Supplementary Submission No 104b

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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Vital Statistics: delay and backlogs - the workload and performance of NSW coroners 2010-2019 and how to cut the backlog of s23 cases

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Introduction

In my first submission to the Select Committee, I discussed some issues relating to the NSW coronial system and argued that it was under-resourced and causing distress to Indigenous families due, especially, to delay. In my second submission, I addressed the strengths and weaknesses of the NSW coronial system and argued for reform.

In this paper, I present empirical evidence concerning the capacity, workload and the performance of NSW coroners for the period 2010-2019. These data are relevant, in particular, to understanding the size and causes of the delay problem which is so distressing for Indigenous bereaved families and which reduces the effectiveness of coroners in preventing future death and injury.

In this paper, I deal only with the "Coroners Court"[1], not with the coronial system as a whole. I am unable to find any publicly available data which would enable me to analyse medical or police coronial investigations.

The Select Committee's inquiry is dealing with deaths in custody. Under the Coroners Act 2009, only 'senior coroners' (that is, the State Coroner and Deputy State Coroners) have power to investigate deaths in custody. The system's capacity in relation to deaths in custody is therefore limited by, among other things, the number of 'senior coroners' available, their workloads and the amount of time they are able to devote to investigating s23 matters.

Numerous submissions highlighted the adverse effects of delay on bereaved families. While the performance of the system can be assessed in a number of ways, a critical measure of performance is the rate at which coroners process s23 cases.

The publicly available data demonstrate that the capacity of specialist 'senior coroners' to deal with s23 cases has diminished over the past decade. Although there was a large spike in numbers in 2019, the numbers of new s23 cases per annum have been reasonably steady over the decade. Incoming *general* reports of deaths of death, however, have significantly increased over the period, adding pressure on coroners.

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[1] As I have explained in my other submissions, there is no statutory coroners court in NSW. The Local Court Act and the Coroners Act do not vest coronial jurisdiction in the Local Court. Coroners are individually commissioned. All NSW magistrates are coroners *ex officio* but other Australian lawyers may be appointed as coroners. It is common in NSW to refer to "the Coroners Court". In fact, this is a misnomer. It is a reference to the courthouse (previously known as "The State Coroner's Court") at which a group of specialist coroners (magistrates of the Local Court) are based. They work fulltime as coroners. They are appointed there by the Chief Magistrate for varying periods but remain magistrates of the Local Court.

The coronial system's problems with dealing with Indigenous deaths in custody in a timely, thorough and effective way must be seen in the context of the system's *overall* capacity, workload and performance.

In respect of deaths in custody, the performance of the coronial system depends on a number of key variables:

- NSW population size and growth
- Death rate
- Numbers of reportable deaths
- Section 23 cases reported
- The number of coroners and individual coroners' workloads.

Quantitative data do not provide a complete picture of the performance of the coroners and the coronial system. In particular, they do not say anything about the quality or impact of investigations, or about the experience of bereaved families and others affected by reported deaths.

Nevertheless, quantitative data enable us to draw some inferences about the quality of the system overall. If delay is excessive and increasing, it has adverse impact on bereaved families. This has been made clear in submissions and also qualitative research referred to in submissions.

Therefore, in this paper, I will use clearance rates of s23 matters as a proxy measure of the performance of the overall system. The data to be discussed below show that the system as currently designed and resourced is inadequate for the task it is required to carry out and probably has been for years.

Capacity

The Productivity Commission's annual *Reports on Government Services* for the period show that NSW has allocated on 5 fulltime positions to its "Coroners Court" for most of the period 2010-2019. In its 2009-2010 report, it counted 5 fulltime equivalent positions.[2] (Victoria had 9 and Queensland 6.4 positions). In its 2020 report, the Productivity Commission stated that in the 2018-19 financial year, NSW had 5 fulltime coronial positions.[3]

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2 Productivity Commission, *Report on Government Services 2010,* (Canberra: 2010), Table 7.11.

3 Productivity Commission, *Report on Government Services 2010,* (Canberra: 2020), Table 7.28. https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/courts

The NSW Local Court *Annual Review 2019,* however, recorded that 11 magistrates held commissions as 'senior coroners'. I am informed that at Lidcombe there are still only 5 fulltime positions but a number of magistrates, including 3 regional magistrates, hold commissions on a part-time basis. A Newcastle and a Lismore magistrate each do a certain amount of coronial work in their regions. However, the available data, and information I have received, suggests that they do relatively little s23 work.

The large majority of deaths in custody are investigated by Lidcombe-based specialist 'senior coroners'. This is clear from analysing findings published on the Coroners Court website which show that overwhelming majority of inquests conducted in NSW, including s23 inquests, are held by the fulltime specialists.[4]

Workload

NSW population – size and growth 2010-2019

The size of the population (including the rate of increase) and the death rate of that population, taken in conjunction with the legal definition of reportable death, are variables that directly influence the size of the caseload of coroners. NSW has the largest population of all Australian states and territories.

The Australian Bureau of Statistics (ABS) estimated the NSW population as at 30 June 2010 to have reached 7.23 million. Almost two-thirds (63.3%) lived in Sydney.[5] In the March quarter of 2019, the Australian Bureau of Statistics (ABS) estimated the resident population of NSW to be 8,071,100 persons.[6] This was an increase in population of approximately 810,000 people (about 11.6%) over the decade.

According to the ABS, approximately 3.5% of the NSW population are Indigenous people (about 266, 000 people in the 2016 census).[7]

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4 See Coroners Court findings https://www.coroners.nsw.gov.au/coroners-court/coronial-findings-search.html

5 ABS, 3235.0 - Population by Age and Sex, Regions of Australia, 2010 (release date 04/08/11) https://www.abs.gov.au/ausstats/abs@ nsf/Products/3235.0~2010~Main+Features~New+South+Wales?OpenDocument#PARALINK14 accessed 04 November 2019.

6 ABS, 3101.0 - Australian Demographic Statistics, Mar 2019 (release date 19/09/19) https://www.abs.gov.au/ausstats/abs@ nsf/0/D56C4A3E41586764CA2581A70015893E?Opendocument accessed 29 September 2019.

7 ABS, "Estimates of Aboriginal and Torres Strait Islander Australians", https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/estimates-aboriginal-and-torres-strait-islander-australians/latest-release accessed 02/11/20

Overall death rates

In 2010, 47,945 deaths were registered in NSW. The standardised death rate was 5.6 deaths per 1,000 standard population.[8] In 2019, the standardised death rate in NSW had reduced slightly to 5.3 deaths per 1,000 standard population.[9] During the decade, the number of registered deaths rose approximately 17% on 2010 figures. 56,058 deaths were registered in NSW (33% of the national total).

Indigenous death rates

For Indigenous people, the standardised death rate in across the country in 2019 was 936.7 deaths per 100,000.[10] (This was nearly double the rate of the Australian population generally.) The median age at death was 60.9 years, increasing from 57.1 years of age in 2010.[11] Although the publicly available data from the Local Court do not reveal this, it is reasonable to infer that, because of higher morbidity and mortality rates of Indigenous people, there is a higher rate of reported deaths of Indigenous people to coroners than for the general population.

Among other things, the Indigenous suicide rate is much higher than for the general population. Suicide or suspected suicide deaths are required to be reported to coroners. Suicide is the fifth leading cause of death for Aboriginal and Torres Strait Islander people.[12] Indigenous people die as a result of self-inflicted harm at approximately twice the rate of non-Indigenous people.[13]

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8 ABS, 3302.0 - Deaths, Australia, 2010 (release date 10/11/11) https://www.abs.gov.au/ausstats/abs@ nsf/Products/B734713570543C41CA257943000CEF9E?opendocument accessed 04 November 2019.

9 ABS, Deaths, Australia (release date 24/09/20) https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release

10 ABS, "Leading causes of death in Aboriginal and Torres Strait Islander people", Causes of Death, Australia 2019 (Release 23/10/20), https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#leading-causes-of-death-in-aboriginal-and-torres-strait-islander-people accessed 04/11/20

11 ABS, "Age-standardised death rates over time", Causes of Death, Australia 2019 (Release 23/10/20), https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#leading-causes-of-death-in-aboriginal-and-torres-strait-islander-people accessed 04/11/20

12 ABS, "Top five leading causes of death", Causes of Death, Australia 2019 (Release 23/10/20) https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#leading-causes-of-death-in-aboriginal-and-torres-strait-islander-people accessed 04/11/20

13 ABS, "Intentional self-harm by Indigenous status", https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#leading-causes-of-death-in-aboriginal-and-torres-strait-islander-people accessed 04/11/20

Indigenous people also die at higher rates than non-Indigenous people due to injury and accidental poisoning.[14] Such deaths are reportable to coroners. According to NSW Health statistics, there are about 40 Indigenous suicides per annum in NSW and that number has doubled since 2006-10.[15] Indigenous suicide rates are about 10 times the rate of deaths in custody. Most of the root causes of deaths in custody and suicide are almost certainly the same.

NOTE: The loss of a loved one to suicide is devastating for families, especially when the person who dies is a child or young person. As many submissions have noted, Indigenous families of prisoners who die in custody need 'wrap-around support'. The same can be said for the significantly higher number of families whose loved ones die by suicide. According to ABS statistics, the Indigenous suicide rate rose during the period 2010-2019.[16] Other forms of traumatic death disproportionately affect Indigenous families who also need 'wrap-around support'.

Incoming reportable deaths

The number of reportable deaths and the resources available to manage them, (particularly the number of coroners), influences how coroners manage their individual and collective caseloads. In particular, as ex-State Coroner Barnes has observed,[17] it influences how coroners exercise their discretion to hold or dispense with holding inquests.

In 2010, 5448 deaths were reported to coroners (or 11.36% of all registered deaths).[18] In 2019, this had risen to 6673: that is, 11.9% of all registered deaths.[19] Deaths reported peaked in 2019, an increase of approximately 22.5% on the 2010 figure.[20] The lowest number of deaths reported in a year occurred in 2013 when only 5340 were recorded. Although the gross numbers of

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14 Australian Institute of Health and Welfare, "Indigenous injury deaths 2011-12 to 2015-16", (Release 13 March 2020), (Canberra: 2020), https://www.aihw.gov.au/reports/injury/indigenous-injury-deaths-2011-12-to-2015-16/contents/table-of-contents

15 NSW Health, HealthStats, "Suicide by Aboriginality, persons of all ages and 15-24 years, NSW 2006-2010 to 2014-2018", http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_Aboriginality_age?&topic=Aboriginal%20health&topic1=topic_aboriginal_health&code=Aboriginality%20atsi%20dqi%20hlp%20bod_damahos

16 ABS, "Top 5 leading causes of death, age-standardised death rates, Aboriginal and Torres Strait Islander people", Causes of Death, Australia 2019 (Release 23/10/20), https://www.abs.gov.au/statistics/health/causes-death/causes-death-australia/latest-release#leading-causes-of-death-in-aboriginal-and-torres-strait-islander-people accessed 04/11/20

17 "A bereaved families focussed Coroners Court restructure". See Appendix A to my original submission to the Select Committee.

18 Local Court *Annual Review 2015,* 20.

19 Local Court *Annual Review 2018*, 21.

20 Local Court *Annual Review 2015* (Sydney: 2016), 20 and *Annual Review 2018,* (Sydney: 2019), 21.

deaths reported annually fluctuates and sometimes falls, the overall trend since 2010 has been to increase, unsurprising as the population of NSW increased annually over the decade. See Figure 1 below:

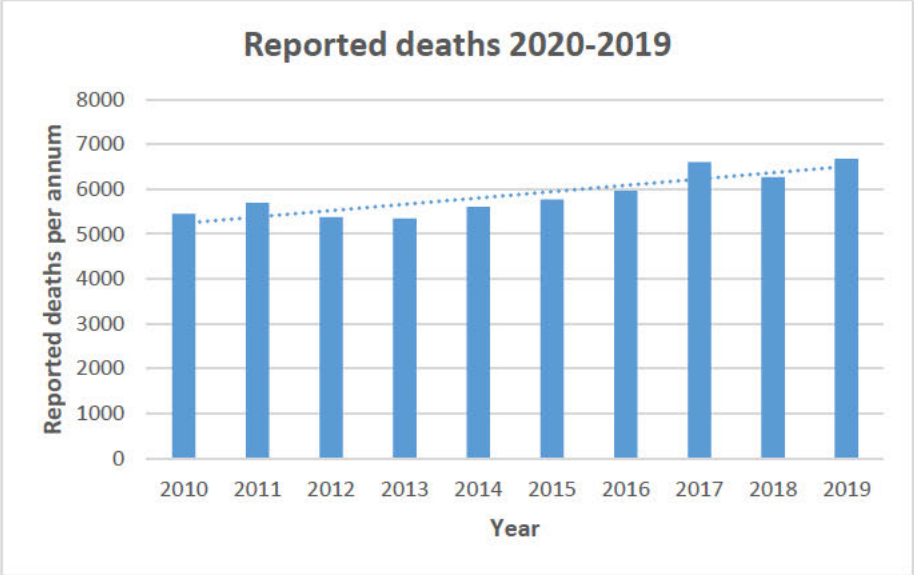

Figure 1: Reported deaths 2010-2019 - trend
Source of data: Local Court Annual Reviews 2010-2019

Incoming and outstanding s23 cases

The following graph illustrates the trend in s23 cases. Despite the efforts of coroners, the incoming cases exceed their capacity to manage s23 cases in a timely manner. In fact, it is probable that their capacity was exceeded several years ago.

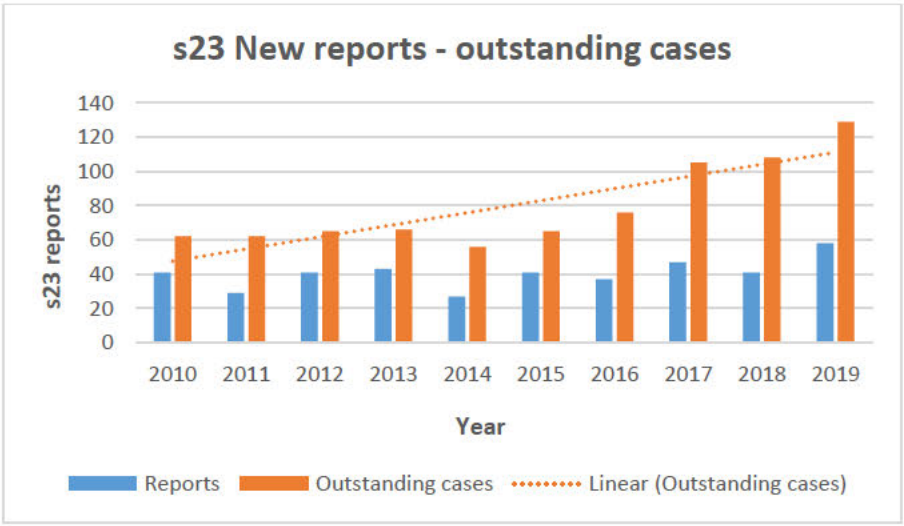

Figure 2: New and outstanding s23 cases 2020-2019 -trend
Source of data: State Coroner's annual s23 reviews.

Indigenous s23 cases

Indigenous people are greatly over-represented in both categories of s23 cases (i.e., deaths in custody and deaths in police operations). As the following data show, deaths of Indigenous prisoners constitute **13.12%** of all deaths in custody in the period 2010-2019. Of total s23 death reported in the period 2010-2019, **11.6%** were of Indigenous people. See Table 1 below:

Year	All DIC	Indigenous DIC	Indigenous s23	All s23
2010	23	3	6	41
2011	20	2	3	29
2012	20	1	2	41
2013	26	3	4	43
2014	14	1	2	27
2015	26	6	7	41
2016	16	1	4	37
2017	28	4	5	47
2018	27	3	7	41
2019	47	5	7	58
Totals	**221**	**29**	**47**	**405**

Table 1: Deaths in custody – Indigenous deaths in custody – Indigenous s23 – all s23 2010-2019
Source of data: State Coroner's annual s23 reports 2010-2019

Although deaths in custody have great symbolic significance for Indigenous people, deaths of Indigenous people in police operations are also highly significant and often involve more trauma than deaths in custody which are frequently due to natural causes.

Both categories of s23 case need to be considered. Deaths in police operations might be considered as more troubling. Such deaths are unnatural, often violent, and involve NSW Police investigating other NSW Police The argument for Indigenous involvement in the investigation of s23 Indigenous deaths in police operations is, therefore, even stronger than in relation to deaths in custody.

Coroners' individual caseloads

The individual caseloads coroners carry directly affect their capacity to conduct inquests. They also influence the thoroughness with which they conduct such inquests and the timeliness of those inquests.

In 2019, 3470 deaths were reported to the State Coroner's Court registry in Sydney. This constituted an average caseload for each of the fulltime specialist positions of 694 matters. (The

actual caseload may not be quite as high as this because the Local Court provides occasional assistance from general bench magistrates. They, however, conduct few, if any, inquests.)

Over the decade 2010-2019, the individual caseload trended upward as the following table and figure show:

Year	Average annual caseload per specialist coroner
2010	613.6
2011	625.6
2012	572.8
2013	561.4
2014	580.2
2015	597.8
2016	621.8
2017	710
2018	684.6
2019	694

Table 2: Specialist coroners – individual annual case load
Source of data: Local Court Annual Reviews 2010-2019.

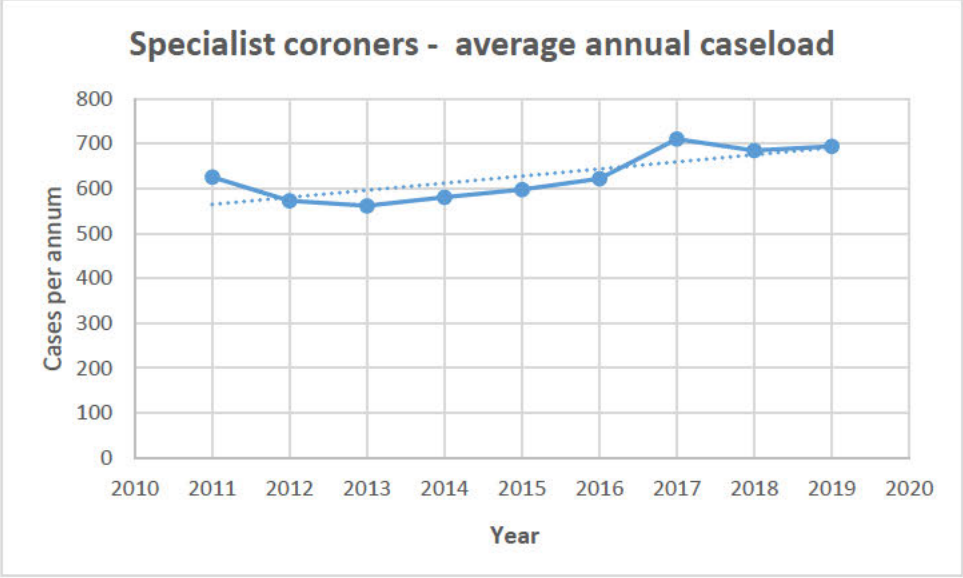

Figure 3: Specialist coroners – average annual caseload trend 2020-2019
Source of data: Local Court Annual Reviews 2010-2019

The average specialist coroner caseload over the decade 2010-2019 was 626.2 cases per annum. During the past 3 years, however, specialist coroners have been carrying average caseloads 697

cases per annum, 111.3% of the decade average and about 120 cases per annum more than in 2013.

Despite the fact that country magistrates receive nearly half all reports of death, specialist coroners based in Sydney (5 positions – one shared), the Local Court's own data show that specialist coroners conduct about **75%** of all inquests conducted in NSW.

Of the 117 inquests completed in 2019 by NSW coroners, findings are available on the "Coroners Court" website for 91.[21] All but three of the published findings were produced by specialist coroners based in Sydney. Two were produced by country magistrates (one of whom was a part-time Deputy State Coroner based in Newcastle) and one was produced by a Deputy State Coroner who was finishing an adjourned case after her return to the Local Court general bench.

Findings are not available in respect of the remaining 26 cases. It is likely that they relate to inquests conducted by regional magistrates who did not provide their findings to the Registrar of the State Coroner's court. Because very few of these inquests resulted in recommendations being made,[22] it can be inferred that most of them were probably mandatory inquests into suspected deaths of missing persons about whom there is not much evidence, unsolved suspected homicides with no significant leads or deaths in which the manner and cause of death is unknown.

In 2020, specialist coroners took over managing all new reports of death under the Coroners Act. They make orders for medical investigations and police investigation and other ancillary directions. Country magistrates have been relieved of these duties. This appears to reflect the Local Court's recognition that specialist skills are needed to ensure quality decision-making in this jurisdiction as well as the heavy workloads of country magistrates. All specialist coroners at Lidcombe takes weekly shifts and are on call 24 hours during their duty weeks. This shift to centralising the decision-making process in the early stages of investigations is intended to increase consistency of decision-making across the system and to improve efficiency.

Although this new procedure is likely to improve decision-making in the system as a whole, it has increased the workload of the specialist coroners. The duty coroner now spends his or her entire duty week managing these decisions. This has resource implications for the total workload of specialist coroners.

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21 Coroners Court, "Coronial Findings", https://www.coroners.justice nsw.gov.au/Pages/findings.aspx#2019findingsandrecommendations accessed 03/11/20.

22 See website of Dept of Communities and Justice, "Government responses to coronial recommendations", https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx All coronial recommendations must be sent to the Attorney-General and any other relevant minister or government organisation. They are collected on the above website together with government responses.

It is not possible to estimate the individual caseloads of *regional* coroners as reported deaths are not detailed by magistrate, courthouse or circuit in the Local Court's published data. They are likely to vary considerably in different areas. In some regional areas, such as Newcastle and the North Coast, a magistrate has been allocated to manage the majority of coronial work, relieving other magistrates of that burden. Reflecting this, the 2019 *Report on Government Services* shows that in 2017-18, NSW had 5.5 fulltime equivalent coronial positions.[23] Five of the fulltime positions were based in Sydney, leaving half a position allocated between two regional magistrates.

The 2020 *Report on Government Services* shows only 5 full time equivalent coronial positions in NSW[24] but the Local Court Annual Review suggests that this is incorrect. It lists 11 magistrates holding commissions as State Coroner or Deputy State Coroners. Four are fulltime specialist Deputy State Coroners, two share a position as specialist coroners, and the rest are part-time coroners.

How much coronial work the part-timers do is not apparent and probably varies over time. Conducting coronial investigations of any complexity is a time-consuming and quite lengthy process. Occasional ad hoc visitations by part-time coroners are not sufficient to cut deeply into backlogs of anything other than relatively straightforward cases (such as deaths due to natural causes) not requiring inquests. The number of deaths reported in 2019 rose by 409 from the previous year, but the number of inquests rose only by 6. This suggests that whatever additional assistance was given to the specialist coroners by the part-timers was very largely in dealing with matters that did not go to inquest.

Performance & delay

Clearance rates

One of the key measures used by the Productivity Commission (and the Local Court itself) to assess performance is clearance rates of cases. This is calculated by dividing the number of finalised cases by the number of new cases received to get a percentage rate. (Finalised cases ÷ incoming = clearance rate %).

Productivity Commission data show that clearances of incoming reported cases were generally maintained at rates of about 100% over the 2020-2019 period despite caseloads increasing significantly. The Local Court has generally good overall clearance rate of coronial matters.

The picture suggested by the generally good overall clearance rates is, however, misleading as the situation regarding clearances rates of s23 inquests shows. Overall clearances can be

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23 Productivity Commission, *Report on Government Services 2019,* Ch 7, Table 7A.24.

24 Productivity Commission, *Report on Government Services 2019,* Ch 7, Table 7A.28.

maintained by avoiding holding inquests. That cannot be done in respect of s23 cases in which inquests are mandatory.

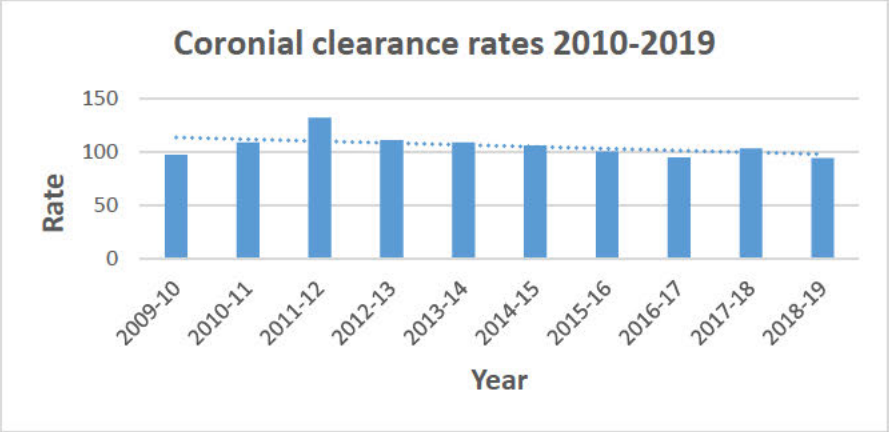

Figure 4: Overall NSW coronial clearance rates 2010-2019
Source of data: Productivity Commission *Reports on Government Services* 2010-2020.

The relatively high clearance rate of general coronial matters is not mirrored by similar results in relation to s23 cases. It has averaged about 80% over the decade. See Table 3:

Year	Reports	Inquests	Outstanding cases[25]	Clearance rate(%)
2010	41	25	62	60.98
2011	29	30	62	103.45
2012	41	39	65	95.12
2013	43	36	66	83.72
2014	27	30	56	111.11
2015	41	36	65	87.80
2016	37	22	76	59.46
2017	47	27	105	57.45
2018	41	38	108	92.68
2019	58	39	129	67.24
Total	**405**	**322**	**129**	**79.51**

25 The arithmetic seems to be incorrect here but I have drawn these figures from the State Coroner's own reports.

Table 3: s23 Clearances 2010-2019
Source of data: State Coroner's annual s23 reports to Parliament on Deaths in custody and police operations 2010-2019

Only twice in the past decade have NSW coroners been able to achieve an annual clearance rate of 100% in s23 cases. This occurred in years in which there were an unusually low numbers of s23 deaths reported.

This is problematic for a number of reasons. First, delay has multiple knock-on effects but is especially distressing for bereaved families.

Second, the growing backlog of s23 cases is now close to the point of being unmanageable. Since 2016, the *entire NSW magistracy* has not managed to conduct more than 120 inquests in a year, yet the backlog of s23 cases is 129.

Third, without significantly increased resources or changed methods (or both), the backlog is likely to increase.

Fourth, with the current structure and management of the coronial system, the only source of further coroners appears to be the Local Court. Transferring magistrates from the general bench to the "Coroners Court" is a zero-sum game, merely transferring pressure from one point to another.

Fifth, concentrating a greater share of coronial resources on s23 cases would reduce the coroners' capacity to investigate other significant cases in which inquests are not mandatory, thereby reducing the coroners' capacity to make preventative recs.

The State Coroner makes no express complaint about deficiency of resources but the growing backlog speaks for itself. It is strong circumstantial evidence of a shortage in the "Coroners Court" of qualified coroners and on the investigative side of sufficient police investment. Other factors are also sure to be in play.

Notwithstanding the growing pressure, however, the data show a gradual increase since 2017 in the proportion of s23 inquests being conducted as the following table and figure show:

Year	All inquests	s23 inquests	s23%
2010	196	25	12.76
2011	290	30	10.34
2012	148	39	26.35
2013	142	36	25.35
2014	140	30	21.43
2015	150	36	24

2016	120	22	18.33
2017	84	26	30.95
2018	111	36	32.43
2019	117	39	33.33

Table 4: s23 Inquests as a proportion of total inquests
Sources of data: Local Court Annual Reviews & State Coroner's annual s23 reports

The following graph illustrates how s23 inquests are now attracting a greater proportion of the effort of senior coroners despite a downward trend in overall inquest numbers.

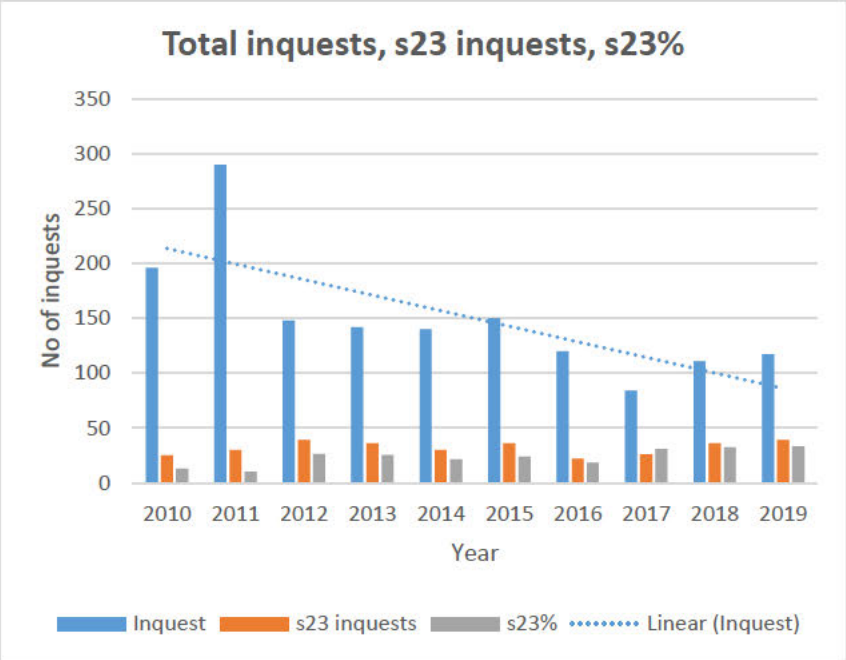

Figure 5: Total inquests, s23 inquests and s23 %
Sources of data: Local Court Annual Reviews & State Coroner's annual s23 reports

.Conclusions

In my previous submissions, I acknowledged the distress and retraumatisation Indigenous families suffer in the coronial system. In this paper, I have provided empirical evidence to assist the Select Committee to understand how the system works and why it does not work optimally.

The empirical data demonstrate that the specialist coroners on whom the system depends are under-resourced and under increasing pressure. Their limited capacity to conduct inquests has diminished over the past decade because of under-resourcing.

On a number of occasions over the past 3 years the Attorney-General has stated that the NSW Government is committed to providing the resources necessary for the coronial system to run properly. In March 2019, he told the *Sydney Morning Herald* that the coronial system "plays a

crucial role in keeping our community safe by making recommendations intended to save lives", and that the government was committed to ensuring the court was adequately resourced. He said he was "always open to improving the coronial jurisdiction" and would be guided by the Coroners Act review, expected to be released this year. [26] Nineteen months after making that statement, and about 6 years after the Coroners Act review he referred to was commenced, the review remains either unfinished or buried.

Under s37 of the Coroners Act, the State Coroner has been obliged since 1995 to make an annual report to Parliament about deaths in custody and police operations. This was one of the recommendations of the Royal Commission into Aboriginal Deaths in Custody. It was intended to keep parliaments alert to the issues the RCIADIC had raised.

State Coroners have complained of "unavoidable delays" in concluding s23 investigations for several years. These are warnings to the government that the coronial system is under-resourced. They have been ignored every year by government and, indeed, by virtually all MPs.

The data show that the coronial system is *not* "adequately resourced" and that, despite heroic efforts by its specialist coroners, it is unable to meet the reasonable expectations of bereaved families, most notably Indigenous families. Indigenous families believe that they receive a blind eye, a deaf ear and a hard hand in the justice system.

There are no simple answers to structural discrimination as deep-set as it is in Australia. But one small, relatively inexpensive step that could be taken to honouring the promise of the Royal Commission into Aboriginal Deaths in Custody would be to establish in NSW an "adequately resourced" coronial system that can do the job for Indigenous people that the Royal Commission wanted done.

Indigenous involvement in *all* coronial investigations into deaths of Indigenous people is desirable, especially in relation to s23 cases but also in cases of suspected suicide. Although s23 cases receive a high profile, there are significantly more cases of Indigenous suicide and other forms of traumatic death than of deaths in custody. The "Coroners Court" urgently needs Indigenous officers to liaise with and provide support to bereaved families in *all* cases.

There are signs of hope for significantly improved performance in the NSW coronial system. The centralisation of the initial decision-making processes has diminished the contribution of country magistrates to the coronial system significantly. This may reflect a recognition by the Local Court of the points made by State Coroner Barnes in 2017, and the Victorian

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[26] Michaela Whitbourn, "'Anachronistic': experts call for a shake-up of the NSW Coroners Court", *Sydney Morning Herald,* 16 March 2019 https://www.smh.com.au/national/nsw/anachronistic-experts-call-for-a-shake-up-of-the-nsw-coroners-court-20190305-p511zf.html

parliamentary (2006)[27] and the WA Law Reform Commission (2012)[28] inquiries, that country magistrates cannot provide high quality coronial services. State Coroner O'Sullivan has made s23 cases and the recruitment of at least one Indigenous officer priorities. The NSW specialist coroners are aware of the challenges and are sympathetic to the needs and claims of bereaved Indigenous families. But the needs are great and the resources to meet them have not been provided by government. It is to be hoped that this review will prompt belated action by the relevant ministers.

The backlog of s23 cases can be addressed in a combination of ways.

First, priority should be given in most cases to Indigenous families. The endemic suspicion and lack of trust in the system must be addressed in a variety of ways. Showing bereaved families that their concerns have high priority would help generate some degree of trust.

Second, in the short term, temporary Deputy State Coroners could be appointed under the Coroners Act to conduct mandatory s23 inquests. Only magistrates are qualified under the Act to be appointed as 'senior coroners'. Suitable people, such as barristers or solicitors with experience in coronial matters, could be appointed as Acting Magistrates for this purpose. Retired judicial officers could also be commissioned as Acting Magistrates and Deputy State Coroners. In the longer term, more permanent appointments are needed in the coronial jurisdiction.

Third, attacking the backlog would also require greater investment of resources in other ways. Families would need legal support. The Legal Aid Commission's coronial team consists of only two solicitors. The Aboriginal Legal Service could, if funded for this, may be able to brief suitable barristers to represent families. The legal profession would probably set up in some cases to provide pro bono support (but suitable people would be needed).

Fourth, assuming that for the foreseeable future the NSW Police continue to carry out s23 investigations, the Commissioner should be requested to make reducing the backlog of Indigenous s23 cases a priority. The State Coroner and the Commissioner would need to negotiate how this would be done and what additional resources the Police Force could provide. Given the sensitivities, as much Indigenous involvement in these investigations as can be managed appropriately is highly desirable. Indigenous coronial officers would be needed urgently for this work.

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

28 WA Law Reform Commission, *Review of coronial practice in Western Australia,* (Project 100), (Perth: 2012), https://www.lrc.justice.wa.gov.au/P/project_100.aspx

Fifth, NSW Health should be directed by the Health Minister to fast-track Indigenous post mortem reports and also to recruit qualified Indigenous officers to Forensic Medical Services as a matter of urgency.

As I have suggested in another paper, flexible processes could also be employed in some cases. If facts are not contested, much quicker, more flexible, more therapeutic inquests could be conducted. For example, it may be possible, in appropriate cases, for senior coroners to hold inquests where families live rather than in courthouses and courtrooms. NT coroners and bodies like the Native Titles Tribunal have incorporate much more flexibility into their processes than is generally the practice in NSW.

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