Submission No 104

INQUIRY INTO HIGH LEVEL OF FIRST NATIONS PEOPLE IN CUSTODY AND OVERSIGHT AND REVIEW OF DEATHS IN CUSTODY

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Date Received: 3 September 2020

Submission to *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*

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3 September 2020

Dear members of the Select Committee,

Thank you for the opportunity to make a submission and for the extension of time.

Introduction

Respect for the Indigenous people of NSW

I make this submission with genuine respect for the Indigenous people of NSW and also for the NSW Parliament.

In this submission I will argue that the NSW coronial system is under-resourced and suffers from inherent design flaws. As a consequence, it cannot perform at an optimal level. ***In particular, a rapidly growing backlog of mandatory inquests into deaths in custody and police operations is threatening to overwhelm the system.*** Increasing delays are adversely affecting bereaved families. This compounds their grief and distress. That experience is likely to be aggravated for the families of Indigenous prisoners who have died in custody. The insufficiency of resources and the design flaws in the systems are masked by 100% overall clearance rates. Publicly available data from the Local Court and the Productivity Commission, when analysed, show that maintaining that clearance rate comes with the trade-off of reducing the system's capacity to conduct inquests and to make death preventive recommendations. Finally, I propose a range of recommendations.

For the purposes of this submission, I accept the arguments made by many that, despite the efforts of people and governments at all levels, Indigenous people in this country are afflicted by the effects of structural racism. By this I do not refer to crude racial prejudice, although that certainly exists in some quarters, but rather to the discrimination that is built into our social, political, economic and cultural structures. That is a very large issue concerning which I do not profess expertise. But it is the necessary background against which I put the following submission.

NSW coronial system is more than coroners

I will address only the question of investigation and review of deaths in custody by the NSW coronial system. (Terms of reference 1 (b), (c) and (d)).

The NSW coronial system is not a single entity but a complex of inter-related organisations, agencies and individuals: coroners, forensic medicine specialists, forensic medicine technicians and support staff, forensic scientists, police investigators, court staff, grief counsellors, family liaison staff, lawyers assisting coroners, police advocates specialising in coronial matters, members of the NSW Bar, the Crown Solicitor's Office Inquiries team, the Justice Department Office of Special Counsel, the Legal Aid Commission Coronial team, and others, such as the Aboriginal Legal Services and medical defence insurers, who participate on ad hoc basis.

The four main institutions of state involved in the system are the Local Court, NSW Health, NSW Police, and the Department of Communities and Justice. Any full consideration of 'the coronial system' must look at the relationships between them. I, however, will confine my submission primarily to the coroners themselves and the Local Court.

My background and qualifications

In 1996, I was appointed a magistrate of the NSW Local Court. I was a Deputy State Coroner 2008-2016. I retired from the Local Court at the end of 2016. I am now an Adjunct Professor at the UNSW Law School, a part-time Deputy President of the NSW Mental Health Review Tribunal, and a member of the NSW Bar. I was a member of the National Judicial College of Australia's Programmes Advisory Committee 2007-2017. I was a 2014 Churchill Fellow – my project being to develop ideas for raising coronial performance standards. I am co-author of *Waller's Coronial Law and Practice in New South Wales* (4th ed, 2010) and *The Australasian Coroner's Manual* (2015). I am now working on a PhD studying the effectiveness of the NSW coronial system in preventing future deaths. I hope to conclude this research by the end of 2021.

Death prevention and coroners – unfulfilled potential

In 1991, the Royal Commission into Aboriginal Deaths in Custody (1987-1991) identified egregious failures in the administration of coronial systems around the country. Nevertheless, it commented:

> [In] human terms, thoroughly conducted coronial inquiries hold the potential to identify systemic failures in custodial practices and procedures which may, if acted on, prevent

future deaths in similar circumstances. In the final analysis, adequate post-death investigations have the potential to save lives.[1]

The Royal Commission sensitised the nation to the wicked problems that colonisation and dispossession has created for both Indigenous and non-Indigenous people. The reforms that flowed were intended to ensure that deaths of Indigenous people in custody were investigated thoroughly, professionally and with the highest degree of sensitivity to the issues and complexities of the individual cases. But it is clear that they were also intended to address and alleviate, at least in part, the structural injustice that had resulted in such a disproportionate number of Indigenous people being imprisoned.

The RCADIC, however, did not explore the practical implications of emphasising the death preventive potential and function of coronial systems. That was not its brief. It was appropriate for State and Territory governments, which have constitutional responsibility for coronial systems, to undertake that important project.

In NSW, certain reforms were undertaken to address the flaws exposed by the RCADIC. In particular, a State Coroner, tasked with co-ordinating coroners statewide, was appointed. Legislation was introduced in all states and territories requiring inquests to be held into all deaths in custody or which occur during police operations.[2] Usually such inquests are conducted by State or Territory Coroners or Deputy State Coroners. This the requirement in NSW. After those reforms, however, the zeal in the Local Court and the NSW Government for transformation of the coronial system to improve its capacity to prevent deaths dissipated.

Since the early 1990s, the death preventive function and potential of the NSW coronial system have never been fully explored by the NSW Government, its agencies and departments, or the Local Court. It has been assumed that granting power under the Act to coroners to make recommendations is sufficient to achieve that objective. Research conducted in Australia, Britain and New Zealand, however, has demonstrated that the power to make preventive recommendations, of itself, is insufficient to save lives and may, in fact, provide only a comforting illusion that 'something is being done'.[3] The power must be exercised *effectively*

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1 Royal Commission into Aboriginal Deaths in Custody, *National Report, Vol 1,* (Canberra: AGPS, 1991), [4.7.4].

2 See ss. 23 and 27(1)(b) Coroners Act 2009 and, previously, s 13A Coroners Act 1980.

3 SM Cordner & B. Loff, "800 years of coroners: have they a future?" (1994), 344 *The Lancet* 799; Jennifer Moore, "An empirical approach to the New Zealand government's review of the coronial jurisdiction", (2014) 21 *J of Law and Medicine* 602; Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016); Lyndal Bugeja and David Ranson, "Coroners' recommendations: A lost opportunity", (2005) 13 *J of Law and Medicine* 173Lyndal Bugeja, "Determinants of coroners' recommendations on external cause deaths in Victoria, Australia", PhD thesis, Monash University 2011; Georgina Sutherland et al., "What happens to coroners' recommendations for improving

and be responded to with genuine intent to mitigate risk of death and injury. We have some way to go in NSW before we can be confident our system is operating optimally.

The need for reform – five propositions

In this submission, in support of an argument for reforming the coronial system to maximise its potential for saving lives, I will advance five propositions:

1. *Review*: In 2014, the Justice Department began a review of the Coroners Act. At the time of writing the review remains incomplete. The reasons for the government's apparent reluctance to finish it are not plain. That review should address structural problems in the system which have been identified by reviews in Victoria, Western Australia and Queensland in the past decade. In any event, I submit that the Select Committee should conduct its own independent review of the NSW coronial system, taking on board the free lessons provided in those interstate reviews.
2. *Reorientate*: The foundational theory of the NSW coronial system needs to be reconsidered – is it to remain a sideshow in the criminal justice system or modernised explicitly to recognise the human value of those whose deaths are investigated, and to contribute to enhancing public health and safety, restorative justice and human rights? I suggest the latter.
3. *Restructure*: If it is to be modernised, the system needs to be restructured. This has been recognised everywhere else in Australia. As the Queensland Auditor-General observed in 2019, coronial systems need to be well co-ordinated so as to meet the needs of families and the community.[4] Arguably the best model in the world for a restructured coronial service is the Victorian coronial system constituted by the Coroners Court and the Victorian Institute for Forensic Medicine. It provides a statewide service by specialist coroners, forensic medicine specialists and in-house researchers engaged in death preventive research.
4. *Resources*: Whatever the structure, the system needs an infusion of resources to meet the internal pressure on it. Three key resources for a Coroners Court that is effective in producing good death preventive and restorative outcomes for bereaved families and the community are (i) excellent family liaison staff – NSW has good people in both the Coroners Court and the Department of Forensic Medicine but both lack Indigenous staff; (ii) research officers trained in social (especially epidemiological) research methods; and

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public health and safety? Organisational responses under a mandatory response regime in Victoria, Australia", (2014) 14 *BMC Public Health* 732; Georgina Sutherland, Celia Kemp & David Studdert, "Mandatory responses to public health and safety recommendations issued by coroners: a content analysis", (2016) 40:5 *ANZ J of Public Health* 451.

4 Queensland Audit Office, "Delivering coronial services", Report 6: 2018-19, (Brisbane: 2019)

(iii) well trained and motivated legal actors – coroners and their legal assistants. Dedicated Indigenous officers of high status and calibre to liaise with families and to work shoulder to shoulder with coroners and other actors in the system could ensure that the concerns and needs of bereaved Indigenous families are met appropriately and in a timely fashion.

5. *Refine*: A culture of constant improvement can be promoted by reorientating the system towards providing the best possible service to bereaved families, and by embracing a new theory and practice of coronership based on restorative justice, public health and safety, and recognition and protection of human rights. A new Act, with modernised objects, a purpose-built structure, and sufficient resources to do the job properly, would liberate the system to develop such a culture.

What are coroners and coronial systems for?

All organisations and systems are based and operate on theories or conceptual frameworks whether implicit or express. Identifying their fundamental purposes - their reasons for being - enables organisations to set their strategic objectives and to guide, control and evaluate their performances. They justify their existence and evaluate their performances in terms of those fundamental theories and objectives.

The NSW coronial system exists to investigate sudden, unexpected, or unnatural deaths, or the natural deaths of people for whom the state has a particular duty of care. These investigations seek to establish, as well as the evidence allows, the facts of a reported death and to make sense of the evidence so that the truth concerning cause and circumstances of death is revealed. I suggest that primary reasons for carrying out such investigations are:

- To demonstrate the state's and the community's recognition of, and respect for, the individual people who have died and their bereaved relatives, as fellow citizens or members of the community;
- To underscore the state's commitment to fundamental human rights, in particular the protection of the lives of the vulnerable;
- To enhance public health and safety by learning the lessons a preventable death may provide; and
- To deliver, as far as possible, a restorative form of truth-seeking and explanation of a death for those who mourn.

In relation to deaths in custody, the House of Lords expressed the purposes of coronial inquiries well in *R (Amin) v Secretary of State for the Home Department.* They include bringing the full facts into the light, exposing culpable conduct, allaying unjustified suspicion, ensuring 'that

dangerous practices and procedures are rectified' and that the bereaved 'may at least have the satisfaction of knowing that lessons learned… may save the lives of others'.[5]

Having established this conceptual framework for a coronial system, we should then be able to design an appropriate system to implement those objectives. But in NSW we have a problem.

The coroners – structural issues

The architectural nostrum that "form follows function" applies as much to systems as to buildings. It is a rule of simplicity and efficiency: identify the function and design accordingly.

In NSW, thirty years after the RCADIC, we are still to create a well-structured coronial system fit for purpose. If the NSW coronial system is to do the job that the Royal Commission and Australian governments intended so many years ago, it needs redesign.

If the primary functions of coronial services are to be implemented optimally, the systems they employ must be designed to carry out those functions as excellently, efficiently and humanely as is practicable. And if the systems do not perform as in those ways, they should be redesigned or replaced. Whether coronial systems perform well or not can be relatively easily tested by asking whether they promote the strategic goals and provide services characterised by high levels of competence, integrity, efficiency, effectiveness and humanity.

In my view, the current 'senior coroners'[6] in NSW are excellent coroners and admirable people. It is doubtful, indeed, whether we have had a better group of individual specialist coroners in this state's history. The quality of their inquests is very high. I am well aware of their sensitivity to the issues that Indigenous people raise in inquests such as those which have been publicised recently. Similarly, in my experience, the general quality of most people who perform significant roles in the system is high.

Nevertheless, the NSW *system* is labouring under the disadvantages of both an underpowered "engine" – its resources - and fundamental design flaws. The major design flaw is a two-tier system of coronial services – one for the metropolitan area and another for regional areas. A small number of magistrates function as coroners exclusively (all based at the Lidcombe coronial and forensic medicine complex),[7] but the vast majority of working coroners in NSW are the country and regional magistrates of whom there are approximately 40. Although only

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5 [2004] AC 653 at [31].

6 This term is used in the Coroners Act to designate the State Coroner and Deputy State Coroners: s 22(1).

7 There are five fulltime positions at Lidcombe. The fulltime coroners are supplemented by a number of other part-timers in Sydney and in the regions.

about 35% of the population of NSW live outside the Sydney metropolitan area, about 45% of deaths reported to coroners in NSW are reported to regional magistrates. This arrangement flows from the facts (a) that the system, historically, has been decentralised and (b) that, since 2010, overworked, undertrained, and under-resourced country magistrates have had coronial jurisdiction added to their already onerous workloads.

Compounding this problem is the fact that coronial services are, from an administrative perspective, a minor jurisdiction in what is primarily a high-volume, specialist criminal court which has an increasingly complex legal jurisdiction and an expanding workload. The Local Court is the largest criminal court in Australia. Its criminal work takes precedence over everything else and that is reflected in the fact that most magistrates are appointed from the ranks of criminal law specialists. Before their appointments as specialist coroners, few magistrates have any experience of inquests or other forms of coronial work.

This hybrid system was criticised by ex-State Coroner Michael Barnes in a submission to the Attorney-General in 2017. He identified several practical problems with this structure and proposed that all coronial work be centralised in the hands of specialist coroners.[8] Arguing for the establishment of an adequately resourced specialist court he wrote:

> I am regularly made aware of regional coroners or their clerks making serious errors… This is not their fault – the clerks have to take charge because the magistrate is either in another centre or is in court. Even when the magistrate coroners are involved, because coronial work is so different from that which takes up most of their time, poor decisions are made. It is a specialist jurisdiction which requires an understanding of and collaboration with other technical specialities…
>
> The inadequacy of resources also manifests in inquest being dispensed with when a hearing should be held having regard to the proper purpose of inquests. Approximately 97.5% of matters are now finalised without an inquest.
>
> Unlike in all states other than Tasmania, the *Coroners Act 2009* (NSW) does not create a coroners court.
>
> Unlike in all states other than Western Australia, local magistrates in NSW still exercise coronial jurisdiction. In all other states full-time coroners complete all coronial cases.

(I note that State Coroner Barnes has had the unique experience of working as State Coroner in two major jurisdictions – his observations should therefore be accorded great weight.

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[8] See Appendix A.

Further, they were made at a time when was leaving the jurisdiction. He cannot be accused of self-interest or 'empire-building').

A Parliamentary inquiry in Victoria in 2006, and a report by the Western Australian Law Reform Commission, were both highly critical of arrangements in those states which mirrored the current NSW system.[9] As a result of the 2006 inquiry, in 2008 Victoria established a stand-alone specialist court separate from the Victorian magistracy.

I, too, have criticised the current structure, particularly on the basis that regional magistrates, because they are, in effect, specialist criminal magistrates, and are heavily engaged in their local court work, have little or no opportunity to undertake specialist training and professional development and, due to the relatively low volumes of coronial work they conduct, do not develop specialist skills by way of experience.[10]

Expertise in any specialist field is developed by a combination of training, professional development, graduated experience and collegiality. In my own experience, I believe it took me about 12 months to 2 years of fulltime experience to become a competent coroner and about 5 years to become reasonably expert at the job. The unintended consequence of regular rotation of magistrates in and out of the coronial jurisdiction is that expertise slowly built up by dint of experience can be dissipated and efficiency of the jurisdiction reduced as new magistrates take time to learn new skills and adjust to the new jurisdiction.

While the Local Court manages the coronial jurisdiction, the needs of that jurisdiction will inevitably be subordinated to the overall needs of the larger organisation. I do not criticise the Chief Magistrate for this. It is a function of the primary mission and structure of the Local Court. But, in my view, that is not in the best interests of the people – especially bereaved families – whom the coronial system is intended to serve that the current institutional arrangements be maintained, especially in the face of the evidence carefully considered in other jurisdictions.

Before the invention of modern high-speed communications, this hybrid structure made sense. A local coroner was indispensable. For a number of reasons, this model is outdated. The

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9 Victoria. Parliament. *Inquiry into the Review of the Coroner's Act 1985*, (2006) https://www.parliament.vic.gov.au/publications/fact-sheets/252-lawreform/inquiry-into-the-review-of-the-coroners-act-1985 ; WA Law Reform Commission, *Review of Coronial Practice in Western Australia,* Project No 100 (Perth: 2012) https://www.lrc.justice.wa.gov.au/_files/P100-FR.pdf

10 Hugh Dillon, "Why NSW needs a specialist coroners court", (2018) 48 *Law Society Journal* 26; Hugh Dillon, "Raising coronial standards of performance: Lessons from Canada, Germany & England", Report to the Winston Churchill Memorial Trust of Australia, August 2015.

Victorian[11] and Western Australian[12] inquiries referred to above found that the quality of coronial services in the regions where magistrates fit in coronial work part-time and after hours was well below the standard fulltime specialist coroners with specialist ancillary services are able to provide.

A specialist court is not necessarily a panacea. Recently, an inquiry by the Queensland Auditor-General found:

> The Coroners Court of Queensland, Forensic and Scientific Services, and the Queensland Police Service (the agencies) each play a key role in supporting coroners. However, none is accountable for managing Queensland's coronial system or coordinating the various activities across the system…
>
> Queensland's coronial system is under stress and is not effectively and efficiently supporting coroners or families. If left unaddressed, structural and system issues, will further erode its ability to provide services beyond the short-term.
>
> Senior people across the system described to us a system that is failing. The coronial system relies on the dedication of staff and good will amongst agencies but lacks system-wide cohesion, with no agency having responsibility for leadership, accountability, planning, and reporting across the system.[13]

Those comments can be applied with equal or greater force to the NSW coronial system. The Auditor-General's report demonstrates that a coronial system should be examined as a complex and holistic, rather than piecemeal, reform undertaken.

The design flaws I have identified, especially when combined with chronic under-resourcing of the coronial system, indirectly, but quite adversely, affect the capacity of NSW senior coroners and many other actors in the coronial system from performing optimally in investigating Indigenous deaths in custody. Although, as I have noted above, nearly half the deaths reported to coroners in NSW are made to regional coroners, relatively few inquests are conducted by them. [14]

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11 Victoria Parliament, Law Reform Committee, "Coroners Act 1985 Final Report", Parliamentary Paper No 229 of Session 2003-06. (Melbourne: 2006)

12 WA Law Reform Commission, "Review of Coronial Practice in Western Australia", Report No 100, (Perth: 2012)

13 Queensland Audit Office, "Delivering coronial services", Report 6: 2018-19, (Brisbane: 2019), 6, 9.

14 See Local Court Annual Reviews 2010-2019.

Under the Coroners Act, coroners are only empowered to make death preventive recommendations when conducting inquests. In practice, most regional inquests of any complexity are referred to city-based specialist coroners. My research has found that about 75% of regional inquests which generate recommendations are carried out by specialist coroners.

In other words, the five fulltime positions in Sydney are carrying out most of the significant coronial work conducted in this state, including regional inquests as well as most s23 inquests into deaths in custody and police operations. Given the criticisms made by State Coroner Barnes, and the obvious facts that regional coroners have large workloads and no specialist training in coronial work, the question must be asked why we persist in maintaining this less than optimal system?

One possible answer is that the NSW Government believes it is cheaper to continue with the system than to establish a specialist court (as in most of Australia and internationally). According to Productivity Commission data, the apparent recurrent cost of running the NSW coroners court is a little more than one-third of the cost of the Victorian Coroners Court. But, as the Attorney pointed out during the Budget Estimates hearings in September 2018, this comparison is misleading because because many of the costs of running the NSW coroners system are absorbed into the general recurrent expenditure of the Local Court and are not separately quantified.[15]

It seems likely, therefore, that the actual costs of coronial services are much closer to those of Victoria than the Productivity Commission's data apparently imply. This raises a question of fiscal transparency but, more importantly, raises the issue of quality – if, as the Attorney appears to imply, the real differential between NSW and Victorian expenditure is relatively insignificant, why do we persist with the unsatisfactory hybrid system that Victoria abandoned in 2008? If, on the other hand, as the Productivity Commission data suggest, we are doing coronial work on the cheap in NSW, what does that say about the government's attitude towards bereaved people waiting years for inquests?

A second, possibly decisive, factor is simply historical inertia. If a problem can be ignored, it will be[16] and has been in NSW for many years by governments of both major parties. This Select Committee is the first serious review of the coronial system for more than a decade and the first independent public review since 1975. There has been no full independent review of the coronial system since the Law Reform Commission undertook one in that year. (I discount the internal statutory review which was commenced in 2014 which has evidently been shelved

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15 See evidence of the Hon. Mark Speakman SC, Budget Estimates, 4 September 2018.

16 See John Kingdon, *Agendas, Alternatives and Public Policies*, (NY: HarperCollins, 1995); Lyndal Bugeja, "The public policy approach to injury prevention", (2011) 17:1 *Injury Prevention* 63.

by the government.) And even this Select Committee is not concentrated on the coronial system *per se*. Unfortunately, the bereaved have few political champions.[17]

Resourcing

To understand the problem of under-resourcing of the NSW Local Court's share of the coronial system, it is first necessary to examine aspects of the court's performance. The publicly available data show that the coronial jurisdiction of the Local Court is not performing well against its own time standards except in one respect (overall clearance rates). The following analysis is taken from a preliminary study I conducted in 2019 of data published by the Local Court and Productivity Commission in respect of the court's performance in the coronial jurisdiction during the period 2010-2018. The primary sources I referred to were the Local Court's own Annual Reviews, the State Coroner's reports to Parliament in respect of deaths in custody and police operations, coronial findings published on the "Coroners Court" website and the Productivity Commission's annual Reports on Government Services. *These data are subject to further revision but, to the best of my knowledge, are accurate.*

100% clearance rates – a misleading impression of efficiency

One of the key measures used by the Productivity Commission (and the Local Court itself) to assess performance of courts is clearance rates of cases.[18] The 'technical efficiency' of service providers, such as courts, is measured by the rate at which providers transform inputs (their resources) into outputs (the services they provide). 'Outputs' are to be distinguished from 'outcomes', which are the *effects* or *impact* of the 'outputs'. As the Productivity Commission concedes, while outcomes are the real focus of its efforts to measure performance of government services, they are often difficult to measure. Where there is a relationship between outputs and desired outcomes, the Productivity Commission measures the outputs. [19] The underlying assumption appears to be that the outputs are inferentially indicative of the success or otherwise of outcomes.

It can be assumed that grieving relatives, other persons affected by deaths reported to coroners, and involved organisations, all hope for expeditious outcomes of coronial cases. But they may have different ideas about what those outcomes should be and how they should be achieved. For example, a family may want an inquest to investigate the

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17 On other hand, I commend the very small number of MPs from both sides of the chamber and the cross-benches who have taken an interest in this issue over the past few years. Without their efforts, it is clear that the government would ignore this issue entirely. It should be a multi-party issue because death does not take political sides.

18 See also evidence of the Hon. Mark Speakman SC, Budget Estimates, 4 September 2018.

19 Productivity Commission, *Report on Government Services 2019*, "Approach to performance measurement", Part A, Chapter 1, https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/approach/performance-measurement accessed 05 November 2019.

circumstances of death and to develop recommendations; but a government agency may want to close the case without such a time-consuming inquiry being held. Simply measuring the speed at which cases are opened and closed is not indicative of the real or desirable outcomes of coronial cases – a range of performance indicators, including *quality* measures, is needed to assess real outcomes. These are not available in the published data and, to my knowledge, have never been developed in NSW or elsewhere.[20]

Despite a gradual increase in reported deaths during the period 2010-2018, NSW coroners were able to maintain an overall case clearance rate of at least 100% most of the time. It has been able to achieve clearance rates placing it in the top four jurisdictions in the Commonwealth for most of that time.[21] Taken by itself, this is a commendable result and does the coroners and the Local Court credit. However, this picture is an incomplete and misleading representation of the overall performance of the coronial jurisdiction.

NSW coronial clearance rates 2009-10 to 2017-18
Source: Productivity Commission, *Reports on Government Services* 2011-2019. All extrapolations are my own.

Annual numbers of inquests – the coronial system under severe pressure

The effort to maintain relatively high clearance rates has coincided with a much sharper decline in the number of inquests and an increase in the number of cases finalised without inquest. Just

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20 Part of my current research is directed toward the problem of developing appropriate measures of the performance of coronial systems.

21 Productivity Commission, *Report on Government Services* 2012-2019, Ch 7 "Courts".

as significantly, the Local Court's data show that the *proportion* of cases going to inquest also declined significantly over the study period. In 2010, 3.6% of incoming cases were taken to inquest. By 2018, however, that figure had exactly halved to 1.8%.[22]

These data show that the cost of maintaining a 100% overall clearance rate is cutting the numbers of inquests conducted per annum. In making discretionary decisions not to hold inquests, thereby enabling themselves to keep up their overall clearance rates, coroners deprive themselves (and the community) of the opportunity to make death preventive recommendations. In a conversation I had with State Coroner Barnes in 2017, shortly before he left the jurisdiction, he lamented this trend. He spoke of numbers of cases which he thought should be investigated by way of inquest but which had been closed because the resources were insufficient to conduct them expeditiously enough to make effective recommendations.

Timeliness and delay in conducting inquests

The Local Court's coronial time standards, which were introduced in 2005,[23] apply not only to the clearance of cases generally but also to inquests. They require 95% of inquests to be completed within 12 months and 100% of inquests to be completed within 18 months. As we have seen, the overall clearance rates were maintained at a more or less constant level of about 100% over the period under study. The limited available data, however, suggest that this is not the case in respect of inquests.

Since 2015, the Local Court has published almost all the inquest findings of specialist coroners based in Sydney. As there are only incomplete annual sets of findings published prior to 2015, I have not taken them into account in this section. Data concerning the performance of NSW coroners and the clearance rate of inquests over the full period 2010-2018 are not available. A limited data set relating to inquests conducted by fulltime coroners can be constructed, however, for the period 2015-2018 from published coronial decisions.

These data are, of course, limited, covering only a relatively short period, and almost entirely relating to inquests conducted by fulltime coroners based in Sydney. Only 10 inquests conducted by regional Deputy State Coroners and magistrates are included in the findings recorded on the Coroners Court website, so few as to make little difference to these results. A further limitation is that, unfortunately, as the Local Court does not publish the inquest findings of *regional magistrates*, it is not possible to determine from publicly available data how closely they comply with the Local Court's time standards in completing their inquests.

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22 See Local Court Annual Reviews 2015 & 2018.

23 Local Court *Annual Review 2005*, (Sydney: 2005), 2.

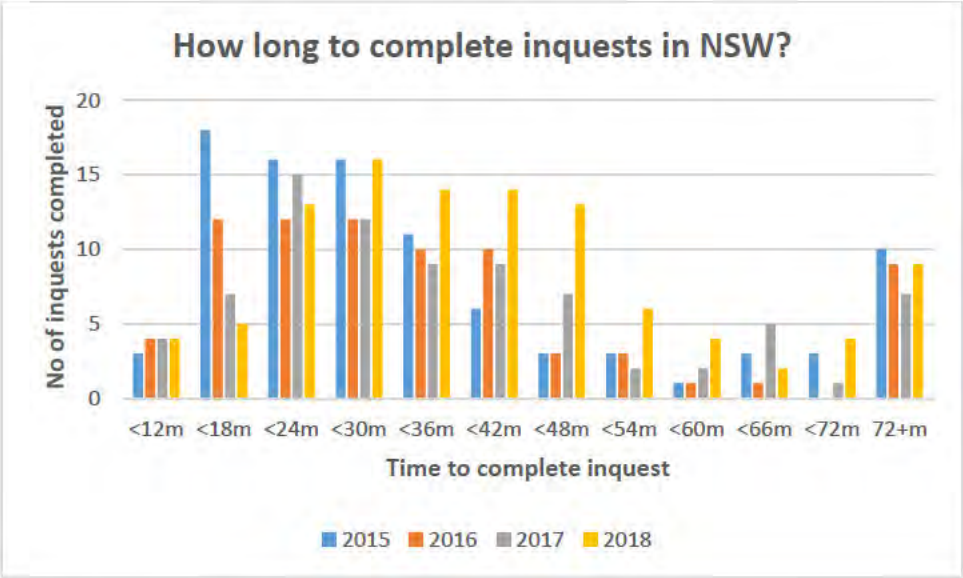
Among other things, inquest findings reveal the date of the death investigated (if it can be ascertained) and the date the findings were made. In this section, I have measured the time taken from the time of death to complete an inquest. I have defined the date of completion as the date on which the coroner delivered his or her findings. This is often some time after the conclusion of the hearing. In some cases, the date of death was not able to be determined by the coroner. In those cases, I have used the approximate date of death as estimated by the coroner or, if this was not done, the date on which remains were discovered or reported to the coroner.

Secondly, it is possible to construct a data set of s23 cases (i.e., cases concerning deaths in custody and deaths in police operations) from the State Coroner's annual reports to Parliament concerning those matters. Those data show that NSW coroners struggled to complete even a relatively small fraction of inquests in compliance with the Local Court's time standards.

Year	<12 m	<18 m	<24 m	<30 m	<36 m	<42 m	<48 m	<54 m	<60 m	<66 m	<72 m	72+ m
2015	3	18	16	16	11	6	3	3	1	3	3	10
2016	4	12	12	12	10	10	3	3	1	1	0	9
2017	4	7	15	12	9	9	7	2	2	5	1	7
2018	4	5	13	16	14	14	13	6	4	2	4	9

Completion time for inquests by specialist coroners – numbers of inquests completed by period
Source: "Coronial findings" website, http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx accessed 11 November 2019.

Together with the sharp drop-off of inquests being completed within 18 months, the following figure also shows an apparent trend, by 2018, for increasing numbers of inquests to take 30-48 months to complete.

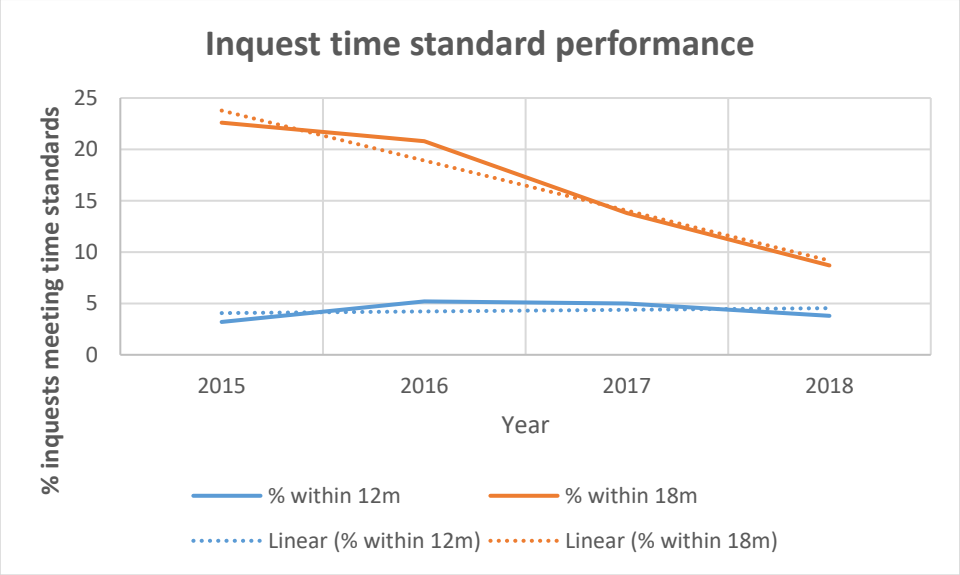


Time to completion of inquests – specialist coroners 2015-2018
Source: "Coronial findings" website, http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx accessed 11 November 2019.

Year	% completed within 12m (Time standard = 95%)	% completed within 18m (Time standard = 100%)
2015	3.2	22.6
2016	5.2	20.8
2017	5	13.8
2018	3.8	8.7

Percentage inquest compliance with Local Court time standards – specialist coroners 2015-18
Source: "Coronial findings" website, http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx accessed 11 November 2019.

These data show that specialist coroners for the period 2015-2018 were unable to meet the Local Court time standards and the performance declined over that four-year period. The data should also be read in conjunction with the sharp downward trend in *numbers* of inquests being conducted.



Inquest completion – time standard compliance trend – specialist coroners 2015-18
Source: "Coronial findings" website, http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx accessed 11 November 2019

Section 23 cases – deaths in custody and police operations – an overwhelming backlog

The problems of completing inquests in a timely fashion and with complying with the Local Court's time standards are also highlighted by the data relating to mandatory s23 inquests into deaths in custody and in police operations.

The data from the State Coroner's annual reports to Parliament show a relatively steady rate of reported deaths, and a relatively steady annual rate of s23 inquests being conducted. The clearance rate in respect of s23 cases, however, has averaged approximately 80% during the period 2010-19. This has resulted in a bank, by the end of 2019, of **129 outstanding cases**.

The problematic nature of that accumulating number of cases is underscored by the fact that, in 2018, the entire cohort of NSW coroners - specialists and regional magistrates combined - was able only to conduct 111 inquests while in 2019, that number rose only to 117.[24] It is clear that if the 'senior coroners' did nothing but s 23 inquests they would still struggle to reduce the backlog and deal expeditiously with additional incoming cases (which average about 40 per annum).[25]

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[24] See *Local Court Annual Review 2019* and *State Coroner's Report to Parliament on Deaths in Custody and Police Operations 2019*.

[25] See State Coroner's Annual Reports to Parliament on Deaths in Custody and Police Operations 2010-2019.

Without significant extra resources – not only increased numbers of coroners but investigators, Counsel Assisting and others who play vital roles in the system – the State Coroner (and the Chief Magistrate who controls the resourcing of the 'coronial jurisdiction') have only two options – either to run 'quick and dirty' s. 23 inquests or move resources away from the Local Court's priority work of criminal trials and sentencing. Neither is viable. The Local Court has limited resources and no fat in the system. I am confident that the State Coroner, Deputy State Coroners and Chief Magistrate do not, and would not, contemplate 'quick and dirty' inquests, especially in relation to the deaths of Indigenous people in custody. The unconscionability of such a course is obvious.

In one of C.S. Forester's Hornblower novels, a Royal Navy frigate pursues a French merchant ship. When the ship surrenders and heaves-to, Midshipman Hornblower is sent aboard with a small British prize crew to bring the ship into an English port. The crew repairs damage done to the ship by a cannon shot into the rigging. They check the rest of the ship which is carrying a cargo of 200 tons of rice. They use a dipstick in the well of the ship to check for water in the bilges. They find none. The ship is placed on course for England. All initially appears to be well. After some time, however, the ship starts creaking loudly. Unbeknownst to the British prize crew, it has been holed below the waterline during the pursuit by the frigate. The rice is absorbing tons of water and expanding rapidly. The data I have discussed above suggest that the coronial system is like that ship, bursting at the seams.

This is not a problem created by the specialist coroners or the Local Court. The resourcing solution therefore is in the government's hands.

The effects of delay on grieving families

Studies have demonstrated that lengthy delay in conducting inquests causes significant distress to bereaved families. The attrition of evidence, financial strain and prolonged grieving, as well as the enforced experience of recounting information years after a fatal event are of particular concern.[26] Dartnell et al.'s study of the experience in the coronial system of grieving families found that some found delay to be "traumatic and even "tormenting" for them.[27] I believe that experience is, unfortunately, common.

It may be even more traumatic for Indigenous families. In addition to their losses of loved ones, they have, as a people, always had troubled relationships with courts and a justice system

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26 See, for example, Stephanie Dartnell, Jane Goodman-Delahunty and Judith Gullifer, "An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice", (2019) 10 *Frontiers in Psychology* Article 2322;

27 Dartnell et al. (2019).

imposed on them. Delay, which is endemic in the NSW coronial system, must afflict them with an added burden of grief and perhaps amplify their sense of injustice.

For people whose historical experience has been one of racism and disrespect, it must be difficult to interpret lengthy delay in the coronial system in any other way than as a lack of recognition of their human worth and dignity as a people, and perhaps as a sign of disrespect to them personally. Cogent medical evidence now suggests that racial and other forms of discrimination places human beings under chronic stress, increasing what is known as the 'allostatic load' or 'allostatic burden'. This burden is thought to have potentially life-shortening effects.[28] Consider, then, the effects of substantial delay on people who are already, for historical and cultural reasons, burdened by a substantial allostatic load. It is reasonable to assume that the added distress caused by delay may itself adversely affect the health and longevity of bereaved Indigenous families, compounding the effects of their distress and grief.

My own embarrassing experiences as a coroner conducting inquests sometimes several years after a fatal event confirms Dartnell et al.'s observations about the traumatising effects of extended delay on families. Once that point has been reached, there is little a coroner can do except apologise and hope to offer a more restorative experience during the actual inquest. On a number of occasions I have felt obliged to apologise to bereaved families for delay. In some cases, I realised that I could personally have done more to accelerate proceeding and had failed. In others, delays in investigations or multiplication of logjams in various parts of the coronial system hamstrung our best efforts to push matters forward expeditiously.

The second major detriment of prolonged delay in the coronial system is that the 'topicality' of the fatal event passes, and with it, often, the incentive to take remedial action in respect of preventable deaths.[29] If coronial action is slow, inquests may come too late to provide worthwhile recommendations, thereby draining the death preventive potential from the investigative effort. This also has adverse impact on family members. For many mourners, the idea that a life has not been lost in vain but will contribute to preventing future deaths is the only source of solace they can find.

Overhanging all this, of course, is the unceasing flow of incoming cases. During my time as a specialist coroner, each of the specialist positions (one shared) was responsible for managing about 650-700 cases per annum. Every magistrate with whom I worked during my 9 years as

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28 See, for example, David M. Cutler, Angus S. Deaton, Adriana Lleras-Muney, "The Determinants of Mortality", Working Paper 11963, National Bureau of Economic Research, January 2006, http://www.nber.org/papers/w11963 ; Scott Burris; Ichiro Kawachi; Austin Sarat, "Integrating Law and Social Epidemiology", (2002) 30 J.L. Med. & Ethics 510.

29 See Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016); Elena Mok, "Harnessing the Full Potential of Coroners' Recommendations" (2014) 45:2 Victoria U of Wellington LR 321.

a coroner remarked, when they joined the group of specialist coroners, on how much harder they worked as a coroner than on the Local Court general bench. That was also my experience. I know that the State Coroner and Deputy State Coroners work hard and sensitively on all their inquests and other investigations. Yet they are paddling against the current and the bereaved families bear the consequences.

Honouring the promise of the Royal Commission into Aboriginal Deaths in Custody

It is a paradox that the NSW Government has been able to find $4 billion in the past few years to build new prisons, largely to house Indigenous people, but will not adequately resource the coroners sufficiently to enable them to conduct inquests into Aboriginal deaths in custody in a timely way, or to maximise their potential for developing death preventive recommendations. A tiny fraction of that prison budget – say 0.1% - could make all the difference to the efficiency and quality of the coronial system.

The philosopher Axel Honneth argues that social conflict is generated largely by a failure of dominant groups in society to recognise the equality and personal worth of minority groups. Minority groups and individuals who perceive themselves to be, and who in fact are, disrespected and refused recognition as people of equal worth and dignity, then struggle for the recognition they need for self-respect and self-esteem. [30] Conflict, rather than reconciliation, ensues.

What other conclusion could Indigenous people draw from the way they are policed, prosecuted, imprisoned in disproportionate numbers than that the institutions of state in this country do not fully recognise them? What other conclusion could they draw from the reluctance of our politicians to embrace the Uluru Statement from the Heart than that, when it comes down to it, they don't matter much? The recent Black Lives Matter and anti-racist uprisings and protests internationally and in Australia appear to be a concrete expression of the kind of struggle for recognition Honneth has described.

The RCADIC was, in effect, a recognition that 'black lives matter'. It was a promise of a concerted effort to address the wicked problems of historic and current racial discrimination and social injustice burdening Indigenous people. Its investigations into coronial failure formed only a fraction of its efforts but one of its most important recommendations was based on the hope that the deaths it had investigated would ultimately preserve others who followed from similar fates.

The Royal Commission's expectation was that coroners would be able to identify systemic failure and make remedial recommendations assumes that coroners and coronial systems have

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[30] Axel Honneth, *The struggle for recognition*, (Oxford: Polity Press, 1996).

that capacity. As we have seen, that assumption is, to say the least, debatable.[31] Due to lack of experience, training and professional development, not all part-time coroners have the capacity to think in terms of systems or can readily identify an issue in a complex system, much less formulate a practicable recommendation to solve a systems issue.[32] This is a different set of skills from those required to conduct summary trials and sentencing in a busy criminal court.

Even if they attempt the frequently difficult task of identifying systemic failure and making recommendations, not all coroners are equally adept at these tasks. Studies in Victoria and New Zealand have criticised coroners' recommendations.[33] Many coroners make few, if any, recommendations at all.[34] Some of the criticisms, I have learned, would certainly apply to my own coronial practice. I am confident that most NSW coroners, if they were aware of the critique, would recognise its application to themselves.

During my 9 years as a coroner I received no training in the skills of analysing systems failure or writing recommendations – I developed what skills I acquired on the job by private study, working with intelligent Counsel Assisting, ad hoc experts and others in coronial teams, and by trial and error on the job. In 2016, hoping to help improve our system, I developed a proposal for a curriculum for the professional development of coroners. (See Appendix B). To my knowledge, that proposal, although forwarded to relevant people involved in judicial education in the NSW Local Court at the time, has never been acted on.

Nor is the preventive capacity equal as between coronial systems in Australia. The Victorian Coroners Court has 29 research staff (not all fulltime) working in its in-house research unit on preventive research. The number of specialist researchers providing support to NSW coroners in its death preventive function is precisely – NIL. (Two researchers are employed in domestic violence homicide research.)[35] The Victorian Coroners Court works closely with the Victorian Institute of Forensic Medicine, which, unlike the Department of Forensic Medicine in NSW, has a strong research orientation. The VIFM and the Victorian Coroners Court have strong links both with Monash University and the National Coronial Information System (NCIS). All of these links add sophistication to the Victorian approach to death prevention. The NSW coronial system, on the other hand, has no formal links with universities and has a limited

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31 See reference at n.3.

32 For some of the complexities in this field, see James Reason, *Human Error,* (Cambridge: Cambridge University Press, 1990; James Reason, *The human contribution: Unsafe acts, accidents and heroic recoveries*, (Farnham: Ashgate, 2008); Henry Petroski, *To forgive design: Understanding failure*, (Cambridge MA: Harvard University Press, 2012). See also Hugh Dillon & Marie Hadley, *The Australasian Coroner's Manual* (Sydney: Federation Press, 2015), ch. 6.

33 See Moore (2016) n.3 above and Sutherland, Kemp & Studdert (2016) n.3 above.

34 Lyndal Bugeja (2011) n.3.

35 See Coroners Act 2009, Chapter 9A.

approach to use of data available in the NCIS. I have been told that regional magistrates rarely make use of NCIS reports or other data.

In respect of coronial systems, the Royal Commission's promise has only partially been fulfilled. In NSW, much more could be done, especially in terms of enhancing the coronial system's capacity to develop robust recommendations for preventing death. Jennifer Schulz Moore, author of a seminal study of the New Zealand coronial system,[36] has outlined several ways that coroners' recommendations could be made more effective. Some are already in practice in NSW but others could be adopted with advantage. (See Appendix C).

The Ontario coroner system is close to finishing a 5-year strategic plan and in 2021 will commence another 5-year program to enhance its public health and safety effectiveness. It will invest in building data management and analysis capacity to quickly identify emerging trends of concern and take expeditious remedial action. The Victorian model has been operating for 12 years and could be improved upon in this state if the appropriate structures were built and resources provided. In both Ontario and Victoria, and to a lesser extent in New Zealand, the coronial systems are focussed on central themes of mitigating risk of death and injury and on restorative methods of coronership. Due to outdated legislation, and other factors, the NSW system lacks such clarity in its objectives.

NSW should look outward to those models if it is to advance in this field.

Recommendations

1. Develop a strategic plan for the coronial system.

2. Modernise the Coroners Act. (The Victorian and New Zealand Acts are models which should be closely considered.)

3. Adopt statutory objects reflecting the modern purposes of coronial systems – especially the enhancement of public health and safety, protection of human rights of persons to whom the state owes a duty of care, and restorative justice for bereaved families.

4. Like the NZ Coroners Act, the objects of a new or amended NSW Coroners Act should pay particular attention to the significance of 'the cultural and spiritual needs of family of, and of others who were in a close relationship to, a person who has died'.[37]

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[36] Moore (2016), n.2 above.

[37] See Coroners Act 2006 (NZ), s 3(2)(b).

5. Recognise the need for a *specialist* coronial system and design it accordingly, including a specialist Coroners Court of NSW.

6. Resource it sufficiently to enable it to carry out its statutory tasks thoroughly but expeditiously.

7. Develop in-house research capacity to assist coroners to identify trends and develop evidence-based death preventive recommendations.

8. Develop partnerships with university public health and safety researchers for the same purposes.

9. Enhance specialist training and professional development of coroners by designing and implementing a structured curriculum of training programs and materials.

10. Encourage the development of new, more restorative procedures – more inclusive of families and others affected by reported deaths, less adversarial, less 'legalistic' – designed to encourage truth-telling, healing and to reduce delay. (The Ontario model should be investigated and adapted in NSW.)

11. Establish a coronial advisory council and panels of advisor experts to assist coroners in their preventive and other functions. Such advisory panels should include qualified Indigenous people. They should also include members of all sectors involved in the coronial system including health, police investigation, public health and safety, and family services.

12. Recruit more Indigenous people, not only to liaise with Indigenous families, but to work in all levels of the coronial system. Doing so would sensitise the system to Indigenous people, open it more to Indigenous people and demonstrate respect and recognition.

13. Develop a set of purpose-built performance standards based on qualitative as well as quantitative criteria.

14. Analyse the performance of the coronial system annually against those standards.

15. Require the State Coroner to produce an annual report.

16. As in Victoria, require response to coronial recommendations within a time limit and publish responses on the Coroners Court website.

17. Develop State Coroner's guidelines for practice and procedure in the coronial system. (Queensland and the England & Wales Chief Coroner provide good examples).

18. Work with Austlii to develop a public national library of coronial findings, recommendations and responses to recommendations.

Conclusions

I believe that the NSW coronial system has significant strengths. In particular, it has intelligent, compassionate people working in it throughout the interrelated complex that forms the system. It is, however, under-performing because it is not designed well for its purpose, it is under-resourced and it is under so much internal pressure that it cannot cope with its workload. Clearance rates of 100 per cent per annum provide an incomplete and misleading impression of the overall performance. The increasing backlog of s 23 cases is the canary in the coal mine.

Secondly, I have made the case that the over-reliance on regional magistrates is one of its fundamental structural flaws. This is not criticise or denigrate those hardworking people nor the senior management of the Local Court. It is, however, an historical legacy whose time has passed.

Thirdly, I have advocated an *explicit* reorientation towards a culture of recognition of the dead and bereaved in a full sense; towards public health and safety; towards adopting a human rights approach, including human rights standards, to deaths involving state agencies; and towards restorative treatment of all affected by deaths reported to coroners.

Finally, I have made strategic suggestions for reform.

My ultimate contention is that lack of action is a policy that dooms the coronial system to come apart at the seams and to fail in its mission. In particular, despite all the efforts of the current State Coroner and Deputy State Coroners, unless urgent action is taken, it will not fulfil the promise made in the Royal Commission into Aboriginal Deaths in Custody.

I commend the members of the Select Committee for undertaking this important work.

Yours sincerely,

Hugh Dillon

Address:
Email:
M:

Appendix A

A bereaved families focussed Coroners Court restructure

Summary

The current arrangements for the delivery of coronial services in NSW are suboptimal because outside of the metropolitan area it is overseen by local magistrate coroners many of whom have insufficient experience and or time to do the work well and the jurisdiction is grossly under resourced.

This leads to inconsistent and inappropriate decisions being made and to delays at crucial stages in the process.

These problems could be addressed by the creation of a Coroners Court presided over by full time coroners.

The problems and their causes

Half of the approximately 6000 deaths reported to NSW coroners each year are dealt with by 36 regional magistrate coroners who preside over 71 country courts outside metropolitan Sydney. As a result some never gain significant experience in dealing with such matters. In reality, much of the work is done by court officers.

All of these magistrate coroners are also responsible for a full caseload of criminal and civil matters. None other than the Newcastle coroner get any time out of court to deal with coroner's matters. Most circuit to a number of courts and coroners' files either lie fallow awaiting the coroner's arrival or chase them from court to court.

Coronial processes can be divided into three discrete stages that each case moves through until it is finalised. Each stage poses different challenges for inexpert coroners.

1. **The initial stage** which every case moves through is particularly sensitive because the bereaved families' grief is so raw, the decisions touch upon such deeply personal issues and need to be made quickly based on sparse evidence so that the state's intrusion into the most private grief can draw back to allow death rituals to proceed. The challenges include:

    - Determining who is the senior next of kin with statutory rights to participate in coronial decisions and to receive the body for burial can require the coroner to evaluate the quality of domestic relationships. Blended families and indigenous sensibilities add to the uncertainty.

    - Deciding what type of autopsy to order or whether organs should be retained involves balancing the public interest in knowing the manner and cause of an unexpected death against what are often the most deeply held spiritual beliefs.

- These decisions require a nuanced appreciation of very sensitive matters and the making of qualitative contested assessments rather than definitive binary choices. All are time critical.

2. **Reviewing the autopsy and investigation reports** requires the coroner to determine what issues to pursue and how far to pursue them. An inquest can only be dispensed with if the coroner is satisfied that the manner an cause of death are "sufficiently disclosed" – a threshold over which reasonable minds may differ

3. **At inquest** the rules of evidence do not apply, witnesses can be compelled to answer incriminating questions. In adversarial fora the parties determine what material to put before the adjudicator. In an inquest the issues can be as broad or as narrow as the coroner can be persuaded to allow. The making of recommendations requires an ability to undertake policy analysis and development.

I am regularly made aware of regional coroners or their clerks making serious errors in each of these three stages. This is not their fault – the clerks have to take charge because the magistrate is either in another centre or is in court. Even when the magistrate coroners are involved, because coronial work is so different from that which takes up most of their time, poor decisions are made. It is a specialist jurisdiction which requires an understanding of and collaboration with other technical specialities.

The inadequacy of resources also manifests in inquest being dispensed with when a hearing should be held having regard to the proper purpose of inquests. Approximately 97.5% of matters are now finalised without an inquest.

Unlike in the civil or criminal jurisdictions:

- those most affected by coroners decisions are rarely legally represented;
- there are scant precedents to guide the decision makers or condition consumers' expectations;
- there are no tangible benefits in the aggrieved appealing - the damage is done in most cases; and
- coroners are required to collaborate with diverse agencies and disciplines.

Unlike in all states other than Tasmania, the *Coroners Act 2009* (NSW) does not create a coroners court.

Unlike in all states other than Western Australia, local magistrates in NSW still exercise coronial jurisdiction. In all other states full-time coroners complete all coronial cases.

Resources

The NSW coronial system is starved of resources. The most recent ROGS demonstrates that:

- Recurrent expenditure on coronial matters in Victoria ($12.8M) and Queensland ($10.3M) exceeds that of NSW ($5.6M) by 128% and 83% respectively.

- Both of those states also have double the FTE of judicial officers devoted to coroners work as does NSW - 0.1 cf 0.2 per 100K of population; and

- Coronial services in the other eastern states deploy almost double the number of FTE administrative staff – NSW 0.6, Vic and Qld both 1.1 staff per 100 coronial finalisations.

Unlike in all states other than Tasmania, there is in NSW no deputy head of the coronial jurisdiction.

The solutions

Option 1

1. In recognition of the specialist nature of the coronial jurisdiction the Act should create a coroners court.

2. In recognition of the importance of the work and the responsibilities of the position, the head of jurisdiction should be a District Court Judge appointed for a fixed term renewable. That is likely to attract applications from among the experienced lawyers who specialise in inquiry work and who are unlikely to apply to become a magistrate.

3. In recognition of the extent of the administrative and policy work and high profile complex inquests the head of jurisdiction must undertake, a deputy head of jurisdiction should be appointed for a fixed term renewable.

4. All coronial cases should be dealt with by full time coroners – the state coroner, the deputy state coroner and however as many magistrates as are required. Currently there are 5 FTE coroners at Glebe including the state coroner. Victoria has 10, Qld has 7. Magistrates identified as suitable by consultation between the Chief Magistrate and the state coroner should be appointed to the coroners court for a fixed term renewable.

5. **Budget implications**. Appointing a DCJ to the position of state coroner has a cost. Aggregating the work currently done by the 36 regional magistrate coroners into full time positions at Glebe/Lidcombe/regional centres is theoretically cost neutral – the same amount of work is to be done, just differently distributed. In reality there is likely to be *some* transaction cost.

Option 2

1. Items 1 and 3 of option 1

2. The initial stage of all coronial cases described in point 1 on page 1 should be dealt with by full time coroners. The 5 FTE coroners currently at Glebe plus one other

coroner's position relocated from the regions and two administrative staff positions also relocated from the regions could undertake this work.

As described on p1, this is the high risk, time critical work undertaken with little outside assistance and minimal opportunity for correction.

3. **Budget implications** Redeploying one coroner and two administrative staff from regional positions to Sydney would be cost neutral. The work that would no longer need to be done in the regions should allow these transfers to occur without negatively impacting the regions.

Michael Barnes

State coroner

August 2017

Appendix B

Towards better professional development of coroners

Experience in most jurisdictions teaches us that the development of *effective* training and professional development programs for judicial officers requires that programmes be conceived and presented by senior judicial officers. The programmes should be judge-led. They should, however, be designed and presented according to adult education principles. This generally requires input from professional educationists. The same principles apply to the design and presentation of training programmes for coroners.

This implies either that the senior coroners designing and presenting the programs are trained to do so in accordance with adult education principles or that they work closely with professional educators. Ideally, the senior coroners would have some training in programme design, facilitation and teaching skills *and* work with a professional educator.

To arm coroners with the requisite skills they need, Coroners Courts should develop curricula that will guide and structure the development of induction and continuous training programs. The curricula should be premised on the assumptions that it is a complex jurisdiction and that most new coroners have little or no experience in this jurisdiction.

A curriculum for ***new*** coroners should therefore concentrate on eight main areas:

(a) developing familiarity with the relevant legislation and procedures of the jurisdiction;

(b) developing an understanding of the experience of bereaved people whose loved ones' deaths have been reported to coroners;

(c) developing an understanding of the factors to be taken into account when making autopsy decisions, and applying the principle of ordering only the least invasive procedure appropriate to the case;

(d) developing an understanding of the basics of forensic medicine (including anatomy, pathology and toxicology);

(e) developing an understanding of the factors to be taken into account when deciding whether or not to hold a discretionary inquest;

(f) developing the skills of conducting and managing inquisitorial proceedings;

(g) developing judgment writing skills;

(h) developing the skills of formulating clear, reasonable, practicable and useful recommendations.

A curriculum of experienced coroners and ongoing professional development should concentrate on increasing the depth of coroners' understandings of complex types of cases and managing complex inquests. This could, for example, entail providing programs concerning:

(a) Hospital cases (surgical, misdiagnoses, care & treatment issues with an emphasis on systems failures rather than personal negligence issues);

(b) The problems of suicide (the psychology of young people, questions of intention, assessing risk of self-harm and self-inflicted death);

(c) The philosophy and legal principles concerning causation;

(d) Accident investigation (aviation, maritime, road transport, industrial, fires – again with an emphasis on systems failures and 'human factors');

(e) Research techniques and the use of epidemiological data to identify systems failures (eg, doctor-shopping drug overdoses; deaths in custody or police operations; rock fishing deaths; youth suicides);

(f) Crime scene investigation techniques;

(g) Case management techniques for conducting complex inquests (eg, using 'stop-watch' orders to limit cross-examination; taking expert evidence concurrently; managing unrepresented parties or difficult counsel, etc).

Appendix C

Improving coronial recommendations: Jennifer Schulz Moore's proposals

Jennifer Schulz Moore, author of a seminal study of the New Zealand coronial system,[38] has outlined several ways that coroners' recommendations could be improved. Some are met in NSW but others could be adopted with great advantage:

(i) Report coronial findings in public law reports
(ii) Target recommendations to specific persons or organisations
(iii) Provide sufficient resources, support and training *in relation to the preventive function*
(iv) Adopt a public health approach to prevention – rather than using only a 'single case' method, identify trends and systemic issues over time
(v) Make 'evidence-based' recommendations only.

In NSW, coronial findings by the State Coroner and Deputy State Coroners based at Lidcombe are published on the Coroners Court website. Findings by regional coroners, however, are <u>not</u> usually published. Recommendations are required to be forwarded to persons or organisations affected, the Attorney-General and any relevant minister.[39] Some NSW coroners cluster cases together but this is the exception rather than the rule.[40]

Moore proposes a 'gold standard' for coronial recommendations:

- They should target an identified person or organisation (who should be consulted before a recommendation is made)
- They should provide a preventive solution to
- They should specify the level of regulation towards which the recommendation is directed (legislation, policy, standards, guidelines, advocacy, etc)
- They should outline a strategy for implementation
- They should identify the population at risk
- They should identify the risk or contributing factors the recommendation seeks to mitigate.

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38 Moore (2016), n.2 above.

39 Coroners Act 2009, s 82(4).

40 An excellent example of this approach was the "Music Festivals" inquest conducted by DSC Grahame in 2019