NEW SOUTH WALES STATE CORONER

Office of the State Coroner
Coroners Court

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The Hon Mr Adam Searle MLC

The Chair of the Select Committee

NSW Parliament House

Macquarie Street

Sydney NSW 2000

5th April 2022

Dear Mr Searle,

I write to advise you of the introduction of the State Coroner's Protocol: Supplementary arrangements applicable to section 23 deaths involving First Nations peoples (the Protocol).

The Protocol will formally commence on 11 April 2022 and I have attached a copy.

You may recall the Coronial Practice Note 3 of 2021 (Practice Note 3) which commenced on 24 September 2021. Practice Note 3 sets out arrangements for the case management of mandatory inquests into all deaths or suspected deaths which fall within the scope of section 23 of the Coroners Act 2009 (the Act). The Protocol will work in conjunction with Practice Note 3, setting out supplementary arrangements applicable where a First Nations person has died in circumstances which enliven jurisdiction pursuant to section 23 of the Coroners Act 2009 (deaths in custody or as a result of police operations). The Protocol is issued pursuant to section 10(d) of the Act.

The Court has introduced these arrangements after a consultation process, and reviewing practices and procedures within the coronial jurisdiction against the recommendations made by the Royal Commission into Aboriginal Deaths in Custody. Through the arrangements set out in the Protocol the Court is committed to increasing engagement with First Nations families from the outset of the coronial investigation, including a dedicated pathway through which:

- The Court can work with the family to identify any cultural considerations relevant to the conduct of the coronial investigation and inquest, as well as any other issues and concerns surrounding the conduct of the coronial investigation.

- The Court can ensure the family is provided with information about the coronial process and their rights in a timely manner, including facilitating legal advice and representation, and

- The Court can ensure the family is provided with regular updates regarding the status of the coronial investigation, including advice in relation to delay and the reasons for delay.

The Protocol also sets out the Court's commitment to ensuring mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of the community.

The court has recently appointed two Aboriginal support workers, Brittanie Miles and Nicolle Lowe, to support families from the beginning of their relative's entry into the system until the finalisation of the inquest. They have already made an enormous improvement to how we work with First Nations families.

An important part of the new protocol is the Family Meeting (Part 10). The family and their legal representatives will be offered the opportunity to meet with key persons involved in the coronial investigation, including the police officer in charge, the forensic pathologist and, where the death occurred in Corrective Services custody, a representative from Corrective Services. This meeting will occur at an early stage. Previously, the family had to wait until the inquest to find out what happened and even then it was difficult to find out all that they wanted to know.

We have been using the Protocol informally since last year and it has been working very well to provide families timely information about the circumstances of the death.

In my view, the provision of information at an earlier stage has helped to develop greater trust in the jurisdiction.

Kind regards,

Teresa O'Sullivan

NSW State Coroner

LOCAL COURT
OF NEW SOUTH WALES

STATE CORONER'S PROTOCOL

ISSUED 9 March 2022
COMMENCES 11 April 2022

Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples

1. PREAMBLE

1.1. This Protocol is established in recognition that First Nations Peoples are uniquely placed within the Australian community as the first peoples of this country. Every First Nations death in custody represents the loss of a valued individual, family and community member, and should be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations Peoples.

Royal Commission into Aboriginal Deaths in Custody

1.2. The final report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) made a number of recommendations across a wide range of areas, including in relation to practices and procedures within the coronial jurisdiction.

1.3. The Local Court has reviewed practices and procedures within its coronial jurisdiction against these recommendations and considers improvements can still be made. In particular, the Court is committed to giving full effect to Recommendation 8 of the RCIADIC:

> *That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.*

1.4. The Court recently issued Coronial Practice Note 3 of 2021 sets out case management arrangements which apply to all deaths occurring in custody or as a result of police operations, irrespective of the background of the deceased.

1.5. However, a considered response to Recommendation 8 requires the establishment of this Protocol to supplement the Practice Note when the death in custody is that of a First Nations person.

1.6. Through this Protocol, the Court is committed to maintaining cultural appropriateness at each stage of an investigation into the death of a First Nations person, particularly in ensuring that the impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss.

2. APPLICATION

2.1. This Protocol is issued pursuant to section 10(1)(d) of the *Coroners Act 2009* (the Act) and applies to all deaths or suspected deaths of First Nations People which fall within the scope of section 23 of the Act.

2.2. This Protocol is to be read in conjunction with Coronial Practice Note 3 of 2021 and sets out supplementary arrangements which apply where the deceased is a First Nations person.

2.3. The Senior Coroner may, after consulting with an Aboriginal Coronial Information and Support Programme (CISP) Officer and/or the family of the deceased, direct that this Protocol apply in whole or in part to an inquest or death or suspected death of a First Nations person.

3. OBJECTS

3.1. The object of this Protocol is to ensure that:

a. All coronial investigations and mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of First Nations Peoples.

b. The families of First Nations Peoples are engaged early and meaningfully in the coronial process and provided with a dedicated pathway through which they can raise:

(i) Any cultural considerations relevant to the conduct of the coronial investigation and inquest, and

(ii) Any issues and concerns surrounding the conduct of the coronial investigation, including concerns in relation to the circumstances of death.

c. The families of First Nations Peoples are provided with information about the coronial process and their rights in a timely manner, including facilitating legal advice and representation, and

d. The families of First Nations Peoples are provided with regular updates regarding the status of the coronial investigation, including advice in relation to delay and the reasons for the delay.

4. COMMENCEMENT

4.1. The Protocol will commence on 11 April 2022

5. DEFINITIONS

5.1. *Determination of jurisdiction* refers to the point at which a Senior Coroner makes a post-mortem direction pursuant to section 89 of the Act.

5.2. *Officer in Charge* refers to a member of the NSW Police Force nominated by the Commissioner of Police or any other person nominated by the Senior Coroner to assist with his or her investigation into a reportable death.

5.3. *Family legal representative* refers to the solicitor with carriage from the Aboriginal Legal Service NSW/ACT (ALS), Legal Aid NSW (Legal Aid) or other legal representative(s) nominated by the family of the deceased person who advises the family representative.

5.4. *Family representative* means the senior next of kin or other person nominated by the senior next of kin to act as a point of contact, including to receive and disseminate information to the family.

5.5. *First Nations Peoples* refers to all Aboriginal and Torres Strait Islander people in Australia.

5.6. *Solicitor assisting* refers to the solicitor from the Crown Solicitor's Office (CSO) or DCJ Legal who is instructed by the Senior Coroner to assist in relation to the coronial proceedings.

6. RECOGNITION OF FIRST NATIONS FAMILY STRUCTURES

6.1. First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

6.2. In recognition of the above, references to 'family' throughout this Protocol should be interpreted flexibly and with respect for these structures and systems. So far as is possible, arrangements should be made to accommodate the deceased's extended family and community, as is appropriate in the circumstances of each case.

7. INITIAL STEPS FOLLOWING DETERMINATION OF JURISDICTION

7.1. The below requirements apply in addition to those set out at Stage One of Coronial Practice Note 3 of 2021.

7.2. Following a determination of jurisdiction, a Senior Coroner will:

a. Ensure the Crown Solicitor's Office or DCJ Legal is instructed to assist in relation to the conduct of the coronial proceedings within 48 hours.

b. Ensure an Aboriginal CISP Officer is assigned as a liaison point for the family representative at the earliest opportunity or within 48 hours.

c. Ensure the family representative or family legal representative is contacted by the Aboriginal CISP Officer at the earliest opportunity or within 48 hours in order to:

(i) Provide initial information regarding the purpose of the coronial process and the role of the Senior Coroner,

(ii) Obtain consent for contact details to be provided to the ALS or Legal Aid (or alternatively, provide contact details for the ALS or Legal Aid) to facilitate legal advice being provided as to the family's rights in relation to the coronial process, and

(iii) Work with the family to identify any cultural and ceremonial considerations surrounding the viewing of the body, any proposed post-mortem examination and release of the body, and

(iv) Work with the family to identify any issues they wish to raise with the coronial investigation, including any issues surrounding the circumstances of death.

d. Ensure the Officer in Charge is contacted by the solicitor assisting at the earliest possible opportunity to determine appropriate arrangements for:

(i) Obtaining statements (such as to facilitate witness interviews being held in a location other than a police station, or for the presence of support persons at interviews with family members where requested),

(ii) The collection of time-critical evidence (such as CCTV footage), and

(iii) Any other relevant issue that requires early direction.

7.3. Where the deceased's status as a First Nations person is not known at the time a determination of jurisdiction is made, the Senior Coroner must ensure the steps outlined above at [7.2] are actioned within one business day of receiving confirmation the deceased is a First Nations person.

8. FACTORS TO BE CONSIDERED IN CORONIAL INVESTIGATION

8.1. When investigating the circumstances of the death, the Senior Coroner will consider any issues determined to be relevant within the scope of the coronial investigation. Where the death is a death in custody, this may include but is not limited to the quality of care, treatment and supervision of the deceased.

8.2. The Senior Coroner will ensure such matters are considered by making specific directions to the Officer in Charge to provide a comprehensive brief of evidence that includes statements from:

a. persons that can give evidence in relation to these factors, and

b. family members who wish to provide statements.

9. ONGOING EXCHANGE OF INFORMATION WITH FAMILY

9.1. In consultation with the Aboriginal CISP Officer, the solicitor assisting the Senior Coroner must ensure that the family representative, or if applicable their legal representative(s), are kept apprised of the progress of the coronial investigation regularly and at minimum intervals of 2 months, (unless the family would prefer less frequent contact) including:

a. Providing updates following completion of each of Stage Two to Stage Five of Coronial Practice Note 3 of 2021, and

b. Any delays arising in the completion of any of the abovementioned Stages and the reason for those delays.

9.2. The solicitor assisting must ensure the family representative, or if applicable their legal representative(s) is consulted on proposed hearing dates to ensure the family is able to attend (should they wish to do so).

10. FAMILY MEETINGS

10.1. Within 2 weeks of receipt of the brief of evidence (or partial brief of evidence) in accordance with Stage Four of Coronial Practice Note 3 of 2021, the Senior Coroner will ensure the family representative (and other family members of the deceased as appropriate in the circumstances) is offered an opportunity to engage in a family meeting with key persons involved in the coronial investigation.

10.2. The purpose of the family meeting is to discuss the following matters:

a. The coronial process, including case management steps and timeframes set out in Coronial Practice Note 3 of 2021,

b. The findings of any post-mortem examination, including initial findings where a final post-mortem report is not available,

c. Any cultural considerations relevant to the conduct of the hearing, and

d. Any other issue the family wishes to raise in relation to the coronial investigation.

10.3. Where the family representative (and other family members of the deceased as appropriate in the circumstances) wishes to participate in a family meeting,

the Aboriginal CISP Officer will ensure a meeting is facilitated with the following persons:

a. The family legal representative(s),

b. The solicitor assisting and counsel (if appointed and available),

c. The Officer in Charge,

d. Where the death occurred in Corrective Services NSW custody, a representative from Corrective Services,

e. The Aboriginal CISP Officer,

f. A Forensic Medicine social worker, and

g. The forensic pathologist who conducted the examination (if requested by the family or the solicitor assisting).

10.4. If the family representative indicates a preference that any of the above persons not attend the family meeting, the meeting must proceed as far as is possible without the person(s).

10.5. The Aboriginal CISP Officer will ensure the family representative is consulted as to the location of the meeting.

10.6. If the final post-mortem report is available, the solicitor assisting will ensure it is provided to the family representative at the family meeting.

10.7. If there is a delay in the provision of the final post-mortem report, the solicitor assisting will ensure the family representative is kept informed of the delay and the reason for the delay is explained.

10.8. Where the family representative (and/or other family members of the deceased as appropriate in the circumstances) does not wish to participate in a family meeting (or this meeting cannot be held for any other reason), the solicitor assisting, in consultation with the Aboriginal CISP officer, must make alternative arrangements to discuss the matters set out in [10.2] above.

11. HEARINGS

11.1. The Senior Coroner will ensure the hearing is:

a. Listed on a date(s) on which the deceased's family is available to attend (should they wish to do so), and

b. Conducted in a culturally sensitive and appropriate manner, including by adhering to any cultural considerations raised by the family of the deceased (so far as is practicable), such as:

(i) The name the family wish to use for the deceased throughout the duration of the hearing(s) (including any directions hearing where applicable) and appropriate warnings about use of the name, including in hearings convened via audio or audio visual link,

(ii) Whether it is appropriate to hear all or part of the inquest on Country, particularly if this would facilitate attendance at the hearing by the deceased's family and members of the community,

(iii) A Welcome to Country or an Acknowledgement of Country is made,

(iv) A smoking ceremony, and

(v) Display and use in court of symbols and items of cultural significance to the deceased and the deceased's family.

11.2. Where it is anticipated the hearing(s) (including any directions hearing where applicable) will be convened through the use of audio or audio visual links, the Aboriginal CISP Officer must make arrangements to ensure the family representative, and family can access and, where approved by the Senior Coroner, participate in the hearing (if required).

11.3. If there is a delay allocating a hearing date, or for any reason the hearing cannot proceed or is adjourned to a later date, the solicitor assisting must ensure the reason is explained to the family representative.

11.4. All legal representatives of interested parties will conduct themselves in the courtroom and in the court precinct in a manner that is respectful of the deceased's family and mindful of the grief and loss experienced by them.

12. FINDINGS AND RECOMMENDATIONS

12.1. Where possible, the Senior Coroner will ensure findings and recommendations are delivered within 6 weeks of receipt of any final submissions.

Magistrate Teresa O'Sullivan
NSW State Coroner

LOCAL COURT
OF NEW SOUTH WALES

STATE CORONER'S PROTOCOL

ISSUED 9 March 2022
COMMENCES 11 April 2022

Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples

1. PREAMBLE

1.1. This Protocol is established in recognition that First Nations Peoples are uniquely placed within the Australian community as the first peoples of this country. Every First Nations death in custody represents the loss of a valued individual, family and community member, and should be understood in the context of the history and harmful results of dispossession and colonisation that continue to be experienced by First Nations Peoples.

Royal Commission into Aboriginal Deaths in Custody

1.2. The final report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) made a number of recommendations across a wide range of areas, including in relation to practices and procedures within the coronial jurisdiction.

1.3. The Local Court has reviewed practices and procedures within its coronial jurisdiction against these recommendations and considers improvements can still be made. In particular, the Court is committed to giving full effect to Recommendation 8 of the RCIADIC:

> *That the State Coroner be responsible for the development of a protocol for the conduct of coronial inquiries into deaths in custody and provide such guidance as is appropriate to Coroners appointed to conduct inquiries and inquests.*

1.4. The Court recently issued Coronial Practice Note 3 of 2021 sets out case management arrangements which apply to all deaths occurring in custody or as a result of police operations, irrespective of the background of the deceased.

1.5. However, a considered response to Recommendation 8 requires the establishment of this Protocol to supplement the Practice Note when the death in custody is that of a First Nations person.

1.6. Through this Protocol, the Court is committed to maintaining cultural appropriateness at each stage of an investigation into the death of a First Nations person, particularly in ensuring that the impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss.

2. APPLICATION

2.1. This Protocol is issued pursuant to section 10(1)(d) of the *Coroners Act 2009* (the Act) and applies to all deaths or suspected deaths of First Nations People which fall within the scope of section 23 of the Act.

2.2. This Protocol is to be read in conjunction with Coronial Practice Note 3 of 2021 and sets out supplementary arrangements which apply where the deceased is a First Nations person.

2.3. The Senior Coroner may, after consulting with an Aboriginal Coronial Information and Support Programme (CISP) Officer and/or the family of the deceased, direct that this Protocol apply in whole or in part to an inquest or death or suspected death of a First Nations person.

3. OBJECTS

3.1. The object of this Protocol is to ensure that:

a. All coronial investigations and mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of First Nations Peoples.

b. The families of First Nations Peoples are engaged early and meaningfully in the coronial process and provided with a dedicated pathway through which they can raise:

(i) Any cultural considerations relevant to the conduct of the coronial investigation and inquest, and

(ii) Any issues and concerns surrounding the conduct of the coronial investigation, including concerns in relation to the circumstances of death.

c. The families of First Nations Peoples are provided with information about the coronial process and their rights in a timely manner, including facilitating legal advice and representation, and

d. The families of First Nations Peoples are provided with regular updates regarding the status of the coronial investigation, including advice in relation to delay and the reasons for the delay.

4. COMMENCEMENT

4.1. The Protocol will commence on 11 April 2022

5. DEFINITIONS

5.1. *Determination of jurisdiction* refers to the point at which a Senior Coroner makes a post-mortem direction pursuant to section 89 of the Act.

5.2. *Officer in Charge* refers to a member of the NSW Police Force nominated by the Commissioner of Police or any other person nominated by the Senior Coroner to assist with his or her investigation into a reportable death.

5.3. *Family legal representative* refers to the solicitor with carriage from the Aboriginal Legal Service NSW/ACT (ALS), Legal Aid NSW (Legal Aid) or other legal representative(s) nominated by the family of the deceased person who advises the family representative.

5.4. *Family representative* means the senior next of kin or other person nominated by the senior next of kin to act as a point of contact, including to receive and disseminate information to the family.

5.5. *First Nations Peoples* refers to all Aboriginal and Torres Strait Islander people in Australia.

5.6. *Solicitor assisting* refers to the solicitor from the Crown Solicitor's Office (CSO) or DCJ Legal who is instructed by the Senior Coroner to assist in relation to the coronial proceedings.

6. RECOGNITION OF FIRST NATIONS FAMILY STRUCTURES

6.1. First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

6.2. In recognition of the above, references to 'family' throughout this Protocol should be interpreted flexibly and with respect for these structures and systems. So far as is possible, arrangements should be made to accommodate the deceased's extended family and community, as is appropriate in the circumstances of each case.

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7.1. The below requirements apply in addition to those set out at Stage One of Coronial Practice Note 3 of 2021.

7.2. Following a determination of jurisdiction, a Senior Coroner will:

a. Ensure the Crown Solicitor's Office or DCJ Legal is instructed to assist in relation to the conduct of the coronial proceedings within 48 hours.

b. Ensure an Aboriginal CISP Officer is assigned as a liaison point for the family representative at the earliest opportunity or within 48 hours.

c. Ensure the family representative or family legal representative is contacted by the Aboriginal CISP Officer at the earliest opportunity or within 48 hours in order to:

(i) Provide initial information regarding the purpose of the coronial process and the role of the Senior Coroner,

(ii) Obtain consent for contact details to be provided to the ALS or Legal Aid (or alternatively, provide contact details for the ALS or Legal Aid) to facilitate legal advice being provided as to the family's rights in relation to the coronial process, and

(iii) Work with the family to identify any cultural and ceremonial considerations surrounding the viewing of the body, any proposed post-mortem examination and release of the body, and

(iv) Work with the family to identify any issues they wish to raise with the coronial investigation, including any issues surrounding the circumstances of death.

d. Ensure the Officer in Charge is contacted by the solicitor assisting at the earliest possible opportunity to determine appropriate arrangements for:

(i) Obtaining statements (such as to facilitate witness interviews being held in a location other than a police station, or for the presence of support persons at interviews with family members where requested),

(ii) The collection of time-critical evidence (such as CCTV footage), and

(iii) Any other relevant issue that requires early direction.

7.3. Where the deceased's status as a First Nations person is not known at the time a determination of jurisdiction is made, the Senior Coroner must ensure the steps outlined above at [7.2] are actioned within one business day of receiving confirmation the deceased is a First Nations person.

8. FACTORS TO BE CONSIDERED IN CORONIAL INVESTIGATION

8.1. When investigating the circumstances of the death, the Senior Coroner will consider any issues determined to be relevant within the scope of the coronial investigation. Where the death is a death in custody, this may include but is not limited to the quality of care, treatment and supervision of the deceased.

8.2. The Senior Coroner will ensure such matters are considered by making specific directions to the Officer in Charge to provide a comprehensive brief of evidence that includes statements from:

a. persons that can give evidence in relation to these factors, and

b. family members who wish to provide statements.

9. ONGOING EXCHANGE OF INFORMATION WITH FAMILY

9.1. In consultation with the Aboriginal CISP Officer, the solicitor assisting the Senior Coroner must ensure that the family representative, or if applicable their legal representative(s), are kept apprised of the progress of the coronial investigation regularly and at minimum intervals of 2 months, (unless the family would prefer less frequent contact) including:

a. Providing updates following completion of each of Stage Two to Stage Five of Coronial Practice Note 3 of 2021, and

b. Any delays arising in the completion of any of the abovementioned Stages and the reason for those delays.

9.2. The solicitor assisting must ensure the family representative, or if applicable their legal representative(s) is consulted on proposed hearing dates to ensure the family is able to attend (should they wish to do so).

10. FAMILY MEETINGS

10.1. Within 2 weeks of receipt of the brief of evidence (or partial brief of evidence) in accordance with Stage Four of Coronial Practice Note 3 of 2021, the Senior Coroner will ensure the family representative (and other family members of the deceased as appropriate in the circumstances) is offered an opportunity to engage in a family meeting with key persons involved in the coronial investigation.

10.2. The purpose of the family meeting is to discuss the following matters:

a. The coronial process, including case management steps and timeframes set out in Coronial Practice Note 3 of 2021,

b. The findings of any post-mortem examination, including initial findings where a final post-mortem report is not available,

c. Any cultural considerations relevant to the conduct of the hearing, and

d. Any other issue the family wishes to raise in relation to the coronial investigation.

10.3. Where the family representative (and other family members of the deceased as appropriate in the circumstances) wishes to participate in a family meeting,

the Aboriginal CISP Officer will ensure a meeting is facilitated with the following persons:

a. The family legal representative(s),

b. The solicitor assisting and counsel (if appointed and available),

c. The Officer in Charge,

d. Where the death occurred in Corrective Services NSW custody, a representative from Corrective Services,

e. The Aboriginal CISP Officer,

f. A Forensic Medicine social worker, and

g. The forensic pathologist who conducted the examination (if requested by the family or the solicitor assisting).

10.4. If the family representative indicates a preference that any of the above persons not attend the family meeting, the meeting must proceed as far as is possible without the person(s).

10.5. The Aboriginal CISP Officer will ensure the family representative is consulted as to the location of the meeting.

10.6. If the final post-mortem report is available, the solicitor assisting will ensure it is provided to the family representative at the family meeting.

10.7. If there is a delay in the provision of the final post-mortem report, the solicitor assisting will ensure the family representative is kept informed of the delay and the reason for the delay is explained.

10.8. Where the family representative (and/or other family members of the deceased as appropriate in the circumstances) does not wish to participate in a family meeting (or this meeting cannot be held for any other reason), the solicitor assisting, in consultation with the Aboriginal CISP officer, must make alternative arrangements to discuss the matters set out in [10.2] above.

11. HEARINGS

11.1. The Senior Coroner will ensure the hearing is:

a. Listed on a date(s) on which the deceased's family is available to attend (should they wish to do so), and

b. Conducted in a culturally sensitive and appropriate manner, including by adhering to any cultural considerations raised by the family of the deceased (so far as is practicable), such as:

(i) The name the family wish to use for the deceased throughout the duration of the hearing(s) (including any directions hearing where applicable) and appropriate warnings about use of the name, including in hearings convened via audio or audio visual link,

(ii) Whether it is appropriate to hear all or part of the inquest on Country, particularly if this would facilitate attendance at the hearing by the deceased's family and members of the community,

(iii) A Welcome to Country or an Acknowledgement of Country is made,

(iv) A smoking ceremony, and

(v) Display and use in court of symbols and items of cultural significance to the deceased and the deceased's family.

11.2. Where it is anticipated the hearing(s) (including any directions hearing where applicable) will be convened through the use of audio or audio visual links, the Aboriginal CISP Officer must make arrangements to ensure the family representative, and family can access and, where approved by the Senior Coroner, participate in the hearing (if required).

11.3. If there is a delay allocating a hearing date, or for any reason the hearing cannot proceed or is adjourned to a later date, the solicitor assisting must ensure the reason is explained to the family representative.

11.4. All legal representatives of interested parties will conduct themselves in the courtroom and in the court precinct in a manner that is respectful of the deceased's family and mindful of the grief and loss experienced by them.

12. FINDINGS AND RECOMMENDATIONS

12.1. Where possible, the Senior Coroner will ensure findings and recommendations are delivered within 6 weeks of receipt of any final submissions.

Magistrate Teresa O'Sullivan
NSW State Coroner
9 March 2022

LOCAL COURT
OF NEW SOUTH WALES

CORONIAL PRACTICE NOTE No. 3 of 2021

Case management of mandatory inquests involving section 23 deaths

ISSUED	24 August 2021
COMMENCES	24 September 2021
AMENDED	8 October 2021

PART A: INTRODUCTION

1. APPLICATION

1.1. This Practice Note is issued pursuant to section 52 of the *Coroners Act 2009* (the Act).

1.2. This Practice Note applies to all deaths or suspected deaths reported to a Coroner which fall within the scope of section 23 of the Act, being where it appears the person died:

- While in the custody of a police officer or in other lawful custody
- While escaping, or attempting to escape, from the custody of a police officer or other lawful custody
- As a result of police operations
- While in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
    - A detention centre within the meaning of the *Children (Detention Centres) Act 1987*
    - A correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*
    - A lock-up

- While proceeding to any of the above institutions or places for the purpose of being admitted as an inmate and while in the company of a police officer or other official charged with the person's care or custody.

2. THE FIRST NATIONS PROTOCOL

2.1. State Coroner's Protocol: 'Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples' (the First Nations Protocol) is to be read in conjunction with this Practice Note and sets out supplementary arrangements which apply where the deceased is a First Nations person.

2.2. Through this Protocol, the Court is committed to maintaining cultural appropriateness at each stage of an investigation into the death of a First Nations person, particularly in ensuring that the impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss.

3. PURPOSE OF CORONIAL INVESTIGATION

3.1. When a death or suspected deaths falls within the scope of section 23 of the Act, the purposes of the coronial investigation are to:

a. Signify respect for life,

b. Ensure, as far as possible, that the full facts are brought to light,

c. Ensure accountability by identifying any systems failures or conduct warranting criticism and recommend remedial action for any such matters, and

d. Reassure the family and friends of the deceased that lessons learned from these deaths may save lives in the future.

4. OBJECTS

4.1. This Practice Note sets out the procedural requirements for the listing and case management of deaths which fall within the scope of section 23 of the Act.

4.2. In setting out these requirements, the objects of this Practice Note are to ensure:

a. All coronial investigations and inquests into reported deaths which fall within its scope are conducted in a timely and proper manner.

b. The families of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a timely and proper manner, including advice in relation to delay and the reason(s) for the delay.

c. Together with the First Nations Protocol, all coronial investigations and mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of First Nations Peoples.

5. COMMENCEMENT

5.1. This Practice Note commences on 24 September 2021 and applies to deaths which fall within the scope of section 23 which occur on or after this date.

6. PREVIOUS ARRANGEMENTS UNDER PRACTICE NOTE 2 OF 2018

6.1. Practice Note 2 of 2018: Case management of Mandatory Inquests Involving Critical Incident Investigations will continue to apply to those deaths which occurred prior to 24 September 2021 where the person died in any of the following circumstances:

a. While in custody of a policy officer (section 23(1)(a))

b. While escaping or attempting to escape from the custody of a police officer (section 23(1)(b))

c. As a result of police operations (section 23(1)(c).

7. DEFINITIONS

7.1. *Determination of jurisdiction* refers to the point at which a Senior Coroner makes a post-mortem direction pursuant to section 89 of the Act.

7.2. *Coronial advocate* refers to the advocate from the NSW Police Force who assists the Senior Coroner in relation to the coronial proceedings where no 'solicitor assisting' is instructed.

7.3. *Solicitor assisting* refers to the solicitor from the Crown Solicitor's Office (CSO) or DCJ Legal who is instructed by the Senior Coroner to assist in relation to the coronial proceedings.

7.4. *Officer in Charge* refers to a member of the NSW Police Force nominated by the Chief Commissioner of Police or any other person nominated by the Senior Coroner to assist with his or her investigation into a reportable death.

7.5. *Family legal representative* refers to the solicitor with carriage from the Aboriginal Legal Service NSW/ACT (ALS), Legal Aid NSW (Legal Aid) or other legal representative(s) nominated by the family of the deceased person who advises the senior next of kin.

7.6. *First Nations Peoples* refers to all Aboriginal and Torres Strait Islander peoples in Australia.

8. INTERESTS OF JUSTICE

8.1. Adjournments and other variations to the below timetable will not be granted unless the Senior Coroner is satisfied that departure is in the interests of justice.

9. RECOGNITION OF FIRST NATIONS FAMILY STRUCTURES

9.1. First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and

community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

9.2. In recognition of the above, references to 'family' throughout this Practice Note should be interpreted flexibly and with respect for these structures and systems. So far as is possible, arrangements should be made to accommodate the deceased's extended family and community, as is appropriate in the circumstances of each case.

PART B: PROCEDURE

10. STAGE ONE: JURISDICTION AND INSTRUCTIONS

10.1. Upon the report of a death, a Senior Coroner will make a determination of jurisdiction under section 23 of the Act.

10.2. Following a determination of jurisdiction, a Senior Coroner will ensure the Crown Solicitor's Office or DCJ Legal is instructed to assist in relation to the conduct of the coronial proceedings if the Senior Coroner considers it necessary and appropriate to do so.

10.3. Following a determination of jurisdiction, the Officer in Charge must contact persons identified as involved officers or employees to ascertain:

a. Whether the agency will represent the person(s) or whether they are otherwise represented, and if so, by whom, and

b. Whether voluntary accounts have been provided by the person(s), and if not, whether they are willing to provide statements voluntarily.

10.4. The Officer in Charge must advise the Senior Coroner of the outcome of these inquiries in the preliminary report to be provided at Stage Two (in accordance with [11.2.e]).

10.5. Throughout the coronial investigation, the Officer in Charge, or if instructed, the solicitor assisting must ensure that the senior next of kin (and any other family member as appropriate in the circumstances), or if applicable their legal representative, are kept informed of the progress of the coronial investigation, including:

a. Providing updates following completion of each of Stage Two to Stage Five below, and

b. Any delays arising in the completion of any of the abovementioned Stages and the reason for those delays.

11. STAGE TWO: PRELIMINARY REPORT AND EARLY PROVISION OF GUIDELINES AND POLICIES

11.1. Within 8 weeks of a determination of jurisdiction, the Officer in Charge must provide a preliminary report of no more than five pages to the Senior Coroner and the solicitor assisting or coronial advocate.

11.2. The report should contain the following information:

a. The background of the reported death (the known circumstances based on information currently available at the time of the report).

b. The current status of the investigation.

c. Identified issues arising from the investigation, including matters which are likely to delay the timely conduct of the investigation

d. The names of any doctors/ clinicians who treated the person while in custody (immediately before their death) and details of the role they played in treating the person.

e. The names of any persons identified as officers or employees involved in the death, details of their legal representative(s), and advice as to whether they have provided (or will provide) witness statements voluntarily.

f. In the case of a death that has occurred in a correctional centre, the names of any officers or employees on duty at the correctional centre, or at the relevant area of the correctional centre, at the time of the death of the person.

g. Identified NSW Police Force, Corrective Services NSW, Youth Justice NSW or Justice Health and Forensic Mental Health Network NSW policies or operational guidelines relating to the investigation and/or circumstances of death.

h. The status of the brief of evidence, including any outstanding items, and whether the brief of evidence will be provided in compliance with the timetable set out at [13.1.a] below.

i. In the case of a death that has occurred in a correctional centre, the status of any investigation being conducted by Corrective Services NSW and whether the investigation report will be provided in compliance with the timetable set out at [13.1.c] below (following consultation with the Corrective Services investigator).

j. Advice as to whether the senior next of kin (or any other family members as appropriate in the circumstances) has been contacted and if so, any issues which they have raised and, if not, the reason why this has not occurred and when contact is proposed to be made.

11.3. Upon assessing the advice provided at [11.2.e], the Senior Coroner may call an early directions hearing to obtain accounts from any involved officer or employee who does not wish to provide a statement voluntarily.

11.4. Upon receipt of the preliminary report, the solicitor assisting or coronial advocate:

a. Will provide to the relevant agency a list of its policies or operational guidelines that are identified in accordance with [11.2.g] above.

b. May request from the relevant agency copies of any policies or operational guidelines listed in accordance with [11.4.a].

c. May request the relevant agency to identify, and provide copies of, any policies or operational guidelines in addition to those listed in accordance with [11.4.a] which are of relevance, or potential relevance, to the circumstances of the death.

d. Will confer with the agency, or their representatives if applicable, in relation to any potential protective orders proposed to be made or sought, or public interest immunity claims proposed to be made, over such policies or guidelines.

11.5. Upon receipt of a request for copies of any policies or operational guidelines under [11.4.b] and/or [11.4.c], the agency must produce the copies requested to the Senior Coroner within 10 business days.

11.6. At the time of production of the policies or operational guidelines, an agency may provide notice to the Senior Coroner of an intention to make an application for protective orders or a claim for public interest immunity over particular material or parts of material should the Senior Coroner wish to serve that material on any other interested party. If such notice is provided, the identified material will only be accessed by the Senior Coroner and the solicitor and counsel assisting or coronial advocate, until such time as the foreshadowed application or claim is determined in accordance with any timetable set under [14.2.g], or is otherwise resolved by agreement.

11.7. A Senior Coroner may extend the timeframe set out in [11.5] on application by the agency where reasonable grounds are established.

12. STAGE THREE: SENIOR CORONER'S CONFERENCE

12.1. If the Senior Coroner considers it necessary and appropriate, upon receipt of the preliminary report a conference will be conducted to discuss the matters in the report with the Officer in Charge and the solicitor assisting or coronial advocate.

13. STAGE FOUR: BRIEF OF EVIDENCE, INVESTIGATION REPORT AND POST-MORTEM REPORT

13.1. Within 12 weeks of a determination of jurisdiction:

a. The Officer in Charge must provide the brief of evidence to the Senior Coroner.

b. The Forensic Pathologist who conducted any post-mortem must provide the final post-mortem report to the Senior Coroner.

c. In the case of a death that has occurred in a correctional centre, the Corrective Services investigator must provide their report to the Senior Coroner.

13.2. A Senior Coroner may extend the timetable set out at [13.1] (and where necessary, the timeframe for the Directions Hearing below in Stage Five) on application where reasonable grounds for a longer period are established. Any such application must be made in writing no less than 14 days prior to the date on which the relevant material is due, and should set out the reasons for delay, as well as the date on which the material will be complete.

13.3. Following receipt of such application in respect of the brief of evidence, the Senior Coroner may request, and the Officer in Charge must provide, a partial brief of evidence consisting of the material available at that time.

13.4. Following receipt of such application in respect of the Corrective Services investigation report, the Senior Coroner may request, and the Corrective Services investigator must provide, any investigation material available at that time, including any witness statements, accounts or incident reports.

13.5. Following receipt of the material referred to in [13.1], [13.3] or [13.4], the solicitor assisting or coronial advocate is to notify any persons who, in the opinion of the Senior Coroner, have a sufficient interest in the subject-matter of the proceedings.

14. STAGE FIVE: DIRECTIONS HEARING

14.1. Within 16 weeks of a determination of jurisdiction, the matter will be listed for a directions hearing before the Senior Coroner to facilitate case management in accordance with section 49 of the Act.

14.2. The Senior Coroner will set a timetable for:

a. The provision of a list of proposed witnesses and proposed issues to be raised in the inquest.

b. The provision of comments by interested parties regarding the proposed witnesses and proposed issues to be raised in the inquest.

c. The provision of any statements including from involved police officers, correctional officers, juvenile justice officers and/ or treating clinicians (as appropriate).

d. The provision of the final post mortem report, if it has not yet been made available.

e. The provision of any other material sought from any parties, including pursuant to a notice to produce or subpoena issued under sections 53 or 66 of the Act.

f. The service of the brief of evidence on the interested parties.

g. Consideration of any protective orders sought or claims for public interest immunity or other objections to material being included in the brief.

h. Any other matters with respect to the conduct of the proceedings as the Senior Coroner considers appropriate.

14.3. If a hearing date cannot be allocated at the directions hearing, the matter will be called over every 12 weeks until a hearing date for the inquest has been allocated.

PART C: SPECIFIC PROCEEDINGS

15. NSW POLICE FORCE CRITICAL INCIDENT INVESTIGATIONS

15.1. This Part applies to a death or suspected death reported to a Senior Coroner where NSW Police Force has declared a Critical Incident in accordance with the NSW Police Force Critical Incident Guidelines (the Guidelines).

15.2. Upon declaration of a Critical Incident by the NSW Police Force, a Senior Critical Incident Investigator is to be assigned to the case without delay in accordance with the Guidelines.

15.3. The matter is to proceed in accordance with Stages One to Five above, with the Senior Critical Incident Investigator responsible for those obligations which are placed on the Officer in Charge.

Judge Peter Johnstone

Chief Magistrate

Magistrate Teresa O'Sullivan

State Coroner

ANNEXURE A

PRACTICE NOTE 3 of 2021 - TIMELINE AND OBLIGATIONS

	TIMELINE	OBLIGATION
STAGE 1 – JURISDICTION AND INSTRUCTIONs	Following a determination of jurisdiction	• Senior Coroner to **instruct CSO or DCJ Legal** ('solicitor assisting') • OIC to contact persons identified as involved officers/ employees
STAGE 2 –PRELIMINARY REPORT & EARLY PROVISION OF POLICIES/GUIDELINES	Within 8 weeks of s 23 determination	• **OIC preliminary report** provided to Senior Coroner and solicitor assisting/ coronial advocate • Upon receipt of preliminary report, solicitor assisting/ coronial advocate to liaise with agency regarding provision of **relevant policies/ operational guidelines** and potential protective orders/ public interest immunity claims over this material
STAGE 3 – SENIOR CORONER'S CONFERENCE	Upon receipt of preliminary report	• **Senior Coroner's conference** with OIC and, if appointed, solicitor assisting/ coronial advocate (discretionary)
STAGE 4 – BRIEF AND PM REPORT	Within 12 weeks of s 23 determination	• **OIC brief of evidence, final PM report and CSNSW investigation report** provided to Senior Coroner • If OIC/ CSNSW unable to comply, Senior Coroner may request partial brief/ report

STAGE 5 – DIRECTIONS HEARING	Within 16 weeks of s 23 determination	• **Directions hearing:** Senior Coroner to set procedural timetable and list matter for hearing • If cannot list hearing, call over every 12 weeks thereafter until hearing date allocated