Supplementary Submission No 104a

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

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

Supplementary Submission

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The NSW coronial system: strengths, weaknesses and the need for reform

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A constructive critique of the NSW coronial system

1 Introduction

The Select Committee has received 128 submissions. A significant number have focussed on the coronial system.[1] The system is an important public institution affecting the lives of thousands of people each year – especially the relatives of people whose deaths are reported to coroners. It is critical that it works optimally for them and the wider community.

The weight of criticism by Indigenous people and organisations was heavy. Most of the criticisms, unsurprisingly, related specifically to the investigation of the deaths of Indigenous people. But many had more general application.

For a former coroner like myself, they made enlightening but also chastening reading, as much because of their heartfelt tone, as for their substantive content. But I will argue that, valid as much of the Indigenous criticism of the coronial system is, a more complex critique is required, including an assessment of the strengths of the current system.

In this paper, I deal, first, with the strengths of the coronial system.[2] Most of the submissions (including my first submission) concerning the coronial system omitted any mention of its strengths and so present an incomplete picture and analysis.

Secondly, I discuss specific criticisms of the coronial system made by Indigenous people or organisations. This will not be confined to the context of deaths in custody but more broadly.

Thirdly, I offer more general criticism of the current system and make suggestions for practical reform.

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1 See, in particular, the submissions of the Legal Aid Commission of NSW, the Chief Magistrate, the Jumbunna Institute of Indigenous Education and Research, the Ngalaya Indigenous Corporation, Ms Lindsay McCabe, Hugh Dillon, the joint submission of Dr Fiona Allison, Prof Chris Cunneen & Dr Melanie Schwartz, the joint submission of Professor Scott Bray & Scraton, and the joint submission of Ms Leetona Dungay and the National Justice Project: https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=266#tab-submissions accessed 20/10/20.

2 In this chapter, when I am referring to the coronial system, I am referring not only to coroners and their staff but to the complex panoply of actors who take leading roles in the investigation of reported deaths including coroners, forensic medicine staff, police investigators, counsellors, social workers, administrators, lawyers assisting coroners, lawyers representing interested parties, and others.

2 Strengths

The positive aspects of the NSW coronial system can categorised in five ways:

- independence;
- culture;
- powers;
- multidisciplinary skills;
- other resources.

2.1 Independence

Independence is an essential protection against 'regulatory capture', the process by which organisations manipulate state agencies which are supposed to control them.[3] A number of strands of independence run through the NSW coronial system.

Chief Justice Gleeson observed in 2004 that an independent judiciary is "a fundamental human right of all citizens."[4] The judicial independence of NSW coroners is, arguably, one of the systems greatest strengths. It is essential to the system's legitimacy, and the reliability and acceptability of coroners' findings. Unlike coroners in many other jurisdictions internationally, Australian coroners are generally judicial officers.

The current State Coroner, Magistrate Theresa O'Sullivan, has a background as an ALS lawyer. Deputy State Coroner Grahame also has an ALS background. A number of the other Deputy State Coroners have Legal Aid Commission backgrounds. They have genuine interest in and empathy for Indigenous and other bereaved families.

Secondly, coroners engage members of the private Bar as Counsel Assisting in many inquests, especially those involving state agencies and agents. In complex or controversial cases, it is standard practice for coroners to be assisted by the NSW Crown Solicitor's Office Inquiries team and by counsel from the NSW Bar.[5] Barristers are required by their own rules to exercise independent judgment and not to operate merely as mouthpieces of their clients or their

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3 Ernesto Dal Bo, "Regulatory capture: A review", (2006) 22:2 *Oxford Review of Economic Policy* 203-225.

4 Murray Gleeson, "Out of touch or out of reach?" in *Advocacy and Judging: Selected papers of Murray Gleeson* edited by Hugh Dillon, (Sydney: Federation Press, 2017), 71.

5 Legal Aid Commission of NSW, Submission to Select Committee, (September 2020), 74. https://www.parliament.nsw.gov.au/lcdocs/submissions/69062/0117%20Legal%20Aid%20NSW.pdf accessed 21/10/20

instructing solicitors.[6] This includes coroners. Counsel Assisting in NSW are usually senior juniors or silks with experience in the jurisdiction.[7] To be of most assistance to coroners, Counsel Assisting are expected to exercise their independent judgment and provide their advice to coroners on that basis. In my experience, they did so regularly and boosted the quality of inquests as a result.

In the Legal Aid Commission's view, 'coronial matters are mostly well-prepared prior to inquest'.[8] In cases involving Indigenous deaths, Counsel Assisting with demonstrated experience with and empathy for Indigenous people are generally preferred if they are available.[9]

A coronial investigation necessarily involves the interests of next of kin.[10] Counsel Assisting may be sympathetic to the concerns of families but cannot represent their interests. In s23 inquests, organisations and officers involved in a death are always represented. In such cases, having the family independently represented is (or should be) a reassurance to the family that their legitimate concerns will be aired; that evidence they contest is tested; and that their submissions on the vital questions of fact, particularly the cause and circumstances of death will be taken into account by the coroner.[11]

The fact-finding exercise and the legitimacy and acceptability of the outcomes are almost always enhanced by a family's contributions. In controversial or complex cases, appropriate legal representation is essential to secure these outcomes. Because of their special circumstances, legal aid is always available to Indigenous families in deaths in custody cases.[12]

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6 Legal Profession Uniform Conduct (Barristers) Rules 2015, r.42.

7 The names of Counsel Assisting are published in coroners' Findings: https://www.coroners.justice.nsw.gov.au/Pages/findings.aspx accessed 21/10/20

8 Legal Aid Commission of NSW, Submission to Select Committee, (Sept 2020), 73.

9 Although there was no formal direction to that effect from the State Coroner while I was a Deputy State Coroner (2008-2016, this was the informal practice. This was well-understood by those managing the Crown Solicitor's Office Inquiries team.

10 *Annetts v McCann* [1990] HCA 57; (1990) 170 CLR 596.

11 Whether families (or even Counsel Assisting) have a right to make submissions on the question of a referral to the DPP is yet to be settled. I note that in the Dungay inquest Deputy State Coroner Lee took the view that this was the coroner's sole province. However, in the inquest into the death of Dwayne Johnstone, State Coroner O'Sullivan took the view that she could receive such submissions. In my view, a coroner is not prohibited by the Act from taking submissions from interested parties on the question and is likely to be assisted by doing so. The Coroners Act should clarify the situation.

12 Legal Aid Commission of NSW, "Submission to Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody", (September 2020), 74.

In marked contrast with many overseas coronial systems, all medical investigations are conducted by specialist forensic pathologists. In cases in which the cause of death is complex, coroners will often seek additional expert medical opinion.[13] Forensic pathologists in many countries are involved in the investigation of death or injuries that may have been inflicted by security forces. The World Health Organisation has noted that conflicts of interests may therefore arise if the investigating pathologists are also government employees.[14]

To ensure that forensic medical investigations in Australia are disinterested diagnostic investigations of the cause of a reported death, the Royal College of Pathologists of Australia imposes tight professional and ethical conditions on trainees and consultant pathologists.[15] In my coronial experience, the impartiality of a forensic pathologist employed by NSW Health was never challenged in any inquest.

2.2 Culture

2.2.1 Family orientation: Although a number of submissions are critical of the lack of care for families, the NSW coronial jurisdiction has what has been described by some as 'a culture of kindness.' This largely manifests itself through the work of the Coronial Information and Support team in the "Coroners Court"[16] and the counsellors in the Department of Forensic Medicine. In the criticisms of the coronial system, this unusually positive, family-orientated ethos is often overlooked.

The Local Court, in its high volume criminal jurisdiction, has nothing comparable. The feelings and sensitivities of defendants and even witnesses are not high order priorities for hard-pressed

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https://www.parliament.nsw.gov.au/lcdocs/submissions/69062/0117%20Legal%20Aid%20NSW.pdf accessed 20/10/20

13 See, for example, the Inquest into the death of David Dungay in which several specialists offered expert opinion evidence as to the mechanism and cause of death. https://coroners.nsw.gov.au/documents/findings/2019/DUNGAY%20David%20-%20Findings%20-%20v2.pdf accessed 22/10/20.

14 World Health Organisation, (Regional office for the Eastern Mediterranean), *Ethical practice in laboratory medicine and forensic pathology,* (Alexandria, Egypt: 1999), 29 https://apps.who.int/iris/bitstream/handle/10665/119604/dsa38.pdf?sequence=1&isAllowed=y accessed 22/10/20.

15 Royal College of Pathologists of Australia, "Internal Quality Assurance Framework: Clinical Forensic Medicine" (2017) https://www.rcpa.edu.au/getattachment/3d7e3e80-d5c4-4ab9-9d10-e4f38e7bbd7c/IQA-Framework-Clinical-Forensic-Medicine.aspx accessed 22/10/20

16 Unlike most other states, NSW has no statutory "Coroners Court of NSW". One courthouse (at Lidcombe) is known as "the Coroners Court".

magistrates. It is assumed that the psychological needs of those people are catered for elsewhere.

When a death is reported to the "Coroners Court", families are almost always shocked, confused and very distressed. They are usually assisted by trained counsellors and social workers of the Forensic Medicine Service (part of NSW Health) and the State Coroner's Court Coronial Information and Support Program ('CISP') team.[17]

The CISP team provide information, guidance and support in navigating the coronial system, especially in the early stages. Immediately after a death is reported, coroners make decisions concerning post mortem medical investigation. Some families have religious or cultural objections to autopsies or organ retention. The CISP team bring these objections to the attention of coroners and seek to negotiate outcomes that satisfy families while enabling coroners to carry out their statutory responsibility of ascertaining cause of death.[18]

The CISP staff explain the processes, the law, the issues coroners are dealing with to families. They liaise between families and coroners and sometime negotiate outcomes regarding autopsies, funeral arrangements, and examination of body organs and other concerns. They also assist families by providing information concerning diagnoses of death, police investigations, and inquests. If families wish to see distressing material such as CCTV footage, photographs of death scenes or forensic reports, CISP or Forensic Medicine counsellors will arrange this in a sensitive way.[19]

The Forensic Medicine counsellors employed by NSW Health manage viewings of bodies and provide short-term grief counselling for families. They also arrange longer term support if families wish to receive it. The Forensic Medicine team also provide a 'Support after Suicide' service, a support group for family members.[20]

The Coroners Act also provides for measures intended to show respect to and assist families:

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17 See Coroners Court website https://www.coroners.nsw.gov.au/coroners-court/help-and-support.html accessed 20/10/20

18 See Hugh Dillon and Marie Hadley, "Autopsies and objections to autopsy", Ch 4 in *The Australasian Coroner's Manual,* (Sydney: Federation Press, 2015), 59-81.

19 Coroners Court website https://www.coroners.nsw.gov.au/coroners-court/help-and-support.html accessed 20/10/20

20 Coroners Court website https://www.coroners.nsw.gov.au/coroners-court/help-and-support/coping-with-suicide.html accessed 212/10/20

- Post mortem examinations of bodies must pay proper regard to the dignity of the deceased person;[21]
- Post mortem examinations must be conducted using the least invasive procedures appropriate to the circumstances of the case;[22]
- Families have rights to object to autopsies and organ retention;[23]
- Families have a right to be legally represented and participate in coronial proceedings;[24]
- Families have rights to suggest witnesses to be called;[25]
- In practice, they may also suggest issues to be investigated by the coroner. This is usually done in a directions hearing or by way of correspondence with the family or their legal representatives;[26]
- Families have rights to examine and cross-examine witnesses.[27]

The family-oriented ethos of the NSW "Coroners Court" was outlined by State Coroner O'Sullivan on her appointment in 2019: 'We work hard to make the coronial experience as positive as we can, to ensure those who have lost a loved one feel supported every step of the way.'[28] In October 2020, the State Coroner instituted 'recognition mentions', a form of public recognition of people who have died and their relatives without the holding of a formal inquest.[29] This is part of her policy of making the jurisdiction as restorative or therapeutic as possible for families.[30]

At their best, coronial systems provide a unique form of institutional and personal recognition of a large number of our fellow human beings who die sudden deaths, and their families and,

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21 Coroners Act 2009, s88(1).

22 Coroners Act 2009, s88(2).

23 Coroners Act 2009, s96.

24 Coroners Act 2009, s57(1) and (3).

25 Coroners Act 2009, s60.

26 Coroners Act 2009, s49. See also commentary on s49 in Abernethy et al., *Waller's Coronial Law and Practice in NSW,* 4th ed, (Sydney: LexisNexis, 2010), 150.

27 Coroners Act 2009, s57(2).

28 Justice Department media release 11 July 2019 https://www.justice.nsw.gov.au/Pages/media-news/media-releases/2019/magistrate-osullivan-to-be-new-state-coroner.aspx accessed 21/10/20.

29 See also Aboriginal Legal Service submission to Select Committee on this point.

30 Author's telephone conversation with State Coroner O'Sullivan on 09/10/20. See also Aboriginal Legal Service, "Submission to Select Committee", (17 September 2020), https://www.parliament.nsw.gov.au/lcdocs/submissions/69098/120%20Aboriginal%20Legal%20Service%20NSW-ACT.pdf

sometimes, their social groups. This form of institutional recognition of people who have died is, at the same time, symbolic of the high value our society places on human life generally.

Even when it falls short, the institution's own aspirational standards and family-centred ethos set a standard against which it can be held to account. The expectation of care, respect and humane treatment is reasonable. When those expectations are not met by, for example, a failure to keep families informed, the disappointment and resentment evident in many of the submissions is almost inevitable. The inconsistency between the ethos of care and the reported experience of Indigenous families in many of the submissions exposes both the inadequacy of family support resources generally and the need for specialist resources for Indigenous families.

2.2.2 Procedural flexibility: While coronial investigations are inquisitorial in nature, and only result in inquests in a small fraction of reported cases, inquests, in practice, combine inquisitorial and adversarial methods. As fact-finders, coroners lead the search party, not the interested parties.[31]

The key difference between coronial inquisitorial methods and those applied by the judiciary in adversarial proceedings is that the coroner, not the parties, decides what issues will be investigated, what witnesses will be called, what documents will subpoenaed or ordered to be produced. Of course, a wise coroner will listen and take into account suggestions for lines of inquiry, evidence to consider and recommendations to be made but it is the coroner's responsibility to lead the way.

Coroners are not bound by the rules of evidence and procedure.[32] 'In the inquisitorial tradition the court has a duty actively to seek the truth'[33] – it is for that reason only that the evidentiary and procedural rules are relaxed. Hearsay, opinion, and other forms of otherwise inadmissible evidence can be admitted, subject to considerations of relevance, weight, fairness and the protection of fundamental rights such as legal professional privilege.[34] Although coroners have greater power than courts to pursue the truth for its own its own sake (within the parameters of their jurisdiction), to prevent unfair damage to reputations they have no powers to commit

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31 See Andrew Cannon, "Finding the facts: The judge should lead the search party", (2011) 37:1 *Monash Law Review* 120.

32 Coroners Act 2009, s58(1).

33 John R. Spencer, (2016) "Adversarial vs inquisitorial systems: is there still such a difference?" (2016) 20:5 *The International Journal of Human Rights* 601, 610.

34 Abernethy et al., *Waller's Coronial Law and Practice in NSW,* 4th ed, (Sydney: LexisNexis, 2010), 160-161.

persons for trial, or enter judgments against people, or even suggest criminality on the part of particular persons, no matter how strong evidence may be.[35] These questions are dealt with in other forums.[36]

An example of family-oriented procedural flexibility is that in NSW inquests families are given an opportunity to make informal statements about their loved ones. These statements do not constitute evidence as such but are an important part of the process of recognising the dead and their bereaved relatives. Although this is sometimes misunderstood, the purpose of the statement is to allow the family to acquaint the coroner and others with the once-living person and the effect their death has had on those who mourn them.[37]

2.2.3 Royal Commission into Aboriginal Deaths in Custody: The RCIADIC finished its work in 1991. In relation to coroners, it made 35 recommendations. Although frequent arguments are made that not all the Royal Commission's recommendations have been implemented, a study commissioned for the Commonwealth Government found that a majority of the recommendations *relating to coroners* had been substantially implemented in NSW.[38] This suggests that the NSW government and coronial system were, at least initially, reasonably responsive to the Royal Commission's arguments and concerns relating to institutional racism and structural disadvantage of Indigenous people in this state. A key recommendation which has been implemented is that there be mandatory inquests into deaths in custody and deaths in police operations.[39]

Perhaps as significantly, State Coroner O'Sullivan, on her appointment in 2019, stated that one of her priorities was investigating Indigenous deaths in custody. She noted that coroners were increasingly acknowledging "the connection between colonisation, dispossession, intergenerational trauma, and health outcomes" for Aboriginal Australians.[40] Her influence and

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35 Coroners Act 2009, ss 81(3), 82(3)

36 See Coroners Act 2009, s78.

37 Judicial Commission of NSW, *Local Court Bench Book,* [44-200] https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html#d5e38089 accessed 20/10/20

38 Deloitte Access Economics, *Review of the implementation of the recommendations of the Royal Commission into Aboriginal deaths in custody,* (Canberra: Dept of Prime Minister and Cabinet, August 2018). My own analysis suggests a similar result.

39 RCIADIC recommendation 11; Coroners Act 2009, ss 23, 27(1)(b).

40 Michaela Whitbourn, "Preventing Indigenous deaths in custody 'a priority': new top coroner", *Sydney Morning Herald* 13 July 2019.

ethos of recognition of Indigenous people is likely to become a powerful institutional strength over time.

2.3 Powers

Coroners' investigations differ markedly from most investigations, ad hoc inquiries and court cases because coroners have a wide discretion to determine the scope of their inquiries. In *Conway v Jerram,* the NSW Court of Appeal observed, 'When an inquest is held, the scope depends on all the circumstances… Just what is the scope of the inquest, is a matter for the coroner: a matter to be exercised using proper discretion and common sense.'[41]

Where that discretionary line is be drawn, however, will depend on the case and the coroner. The discretion, however, is largely unfettered and unguided.[42] Interventions by Australian Supreme Courts to restrain or limit the exercise of coronial discretion are, in practice, (perhaps surprisingly) rare.[43] How they exercise that discretion determines the width of their investigation and therefore the complexity of the fact-finding exercise.

There are, however, limits. A line of authority limiting the range of coronial inquiries and prohibiting coroners from conducting a 'roving Royal Commission for the purpose of inquiring into any possible causal connection, no matter how tenuous, between an act, omission or circumstance on the one hand and the death of the deceased on the other' has developed in Australia.[44]

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41 [2011] NSWCA 319 at [47]-[48] per Young JA.

42 But see Simon Walter et al., "Factors predicting coroners' decisions to hold discretionary inquests", (2012) *Canadian Medical Association J.* DOI:10.1503 /cmaj.110865 accessed 21/08/20; see Maxwell McLean, "Contradictory coroners? Decision-making in death investigations"(2017) 70 *Clinical Pathology* 787–791. doi:10.1136/jclinpath-2017-204333 for commentary on variations in discretionary inquests in England. See also Hugh Dillon & Marie Hadley, *The Australasian Coroner's Manual,* (Sydney: Federation Press, 2015), 82.

43 *Harmsworth v State Coroner* [1989] VR 989 is the leading case on this topic. The author conducted a search for citations of *Harmsworth* in LawCite on 21 August 2020. 23 citations were found. Only in *Harmsworth, Commissioner of Police v Hallenstein* and *Doogan* were Supreme Courts found to have intervened to circumscribe a coronial inquiry. (See n.48 for citations). See also *R v Randall*, *Ex parte The Salvation Army (Queensland) Property Trust* (unreported, Full Court S Ct (Q), OS No 21 of 1983, 24 August 1983) cited in *Atkinson v Morrow* [2005] QSC 92 at [28].

44 *Re State Coroner; Ex parte Minister for Health* [2009] WASCA 165 at [46] per Buss JA. See also *Harmsworth v State Coroner* [1989] VR 989; *Chief Commissioner of Police v Hallenstein* [1996] VicRp 51; [1996] 2 VR 1; *R v Doogan; Ex parte Lucas-Smith* [2005] ACTSC 74 and *Conway v Jerram* [2011] NSWCA 319.

Judicial modesty, experience (or inexperience), knowledge (or incomplete knowledge), and limitations of resources and time may also be powerful constraints on the scope of an inquest.[45] (For these reasons, some commentators hold the debatable view that inquests are 'a poor medium for revealing important information surrounding controversial deaths'.[46] While accepting that some inquests can be criticised, I disagree with the generality of the premise.)

Coroners have powerful statutory evidence-gathering and investigative powers. They can give directions to forensic pathologists to conduct medical investigations.[47] They can issue 'Coronial investigation scene orders' similar to search warrants to police to gather physical evidence.[48] They can also direct police officers to conduct investigations.[49] Coroners can also seek the assistance of coroners from other Australian jurisdictions.[50] Documents and physical evidence can be ordered to be produced [51]or subpoenaed.[52] Coroners also have statutory powers to issue case management directions.[53] Coroners can personally view bodies or places relevant to their inquiries.[54] Coroners can compel witnesses, including state agents, to attend inquests[55] and compel evidence to be given even over objection on the grounds of self-incrimination if it

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45 Time is a particular constraint. Both in NSW and Victoria, more than 6000 deaths are reported to coroners per annum. Because of this volume of work, not every case can be (or should be) run as a form of test case. For example, the inquest into the death of Tanya Day by Victorian Deputy State Coroner English took 15 hearings days. It then took the coroner 5 months to deliver a 111 page decision. The Lindt Café inquest in NSW took State Coroner Barnes more than 2 years to complete. These kinds of inquests can highlight serious issues needing urgent policy attention but, given limited coronial resources, they are necessarily the exception rather than the rule. State Coroner Jerram (2007-2013) had a view that there were many issues worth exploring at inquest and therefore imposed a guideline that inquests should not be listed for more than 5 days unless she gave her permission.

46 Tim Newburn, "The Hillsborough Report once and for all lays bare the lies", *The Guardian* 12 September 2012 quoted by Rebecca Scott Bray and Greg Martin, "Exploring fatal facts: current issues in coronial law, policy and practice", (2016) 12:2 *International J of Law in Context* 115 at 117; see also Phil Scraton and Kathryn Chadwick, *In the arms of the law: Coroners' inquests and deaths in custody,* (London: Pluto Press, 1987). In my view, this is a very sweeping generalisation based largely on contentious cases in Britain. How relevant they are in the Australian context is questionable.

47 Coroners Act 2009, s89.

48 Coroners Act 2009, s40.

49 Coroners Act 2009, s51(2)

50 Coroners Act 2009, s102.

51 Coroners Act 2009, s53.

52 Coroners Act 2009, s66(1).

53 Coroners Act 2009, s49.

54 Coroners Act 2009, s55.

55 Coroners Act 2009, ss66(1), (2); 69.

is in the interests of justice to do so.[56] Coroners have contempt powers (rarely used but useful).[57] They have powers to close the court and to prevent publication of evidence, submissions, questions or warnings if they consider it is in the public interest to do so or the case relates to a self-inflicted death.[58] If they hold inquests, coroners have power to make recommendations in relation to 'any matter connected with the death' (or suspected death or fire) being investigated.[59] In some circumstances, coroners can reopen inquests or start a fresh inquest.[60]

2.4 Multi-disciplinary skills

The coronial system is a complex combining elements from several disciplines and professions: the judiciary (coroners); forensic medicine and forensic sciences; police and other specialised investigations; law and advocacy; social work and grief counselling; public administration; public health and safety research. Three major NSW Government departments – Communities and Justice, NSW Health and Police – make major contributions to this system. Elements of each them are integrated relatively seamlessly through the Coroners Act and administrative practice.

As the NSW Bar stated in its submission to the Select Committee, the coronial system has 'an established and unique capacity to marshal resources from different disciplines, test hypotheses and robustly analyse disquieting facts in connection with deaths.'[61]

2.5 Other resources

2.5.1 The Local Court: The "Coroners Court" forms part of the Local Court.[62] The Chief Magistrate has power under the Local Court Act allocate magistrates to positions within the

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56 Coroners Act 2009, ss 58(2), 61. If a witness objects on grounds of self-incrimination, and the coroner is satisfied both that there are reasonable grounds for the objection and that it is in the interests of justice for the evidence to be given, the witness can be compelled but must be given a certificate protecting against the use and derivate use of that evidence: s61.

57 Coroners Act 2009, s103.

58 Coroners Act 2009, ss 74-76.

59 Coroners Act 2009, s82(1).

60 Coroners Act 2009, s83.

61 NSW Bar Association, "Submission to Select Committee", (26 September 2020), https://www.parliament.nsw.gov.au/lcdocs/submissions/69164/0003a%20New%20South%20Wales%20Bar%20Association.pdf; see also Abernethy et al., *Waller's Coronial Law and Practice in NSW* 4th ed. (Sydney: Federation Press, 2010), 1.

62 The Chief Magistrate has described it as one of the "lesser jurisdictions" of the Local Court: Confidential discussion paper on the administration of the coronial jurisdiction, 19 February 2007. I

court and to decide how many specialist coronial positions will be created.[63] Although I argue later that the "Coroners Court" should be established as a specialist statutory court managed by the State Coroner, the fact that the Chief Magistrate has power to place magistrates into or out of the coronial jurisdiction means that the judicial element of the system can be regularly refreshed and specialist coroners who are under-performing or need a change can be replaced.

2.5.2 New physical facilities: A new forensic medicine and coronial court complex was opened in Lidcombe in 2019. This is a state of the art building designed to enable collaboration between coroners, forensic medicine staff, police advocates assisting the coroners, family support staff and administrative staff. It is also intended to provide a more comfortable physical environment for families, witnesses, legal professionals and others than the old building in Glebe it replaced.

2.5.3 The National Coroners Information System: This a national database, established in 2000, of coronial data provided to it by all Australian states and territories plus New Zealand. The raison d'etre of the NCIS is to assist coroners, policy makers and researchers identify patterns of preventable death and to support death and injury prevention policy. The system is funded jointly by the Commonwealth, New Zealand and state/territory governments. The NCIS publishes bulletins about coronial recommendations and individual fact sheets. It can provide individual reports to coroners.[64]

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In summary, the NSW coronial system has significant strengths. They are, however, no reason for self-congratulation or complacency. For all its considerable strengths, the system is

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received this in 2019 as a result of an application under the Government Information (Public Access) Act. Curiously, however, the Local Court itself has no coronial jurisdiction. Neither the Local Court Act 2007 nor the Coroners Act 2009 specifically creates the jurisdiction within the Local Court. The Local Court Act creates a civil, a criminal and a 'special' jurisdiction within the court: s9. The special jurisdiction empowers the court to deal with certain kinds of applications. While for practical purposes the Local Court administers the Coroners Act, the Act confers coronial jurisdiction only on individual persons, including all magistrates, not on the Local Court.

63 Local Court Act 2007, s23(1). See also evidence of Attorney-General Speakman at Budget Estimates hearings, 4 September 2018 in which he stated that the Chief Magistrate was responsible for allocation of coroners to the coronial jurisdiction. This skirted the question of the government providing extra magisterial positions to be allocated to the coronial jurisdiction. This could, of course, be negotiated with the Chief Magistrate who has made the point that the jurisdiction is under-resourced.

64 Jessica Pearse and Leanne Daking, "The National Coroners Information System: contributing to death and injury prevention", (2007) 36:2 Health Information Management Journal 54-57; Lyndal Bugeja, "The utility of medico-legal databases for public health research: a systematic review of peer-reviewed publications using the National Coronial Information System", *Health Research Policy and Systems* (2016) 14:28 DOI 10.1186/s12961-016-0096-1; See also NCIS website: https://www.ncis.org.au/ accessed 22/10/20.

overstretched, under-resourced and in need of reform. Before turning to those general issues, however, I now turn to consider criticisms made of the system in its relations with Indigenous people. This analysis is based largely on submissions made to the Select Committee.

3 Indigenous criticism of the NSW coronial system

For every complex problem, there is an answer that is clear, simple and wrong – H.L. Mencken

Nearly 130 submissions have been made to the Select Committee. Of these, about 25 refer specifically to the coronial system. They expose the complexity of the problem of making the coronial system work optimally for Indigenous people. Several themes emerged in the submissions criticising the system:

(i) Structural discrimination and disadvantage;

(ii) Lack of trust in the system by Indigenous people and some supporters;

(iii) A call for greater accountability of state agents and organisations involved in deaths in custody;

(iv) A need for independent investigation of deaths;

(v) A need for greater Indigenous power and involvement in the system;

(vi) The centrality of bereaved families in the process;

(vii) A need for greater cultural sensitivity, respect and safety for Indigenous families in the system;

(viii) A need for more support for families directly and by way of legal advice and representation;

(ix) The need for improved response to coronial recommendations

(x) Resourcing and reform of the coronial system structurally and operationally, especially the reduction of delay.

These criticisms are inter-related and there is, therefore, no simple, clear answer to them.

In my view, these themes can be grouped around three main concepts:

- The centrality of the family and the need to support them;
- Transparency and independence of investigation; and
- The need for processes that are therapeutic rather than retraumatising.

3.1 The centrality of family – 'wrap-around' support of Indigenous people by Indigenous people

The initial reporting of a death is an emotionally sensitive stage. Usually families are informed of a death by police officers. As many submissions illustrate, this is not desirable. The ALS argued cogently for 'wrap-around support' for bereaved Indigenous families, starting with the first contact.

The Koori Engagement Unit established by the Victorian Coroners Court and staffed by Indigenous officers is a model that could be emulated in NSW. As at June 2019, the unit was engaged with about 100 Indigenous families.[65] NSW does not have any equivalent unit or even an Indigenous officer on the staff of the "Coroners Court" or the Forensic Medicine Service.[66] It needs such people to be integrated into the coronial system.

In NSW, there are on average 4-5 Indigenous deaths in custody or police operations per annum. This load would be insufficient to fully occupy even one Indigenous officer. NSW, however, has the largest and most diverse Indigenous population in Australia, about half of whom live in regions.[67] Apart from s23 cases, it is probable that deaths of more than 200 Indigenous people are reported to coroners annually.[68] This suggests that a team about twice the size of that in Victoria is needed.

A complicating factor is that some families live in relatively remote parts of the state such as Wilcannia, Bourke and Brewarrina. For an Indigenous officer to travel very long distances from the Coroners Court in Sydney is likely to lead to unacceptable delay in information being given to families.

There are 55 Aboriginal Medical Services[69] in NSW and a number of Aboriginal Legal Services. If the "Coroners Court" had an Indigenous team, it may be possible for the court to

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65 Aboriginal Justice, "Koori registrar in Coroners Court", https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-7 accessed 24/10/20

66 Legal Aid Commission (2020), 80.

67 Aboriginal Affairs NSW, "Key Data – NSW Aboriginal People", (September 2020) https://www.aboriginalaffairs.nsw.gov.au/media/website_pages/new-knowledge/facts-and-figures/KEY-DATA-ABORIGINAL-PEOPLE-SEP-2020.pdf

68 This estimate is based on Indigenous deaths constituting approximately 3.5% of the total number of deaths reported annually (about 6500). 6500 x 3.5% = 227.5.

69 See Better to Know https://www.bettertoknow.org.au/AMS.html

form working relationships between those services and its Indigenous officers to ensure that families receive timely information but in culturally safe way.

3.2 Independent investigation

Transparent, independent investigation is, in practical terms, the most difficult problem to solve. The current system is not trusted by Indigenous people. That makes investigating deaths in custody thoroughly and professionally even more important than it might be in other cases. But investigative skills are largely the domain of trained detectives, ex-detectives and other professional investigators.

Calls have been made for Indigenous investigators to investigate deaths in custody. Where they would come from is not immediately apparent. It is a matter of common knowledge that NSW has few Indigenous police officers. Whether any of them are detectives and would volunteer for this work is also unknown.

A second practical issue is that an annual workload of 4-5 deaths in custody or police operations is likely to be insufficient workload to occupy a team of investigators fully. (It would probably need to work on a number of coronial investigations.)

A third practical issue would be the question of giving non-police independent investigators the necessary powers to conduct investigations.

One solution to the practical issues may be to establish an investigative unit within the "Coroners Court". It could be staffed by trained investigators who may or may not be Indigenous but who would work with Indigenous officers of the "Coroners Court" in investigating deaths of Indigenous people. This could be a NSW Police unit or a unit like the ICAC investigation unit.

The keys would be (i) to have Indigenous officers working with the investigators to liaise with families, provide them information, and incorporate Indigenous voices in the process to ensure that the family's concerns were properly addressed; and (ii) to provide the investigators with appropriate powers. This would enhance the legitimacy of the process for Indigenous people.

Until about 2008, the NSW Homicide Squad allocated a small number of detectives specifically to coronial investigations. Those officers developed particular expertise in investigating medical matters and fatal cases involving systems failure. A similar kind of unit of professional investigators, (not necessarily NSW Police officers), working with Aboriginal liaison may be able to generate trusting relationships with family members and also provide a high standard of investigative expertise.

In my view, giving the Law Enforcement Conduct Commission (LECC) the role of overseeing investigations of Indigenous deaths is not a satisfactory answer. Even if given further power to oversee investigation of deaths in custody, or an Indigenous Commissioner were to be appointed, or both, this would not solve the immediate problem of lack of trust between investigating police on the ground and Indigenous families.

The LECC has little, if any, current ability to oversee the system. It has two main functions – investigating suspected serious misconduct, maladministration and corruption in law enforcement agencies, and handling serious complaints against law enforcement officers and agencies.[70] My understanding is that its oversight of Critical Incident investigations has little practical impact on those investigations and operates merely as a weak safeguard against incompetence.

Given the unhappy relationship between the Indigenous community and the NSW Police, there is probably real merit in appointing an Indigenous Commissioner or Assistant Commissioner to ensure that complaints against police by Indigenous people or organisations are investigated appropriately. But that is a different issue from investigations of deaths in custody or police operations and should be dealt with separately.

The question of transparent, independent investigation *by coroners* arose in some submissions. Professor Behrendt, in her evidence to the Select Committee said that Indigenous people tend to see all courts as part of the same system.[71]

The Local Court of NSW, Australia's largest criminal court, is also the court responsible for conducting inquests into deaths in custody. Some magistrates imprison people and other magistrates investigate their deaths in custody.[72] Regardless of the quality of the coroners and their undoubted integrity, this appears, in principle, to be problematic.

If all deaths in custody and police operations were handled by the State Coroner and Deputy State Coroners at the main coronial court in Sydney, it might be considered the Local Court had, in effect, isolated its s23 coronial operations. For a number of years, however, part-time Deputy State Coroners have been working as both magistrates and coroners in a number of regional centres. More part-time Deputy State Coroners have been appointed in recent times.

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70 Law Enforcement Conduct Commission Act 2016, s3.

71 Select Committee hearing, Tuesday 27/10/20. [see transcript].

72 See the submission of the Chief Magistrate to the Select Committee (26/08/20)

The part-time DSCs work predominantly as magistrates in the criminal jurisdiction but also have jurisdiction to conduct inquests into deaths in custody. A question of apprehended bias may arise, especially if inquests are being conducted in the same courthouses and courtrooms as are used for criminal proceedings. The test is 'whether a fair-minded lay observer *might* reasonably apprehend that the judge *might* not bring an impartial and unprejudiced mind to the resolution of the question the judge is required to decide'.[73]

In cases of Indigenous deaths in custody or police operations, the perspectives of Indigenous people on this issue might reasonably differ from those of non-Indigenous people and be objectively reasonable at the same time.

Separating the current nexus between the criminal and coronial functions by establishing a separate Coroners Court would be a step towards paying due respect to Indigenous people and their perspectives at relatively small cost. (See further below at [4.1.1]

3.3 Therapeutic or restorative approaches – flexible process, reducing delay, remedial recommendations

One of the principal benefits of applying a therapeutic or restorative methodology widely would be reduction of delay. Malbon has described a process developed in Ontario in the 1990s to overcome cumbersome procedures by holding 'informal family conferences' (as the Ontario Chief Coroner described them). In evidence to the Queensland review of its Coroners Act in 1997, the Ontario Chief Coroner, Dr James Young, stated:

> An informal discussion is held in which information about the death is shared and the coroner raises any concerns he or she may have about the investigation. Often an expert investigator attends the meeting. It is usually made clear that the information about the death is only preliminary, and that more information may be provided later, and that this may change the case's direction. When a meeting goes well, there is a frank discussion about the cause of death; the institution outlines where they consider things went wrong and their recommendations to prevent the same thing occurring again; and the institution and the coroner agree on the measures to overcome a similar death occurring.[74]

Dr Young also said that families and organisations had initially been suspicious of this process but over time confidence had developed in it. If the conference is successful, public inquests are not held but organisations are on notice that an inquest will be held if any further similar

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73 *Johnson v Johnson* (2000) 201 CLR 488 at [11].

74 Justin Malbon, "Institutional responses to coronial recommendations", (1998) 6 *J of Law and Medicine* 36, 47. I have provided a copy of this paper to the State Coroner for her information.

death occurs.[75] Apart from reducing delay and retraumatising relatives, a further benefit of this procedure is 'buy-in' from organisations – they embrace remedial death preventive action.[76]

The 2006 parliamentary report into the Victorian coronial system also saw strengths in the Ontario approach. Less formal proceedings offered a number of advantages:

- Feasible recommendations negotiated with their recipients;
- Increased likelihood of implementation of recommendations;
- Reduced costs and delay;
- A more flexible system.[77]

When the facts of a case are generally agreed, and testing of evidence in respect of the cause or circumstances of the death is not necessary, there appears to be considerable potential for more therapeutic, less formal, less complex procedures to be adopted for mandatory inquests.[78] Suggestions made in some submissions include holding inquests on country, incorporating cultural ceremonies such as smoking ceremonies, commencing inquests with a Welcome to Country or Acknowledgement of the Elders and people, placement of Indigenous symbols or significant objects in the inquest room[79] and 'recognition mentions'.[80]

A useful model that might be adapted in the coronial system is the Open Disclosure policy of the health system. NSW Health's Open Disclosure policy requires:

- Acknowledgment of significant patient safety incidents,
- 'Truthful, clear and timely communication' on an ongoing basis;
- An apology to the patient or support person 'as early as possible';
- Support for the patient; and
- Attention to investigating the incident with a view to improving patient safety.[81]

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75 Malbon (1998), 47.

76 Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016), 125.

77 Law Reform Committee, Parliament of Victoria, *Report on Coroners Act 1985,* Parliamentary Paper No 229 of Session 2003-06, (Melbourne: 2006), xlix. https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

78 Coroners Act 2009, s58.

79 Alison, Cunneen and Schwartz (2020), 8.

80 Aboriginal Legal Service (NSW/ACT) (2020), [3.2.2]

81 NSW Health, "Open Disclosure Policy" (2014), https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2014_028.pdf

Open Disclosure is underpinned by the philosophy that not only are patients and families entitled as of right to critical information delivered in a timely and sensitive fashion but that it is more therapeutic for families and health practitioners than a highly legalistic approach and more likely to resolve potential conflict than traditional legal methods.

Provided they were managed safely, fairly and skilfully by coroners, using proven techniques of restorative justice, such meetings may be an option that, in some cases, would be attractive to Indigenous families. A more formal, but non-adversarial, inquest could then follow in public.

As a large majority of deaths in custody deaths are due either to natural causes or self-inflicted harm, it would seem that the potential for flexible, therapeutic processes is considerable. State Coroner O'Sullivan is open to these methodologies. The Coroners Act permits flexibility. With sensitivity and respect, they may be appropriate in some cases.

Of course, in contentious cases, the usual procedures, involving adversarial testing of evidence and submissions critical of witnesses being made, could be employed as necessary or appropriate.

4 Other significant issues

Although the NSW coronial system has considerable strengths, it is not designed optimally and therefore cannot perform optimally. A number of factors which, taken singly and in combination, leave NSW with a sub-optimal coronial system. Reform is needed in respect of:

- structure
- discretion to hold inquests
- legislation
- strategic direction and purpose
- performance measurement
- resources

4.1 Structure

4.1.1 A paradoxical conflict: As at 31 December 2019, 139 magistrates were members of the Local Court bench. Of these, 11 held commissions as State Coroner or Deputy State Coroners. There are, however, only 5 full-time specialist coronial positions, one of which is shared. In terms of case numbers, the Local Court is the largest criminal court in Australia, in 2019 handling more than 350,000 criminal matters and more than 38,000 apprehended violence

applications.[82] The Local Court also dealt with approximately 87% of the criminal matters relating to Indigenous defendants in NSW, about 26,000 people.[83] In terms of case numbers, the coronial jurisdiction deals with a small fraction of the total Local Court workload. In 2019, 6673 deaths were reported under the Coroners Act.[84]

Apart from any other consideration, (of which there are several), this paradox, and Indigenous distrust of the criminal justice system, demonstrates the desirability of separating the coronial function from the criminal courts in both physical and legal senses. Models for doing so include a stand-alone court such as the Victorian Coroners Court or the New Zealand Coroners Court, or a 'court within a court' like the Children's Court of NSW or the Queensland Coroners Court.

The Children's Court is presided over by a District Court judge.[85] Children's magistrates are appointed by the Chief Magistrate in consultation with the President.[86] The Queensland State Coroner presides in the Coroners Court and has a consultative relationship with the Chief Magistrate concerning resources and guidelines or directions the State Coroner wishes to issue.[87] (Although all Queensland magistrates are coroners *ex officio,* they no longer carry out coronial work: all such work is done by fulltime coroners.)

4.1.2 An awkward hybrid structure: 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, the coronial jurisdiction was tacked onto the magistracy in the early 1900s. Previously a coroner system similar to that of England had operated. This reform increased administrative efficiency at that time. This arrangement, however, as was understood in the rest of Australia several years ago, is now anachronistic. The significance of a local coroner is greatly diminished by modern communications. The criminal and civil responsibilities of Local Court magistrates are more complex and demanding by several orders of magnitude than they were for three quarters of the 20th century.

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82 Local Court *Annual Review 2019,* (Sydney: 2020), 17-18. https://localcourt.nsw.gov.au/documents/annual-reviews/Local_Court_Annual_Review_2019_v1_accessible.pdf

83 Henson (2020), [10].

84 Local Court (2020), 21.

85 Children's Court Act 1987, s6A.

86 Children's Court Act 1987, s7.

87 Coroners Act 2003, s76.

The coronial jurisdiction is described by the Local Court as one of its 'lesser' jurisdictions.[88] In other states and countries, the coronial system has a name such as the 'Coroners Court of Victoria' or 'the British Columbia Coronial Service'. In NSW, there is no equivalent because there is no such organisation. The commonly used term "Coroners Court" is a misnomer in NSW, as is the phrase "coronial jurisdiction of the Local Court". Neither the Local Court Act nor the Coroners Act directly confer jurisdiction on the Local Court in coronial matters. Although most coroners are magistrates, they are invested with the office of coroner as individuals.

In its coronial jurisdiction, the Local Court operates, in effect, with a hybrid structure. In metropolitan Sydney, a court staffed by specialist coroners deals with 50-55% of reported cases. Regional magistrates and courthouses managed approximately 45% of reported cases. In August 2017, this system was criticised by the then State Coroner, Magistrate Barnes, in a submission to the Attorney-General:

> 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 hybrid system operated by NSW was in use in Victoria until 2008. It was abandoned and replaced by a stand-alone Coroners Court following an inquiry by the Victorian Parliament in 2006.[89] The WA Law Reform Commission was equally critical of general magistrates bearing

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88 Judge Graeme Henson, "Chief Magistrate's Discussion Paper: Coronial Jurisdiction" (Unpublished, 2007). This is a document written for discussion purposes sent by the Chief Magistrate to the Director of Policy in the Attorney-General's Department when revision of the Coroners Act 1980 was being considered by the NSW Government. It was provided to the author pursuant to the Government Information (Public Access) Act 2009.

89 Law Reform Committee, Parliament of Victoria, (2006), 12-14, 432, 602. https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

responsibility for coronial investigations because lack of capacity resulted in sub-standard service.[90]

As Barnes observes, unlike most coronial systems in Australia (and, indeed the world), NSW coroners constitute a small component of a much larger organisation. As he implies, except in the case of the small number of specialist coroners, coronial work is subordinated to the priorities of a much larger organisation.

The performance of the complex which comprises the coronial system in NSW depends on the performance of the coroners. They stand at the centre of the system and provide its direction to the medical and police investigators. But general magistrates rarely have the training or experience to deal with complex medical issues and many have had no experience working with police investigators. Magistrates may be presumed to be competent in assessing questions of disputed evidence and in delivering reasoned decisions based on law and fact. But there is little in the experience or training of general magistrates to prepare them for this complex, specialist jurisdiction.[91]

Expecting untrained, inexperienced people to operate effectively is, as Barnes implies, a mistake. New magistrates receive a short period of training in coronial affairs at the State Coroners court before commencing their country service. Regional magistrates receive a yearly talk of 1-2 hours from one of the specialist coroners as part of their continuing professional development. One chapter of the Local Court Bench Book relates to coronial matters.[92]

Moreover, in the regions, for obvious reasons, Local Court magistrates must work at arm's length from police officers. Yet, when conducting coronial investigations they must direct the investigation and, often, work with a local police prosecutor who performs the role of Counsel Assisting. The awkwardness and undesirability of these conflicting types of relationship is self-evident.

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90 WA Law Reform Commission, *Review of the coronial practice in Western Australia,* Project No. 100, (Perth: 2012), 14.

91 This observation is derived from a series of interviews I conducted with coroners, legal practitioners and others with specialist knowledge of Australian and Ontario coronial systems in 2020 as well as my own 9 years of experience as a coroner.

92 Judicial Commission of NSW, *Local Court Bench Book,* "Coronial matters", [44-000]. https://www.judcom.nsw.gov.au/publications/benchbks/local/toc_coronial_matters.html accessed 20/10/20.

Added to this are the difficulties of conducting inquests in the middle of managing busy criminal and civil lists. Regional magistrates may, for example, have to interrupt an inquest to conduct an urgent bail application or make an Apprehended Violence Order. The counter-therapeutic effects on bereaved families can only be imagined.

4.1.3 Co-ordinating with partners in the system: Co-ordination of the coronial system works by a series of ad hoc arrangements rather than in a systematic way. The complexity of the coronial system, however, indicates the need for policy and resource co-ordination. The fact that an ad hoc taskforce had to be pulled together in 2019 at the behest of the Health Minister to tackle the problem of delay in the system highlights the need for permanent systemic co-ordination.[93] This might be done, for example, by establishing a coronial council or board. Caution would be needed to ensure that judicial independence was not compromised but administration, policy and resource allocation could be managed that way.

4.2 Unfettered and unguided discretion: Very little is known about how coroners exercise their discretionary powers. It has been observed that there is a 'paucity of research examining how coroners function and make decisions [which] may result from the absence of suitable sources of data, the lack of a public health tradition in most coroners courts, and the traditional focus of courts and legal scholars on case-by-case analyses, as opposed to empirical studies at the population level.'[94]

NSW regional magistrates have heavy workloads,[95] and have an unfettered and unguided discretion as to whether they will hold inquests in cases other than in mandatory cases. Inevitably, therefore, a tension arises between the immediate demands to deal with their caseloads of criminal and civil work (including apprehended violence and other types of applications) and voluntary assumption of an even heavier workload.

The Local Court's own data show that country magistrates, in fact, conduct relatively few inquests.[96] It is probable that a significant proportion of them are mandatory cases. In Barnes's

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93 Legal Aid Commission (2020), 77.

94 Simon J. Walter et al. "Factors predicting coroners' decisions to hold discretionary inquests", *Canadian Medical Association Journal* 20 March 2012, 184:5, 521-528 at 526.

95 See Chief Magistrate's foreword to the Local Court *Annual Review 2019* (2020), https://localcourt.nsw.gov.au/documents/annual-reviews/Local_Court_Annual_Review_2019_v1_accessible.pdf

96 Local Court *Annual Review* (2020), 21. The data show that in 2019 48% of reports of death were made to regional coroners, but they only conducted 31% of inquests.

view, there appear to be numerous cases 'when a hearing should be held having regard to the proper purpose of inquests' but is not.[97]

The question of coronial discretion rarely receives attention from the NSW Supreme Court. The NSW Local Court Bench Book, in its chapter on "Coronial Matters" tells magistrates when inquests are mandatory and when they may dispense with holding inquests but otherwise provides no assistance to coroners deciding whether or not to hold an inquest.[98]

Nor, in contrast with other jurisdictions such as Victoria, Queensland and New Zealand, do the objects of the Coroners Act suggest any particular criteria or direction.[99] To my knowledge, there are no State Coroner's guidelines as to what criteria should be taken into account coroners decide whether or not to hold a discretionary inquest. It is left up to individual coroners. By contrast, guidance is provided to coroners in Victoria, Queensland and New Zealand.[100]

4.3 Legislation

The flaws in the NSW Coroners Act are manifold. They include the structural issues I have touched on. Here, I deal with three other matters only.

4.3.1 Inadequate objects: In other modern Coroners Act, such as the New Zealand and Victorian Acts, the legislation provides broad strategic guidance to their coronial systems. In particular, they lay emphasis on the prevention of death and injury.[101] The NZ Act also pays particular attention in its objects to recognising 'the cultural and spiritual needs of family of, and of others who were in a close relationship to, a person who has died'.[102]

The Victorian Act pays particular attention to the recognition of families and their distress, as well as the need for cultural respect in coronial operations.[103] The NSW Act, on the other hand,

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97 Barnes (2017), 2.

98 Local Court Bench Book, "Coronial Matters", [44-160], https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html#p44-160 accessed 26/10/20.

99 See Coroners Act 2009,

100 Judicial College of Victoria, *Coroners Bench Book* (Melbourne: 2010), [9.2.1]

101 Coroners Act 2008 (Vic), s1(c); Coroners Act 2006 (NZ) s3(1)(b). See also Coroners Act 2003 (Qld), s3(d).

102 Coroners Act 2006 (NZ) s3(2)(b(i).

103 Coroners Act 2008 (Vic), s8.

in its objects, relates only a series of mechanical objectives, giving no hint that the legislature or coroners are concerned with the impact of sudden death on bereaved relatives and others.[104]

Objects in a statute reveal its underlying philosophy or policy. 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?

4.3.2 Subordination of the State Coroner to the Chief Magistrate: Section 10(1) of the Coroners Act places responsibility for overseeing and co-ordinating coronial services in NSW on the State Coroner.[105] The State Coroner is required to ensure that reported deaths, suspected deaths, fire and explosions are 'properly investigated' and inquests are held when 'require' or 'desirable'.[106] To this end, the State Coroner has the function of issuing guidelines to 'assist them in the exercise or performance of their functions'.[107]

Section 10(2) of the Coroners Act provides, however, that 'the State Coroner is, in the exercise of a function under [s10], subject to the control and direction of the Chief Magistrate.' This appears to be a statutory provision unique to NSW. The administrative purpose behind it appears to be ensuring that the Local Court, including the State Coroner and specialist coroners, remain under the overall management and supervision of the Chief Magistrate.

In principle and practice, s10(2) is inappropriate. The appointment of State Coroners, the mandating of inquests into deaths in custody and police operations, and judicial independence of coroners were three of the most significant symbolic reforms proposed by the RCIADIC.[108]

It is therefore paradoxical that the judicial officer with statutory responsibility for ensuring the proper investigation of deaths of Indigenous people in custody is subordinate in the exercise of that function to the head of jurisdiction in Australia's largest criminal court.

The actuality of conflict of interest or bias is likely, in practice, to be minimal. But, given Indigenous lack of trust in the system, it ought be addressed. Establishing a statutory specialist

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104 Coroners Act 2009, s3.

105 Coroners Act 2009, s10(1)(a).

106 Coroners Act 2009, s10(1)(b), (c).

107 Coroners Act 2009, s10(1)(d).

108 RCIADIC National Report (1991) Vol 5, Recommendations 7, 8, 9 and 11. http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol5/5.html#Heading8

coroners court would go some distance to obviating the issue. It could be established on the lines of the NSW Children's Court or the Queensland Coroners Court under the broad umbrella of the Local Court's administration but with separate powers and specialist administration.

The second problem with s10(2) is that the State Coroner is given various statutory functions and responsibilities but the Chief Magistrate both controls and directs the State Coroner in carrying out those functions and decides what resources the State Coroner will have. The Local Court's main work will always take precedence over a 'lesser jurisdiction'.

If a specialist Coroners Court were to be established under the umbrella of the Local Court, the State Coroner should have the proper powers and responsibility of managing the jurisdiction (in consultation with the Chief Magistrate) as in other jurisdictions. The RCIADIC recommended that State Coroners be appointed and be given the status of District or County Court judges. The President of the NSW Children's Court is a District Court judge. This is an appropriate model as is the Coroners Court of Victoria, a stand-alone court also headed by a County Court judge. Whether it should be a stand-alone court or a specialist court under the umbrella of the magistrates court, as in Queensland needs close consideration. Both models have strengths and weaknesses.

4.2.3 *Jurisdiction:* As I have noted above, neither the Local Court Act nor the Coroners Act confers coronial jurisdiction on the Local Court itself. Rather, jurisdiction is conferred on coroners individually by the Coroners Act. In practical terms this may make little difference but it is an example poor drafting and an anachronistic legislative approach to coronership by the NSW Government and Parliament. A statutory specialist Coroners Court is needed.

4.4 Strategic direction and purpose

The great management thinker, Peter Drucker, argued:

> To make service institutions and service staffs perform does not require genius. It requires, first, clear objectives and goals. Next, it demands priorities on which resources can be concentrated. It requires, further, clear measurements of accomplishment. And, finally, it demands organised abandonment of the obsolete.[109]

NSW fails on all four Drucker criteria. It has nothing to compare with this combination of objectives, action plans, performance measurement and review of its own performance.

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[109] Peter F. Drucker, *Management* (revised edition) (NY: Harper Business, 2008), 141.

The Drucker principles are practised in Ontario which has a 5-year strategic plan for its death investigation system.[110] It set four strategic objectives each of required a number of specific actions to be taken. In relation to each objective a set of performance indicators was described. As at February 2020, a new strategic plan was being planned for 2021-2025.[111] The first objective of the 2015 plan related to optimising the Ontario system's use of human and technological resources; the second, to efficient and effective investigation; the third, to managing and optimising the use of data; and the fourth, to enhancing their review mechanisms.

The kind of strategic vision driving operations in Ontario would be difficult, if not impossible, to generate in NSW when the coronial system is locked into another, much larger organisation with different objectives, plans and performance measurements, and when the objects in its governing legislation do not provide any overall vision of the optimal coronial system. These managerial considerations demonstrate the desirability of a specialist coronial court.

4.5 Performance measurement

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, that is, the rate at which incoming cases are finalised on an annual basis.) 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. 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.

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 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%.[112]

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

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110 Ontario Ministry of Community Safety and Correctional Services, "Strategic plan for Ontario's death investigation system, 2015-2020", (Toronto: 2015)

111 Hugh Dillon, Interview with Dr Dirk Huyer, Chief Coroner of Ontario, Sydney 13/02/20.

112 See Local Court Annual Reviews 2015 & 2018.

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. This is because, before recommendations can be made under the Coroners Act, an inquest must be held.[113]

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.

As the Ontario Strategic Plan demonstrates, the performance of a death investigation system can and should be measured in a variety of ways, not pegged to a single, potentially misleading criterion. Both quantitative *and* qualitative measures are required. The strategic plan outlines 31 goals to be measured.[114] NSW, by way of contrast, the Local Court measures its coronial performance (in public) by reference only to a small number of measures: reported deaths, matters finalised, and inquests conducted.[115] Additional data can be extracted from the State Coroner's annual reports to Parliament but they are not published on the Local Court website. They merely provide data as to the number of s23 deaths reported annually (with a sub-set of Aboriginal deaths); numbers of s23 inquests conducted; and the size of the backlog.[116]

For courts such as the Local Court in its criminal jurisdiction, it is reasonable to judge the quality of its performance largely on the basis of its efficiency measured in terms of clearance rates. The effects of poor quality decision-making by judges and magistrates can largely be cured by appeal courts. Judges and magistrates whose decisions are overturned usually learn from their mistakes. Appeal judgements can be read and adjustments made to practice. Numbers of appeals upheld against judges and magistrates can be counted. These are indicators of quality that are readily available to heads of jurisdiction.

Measuring the quality of the coronial system's performance is necessarily very different. The jurisdiction has no equivalent of criminal and civil appeals to correct it. The standard measures of court efficiency are necessary but not sufficient to assess performance in this field. In Victoria, the State Coroner's annual report provides data such as the number of

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113 Coroners Act 2009, s82(1).

114 Ontario Ministry of Community Safety and Correctional Services (2015).

115 See Local Court *Annual Review 2019* (2020), 21.

116 See State Coroner (2020), 1, 577.

recommendations made and accepted, the patterns of reported deaths and duration of investigations.[117] NSW currently lacks such measures. More research and analysis is needed.

4.6 Resources

In 2017, Barnes informed the Attorney-General that the coronial system was 'starved of resources' and that a restructure was needed. [118]Additional part-time Deputy State Coroners, were subsequently appointed on the recommendation of the Chief Magistrate.[119] Nevertheless, as the State Coroner's 2019 report to Parliament on deaths in custody reveals, the backlog of s23 inquests is growing annually.[120]

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 10-year period 2010-19. This has resulted in a bank, by the end of 2019, of 129 outstanding cases.[121] 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.[122] It is clear that if the 'senior coroners' did nothing but s 23 inquests they would still struggle to reduce the backlog against a steady tide of incoming s23 cases (which average about 40 per annum).[123]

If enhancing recognition of families, cultural respect, public health and safety, restorative justice and human rights are the preferred goals of the NSW Government for the coronial system, the Ontario and Victorian systems both present features that could be adopted to sharpen the overall performance of the NSW system. In addition to Ontario's therapeutic jurisprudence, strategic planning, and performance measurements could be added a research unit modelled on the Victorian Coronial Prevention Unit.

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117 State Coroner of Victoria, *Coroners Court Annual Report 2018-2019* (Melbourne: 2020). I consider other measures in Chapter [x]

118 Barnes (2017).

119 Local Court *Annual Review 2019,* 21.

120 See State Coroner (2020), 577.

121 These calculations can be made from the data published in the State Coroner's 2019 annual report.

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

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

In 2018-2019, the Victorian Coroners Court had 25 research staff working in its in-house research unit on preventive research in four main areas: health, mental health, family violence and general. They assisted coroners in 671 matters. They provided reports in relation to factors which may have contributed to deaths; frequency of types of death and common risk factors; previous interventions and their effectiveness; regulations and standards; and previous coronial recommendations.[124]

The number of specialist researchers providing support to NSW coroners in its death preventive function was precisely - Nil. (Two researchers are employed in domestic violence homicide research but rarely contribute in relation to inquests.)[125] 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). 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 approach to use of data available in the NCIS. To develop recommendations, NSW coroners rely largely on their own research, outside expert reports or research provided to them by their Counsel Assisting and solicitors for inquests.

The inadequacy of resources is a drag on current performance and it inhibits improving performance, especially in relation to supporting families, conducting better quality inquests and producing better quality preventive recommendations. In the last quarter of 2020, with the resources available to it, and using its current methods, the empirical evidence demonstrates that the coronial system has no hope of clearing its current backlog of inquests into deaths in custody and police operations and is sinking under the weight of its work.

The consequence is increasing delay and diminishing the capacity of coroners to make effective preventive recommendations. The effect of delay and other shortcomings of the system – but especially delay - on bereaved families is immeasurable but, as the submissions to the Select Committee make clear, universally adverse.

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124 State Coroner of Victoria (2020), 28.

125 See Coroners Act 2009, Chapter 9A.

5 Conclusions

In this paper, I have argued that the NSW coronial system has a number of impressive strengths but also has a number of serious deficiencies. These features of the jurisdiction manifest themselves in various ways in the day-to-day operations of the system.

The current review, and the submissions made by Indigenous people and organisations, has exposed further flaws in the operation of the overall system and the need for serious and immediate reform.

Reforming the coronial system to ensure that it does not exacerbate the suffering of and injustice done to Indigenous people would not eliminate the root causes of that suffering and injustice. It is a limited but serious project that it is well within the power of the Parliament to undertake and realize. It would be relatively inexpensive and could make a serious difference to Indigenous families unfortunate enough to be drawn into the system.

Reforming the coronial system would also be a show of good faith with the Indigenous peoples of NSW. They should be integrally involved in any such process. Such a consultation process could have a transformative effect on coroners themselves and on all actors in the system. In my view, it is likely that lessons learned from consulting with Indigenous people and organisations would not only improve coronial services for Indigenous families but would have a knock-on effect for all bereaved families involved in the coronial system.