad Hazzard MP
Minister for Health and Medical Research

Mark Speakman
Attorney General

The Hon. Adam Searle, MLC
Chair
Select Committee on the coronial jurisdiction in New South Wales
coronial.jurisdiction@parliament.nsw.gov.au

Our ref H21/202443-1

Dear Mr Searle

Select Committee on the coronial jurisdiction in New South Wales

We write in relation to the Select Committee on the coronial jurisdiction in New South Wales.

In July 2021, Mr Mark Follett, Executive Director, Policy, Reform and Legislation Branch, Department of Communities and Justice, wrote to you and provided a submission to the inquiry on behalf of the NSW Government.

The NSW Government submission referred to the Improving the Timeliness of Coronial Procedures Taskforce (Taskforce), which was established in July 2019 to identify ways to reduce delays in coronial procedures and improve the experiences of families and loved ones. The submission noted the Taskforce was in the process of preparing a progress report on its work. The Taskforce recently finalised this report and a copy is enclosed for the Select Committee's information.

Yours sincerely

Brad Hazzard
Minister for Health and Medical Research

Mark Speakman
Attorney General

26 November 2021

Encl. *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce*

Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce

October 2021

NSW GOVERNMENT

Acknowledgment and Copyright page.

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1. Executive summary

In July 2019, the NSW Government established the Improving the Timeliness of Coronial Procedures Taskforce (Taskforce) to identify ways of improving the timeliness of coronial procedures and the experiences of families and loved ones.

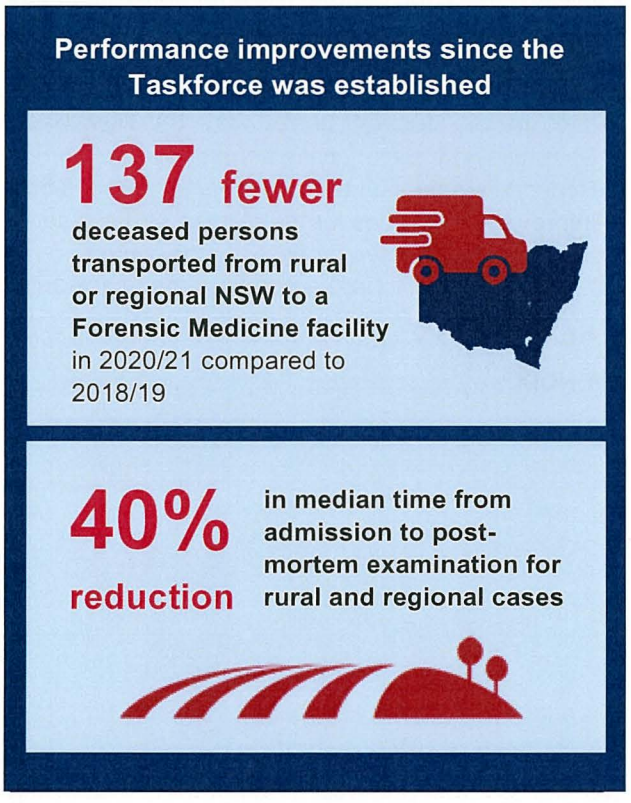
The Taskforce was established in response to representations made by, or on behalf of, families between October 2018 and February 2019. These representations expressed concerns about deceased persons being transferred away from their local communities, delays in deceased persons being returned to their families and timeframes for the finalisation of post-mortem reports. Many of these representations were from or on behalf of families in rural and regional areas.

The Taskforce understands there can be significant health, financial and/or social impacts on individuals, families and communities as a result of the sudden, unexplained and traumatic death of a loved one. Navigating the coronial pathway adds to this burden.

The Taskforce has examined the coronial pathway, excluding processes involving inquests and the dispensing of coronial matters by a Coroner, and identified a range of initiatives to improve the coronial system (shown in Figure 1.1). These include increased education and support for general practitioners on issuing Medical Certificates of Cause of Death, reforms to the *Coroners Act 2009* (NSW) (*Coroners Act*), process improvements and centralising initial coronial directions for rural and regional deaths. These initiatives are in varying stages of implementation, as outlined in Chapter 4.

The Taskforce has identified key performance indicators (see Table 1, below) for agencies to measure the impact of these initiatives over time. While it will take some time before the full benefits of all these initiatives are realised, there have already been notable performance improvements since the Taskforce was established. These are summarised in Chapter 5, and include:

- a reduction in the number of deceased persons transferred to a Forensic Medicine facility,
- improved timeframes for the release of deceased persons back to their family,
- more consistent and timely coronial directions being made, and
- improved timeframes for finalising post-mortem reports.



As many of the Taskforce's initiatives are now either complete or have entered the implementation phase, the time-limited Taskforce is expected to conclude by the end of 2021.

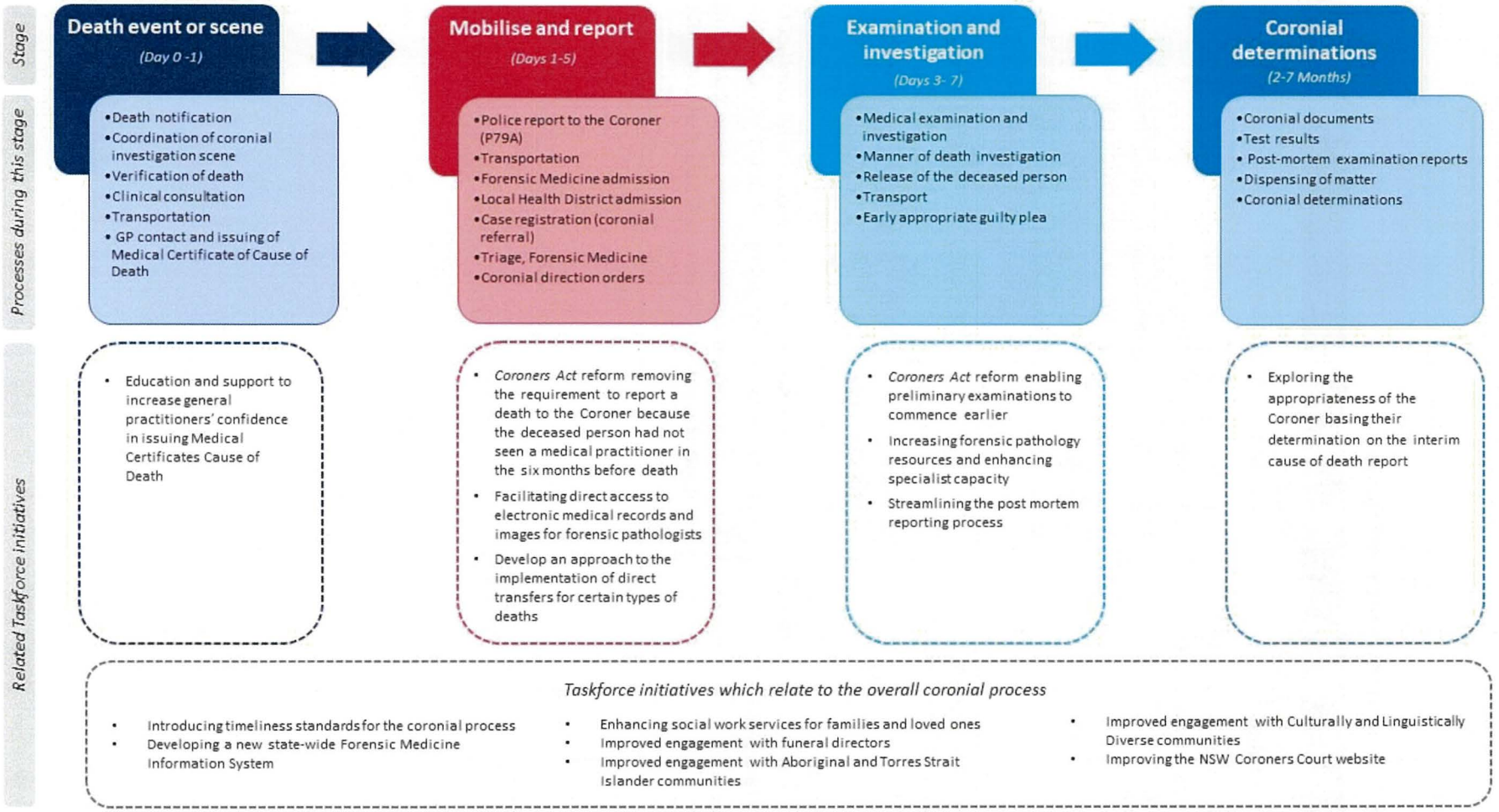
The Coronial Services Committee, an interagency committee chaired by the State Coroner, will have oversight of ongoing Taskforce initiatives beyond 2021.

Table 1: Key performance indicators

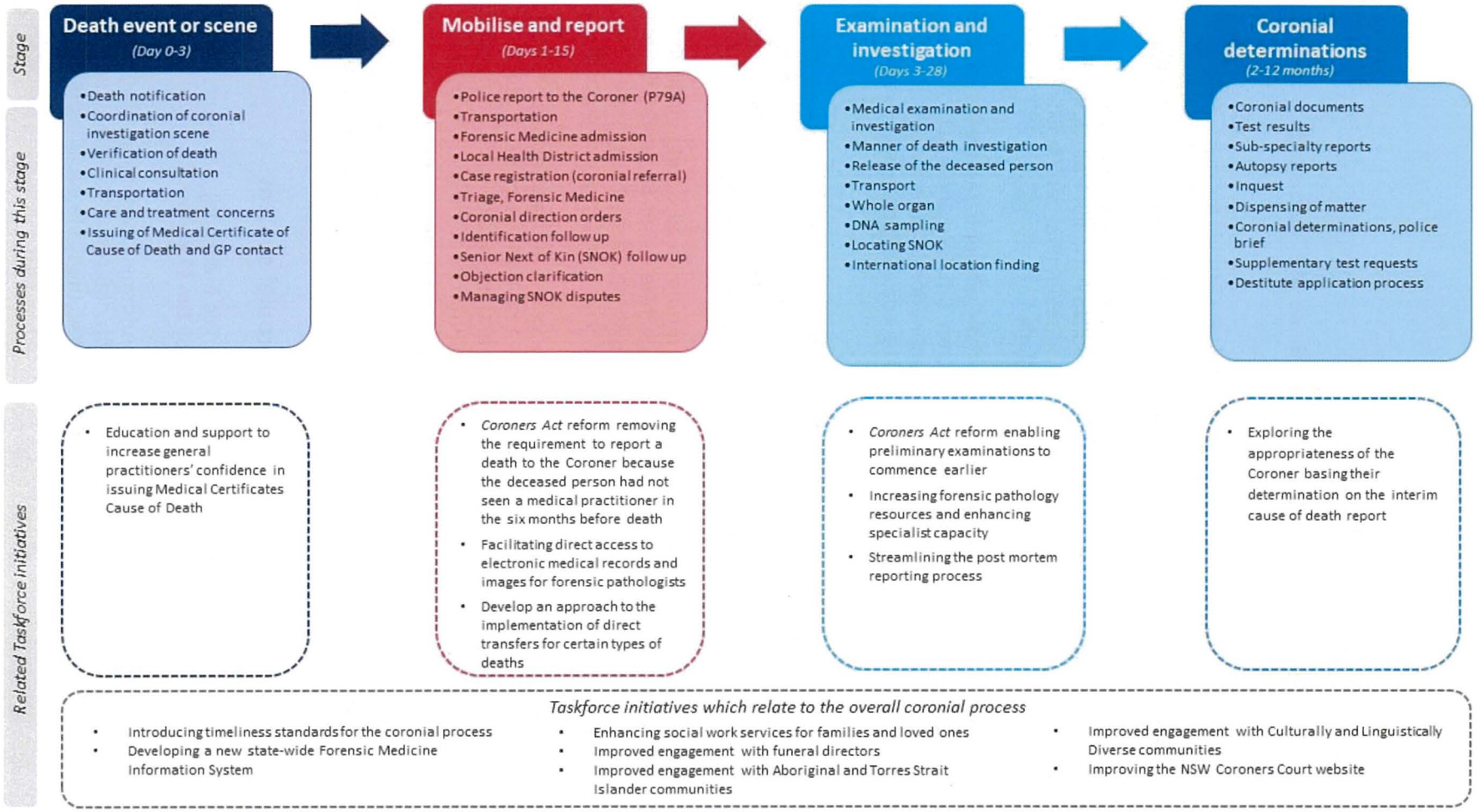
Taskforce objective	KPI
Reduce over reporting of natural deaths	Proportion of coronial referrals which are for natural cause deaths (compared to FY 2018/19).
Reduce delays in the release of deceased persons	Proportion of cases requiring invasive post-mortem examination (compared to FY 2018/19).
	Median turnaround time from Forensic Medicine admission to post-mortem examination for rural and regional deaths (compared to FY 2018/19).
	Median turnaround time from Forensic Medicine admission date to body release date for rural and regional deaths (compared to FY 2018/19).
Reduce delays in finalising post-mortem reports	Median turnaround time for post-mortem report completion (compared to FY 2018/19).
	Monitoring post-mortem report clearance rate (ratio of post-mortem investigation reports completed to new post-mortem examinations performed).
Improve communication with families	Deceased person's family receives initial contact from a Forensic Medicine social worker within 24 hours of admission.
	Deceased person's family receives discharge contact from a Forensic Medicine social worker within 24 hours of completion of the medical investigation.

Figure 1.1 Overview of the coronial process and Taskforce initiatives

Typical case



Complex case



2. Introduction

2.1 The coronial system in NSW

Under the *Coroners Act*, certain deaths, such as those which are sudden, unexpected or unexplained, must be reported to the Coroner.

In NSW, the State Coroner oversees and coordinates coronial services, subject to the direction and control of the Chief Magistrate of the Local Court. There are five full time coroners in NSW and regional Magistrates also undertake some coronial work as part of their Magistrate duties.

The coronial pathway involves three key NSW Government agencies: the NSW Police Force, the Department of Communities and Justice (DCJ) and NSW Health Pathology. There are also several stakeholder groups involved, including hospital and residential care facilities, funeral transport services, funeral directors and primary and specialist clinicians.

Once a death has been reported to the Coroner, the Coroner is required to confirm the death occurred and make findings as to the identity of the deceased, the date and place of death and the cause and manner of death. The Coroner may also make recommendations in relation to matters connected with the death, such as public health and safety issues. The coronial process is summarised in the diagrams at Figure 1.1.

The workload for the coronial system in NSW has increased in recent years. Over the last five financial years, the number of deaths reported to the coronial jurisdiction each year has increased by approximately 19% (Report on Government Services 2020). There has been a corresponding increase in the pending caseload for the coronial jurisdiction over the same period.

The 2021-22 State Budget has increased funding for the Local Court jurisdiction, investing $56.1 million over the next four years to appoint eight extra magistrates. This includes an additional resource for the coronial jurisdiction, with one of the eight new magistrates to be assigned exclusively to that jurisdiction. In addition, as noted above, general Magistrates may also perform some coronial work in regional matters.

The funding boost will also support the enhancement of the Coronial Case Management Unit (CCMU) located at the Forensic Medicine Coroners Court Complex in Lidcombe. The CCMU was established in 2017 and co-locates staff from DCJ, NSW Health and the NSW Police Force to collectively manage the early stages of the coronial process, for deaths referred from the greater Sydney metropolitan area. The CCMU model supports the coroner to make timely, consistent and appropriate directions.

Further, the additional funding will enable the continuation of a pilot initiated during the COVID-19 pandemic to centralise decision-making for regional deaths on an ongoing basis. The benefits of this model are discussed in further detail in Chapter 5.

2.2 The role of Forensic Medicine in the coronial system

NSW Health Pathology's Forensic Medicine (Forensic Medicine) is responsible for conducting medical investigations into reportable deaths, as directed by the Coroner.

Coronial post-mortem examinations can only be performed by qualified and credentialed forensic pathologists who are supported by a specialist team of forensic mortuary technicians, radiologists and radiographers, clinical nurse consultants and forensic medicine social workers.

Forensic Medicine has dedicated facilities in Sydney, Newcastle and Wollongong with specialist equipment to help determine the cause of death in the least invasive way possible.
Forensic Medicine has triage and case management functions for all deaths reported to the Coroner in NSW. Statewide triage of coronial referrals is managed by a team of Forensic Medicine staff in collaboration with agency partners from DCJ and the NSW Police Force. At Forensic Medicine Sydney, the triage activities occur in the CCMU located at the Forensic Medicine, Coroners Court Complex.

At Forensic Medicine Newcastle, the triage function is managed through the Rural Triage Centre (RTC). The RTC consists of Forensic Medicine staff who coordinate the triage of coronial referrals for regional areas of NSW. The RTC was established to avoid the unnecessary transfer of deceased persons away from their communities, ensure timely liaison with Local Court magistrates exercising coronial jurisdiction and provide access to Forensic Medicine social work support for the deceased person's family and loved ones.

The triage function is an inter-agency partnership with key responsibilities in the coronial process shared by staff from the NSW Coroners Court and other courts exercising coronial jurisdiction, NSW Police officers, forensic pathologists, clinical nurse consultants and forensic social workers.

In response to the COVID-19 pandemic, since March 2020 the initial coronial direction for rural and regional deaths has been centralised and allocated to a Senior Coroner at the NSW Coroners Court. Subsequent decision-making regarding these deaths remains in the domain of the magistrates in the regional courts. As noted above, the allocation of additional funding as part of the 2021-22 State Budget will enable the pilot of centralised decision making for regional deaths to be continued on an ongoing basis. The benefits of this model are discussed in further detail in Chapter 5.

3. About the Taskforce

3.1 Establishment

In July 2019, the Acting Secretary, NSW Health, and the Secretary, Stronger Communities cluster, established a time-limited Taskforce to identify ways of improving coronial procedures and the experiences of families and loved ones.

3.2 Membership

The Taskforce includes representatives from DCJ, the NSW Coroners Court, the NSW Police Force, NSW Health Pathology and the NSW Ministry of Health, as well as judicial representatives (the Chief Magistrate and the State Coroner).

It is co-chaired by the Executive Director, Policy, Reform and Legislation, DCJ, and the Chief Health Officer and Deputy Secretary, Population and Public Health, NSW Health.

3.3 Taskforce objectives

The Taskforce identified four overarching objectives to improve the coronial system in NSW:

- reduce over reporting of natural deaths,
- reduce delays in the release of deceased persons,
- reduce delays in finalising post-mortem reports, and
- improve communication with families.

The Taskforce has identified and commenced implementing a range of initiatives to achieve these objectives, which are mapped against the coronial process in Figure 1.1 and discussed in further detail in Chapter 4.

4. Taskforce initiatives to improve the coronial system in NSW

4.1 Reduce over reporting of natural deaths

General Practitioners (GPs) can issue a Medical Certificate of Cause of Death if they are 'comfortably satisfied' as to the likely underlying cause of a natural death. There are limited circumstances in which a GP should not issue a Medical Certificate of Cause of Death and a death should instead be reported to the Coroner. These include violent or unnatural deaths, a sudden death the cause of which is unknown or deaths under suspicious or unusual circumstances.[1]

Despite this, natural cause deaths account for approximately 60% of deaths reported to the Coroner each year. In 2019, this equated to approximately 3,980 cases out of a total of 6,525 deaths (or 61% of cases) reported to the Coroner.

The Taskforce undertook data analysis to better understand the reasons why GPs may be reluctant to issue a Medical Certificate of Cause of Death. Commonly reported reasons included the GP:

- believed the patient's pre-existing conditions would not have resulted in death
- was unfamiliar with the patient due to infrequent attendance
- had not seen the patient recently or they were uncertain about the precise cause of death.

Supporting GPs with tools and guidance to increase their confidence in certifying natural cause deaths will enable coronial system resources to focus on deaths that warrant the scrutiny of the Coroner. It is also expected to improve timeliness by alleviating pressure on the coronial system.

Initiatives

Coroners Act reform removing the requirement to report a death to the Coroner because the deceased person had not seen a medical practitioner in the six months before death

The *Coroners Act* 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. This reform is expected to reduce the number of natural cause death referrals to the Coroner, thereby enabling the coronial system to focus on deaths that warrant investigation. An education campaign was undertaken to ensure general practitioners were aware of this change. This included three newsletter articles published by the Royal Australian College of General Practitioners (RACGP), which is the largest professional general practice organisation in Australia and a key channel for engagement with general practitioners in NSW.

The amendment commenced on 20 January 2020 and already appears to have had a positive impact. Between December 2019 to February 2020, general practitioners reported not issuing a Medical Certificate of Cause of Death on 18 occasions because it had been over six months since they had cared for the patient. A significant reduction has occurred since the reform commenced, with this reason only being reported twice between March 2020 to June 2020.

Education and support to increase general practitioners' confidence in issuing Medical Certificates of Cause of Death

NSW Health collaborated with the RACGP to provide a webinar for general practitioners about how and when to complete a Medical Certificate of Cause of Death and which deaths should be reported to the Coroner. The webinar was held on 26 August 2020 and received a very positive response, with evaluation survey feedback indicating participants found it informative and felt it provided clarity on a topic rarely

[1] See section 6, *Coroners Act 2009* (NSW)

discussed in such a practical way. The webinar is available for medical practitioners to view online[2] and was promoted in a RACGP newsletter article to extend the reach of the webinar.

NSW Health continues to explore further opportunities to deepen general practitioners' understanding of the coronial process and how to correctly complete a Medical Certificate of Cause of Death, including additional webinars and other resources.

4.2 Reduce delays in release of deceased persons

The NSW Government recognises the concerns raised by people, particularly those from rural and regional areas, about the length of time taken for their deceased loved ones to be transferred for post-mortem examination and returned to their family.

Coronial post-mortem examinations can only be performed by highly qualified forensic pathologists who require the support of forensic mortuary technicians, radiologists and radiographers, clinical nurse consultants and forensic medicine social workers, as well as specialised equipment.

Forensic Medicine follows international best practice and makes best use of limited forensic medicine resources. The current model of dedicated facilities at Sydney, Newcastle and Wollongong ensures families and coroners receive timely, respectful answers. It also allows for essential training and supervision of forensic pathology trainees, as well as a collaborative environment for case peer review.

The model is supported by a state-wide multi-disciplinary interagency triage process in which forensic duty pathologists and clinical nurse consultants across the three Forensic Medicine sites review and discuss medical records with local doctors and, where appropriate, provide support and guidance for the issuing of a Medical Certificate of Cause of Death or Coroner's Certificate.

The triage process can help remove the need for a deceased person to be transferred to a Forensic Medicine facility, thereby reducing the number of natural deaths entering the coronial pathway. When a medical examination is required by the Coroner, the Forensic Medicine team schedules all activities in such a way as to minimise the time from admission of the deceased person to their release into the care of an appointed funeral director.

The NSW Government also recognises there are occasions when the timeframes for the release of deceased persons cause additional distress for family members. The timeframe for a post-mortem examination and subsequent release of a deceased person may be extended for a range of reasons, including:

- the case is complex and additional tests are required,
- family members raise objections,
- the case is associated with a Police investigation,
- when there has been a temporary increase in the number of admissions to Forensic Medicine, as occurred in the 2018/19 period.

Timeliness may also be affected by delays in accessing medical records, medical images and other relevant information. Forensic Medicine clinicians rely on timely access to clinical information to support decision-making, inform discussions with general practitioners regarding issuing a Medical Certificate of Cause of Death, make recommendations to the Coroner, compare and interpret radiological images, perform post-mortem examinations and finalise coronial case reports. As Forensic Medicine clinicians rely

[2] The Royal Australian College of General Practitioners (RACGP), 'To report or not to report? Understanding when and how to report a death to the Coroner', available at: www.racgp.org.au/racgp-digital-events-calendar/online-event-items/on-demand/understanding-when-and-how-to-report-a-death-to-th

on hospitals and GPs to copy and transfer medical records and images, either electronically or in hardcopy, delays in receiving these can extend timeframes.

Uncertainty about when a deceased person will be released can make it difficult for their family to plan a funeral and make associated arrangements, such as organising travel and/or leave from work to attend the funeral. For this reason, all Forensic Medicine social workers encourage families not to set a date for a funeral until the final Release Order has been received from the Coroner.

Initiatives

Coroners Act reform enabling preliminary examinations to commence earlier

An amendment to the *Coroners Act* commenced on 20 January 2020 to enable preliminary examinations of deceased persons to be carried out without the need for a coronial direction. Section 88A lists different types of preliminary examination, such as visual examination of the remains, collection and review of personal and health information and imaging of the remains. This reform enables preliminary examination to be undertaken as early as possible upon admission to a Forensic Medicine facility. This allows the coronial process to start earlier and may negate the need for an invasive procedure, enabling the deceased person to be returned to their family sooner.

Forensic Medicine has begun a phased implementation of preliminary examinations using a 'case-type' approach. This involves identifying certain types of deaths (such as suicide, where there are no suspicious circumstances or suspected infectious cases) where a particular type of preliminary examination can provide additional necessary information to improve timeframes. Staged implementation is necessary to enable the impact and practical application of each type of preliminary examination to be assessed for specific case types.

Facilitating direct access to electronic medical records and images for forensic pathologists

Forensic Medicine forensic pathologists have been given access to the NSW Health Enterprise Image Repository (EIR) and technical arrangements have been made to give them access to local health districts' electronic medical records (eMR). All forensic pathologists now have access to the eMR and further refinements are being made to optimise access. Being able to directly access the EIR and eMR, rather than having to request copies of these from hospitals, will enable Forensic Medicine clinicians to access ante-mortem records more efficiently and to expedite their advice to the Coroner, reducing overall timeframes.

Considering implementation of direct transfers for certain types of deaths

The Taskforce is considering phased implementation of direct transfers for certain types of deaths in rural and regional areas to enable deceased persons to be returned to their families sooner. While currently triage must occur and a coronial direction made before transfer can be arranged, under the proposed model police would arrange for the deceased person to be transferred to a Forensic Medicine facility as soon as possible if satisfied the death meets certain criteria. A pilot of direct transfers for certain types of deaths in the Riverina Police District will commence in November 2021, which will assess the potential benefits of this approach.

4.3 Reduce delays in finalising post-mortem reports

The lengthiest phase of the coronial process is the post-mortem investigation. Currently a Coroner or Local Court magistrate exercising coronial jurisdiction cannot make a decision to dispense with or to hold an inquest until they receive the final post-mortem report. 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. The NSW Government recognises delays in finalising post-mortem reports may cause distress for grieving families.

A key reason for the lengthy timeframes for finalising post-mortem reports is the limited number of forensic pathologists, both in Australia and worldwide. There is also an extremely limited number of neuropathologists in NSW, which can impact timely completion of reports. This is because forensic pathologists rely on neuropathological interpretation of the brain to assist in determining the cause of death in a number of complex cases that undergo post-mortem examination.

Initiatives

Increasing forensic pathology resources and enhancing specialist capacity

Forensic Medicine has taken steps to enhance specialist capacity. This included recruiting two forensic pathologists after an extensive international search to ensure current capacity could be maintained. Forensic Medicine has also recruited a clinical training coordinator and currently has four forensic pathology trainees.

To reduce delays stemming from the lack of neuropathologists in NSW, Forensic Medicine is implementing a strategy to further develop the neuropathology skillsets of its forensic pathologists. This is expected to improve timeframes for final reports by ensuring neuropathology support will be available at all Forensic Medicine sites in the event a specialist neuropathologist is unavailable.

Developing a new statewide Forensic Medicine Information System

Forensic Medicine is in the process of developing the Forensic Medicine Information System (FMIS). The FMIS will capture all workflow, clinical information, case management and reporting requirements for Forensic Medicine. The FMIS will have many benefits which are expected to improve timeframes for the coronial system and improve support for families. These include facilitating the efficient receipt of information through electronic systems, improving engagement with families by forensic social workers by assigning automated tasks, eliminating manual processes and enabling real time communications with the Coroner, Local Court magistrates exercising coronial jurisdiction and other key parties. The FMIS is currently in the design phase and is expected to go live in March 2022. Many of the timeliness initiatives for Forensic Medicine identified by the Taskforce are dependent on the successful implementation of the FMIS.

Streamlining the post-mortem reporting process

Forensic Medicine has developed templates for use in the FMIS which will streamline the production of post-mortem reports by single point of data entry, auto-populating some information and reducing manual administrative input for certain causes of deaths. It is anticipated that post-mortem reports produced using these templates will be more consistent and more readily understood by families. The templates will be programmed into the FMIS. Forensic Pathologists will also be able to use voice to text dictation in the FMIS which will further increase efficiency.

Exploring the appropriateness of the Coroner basing their determination on the interim cause of death report

An audit of a subset of interim and final post-mortem reports has been undertaken to determine if there are certain types of cases where it may be appropriate for the Coroner to make a determination based on an interim report. For this to be considered, there would need to be evidence of a high rate of consistency between the cause of death identified in interim cause of death reports and final reports for the particular

case type. The audit found a high concordance between interim cause of death reports and final post-mortem reports for presumed suicide by hanging cases. Similarly, where a cause of death had been identified in the interim cause of death report for a presumed natural cause death, there was high concordance with the final post-mortem report. The State Coroner is considering the findings of the audit and the potential process changes which may be appropriate as a result. For example, the Coroner may be able to finalise such cases sooner if they were not required to wait until they receive the final post-mortem report to make a determination as to the cause of death.

Introducing timeliness standards for the coronial process

The Taskforce is developing timeliness standards for the key steps in the coronial process to support monitoring of performance, including the impact of Taskforce initiatives. Contemporary accreditation processes are based upon agreed performance standards. These agreed timeliness standards, in combination with clinical standards also being developed, will form the basis against which each agency will monitor compliance against the standard and the key performance indicators. The Coronial Services Committee, which is discussed in Chapter 6, will monitor compliance with the timeliness standards into the future.

4.4 Improve communication with families

The NSW Government recognises the importance of sensitive, timely and accurate communication with loved ones, especially where there are unavoidable delays in the coronial process.

Throughout the coronial process, families and loved ones of the deceased may have contact with a range of agencies, including NSW Police, Forensic Medicine and/or the NSW Coroners Court.

A key resource to help families and loved ones understand the coronial process is the NSW Coroners Court brochure on the initial steps after a death is reported to the Coroner.[3]

There are also support services available for the deceased person's loved ones. The Coronial Information and Support Program (CISP) provides enhanced communication between the Coroners and Local Court magistrates exercising coronial jurisdiction within NSW and bereaved individuals and families. The CISP social work team assist senior next of kin, individuals and families to access accurate and timely information about all aspects of coronial proceedings. CISP provides a supportive environment to individuals and families and provides guidance in relation to appropriate referral pathways to grief and loss services for immediate and ongoing support.

Bereaved families accessing the coronial pathway are also supported by the Forensic Medicine Social Work team, which provides care coordination and case management activities across a care continuum. Forensic Medicine social workers contribute to the timely access to information for the senior next of kin, support families to be able to express their grief in a safe environment and contribute to the commencement of the restoration of health and wellbeing following the death event.

Funeral directors are also a significant source of information and support for grieving families, and interact with all agencies in the coronial process. Family members often seek information about Forensic Medicine procedures and timeframes from funeral directors, and therefore it is important that funeral directors have a good understanding of the coronial process and reliable information about expected timeframes.

[3] NSW Government, 'Initial Steps after a Death is Reported to the Coroner', available at: https://www.coroners.nsw.gov.au/coroners-court/resources/publications.html

Initiatives

Enhancing social work services for families and loved ones

Forensic Medicine recruited two additional social workers to provide support and information for families. This equates to a 25% increase in Forensic Medicine social work resources in NSW. They have also introduced the Forensic Medicine Social Work Model of Care to ensure families receive early and consistent contact and support throughout the coronial process.

Improved engagement with funeral directors

Joint understanding of the coronial system is being achieved through extensive engagement with funeral directors, enabling them to better support families. This has included targeted newsletters, a survey seeking feedback, attending industry events, offering tours of Forensic Medicine facilities and publishing articles in industry magazines.

Engaging with Aboriginal and Torres Strait Islander communities

DCJ has established two Aboriginal Family Liaison Officer roles within its CISP social work unit that commenced in September and October 2021. These officers will assist families throughout the coronial process from initial contact through to conclusion, including assisting with the identification of Aboriginal and Torres Strait Islander status, helping families to better access information and participate in the process, and ensuring culturally appropriate practices are maintained. DCJ has also commenced a joint project between the NSW Coroners Court and the Aboriginal Services Unit to develop a culturally appropriate coronial brochure.

Forensic Medicine continues to outreach to Aboriginal and Torres Strait Islander communities and services to discuss ways to improve the experience of the coronial process for families, through shared newsletter distribution, attendance at site facilities and direct communication with Aboriginal Liaison Officers working directly in local communities.

Engaging with Culturally and Linguistically Diverse (CALD) communities

Engagement between Forensic Medicine and the Muslim community in Sydney has identified a range of concerns for bereaved families. These include a need to better understand what a post-mortem examination involves, how to lodge an objection, the timeframes of a post-mortem examination, the role of the senior next of kin and for communication materials with a specific cultural/religious focus. Engagement is continuing with funeral directors and the Australian National Imams Council about hosting information sessions in the community and providing input into culturally appropriate material.

Forensic Medicine will conduct outreach and engagement with other CALD communities in 2021 to improve the experience for bereaved families who may feel confused, distressed or excluded as a result of sensitivities related to cultural, religious or linguistic diversity.

Improving the NSW Coroners Court website

The NSW Coroners Court has updated its website to make it more user friendly, including improving navigation, search functionality and compatibility with mobile devices. A page with information about how to provide feedback, compliments and complaints has also been added to the website to make it easier for members of the public to provide feedback on their experiences with the coronial system.[4]

[4] Coroners Court, 'Feedback, complaints and compliments', available at: www.coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/feedback--complaints-and-compliments.html

5. Monitoring the impact of Taskforce initiatives

5.1 Key performance indicators for measuring the Taskforce's progress

The Taskforce has identified key performance indicators (KPIs) which will be used to measure coronial system performance and to assess whether the initiatives implemented have been effective in achieving the Taskforce's objectives (see Table 1, p 5). The KPIs reflect matters which are often of greatest importance to families and loved ones, including the time taken for the deceased person to be returned to their family and for post-mortem reports to be finalised.

5.2 Performance improvements since the Taskforce was established

While some of the Taskforce's initiatives are yet to be fully implemented and their benefits reflected in data, there is evidence some of the initiatives implemented to date have already resulted in performance improvements.

Streamlining the early case management of coronial matters

In March 2020, in response to the COVID-19 pandemic, the function of making the initial coronial direction for rural and regional deaths was centralised and allocated to a Senior Coroner at the NSW Coroners Court.

This has especially benefited regional families, as it has reduced the average timeframe from when a death is reported to the Coroner to when an order authorising the release of the deceased person to their family has been made. It has also improved the average time to obtain a Medical Certificate of Cause of Death or Coroners Certificate for deaths confirmed as natural causes, enabling families to access death certificates more quickly for estate finalisation.

Other benefits of this model include:

- For families – coronial directions (regarding 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 regional families including:
    - more timely and informed communications
    - improved capacity to address family concerns
    - faster release of the deceased person
    - quicker access to death certificates and
    - reduced distress.

- For the community – a higher number of coronial investigations are able to be finalised at an earlier stage through the issue of a Medical Certificate of Cause of Death or Coroners Certificate, resulting in a reduction in the number of post-mortem examinations, police investigations and associated costs.

As noted above, the 2021-22 Budget provides funding for eight new magistrates in the Local Court, including one new magistrate to be assigned exclusively to the coronial jurisdiction. This will enable the successful pilot of centralised decision making for regional deaths to be continued on an ongoing basis.

Additional funding has also been allocated to enhance the resources of the CCMU which coordinates the initial coronial direction process. This has enabled additional roles to be created for which recruitment is currently underway.

Reduction in the number of deceased persons being transferred to a Forensic Medicine facility

Over the past five years and since the RTC was established, an increasing proportion of rural and regional referrals have been managed without the deceased person being transferred to a Forensic Medicine facility. Continuing this trend, in 2020/21, the deaths of 839 deceased people from rural and regional NSW were referred to the Coroner but did not require transport to a Forensic Medicine facility. This means 137 fewer deceased persons from rural or regional NSW were transported to a Forensic Medicine facility compared to 2018/19.

This outcome is a result of improvements to the triage process. These include forensic pathologists and clinical nurse consultants reviewing medical records with local doctors and providing support and guidance for issuing a Medical Certificate of Cause of Death or Coroner's Certificate if appropriate, thereby negating the need for a deceased person to be transferred to a Forensic Medicine facility.

Improved timeframes for the release of deceased persons

As outlined in this report, the Taskforce has implemented several initiatives to enable deceased persons to be released sooner. These initiatives have significantly improved average timeframes, as illustrated by comparing data from before and after the Taskforce was established (i.e. comparing timeframes data for the 2018/19 year to the 2020/21 year).

In the 2018/19 year, 37% of post-mortem examinations from rural and regional NSW performed at Forensic Medicine Newcastle were undertaken within three days or less from admission. In 2020/21, this had increased significantly to 65%, meaning 65% of post-mortem examinations of deceased persons from rural and regional NSW now take place within three days from admission.

The median time from admission to release for rural and regional deceased persons who undergo post-mortem examination has decreased by 25%, down from 8 days to 6 days. This has enabled grieving families to progress with funeral arrangements for their loved ones in a more timely manner.

Improved timeframes for finalising post-mortem reports

The average number of reports finalised per month (i.e. comparing data from the 2018/19 year with the 2020/21 year) increased by 13%, resulting in approximately an additional 32 reports finalised per month. This trend is expected to continue due to a range of initiatives, including additional resourcing and enhanced specialist capacity, system improvements (including the new FMIS) and standardised, templated reports. Improved timeframes will significantly benefit the community, resulting in more timely resolution for grieving families.

Over the last 21 months there has been a 48% reduction in the number of post-mortem reports waiting to be finalised for longer than 6 months.

In June 2021, 82% of post-mortem reports relating to rural and regional deceased persons were completed within six months, with a median completion time of four months.

5.3 Select committee on the coronial jurisdiction in New South Wales

On 6 May 2021, the NSW Legislative Council established a select committee to inquire into and report on the coronial jurisdiction in NSW ('the select committee'). The terms of reference for the select committee include[5]:

(a) the law, practice and operation of the Coroner's Court of NSW, including:
(i) the scope and limits of its jurisdiction,
(ii) the adequacy of its resources,
(iii) the timeliness of its decisions,
(iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
(v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,
(vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health,

(b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary,

(c) the most appropriate institutional arrangements for the coronial jurisdiction in New South Wales, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement, and

(d) any other related matter.

On 13 May 2021, the select committee called for submissions to its inquiry from interested stakeholders and members of the community.[6] The NSW Government made a submission to the inquiry, which references the Taskforce.[7]

The select committee is due to report by 29 April 2022 and the report will reflect upon the impact of the Taskforce. The final report and its recommendations may provide a further opportunity to strengthen the initiatives of the Taskforce and the overall functioning of the coronial jurisdiction.

[5] Legislative Council, 'Select Committee on the coronial jurisdiction in New South Wales - Terms of Reference', available at: https://www.parliament.nsw.gov.au/lcdocs/inquiries/2809/Terms%20of%20Reference%20-%20Inquiry%20into%20the%20coronial%20jurisdiction%20in%20New%20South%20Wales.pdf
[6] Legislative Council, 'Submissions open for the Inquiry into the Coronial Jurisdiction in NSW', Media Release, 13 May 2021, available at: https://www.parliament.nsw.gov.au/lcdocs/other/15551/Coronial%20jurisdiction%20in%20NSW%20-%20Media%20release.pdf
[7] NSW Government, 'Government Submission – Select Committee on the coronial jurisdiction in NSW', July 2021, available at: https://www.parliament.nsw.gov.au/lcdocs/submissions/73447/0018%20NSW%20Government.pdf, p 5.

6. Next steps

The work plan at Appendix A summarises the status of Taskforce actions. As most Taskforce initiatives are either complete or in an implementation phase, the Taskforce will cease meeting regularly in 2021, reconvening in late 2021 to assess the impact of its initiatives.

The Coronial Services Committee (CSC) will have oversight of ongoing streams of work after 2021, as well as monitoring compliance with the timeliness standards. The CSC is an interagency committee chaired by the State Coroner and includes senior representatives from coronial service providers, including NSW Police, DCJ and Forensic Medicine. The committee meets quarterly and aims to continuously improve the delivery of coronial services to deceased persons, their families, and loved ones.

APPENDIX

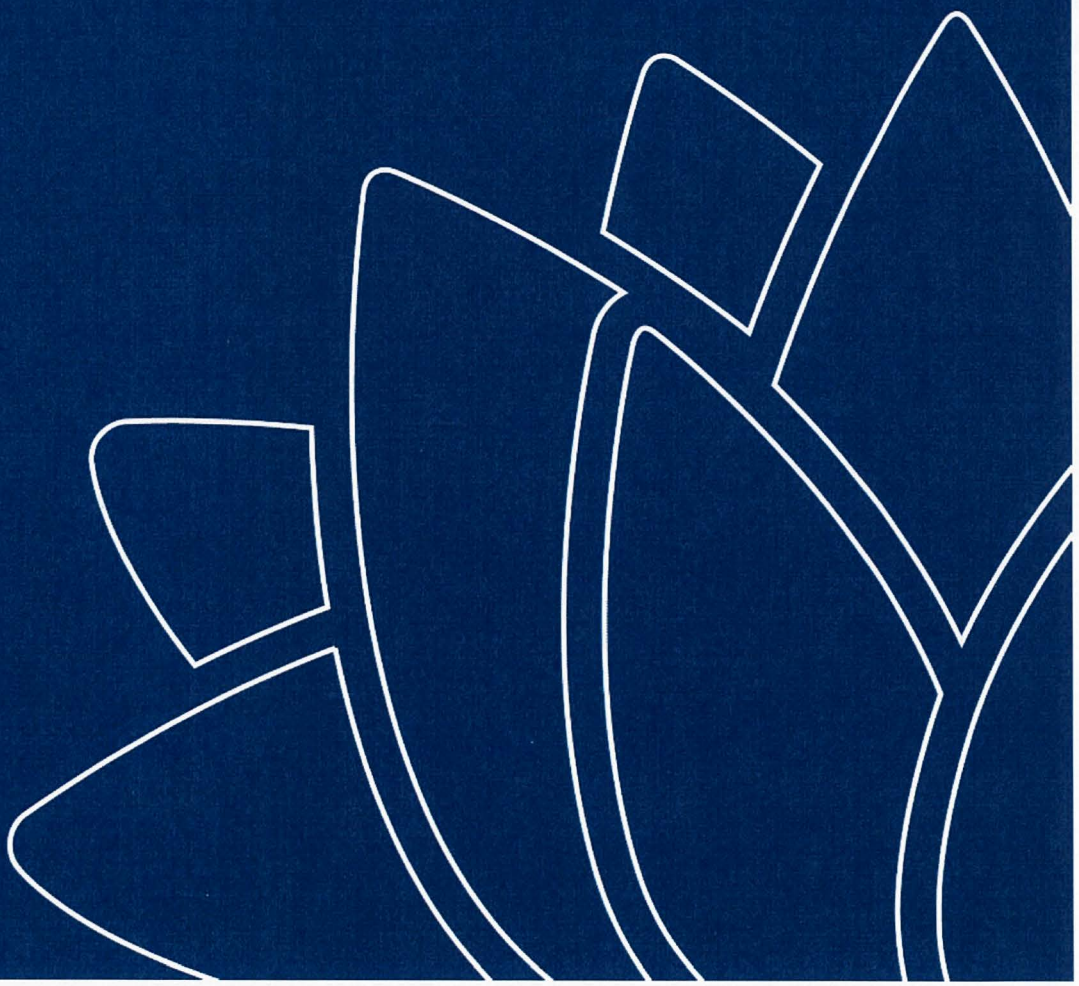
A. Taskforce work plan as at 31 August 2021

Taskforce objective	Relevant initiatives	Lead agency	Timeframe	Status as at 31 August 2021	Ongoing activity beyond 31 August 2021
Reduce over reporting of natural deaths	Amend the *Coroners Act* to remove the requirement to report a death to the Coroner on the basis the deceased person had not seen a medical practitioner in the 6 months prior to death	DCJ	Q1 2020	Complete	N/A
	Identify barriers to GPs issuing Medical Certificates of Cause of Death (MCCDs) and implement strategies to address them	Forensic Medicine and MoH	Ongoing	Ongoing	Refer to ongoing activity for initiative 'Education to improve GPs' understanding of the coronial system and increase confidence in issuing MCCDs'.
	Inform GPs about the *Coroners Act* amendments and the implications for issuing MCCDs	MoH	Q1 2020	Complete	N/A
	Education to improve GPs' understanding of the coronial system and increase confidence in issuing MCCDs	MoH	Ongoing	Ongoing	MOH will continue exploring further opportunities for education, including another webinar in 2021/22.

Taskforce objective	Relevant initiatives	Lead agency	Timeframe	Status as at 31 August 2021	Ongoing activity beyond 31 August 2021
Reduce delays in the release of deceased persons	Amend the *Coroners Act* to allow a forensic pathologist to undertake preliminary examinations of deceased people without a direction from the Coroner	DCJ	Q1 2020	Complete	N/A
	Streamline Forensic Medicine's access to NSW Health's electronic medical records (eMRs) and Electronic Image Repository	Forensic Medicine and MoH	Q4 2021	Ongoing	Access to the LHD eMRs for forensic pathologists has been finalised, with further refinements now being made to optimise access.
	Investigate the possibility of completing preliminary examination (e.g. express toxicology) for certain causes of death and implement if deemed appropriate	Forensic Medicine	Rapid toxicology testing is currently available as part of a preliminary examination for some cases. Forensic Medicine will systematically work through other potential preliminary examinations that will provide clinical benefit and improve timeframes, bringing them online when available.	Ongoing	Forensic Medicine to continue phased implementation of different types of preliminary examination.

Taskforce objective	Relevant initiatives	Lead agency	Timeframe	Status as at 31 August 2021	Ongoing activity beyond 31 August 2021
	Consider implementing direct transfers for certain types of deaths if deemed appropriate	Forensic Medicine, Coronial Services and NSW Police	Q4 2022	Ongoing	A 12 month pilot of direct transfers for certain types of deaths will commence in November 2021 in the Riverina Police District to assess the potential benefits and/or negative outcomes of this model.
Reduce delays in finalising post-mortem reports	Investigate whether it is possible to finalise natural cause death matters and suicide by hanging cases on the basis of interim post-mortem reports	Forensic Medicine, MoH and DCJ	Q1 2022	Ongoing	State Coroner and relevant Taskforce members to consider audit findings and how changes regarding interim cause of death could be operationalised for the case types identified. This relies upon implementation of the FMIS.
	Consider templates to reduce post-mortem investigation requirements for certain causes of death and implement if deemed appropriate	Forensic Medicine	Q1 2022	Ongoing	The new templates will be programmed into the FMIS, which is expected to go live in March 2022.
	Explore opportunities to increase the timeliness of the post-mortem report writing process	Forensic Medicine	Q2 2020	Complete	N/A
Improve communication with families	Investigate opportunities to improve communication with families, ensuring accuracy and consistency	DCJ and Forensic Medicine	Ongoing	Ongoing	DCJ to produce a culturally appropriate coronial brochure for the

Taskforce objective	Relevant initiatives	Lead agency	Timeframe	Status as at 31 August 2021	Ongoing activity beyond 31 August 2021
	across agencies, and implement if deemed appropriate				Aboriginal and Torres Strait Islander community. Forensic Medicine to continue engagement with funeral directors.



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