Submission No 17

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: New South Wales Bar Association

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Submission to Select Committee Inquiry into the Coronial Jurisdiction in NSW

9 July 2021

Promoting the administration of justice

The NSW justice system is built on the principle that justice is best served when a fiercely independent Bar is available and accessible to everyone: to ensure all people can access independent advice and representation, and fearless specialist advocacy, regardless of popularity, belief, fear or favour.

NSW barristers owe their paramount duty to the administration of justice. Our members also owe duties to the Courts, clients, and colleagues.

The Association serves our members and the public by advocating to government, the Courts, the media and community to develop laws and policies that promote the Rule of Law, the public good, the administration of and access to justice.

The New South Wales Bar Association

The Association is a voluntary professional association comprised of more than 2,400 barristers who principally practice in NSW. Currently, 450 of our members report practicing in the coronial jurisdiction. We also include amongst our members judges, academics, and retired practitioners and judges.

Under our Constitution, the Association is committed to the administration of justice, making recommendations on legislation, law reform and the business and procedure of Courts, and ensuring the benefits of the administration of justice are reasonably and equally available to all members of the community.

This Submission is informed by the insight and expertise of the Association's Inquests and Inquiries and First Nations Committees.

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EXECUTIVE SUMMARY AND RECOMMENDATIONS

The New South Wales Bar Association (the Association) welcomes this inquiry and supports modernisation and reform of the NSW coronial system.

The Association submits that the coronial system should be viewed as a complex or network comprised of elements drawn from the judiciary and legal profession, medicine, police and other investigative agencies, family liaison and support services, and public administration. The current system is not optimally designed, structured or co-ordinated. A new system is needed to co-ordinate the various elements efficiently and to meet the objectives of the coronial system.

At present the purposes and objectives of the coronial system are not clearly delineated in the *Coroners Act 2009* (NSW) (2009 Act), legal authority or public policy. A conceptual framework is needed to guide, control and evaluate how the system performs and should perform.

Modern coronial theory has emphasised four primary purposes of coronial death investigations:

- fact-finding in relation to reported deaths;
- prevention of future death and injury;
- therapeutic and restorative processes; and
- accountability of state agencies involved in reported deaths and support of human rights.

A reformed system should be specifically designed, structured and resourced to meet those ends. To that end, the Association submits that a new, fully reformed Coroners Act and a statutory specialist Coroners Court are required.

The current structure of a group of specialist coroners within the Local Court (the State Coroner and Deputy State Coroners based at Lidcombe) managing all metropolitan reported deaths plus country and regional magistrates managing reported deaths in their localities is not best practice. NSW is the only Australian jurisdiction that still supports such a structure for a coronial system. Coronial work should be recognised as specialist work.

The Association supports the adoption of innovative and flexible procedures being implemented by the State Coroner and Deputy State Coroners, where appropriate. We submit that practices in other jurisdictions, such as Ontario, Canada show great potential for practice in NSW.

Delay and backlogs have become chronic and beyond the current capacity of the State Coroner and specialist coroners to manage successfully. They are acute in relation to s 23 inquests into deaths in police operations and deaths in custody which, because of high levels of incarceration, disproportionately affect First Nations people, their families and communities. The delays and backlogs reveal that, despite the best efforts of those involved, the coronial system is under-resourced to meet its current workload. It is also under-resourced to fulfil its death preventive potential. Restructuring and the investment of additional resources are required for both purposes.

NSW has a sub-optimal system of response to coronial recommendations. Other jurisdictions, especially Victoria, have more efficient regimes of managing recommendations and responses.

The Association fully supports the State Coroner's initiatives to make the coronial system more responsive to the needs of First Nations families and communities. They include the employment of First Nations family liaison officers and a new draft protocol for managing First Nations deaths in custody. We submit that a Koori Engagement Unit, similar to that now operating in Victoria, should be established.

Operational arrangements between the Coroners Court, NSW Health, the Department of Communities and Justice and NSW Police require, in our submission, strategic oversight on a permanent basis.

Practice and organisation in a number of other jurisdictions, especially Victoria, Queensland, New Zealand and Ontario Canada, suggest a number of ways in which the NSW system could be reformed.

Taking into account lessons that can be learned from other jurisdictions, the Association submits that the most appropriate institutional arrangement for NSW would be to establish a system with at least the following features:

- A new Act adopting the best features of, especially, the Victorian and New Zealand Acts, especially the statutory objects. The statute should expressly declare its basic purposes. The objects should emphasise:
    - the centrality of the experience and needs of bereaved families, and others affected by reported deaths, in the conduct of coronial investigations;
    - the unique and honourable place of First Nations people within the Australian community as the First Nations of the land;
    - the unique needs of First Nations people within the coronial system given the impact of colonisation, dispossession and systemic discrimination upon First Nations people[1];
    - the role of First Nations coroners and First Nations commissioners (or similar title) to sit on all inquiries relating to the death of a First Nations person;
    - the need, as far as possible to apply therapeutic and restorative processes when conducting investigations;
    - the need for the court to conduct proceedings in a way that is flexible and responsive to the particular circumstances of each investigation;
    - the pivotal role of the coronial system in the prevention of future death and serious injury; and
    - its role in providing one form of accountability, and supporting and protecting human rights, by investigating deaths caused or contributed to by state agencies and agents.

- A specialist court, clearly constituted with specialist jurisdiction, to stand as the hub of the coronial death investigation system;
- The system should be co-ordinated and, as far as reasonably practicable, integrated with a view to achieving maximum efficiency of its operations and optimal outcomes for bereaved families and others affected by

[1] Evidence given to the Inquiry into the High Level of First Nations People in Custody (2020-21) supports such an amendment being made.

reported deaths. A strategic oversight board or committee along the lines of the Queensland Coronial Services Governance Board to co-ordinate the system and provide strategic planning should be established;

- In recognition of the special position of First Nations people in the Australian community, and the particular significance and sensitivity of investigations of First Nations deaths in custody, a number of positions should be allocated for senior First Nations people on any governance board or committee that may be established to oversee the NSW coronial system;
- A series of standing death review committees similar to the Ontario Canada model to work within the coronial system in a co-ordinated fashion;
- A coronial public health and safety research unit with the Coroners Court to collect and analyse coronial data with a view to (a) contemporaneous identification of patterns and trends of risk; (b) alerting appropriate public agencies to the emergence of such trends; and (c) supporting the coronial system more broadly in its preventive function;
- Co-ordinated connections between the coronial public health and safety research unit and public health and safety organisations and research units in universities and government agencies;
- The system should be resourced sufficiently to enable it to complete all s 23 inquests within 12 months of a death being reported and to complete investigations into all preventable deaths within 18 months (accepting that, as discussed below, in practice there will sometimes be good reasons relating to other disciplinary or curial processes which mean that these time frames will not be achievable in every single case);
- A statutory mandatory response regime similar to that provided in the Victorian Act but with the additional elements that (a) non-government persons and agencies would also be required to respond; (b) that the State Coroner could require a further response if a response was not filed within a particular timeframe or did not adequately explain what action had been taken or, if the recommendation had been rejected, did not provide satisfactory reasons; and (c) that the State Coroner could, through the Attorney General, provide a report to the Parliament in circumstances where no response, or no adequate response, is received within the time allowed; and
- The State Coroner or strategic oversight board should be required to produce an annual report to Parliament on the performance of the coronial system.

Further recommendations

- The Select Committee should make inquiries with that the Queensland Coronial Services Governance Board to ascertain what lessons could be drawn from its experience for NSW;
- The NSW coronial system should be aligned with practice in Queensland, Victoria, and most other Australian and international jurisdictions, and undertake management of all coronial investigations;
- The Association submits that the Select Committee should take appropriate steps to make an appropriate comparison of the relative costs of the NSW and Victorian coronial systems;
- Consideration should also be given to whether there is an appropriate role for a standing committee of the NSW Parliament in regularly reviewing the adequacy of responses to coronial recommendations.

INTRODUCTION

Although there have been internal reviews of the Coroners Act in the past, this is the first comprehensive *public* inquiry into the coronial system of NSW since 1975 when the Law Reform Commission carried out a study.[2] The current inquiry was recommended by the Select Committee Inquiry into High Level of First Nations People in Custody which reported in April 2021.[3]

Since the NSW Law Reform Commission reviewed the *Coroners Act 1960*, the Acts have been amended on a number of occasions and two new Coroners Acts have been enacted (1980 and 2009).

Section 109 of the 2009 Act required the Attorney General to conduct a statutory review of the Act 'to determine whether the policy objectives of the Act remain valid" and whether the terms of the Act remained appropriate to achieve them.[4] The review was to be commenced 5 years after the Act had been assented to and a report tabled in both houses of Parliament within a further 12 months.[5] Although a review process was commenced by the then Department of Justice in 2014, and a draft report was produced by June 2017, the review remains incomplete and no report has been tabled by the Attorney.

In comparable Australian and international jurisdictions, comprehensive public reviews of their coronial systems have been undertaken: Victoria (1980); Queensland (1997); New Zealand (2000); England & Wales (2003); Victoria (2006); Ontario (2008); and Western Australia (2012). Further reviews of the Queensland system were carried out by the Queensland Ombudsman in 2006 and the Queensland Auditor-General in 2018. The Royal Commission into Aboriginal Deaths in Custody (1987-1991) also examined the operations of coronial systems in respect of deaths in custody of First Nations people. A significant section of the report by the Select Committee on the High Level of First Nations People in Custody also considered the performance of the NSW coronial system.

The Association therefore welcomes this inquiry into the NSW coronial system. In this submission we will address the terms of reference in the order in which they appear.

The submission draws upon the research work of Adjunct Professor Hugh Dillon into comparative coronial jurisdictions along with the practical experience of the Association's members who regularly appear within the jurisdiction, whether as Counsel Assisting the Coroner or representing the interests of family or sufficient interest parties.

Members of the Bar with experience in the coronial jurisdiction are well aware of the dedication and work ethic of the coroners, members of the Department of Forensic Medicine, lawyers and police officers who assist

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2 Law Reform Commission of NSW, *Report of the Law Reform Commission on the Coroners Act, 1960* L.R.C 2 (Sydney: 1975).

3 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody *Report No 1.* https://www.parliament.nsw.gov.au/lcdocs/inquiries/2602/Report%20No%201%20-%20First%20Nations%20People%20in%20Custody%20and%20Oversight%20and%20Review%20of%20Deaths%20in%20Custody.pdf .

4 *Coroners Act 2009* s 109(1).

5 *Coroners Act 2009* s 109(2) and (3).

coroners, family counsellors and liaison staff, public servants and others involved in the coronial system. The Association has the greatest respect for the diligent people working in this system.

Although this submission will critically analyse aspects of the NSW coronial system, nothing within it is intended as criticism of any of the hardworking and under-resourced people who work within the system presently and whose dedication and commitment enables it to work as well as it does. Rather, the focus is upon highlighting the potential for systemic improvement in a wider context and so that our community can draw greatest value from the important work of the Coroners Court and the coronial system.

(A) THE LAW, PRACTICE AND OPERATION OF NSW CORONERS COURT

1. Scope and limits of jurisdiction

1.1 Jurisdiction

Although all NSW magistrates are coroners *ex officio*, under the 2009 Act coroners hold office individually and do not have to be magistrates.[6] Neither the *Local Court Act 2007* nor the 2009 Act directly confers jurisdiction on the Local Court in coronial matters. Although the terms "Coroners Court of NSW" and "coronial jurisdiction of the Local Court" are commonly used, they do not reflect the statutory reality.

This has real consequences, for example in relation to the application to the Coroners Court of other statutory schemes referring to "a court".[7] Some of these consequences are explored in more detail below. But our starting point is that the position of coroners in this state ought to be regularised by the creation of a statutory Coroners Court of NSW.

1.2 Fundamental questions and first principles

In considering the 'the scope and limits' of the 'coronial jurisdiction' it is critical, first, to understand that what has been termed 'the coronial jurisdiction' is a death investigation system – a multi-disciplinary network or complex – involving elements drawn from the judiciary and legal profession, medicine, police and other investigative agencies, family liaison and support services, and public administration. Coroners and the Coroners Court form only the most visible part of this complex. They can be regarded as the hub around which a wider system works.

The 'coronial jurisdiction' also includes a fire investigation system into certain fires and explosions as provided in s 30 of the 2009 Act. This similarly involves a multi-disciplinary network extending to specialist investigators examining cause and origin of subject fires and explosions. As the events of the 2019/2020 Black Summer bushfires demonstrate, this is a significant and further specialised area of work for the Court. Further, as the Royal Commission into Natural Disaster Arrangements reported "climate change has already increased the frequency and intensity of extreme weather and climate systems that influence natural hazards…Further global warming over the next two decades is inevitable. As a result…floods and bushfires are expected to become more frequent and intense."[8] It can be expected, therefore, that inquiries into catastrophic fires, which are complex scientific cases, will become more common as well.

A consideration of the 'scope and limits' of this system raises the question of its fundamental purposes and objectives. In short, what outcomes are being sought? That in turn raises the question how best to achieve the

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6 2009 Act ss 12, 14, 16.

7 See eg *Uniform Civil Procedure Rules 2005* r 33.3(2)(b) and 33.13 (relating to the issue of subpoenas).

8 See Royal Commission into Natural Disaster Arrangements Report (Canberra: October 2020) Ch 2 "Natural disaster risk". https://naturaldisaster.royalcommission.gov.au/publications/html-report/chapter-02 at 2.4-2.5.

outcomes being sought. This requires examination of the design of the system. We will address that issue in this submission.

1.3 What are the purposes of the NSW coronial system?

A theoretical or conceptual framework is needed to guide, control and evaluate public sector performance.[9] Such a framework can be used both to explain how a system works but also how it *should* work. [10]

In a decent society, such as NSW strives to be, sudden and unexpected deaths are, in a real sense, public events. What affects one person or family or section of the community has meaning for the wider community because of a common humanity but also the potential wider ramifications of sudden, unexpected, unexplained or violent deaths. The authors of *Waller's Coronial Law and Practice* (4th ed.) observed:

> *Death raises troubling questions and issues. Civilised societies know that what harms one of its members may harm many others and therefore coroners, from ancient times, have sought to throw light into dark places, to allay suspicions and fears and to help the living commemorate the dead with some peace of mind.*[11]

Modern coronial theory and practice (as discussed in the various inquiries referred to above and the learned literature[12]) have emphasised four primary purposes of coronial death investigations:

- fact-finding in relation to reported deaths (identity, time and place, cause and circumstances of death);
- prevention of future death and injury;
- therapeutic and restorative processes for those affected by reported deaths, especially but not only family members; and
- accountability of state agencies involved in reported deaths and support of human rights.

In practical terms, one significant historical institutional form of recognition of, and care for, the dead and the grieving, is to investigate sudden deaths with a view to preventing further similar deaths, providing solace to the grieving and interrogating the accounts of persons and agencies involved in reported deaths. In this way, real meaning is given to the value of a shared or common humanity.

These objectives and principles are well-understood and endorsed by coroners and most experienced practitioners involved in the NSW coronial system but the 2009 Act, unlike similar legislation in other jurisdictions does not explicitly state its underlying principles and values. In other jurisdictions, such as New

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9 Carol Harlow, "Changing the mindset: the place of theory in English administrative law", (1994) 14 *Oxford J of Legal Studies* 419 at 419.

10 John Braithwaite, 'Restorative justice and therapeutic jurisprudence (2002) 38 *Criminal Law Bulletin* 244, 257.

11 John Abernethy et al., *Wallers's Coronial Law and Practice in New South Wales,* 4th ed, (Sydney: Federation Press, 2020), 1.

12 See, in particular, Ian Freckelton and David Ranson *Death investigation and the coroner's inquest* (Melbourne: Oxford University Press, 2006) and Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016). See Appendix A: *Coroners Act 2008* (Vic) ss 1; *Coroners Act 2006* (NZ) s3.

Zealand and Victoria, their statutory objects expressly reflect respect for families, cultural diversity and a death preventive orientation. Appendix A sets out the relevant sections of the New Zealand and Victorian statutes.

The Association submits that the objects of the NSW coronial legislation should be amended specifically to emphasise:

- the centrality of the experience and needs of bereaved families, and others affected by reported deaths, in the conduct of coronial investigations;
- the unique and honourable place of First Nations people within the Australian community as the First Nations of the land;
- the unique needs of First Nations people within the coronial system given the impact of colonisation, dispossession and systemic discrimination upon First Nations people;[13]
- the role of First Nations coroners and First Nations commissioners (or similar title) to sit on all inquiries relating to the death of a First Nations person;
- the need, as far as possible, to apply therapeutic and restorative processes when conducting investigations;
- the need for the court to conduct proceedings in a way that is flexible and responsive to the particular circumstances of each investigation;
- the pivotal role of the coronial system in the prevention of future death and serious injury; and
- its role in providing one form of accountability, and supporting and protecting human rights, by investigating deaths caused or contributed to by state agencies or agents.

1.4 The current design and structure of the coronial system in NSW

The 2009 Act implies a hierarchical structure with coroners in top-down fashion directing and conducting most of the work, with inquests being the primary activity. This reflects an anachronistic model of the system.

The reality is otherwise. The coronial system is a multi-disciplinary complex or network in which coroners play only one part. About 6000 deaths are reported to coroners annually in NSW but only about 110 inquests are conducted.[14] Most of the investigative work is conducted by forensic pathologists and scientists (with their allied support staff) and by NSW police investigators. In relation to inquests, legal assistance is provided to coroners. In almost every case, families are provided support by in-house counsellors or court staff.

In NSW, three government departments (Communities and Justice, NSW Health and NSW Police) and the Local Court share primary responsibility for operating the NSW system. In some other comparable jurisdictions, however, such as Victoria and Ontario, much of the coronial system – coroners and forensic pathology services – is managed under the umbrella of a single government department. This seems likely to increase the overall efficiency of the system.

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13 Evidence given to the Inquiry into High Level of First Nations People in Custody (2020-21) supports such an amendment being made.

14 Local Court *Annual Review 2020*, 22.

The NSW coronial system has a number of considerable strengths including high quality fulltime coroners, excellent forensic pathologists and allied forensic services, experienced and skilful family support officers and outstanding legal support for coroners conducting inquests. Nevertheless, it has serious structural issues which detract from its capacity to work efficiently and effectively to meet the objectives identified above.

In 2018, a report by the Queensland Auditor-General on the Queensland coronial system strongly criticised the structure of that state's coronial system (which is similar to that of NSW). It noted that the Coroners Court, the Queensland Health Department's Forensic and Scientific Services section and Queensland Police all played vital roles in the system but that the State Coroner, who was 'legally accountable' for co-ordinating the system had 'little functional control over the resources needed to effectively fulfil this responsibility'.[15]

The Auditor-General found that the system was stressed and under-resourced to meet its present and future needs, was poorly co-ordinated, had inadequate case management systems and had ineffective planning. The report observed that:

> *The coronial system relies on the dedication of staff and good will amongst agencies but lacks system-wide cohesion, with no agency having responsibility for leadership, accountability, planning, and reporting across the system.*[16]

The consequences of these deficits were found to be growing backlogs, regional disparities and 'a lack of support and information to families'.[17]

Queensland, with a population of about 5 million people, has a specialist Coroners Court with 8 full time coroners managing all deaths reported in that state. NSW, on the other hand, with a population roughly 40% bigger than Queensland, has only 5 fulltime coronial positions, based at Lidcombe.[18] They are provided with some assistance by magistrates from the Local Court from time to time but, as the Chief Magistrate has emphasised over a number of years in his annual reports, the Local Court is under-resourced for its core business. That additional assistance is, presumably, limited.[19]

According to NSW Local Court data, approximately 45% of all reports of deaths are made to regional magistrates.[20] This is a disproportionate number – only approximately 35% of the NSW population resides in the regions.[21]

NSW currently has a decentralised coronial system with non-specialist coroners managing much of the regional work. The current structure of the NSW system, in our submission, is therefore even less efficient and less likely

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15 Queensland Auditor-General, *Delivering coronial services,* Report No 6: 2018-19 (Brisbane: 2018), 6.

16 Queensland Auditor-General, *Delivering coronial services,* Report No 6: 2018-19 (Brisbane: 2018), 9.

17 Queensland Auditor-General, *Delivering coronial services,* Report No 6: 2018-19 (Brisbane: 2018), 9.

18 We understand that an additional Deputy State Coroner position has been funded in the next NSW budget.

19 His Honour Judge Graeme Henson, *Local Court Annual Review 2020,* 2-4. His Honour has made the same complaint of lack of resources in a number of recent Annual Reviews.

20 See Local Court Annual Reviews 2010-2019.

21 In mid-2020, according to the Australia Bureau of Statistics, the population of NSW was slightly over 8 million people, with 5,300,000 living in Sydney.

to produce effective outcomes for bereaved families than the Queensland system was in 2018. The need for co-ordination is even greater than in Queensland.

The Queensland solution involved a Coronial Services Governance Board whose members include the State and Deputy State Coroner, the Chief Forensic Pathologist, senior members of Queensland Health, Queensland Police, Queensland Treasury and the Department of Premier and Cabinet to implement the Auditor-General's recommendations. We understand the Queensland Coronial Services Governance Board is currently working on reforming the coronial framework for that state and plans to complete the first stages by 2022.

NSW has recently set up a Coronial Services Committee to co-ordinate the operations of the NSW coronial system. The committee meets quarterly and has representatives from the Department of Communities and Justice, NSW Health and NSW Police as well as from the Local Court. We understand that this committee is primarily involved with operational issues rather than the broader strategic questions the Queensland Board is engaging with.

We submit that the Select Committee should make inquiries with the Queensland Board to ascertain what lessons could be drawn from its experience for NSW.

As result of recent administrative changes introduced by the current NSW State Coroner early in the COVID outbreak, most of the critical early decisions concerning medical and police investigations are being centralised at Lidcombe. This is intended and expected to result in greater consistency of decision-making, increased efficiency and improved outcomes. Nevertheless, this administrative takeover of some of the regional magistrates' coronial responsibilities stretches the already-limited resources of the fulltime coroners in Lidcombe who work as duty coroners one week in five.

Inquiries conducted by the Victorian Parliament (2006) and the West Australian Law Reform Commission (2012) criticised the hybrid systems, similar to that which currently operates in NSW, that operated in those States at the time.[22] The Inquiries took the view that regional magistrates were under-resourced to provide an appropriate service, especially to families, and recommended that specialist coronial services manage all death investigations, including liaison with families.

Most NSW magistrates are criminal law specialists by training and experience. Competence in this field, while useful, does not immediately translate into competence in a multi-disciplinary jurisdiction which requires the development of specialist skills, especially of basic forensic medicine, and the skills of conducting inquisitorial proceedings, working with Counsel Assisting, forensic pathologists and police investigators and sensitivity to communications with and around grieving families. This is a different skill set from that generally exercised on the Local Court bench.

Further, hearings conducted across two or more days frequently lead to the need for the presiding coroner to make detailed findings on important matters (whether agreed or contested by interested parties) and then draw

[22] Victoria Parliament. Law Reform Committee. *Inquiry into the Review of the Coroner's Act 1985* https://www.parliament.vic.gov.au/publications/fact-sheets/252-lawreform/inquiry-into-the-review-of-the-coroners-act-1985 ; WA Law Reform Commission *Review of the coronial practice in Western Australia* Project No 100 https://www.lrc.justice.wa.gov.au/P/project_100.aspx

upon those findings to determine cause and manner of death. It is the experience of members of the Bar working in the jurisdiction that, despite their best efforts, the Local Court bench often lack the time and resources to dedicate to timely provision of appropriately detailed findings.

NSW and the ACT are the only remaining Australian jurisdictions in which non-specialist magistrates are still responsible for coronial investigations. To our knowledge there are few, if any, similar hybrid systems in the common law world. The ACT Chief Magistrate has called for a dedicated coroner to be appointed and the ACT Attorney-General recently announced that 'reform is on its way'.[23]

In the Association's submission, NSW should follow suit and establish a specialist court to manage the coronial elements of the NSW system.

If a large proportion of reportable deaths are being reported to magistrates who struggle to deal with them in an optimal fashion due to competing demands, it follows that the system needs to be changed so that regional death investigations are conducted appropriately, preventable deaths are properly identified and remedial action, if possible, is taken.

It is important for regional communities to feel that reported deaths are investigated locally. Although the Association argues for a specialist court, we believe that it is critical that inquests continue to be conducted in regional centres and country towns. This shows respect for, and recognition of, local families, communities and services. Inquests held in country towns and regional cities are often well-reported and local lessons are publicised. The Association's view is that specialist coroners should travel to the regions to conduct these inquests. Just as Sydney people do, country and regional families and communities should know that they are receiving specialist attention for sudden and unexpected deaths. Local knowledge is often important but, when relevant, it can be provided by local witnesses and investigators to coroners.

A Local Court protocol of 2010 required that local magistrates transfer inquests to the fulltime Coroners Court if a case is complex or is anticipated to run for more than 5 days.[24] To our knowledge, that protocol still applies. It is the experience of members of the Bar that cases shorter than a week are often transferred from regional courts to the specialist coroners on grounds of complexity. They are often medical or health-related cases.

A majority of inquests held in country and regional centres are, in fact, currently conducted by the State Coroner and Deputy State Coroners who travel from Sydney. As far as we are aware, there have been no complaints made by local residents about this. In 2019, for example, Local Court data show that 117 inquests were held in NSW. Of these, 77 were held in Sydney and 36 in other places.[25] Findings were published on the Coroners Court website only in 87 cases but they show that the Sydney-based specialist coroners conducted inquests into

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23 Alex Crowe, "Coroner's Court backlog causing grief for families", Canberra Times 14 March 2021 https://www.canberratimes.com.au/story/7162870/plea-for-coroners-court-reform-renewed-as-backlog-adds-to-family-trauma/ . ACT Attorney-General Rattenbury has declared that a specialist coroner is "a crucial reform in pursuing a restorative justice lens for the ACT": email to Adjunct Professor Hugh Dillon 9 December 2020.

24 Appendix B.

25 See Local Court *Annual Review 2020*.

32 deaths which occurred in the regions.[26] Only one inquest reported on the Coroners Court website was conducted by a regional magistrate.[27]

This data demonstrates that, in practice, NSW is already operating a quite centralised specialist coronial system but without a statutory foundation or an appropriate administrative structure and half the specialist coroners the Victorian system employs and only a fraction (about 5/8) of the number of specialist coroners the Queensland system utilises.

For the benefit of the people of NSW, the Coroners Court, should be aligned with Queensland, Victoria, and most other Australian and international jurisdictions, and undertake management of all coronial investigations.

1.5 Contribution to death prevention

Data from the National Coronial Information System show that approximately 60% of reported deaths in NSW are due to natural causes.[28] While a proportion of natural cause deaths are likely to have been preventable, others are reportable only because no Medical Cause of Death certificate has been issued. In many cases, therefore, death investigations will find no systemic failings requiring remedial action.

In other cases, remedial action is taken by appropriate bodies, thus obviating the need for recommendations to be made. The fact that deaths are investigated by coroners may well be a motivating factor in this regard. Because of this motivating factor, as well as delay in holding inquests, coronial recommendations are often pre-empted.[29]

Nevertheless, a number of studies, and publicly available data, suggest that the NSW coronial system is not making the contribution it potentially could to the prevention of future death and serious injury. A study of Victorian magistrates prior to the 2008 reforms found that few make any significant contribution to systemic reform for preventing future deaths and injuries. The study discovered that magistrates made few recommendations and lacked the appropriate skills to conduct incisive inquests and to formulate useful

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26 In our submission, to assess the performance of the coronial jurisdiction, and for public health and safety research purposes, it is important that *all* coronial inquest findings are reported. A centralised specialist court would more readily manage this issue.

27 See the Coroners Court website for the 2019 published findings. The analysis is the Association's.

28 National Coronial Information System *Annual Report 2018-19*. https://www.ncis.org.au/wp-content/uploads/2020/10/NCIS-Annual-report-2018-19-Final.pdf

29 See Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016), Ch 4 "Do coroners' recommendations disappear into a black hole?", 116-161. See also Georgina Sutherland et al., "What happens to coroners' recommendations for improving public health and safety? Organisational responses under a mandatory response regime in Victoria, Australia" (2014) 14 BMC Public Health 732; Ray Watterson, Penny Brown and John McKenzie, "Coronial recommendations and the prevention of Indigenous death", (2008) 12 Special edition 2 *Australian Indigenous Law Review* 4.

recommendations.[30] A comprehensive New Zealand study published in 2016 was also critical of the performance of coroners in producing death preventive recommendations.[31]

Examination of coronial recommendations and government responses demonstrates that very few NSW regional magistrates appear to conduct inquests resulting in death preventive recommendations.[32] As the data shown above demonstrate, few inquests are conducted by regional magistrates.

This shows that very little, if any, significant contribution is being made, *or is able to be made,* by NSW regional magistrates. The irresistible inference, in our submission, is that a combination of heavy workloads, inexperience in the jurisdiction, and lack of appropriate resources, including in-depth specialised coronial training, undermines the capacity of NSW regional magistrates to undertake inquest work which has evolved to become complex specialist work.

The Association does not in any way criticise the hard-working and professional magistrates who serve country and regional NSW. Our submission, rather, is that they should not be burdened with onerous coronial responsibilities that are not part of their core work and professional training.

1.6 Therapeutic jurisprudence and restorative justice

The Association notes that the 2009 Act provides that a coroner is not bound by the rules of evidence and procedure that apply in a general court of law: s 58. With the proviso that the processes are fair and relevant in the circumstances of the case, the Association supports the development of imaginative and flexible procedures. (In section (B) of these submissions, we highlight alternative procedures developed in Ontario.

A number of studies have shown that inquests can be both positive and negative experiences for bereaved families. One Australian published in 2019 found that families appreciated an opportunity to be heard, a chance for education, and sensitive treatment and language.[33] Family members interviewed for the study told the researchers that humanity and emotion on the part of coroners and others investigating deaths facilitated family involvement. "If you are going to be human with me, I'll be human with you" one person was quoted as saying.[34]

Another Australian study found that coronial investigations that scrutinised the culture of an organisation involved in a death, and which sought to identify systemic failures, assisted family members with understanding why the fatality occurred. This information enabled the healing process to begin as family members sensed that justice had finally been achieved for their loved one.[35]

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30 Associate Professor Lyndal Bugeja, "Determinants of coroner' recommendations on external cause of death in Victoria, Australia", PhD thesis, Monash University (2011).

31 Jennifer Moore (2016).

32 See NSW Dept of Communities and Justice, "Government Responses to Coronial Recommendations" https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

33 Stephanie Dartnell, Jane Goodman-Delahunty and Judith Gullifer, "An opportunity to be heard: Family experiences of coronial investigations into missing people and views on best practice", (2019) 10:2322 *Frontiers of Psychology* 1-17, *doi*: 10.3389/fpsyg.2019.02322.

34 Dartnell et al. (2019), 9.

35 Mark Ngo et al., "Bereaved family members' views of the value of coronial inquests into fatal work accidents", (2021) 82:3 *Omega – Journal of Death and Dying* 446-466.

This study shows that while some family members may be concerned with identifying blameworthy individuals, many are as concerned or more concerned with detecting systems failure and prevention of future deaths and injury. Unlike most forms of death investigation, family participation is welcomed in inquests. Studies have shown that family members sometimes feel that they have regained dignity and lost self-esteem when they are listened to by a person in authority such as a coroner.[36]

Members of the Bar who are experienced in the jurisdiction report that all Lidcombe-based coroners are conscious of this aspect of their jurisdiction and work hard with Counsel Assisting and solicitors to make the process as therapeutic as possible. The State Coroner is conscious of the need and the opportunity to make the process as restorative and therapeutic as the circumstances of each case, and the resources available, will allow. The Bar Association fully supports this approach.

A case study in an empathetic and imaginative use of flexible procedures was the inquest into the suspected death of Ben Dominick. This was a missing person case in a very remote community. Evidence was taken using walk throughs and recorded evidence from witnesses at the scene, as well as by roundtables in court. The novel approach taken by State Coroner O'Sullivan and her Counsel Assisting was reported as being 'both forensically and professionally rewarding. It is an example of how adapting processes in the coronial jurisdiction can enhance both the core and therapeutic functions of the jurisdiction.' [37]

In some cases, it is inevitable that facts and interpretations of evidence will be contested in an adversarial fashion. Natural justice will sometimes require this. Nevertheless, the Association submits that flexible, non-adversarial processes, if conducted fairly and in a timely manner, and with commitment from relevant agencies to engage meaningfully in the process, are likely to enable more therapeutic and restorative outcomes to be reached, and are also likely to be less resource intensive and more efficient and therefore more timely than the more formal set-piece inquests that are standard in NSW.

1.7 Accountability, human rights and recognition of First Nations people

The Coroners Act provides that all deaths in custody or deaths which are caused by police operations must be subject to mandatory inquests but also provides that only 'senior coroners' have jurisdiction to hold inquests into deaths of children in care, deaths of children about whom reports have been made to child welfare authorities, disabled people living in residential care or being provided services by the state.[38] These are amongst the most vulnerable people in our society. How and why people die in those settings is a measure of the quality of those settings and underpins public confidence in them. The requirement that a senior coroner investigate the deaths of particularly vulnerable people underscores this point.

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36 Mark Ngo et al, (2021), 459.

37 See Ann Bonnor, "Changing the landscape: inquest into the disappearance of Ben Dominick", *NSW Bar News*, Autumn 2021. https://barnews.nswbar.asn.au/autumn-2021/40-changing-the-landscape-inquest-into-the-disappearance-of-ben-dominick/

38 *Coroners Act* s 24.

1.7.1 Accountability

The term 'accountability' can be, and is, used in multiple ways. In our submission, because the Coroners Court is an inquisitorial or investigative, rather than adjudicative, institution, an important meaning of 'accountability' in the coronial context is that witnesses and organisations involved in a reported death have a responsibility to provide information – an account or explanation of their involvement in the death itself or the response to it. This is to achieve the "root cause" analysis necessary to explain a cause of death and the prevention of death in similar circumstances. Necessarily, where it is the case that crime, negligence, or misconduct were contributing factors, accountability in the sense of liability may also arise, but it does not arise directly in the coronial context.

As we will show in the next section of this submission, because of flaws in the 2009 Act, obtaining a full account from witnesses during the course of an investigation can be highly problematic. It is only during an inquest, and by taking an objection on the grounds of self-incrimination, that a witness can give a protected account of his or her evidence.

1.7.2 Human rights standards

Coronial investigations may involve the human rights of those whose deaths are being investigated, bereaved family members or others. Members of the Bar in NSW and other states have argued that viewing coronial investigations through the lens of human rights is a constructive approach.[39] Ian Freckelton QC, a Melbourne barrister with a national coronial practice and a leading academic authority on coronial law and practice has (with Simon McGregor) argued:

> *Human rights law should be welcomed in the coronial domain. It has the potential to facilitate better informed and contextualised findings, comments and recommendations and it is likely to be consistent with the avowed obligations expressed within current coronial legislation and its interpretation in Australia and New Zealand's superior courts. Moreover, the incorporation into findings and recommendations that there have been violations of human rights, as set out in international instruments or domestic human rights legislation, which have led to avoidable deaths is likely to lend greater weight to coronial recommendations directed toward reducing the risks of further such violations. This is an opportunity to be embraced within coronial law as it has the potential to enhance the efficacy of the recommendatory function of coroners which constitutes a considerable component of the contemporary relevance of the reinvigorated coronership that is evolving.*[40]

In our submission, Freckelton QC's argument carries considerable weight. There is, however, little Australian authority on the subject of human rights in Australian coronial law and practice. Human rights standards

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39 See Ian Freckelton and Simon McGregor, "Coronial law and practice: A human rights perspective" (2014) 21 *Journal of Law and Medicine* 584. See also NSW Bar Association online CPD seminar Kristina Stern SC, Simeon Beckett, Craig Lenehan SC, Peggy Dwyer, The Hon Angus Stewart "Ways that human rights can assist in your practice at the bar", 1 June 2021.

40 Freckelton and McGregor (2014), 601.

developed in other jurisdictions, especially the UK, may provide useful benchmarks for NSW coronial investigations of deaths in custody, police operations and other forms of state involvement in fatalities. We discuss this further below in section (B) of this submission.

1.7.3 Recognition of First Nations people

The Royal Commission into Aboriginal Deaths in Custody emphasised the critical role the coronial system should play in investigating deaths of First Nations people in custody.[41] This was also recognised in the 15 April 2021 report of the NSW Parliament's select committee Inquiry into High Level of First Nations People in Custody established in 2020 (Report No 1 – First Nations People in Custody and Oversight and Review of Deaths in Custody).

The Inquiry into High Levels First Nations People in Custody reported that delay and lack of information were two of the most distressing aspects of coronial investigations for some First Nations families whose loved ones had died in custody.[42] A study by Australian researchers has shown that for family members, information about how a death occurred, and whether similar deaths could be prevented in future, is critical. Accountability of persons and organisations involved in fatal incidents is also very important for families.[43]

During that inquiry, the Aboriginal Legal Service submitted that 'wrap-around' support was needed for First Nations families throughout the coronial process. In our view, this should be regarded as a first step towards even stronger and more therapeutic connections between the Coroners Court and First Nations families and communities. The Victorian Koori Engagement Unit appears to be a ground-breaking initiative. We submit that a dedicated and well-resourced First Nations family liaison unit similar to the Victorian Coroners Koori Engagement Unit should be established within the Coroners Court.[44]

How information and explanations are provided to bereaved families, and at what time, and how regularly information is updated, were important questions at the Inquiry into High Level of First Nations People in Custody. So, too, were concerns that coronial processes themselves may add to distress or even retraumatise bereaved First Nations families and communities.

Anecdotal evidence from members of the Bar, family members, coroners and others suggests that the earlier family members receive trustworthy information, and the more they are kept regularly informed of progress of investigations, the less traumatising the coronial process is for them. That may particularly be the case for First

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41 RCADIC Report Vol 1, Ch 4. http://www.austlii.edu.au/au/other/IndigLRes/rciadic/national/vol1/

42 Inquiry into High Levels First Nations People in Custody and oversight and review of deaths in custody Report Ch.6, https://www.parliament.nsw.gov.au/lcdocs/inquiries/2602/Report%20No%201%20-%20First%20Nations%20People%20in%20Custody%20and%20Oversight%20and%20Review%20of%20Deaths%20in%20Custody.pdf

43 Mark Ngo et al, (2021), 458.

44 See "New protocol for coronial investigations into Indigenous deaths in custody", https://www.coronerscourt.vic.gov.au/new-protocol-coronial-investigations-indigenous-deaths-custody

Nations families. The appointment of First Nations officers and the new draft protocol which requires early engagement with families are important initiatives.

We support the Coroners Court's new draft protocol for managing deaths of First Nations people in custody.[45] We also support all efforts taken by the State Coroner and others involved in coronial investigations to make them as culturally safe and supportive as possible for First Nations families and their communities.

In the draft protocol, by placing emphasis on family conferences, it is clear that the State Coroner has embraced a philosophy which is to make the process as culturally safe, restorative and therapeutic as possible. Although there are likely to be occasions when inquests appropriately become contests in relation to some issues, the Bar Association supports the State Coroner's general non-adversarial, restorative approach, especially in relation to inquests involving First Nations people.

The presence of First Nations people within the coronial system in positions not only of support, but also of power, is of great importance in creating a culturally safe institution, as well as in clearly identifying and preventing the deaths of First Nations peoples in institutional settings. We therefore submit that First Nations coroners be appointed to the Coroners Court as a matter of urgency, that a First Nations Commissioner (or similar title) sit on any inquiry into the death of a First Nations person and that on any governance board or committee that may be established to oversee the NSW coronial system[46] a number of positions should be allocated for First Nations people.

In June 2019, First Nations children made up 37% of children in out of home care but only 6% of the total child population in Australia. First Nations children were 9.7 times more likely to be removed from their families than non-First Nations children. That is a total of 20,077 children. There are 81% of First Nations children on long-term guardianship orders. NSW uses these long-term orders at twice the rate of the national average (Family Matters Report Nov 2020, SNAICC and Family is Culture Review Report: Independent review of Aboriginal Children and Young People in Out of Home Care (2019), Chaired by Prof Megan Davis).

The NSW Ombudsman Child Death Review Report 2015 identified trends in child mortality including First Nations children. While less than 5% of children in NSW are Indigenous, First Nations children represent 10% of child deaths between 2001 – 2015, with more than 2.3 First Nations children dying for every one non-First Nations child in 2015. This correlates with indices of socio-economic disadvantage (the poorest dying at more than twice the rate of the richest). 20% of children who died in NSW had a child protection record. Eight died while in state care at the time of their death. Suicide is the leading cause of death of children aged 15 – 17, accounting for the cause of 25% of deaths, and had substantially increased as a cause of death of First Nations young people. A 2015 review by Family and Community Services of the deaths of 111 young people with a child protection history noted the high rate of cases (93 of 111) that were closed or unallocated by FACS at the

45 **See** Appendix C.

46 See section 1.4 of these submissions and our discussion of the Queensland Coronial Services Governance Board.

time of their death. The leading cause of death for this group was suicide (41 young people).(Family and Community Services (2015), Child Deaths 2014 Annual Report: learning to improve services. NSW Government, p. 36).

However, no analysis of the child protection report and experience or exposure to abuse has been made in the Reports. Similarly, no analysis of the rates of suicide of First Nations people leaving state care and who have been exposed abuse have been made, although in Queensland it is clear that First Nations adults also die by suicide at a disproportionately high rate[47].

Taken together, it is submitted that these figures make a case for coronial investigation of the deaths of all First Nations children and young people who were in care or had a child protection history at the time of death, or who were previously in state care as children.

1.8 The need for a new Coroners Act

Members of the Bar with experience in the jurisdiction have identified many issues and problems with the current 2009 Act. In this part of our submission the Association will not attempt a microscopic analysis of each provision of the 2009 Act, nor attempt to identify every problem with its terms. Rather, we will address a number of issues to demonstrate that a root-and-branch revision of the 2009 Act is required.

47 Suicide in Queensland Annual Report 2019

1.8.1 The structure of the Act itself

In State Coroner Barnes's submission of 2016 to the statutory review[48], he argued that the structure of the 2009 Act does not follow a logical pattern. He proposed instead a re-ordered structure that would follow the natural sequence of most coronial cases thus making the law more accessible. The following structure would achieve this.

- Preliminary – the objects of the Act; commencement date; reference to the dictionary.
- Reportable deaths defined, including locality jurisdiction.
- Obligation to report
- Coroners' jurisdiction to investigate
- Autopsies, orders and objections
- Powers of investigation
- Inquests and inquiries
- Findings
- Fresh inquests and inquiries, appeals
- Access to coronial documents and physical evidence
- Appointment of state coroner, deputy state coroners, local coroners, administration
- Miscellaneous

This proposal appears to make obvious sense whereas the current structure, with its over-emphasis on the activity involved in holding inquests, lacks the coherence of the Barnes proposal. Once more, the need for a new Act seems demonstrated.

1.8.2 Is the current list of mandatory inquests appropriate?

Section 27(1) of the 2009 Act requires inquests to be held in relation to:

- Suspected homicides[49]
- Deaths in custody (s 23)[50]
- Deaths due to police operations[51]
- Deaths in which the medical/physiological cause of death is uncertain[52]
- Deaths in which the manner of death is uncertain[53]
- Suspected deaths of missing persons.[54]

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48 Appendix D.

49 *Coroners Act* s 27(1)(a)

50 *Coroners Act* s 27(1)(b)

51 *Coroners Act* s 27(1)(b)

52 *Coroners Act* s 27(1)(d)

53 *Coroners Act* s 27(1)(d)

54 *Coroners Act* s 27(1)(c)

Mandatory inquests constitute a large proportion of total inquests conducted by coroners in NSW. In 2020, 77 findings were published on the NSW Coroners Court website. All but two were findings of fulltime coroners at Lidcombe.[55] The published findings fell into the following categories:

- Suspicious deaths (including a murder/suicide case) – 11
- Missing persons – 13
- Deaths in police operations – 8
- Deaths in custody – 24
- Health-related deaths – 10
- Accident – 1
- Unexplained manner and cause of death – 5
- Aged care – 2

Therefore in 61/77 (79%) cases inquests were mandatory.

To hold state agencies and agents accountable, there are strong reasons for requiring inquests in relation to deaths in custody, in police operations and in relation to suspicious deaths. The Association submits that some other categories of deaths and suspected deaths should be investigated but that coroners should have a discretion to hold or not hold an inquest.

We submit that there is, in fact, a much stronger case for making inquests mandatory in respect of the deaths of children and adults in care, and involuntary psychiatric patients, than there is for holding inquests when there is no available medical diagnosis of death, and no suspicious circumstances and no questions of public health and safety or a wider public interest arise.

In many cases, such as the suspected deaths of missing persons, or undiagnosed deaths, a quicker, more flexible, more family-oriented approach would be to hold a conference in which family members, investigators, grief counsellors, forensic pathologists and the coroner can discuss the case if the family desired. Otherwise, families could be provided with all relevant information but need not be burdened by a formal inquest.

The Victorian Act provides that deaths in custody and care must be investigated but does not require an inquest to be held if the death was due to natural causes.[56] Some deaths due to natural causes may, nevertheless, raise questions about the care and treatment of the person who died. Systems issues may also arise. Such cases should probably be subject to mandatory inquest. Given the history of First Nations deaths in custody, there is a strong case for mandatory inquests in all such cases.

In other cases, following thorough investigation and consultation with family members, it may be appropriate *not* to hold a mandatory public inquest but a family conference in which the family can be provided with all the information they wish to have.

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55 According to the Local Court Annual Review the Local Court as a whole conducted 112 inquests. Findings for 35 cases were not published on the website.

56 *Coroners Act 2008* (Vic) s 52(3A).

If a non-First Nations person dies in custody and a coroner is satisfied that the death is due to natural causes, and that no care and treatment issues or systemic issues arise, and there is no request by family members for an inquest or family conference, there may be a case for not holding an inquest. Nevertheless, if such a position was adopted, accountability and transparency is required. Coroners should be required to publish 'chamber findings' in relation to such cases on the Coroners Court website. Further, the family should be given a "cooling off" period to grieve and decide whether they wish a formal public inquest to be held.

1.8.3 Should guidelines for discretionary inquests be incorporated in the Act?

In civil and criminal courts, the exercise of discretion is guided by general principle, such as reasonableness, by statute and authority, by practice manuals and commentaries, and policed by appeal processes.

The Victorian Act sets out clear objects and a number of factors to be taken into account when exercising coronial jurisdiction.[57] The Victorian Coroners Court Bench Book provides extensive treatment of the factors that should be considered by coroners concerning discretionary inquests. It is published on the internet.[58] The Queensland State Coroner's Guidelines sets out principles for coronial practice and a number of factors which should be considered in relation to discretionary inquests.[59] The Queensland guidelines are available to members of the legal profession and wider community on the Coroners Court website.

In contrast, the 2009 Act provides no guidance to coroners as to how to exercise their discretion to hold or dispense with holding inquests. Nor does the Local Court Bench Book provide any direction as to what factors coroners should consider when deciding whether to hold a discretionary inquest.[60] There are no State Coroner's Guidelines or Practice Notes on this subject.[61]

In our submission, it would assist coroners, the legal profession and the wider community if guidance was provided as in Victoria and Queensland. The statute should set out guiding principles and the Bench Book or State Coroner's guidelines should give a more detailed treatment of the factors to be taken into account when deciding whether or not to hold a discretionary inquest.

Statutory and administrative guidelines would assist coroners make reasonable discretionary decisions. They would also make them more accountable for decisions to dispense with inquests. Guidelines would provide a framework for scoping inquests. They would provide a rational foundation for requests by families and legal

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57 Coroners Act 2008 (Vic) ss 1, 6, 8.

58 Victorian Coroners Court Bench Book Ch 9.2.1 (online edition) https://www.judicialcollege.vic.edu.au/eManuals/Coroners/indexpage.htm#37543.htm viewed 11 June 2021.

59 Queensland State Coroner's Guidelines 2013, Ch 9 https://www.courts.qld.gov.au/__data/assets/pdf_file/0013/206140/osc-state-coroners-guidelines-chapter-9.pdf

60 See Judicial Commission of NSW, *Local Court Bench Book,* "Coronial matters" Ch, [44-000] viewed 11 June 2021.

61 There is some discussion of the issue in Abernethy et al., *Waller's Coronial Law and Practice in NSW* 4th ed., (Sydney: LexisNexis Press, 2010) and Dillon & Hadley *The Australasian Coroner's Manual* (Sydney: Federation Press, 2015) but these are not official publications and coroners may not have access to them.

practitioners for inquests to be held. They would provide benchmarks for the Supreme Court in its supervisory role in the jurisdiction.[62] The lack of them is a significant flaw in the current statute and practice materials.

The Association submits that the Act should provide that families must be given an opportunity to make representations to the coroner on the relevant factors before a decision is made to dispense with an inquest. This could be done by way of correspondence or in some other fashion, such as a family conference. The Act should also require that reasons be given in writing to family members if their request for an inquest is turned down.

1.8.4 Section 61: objections on the grounds of self-incrimination

One of area of frequent difficulty for witnesses and their legal representatives is the lack of protection under the Act for witness statements. Under the Act, it is only when a witness participates *in coronial proceedings* and objects to answering questions that they gain protection under the Act: s 58(2), 61.

This gap in statutory protections for witnesses results in a strong disincentive for witnesses to provide statements or an incentive to provide minimalist accounts. That, in turn, results in investigations that often provide less than full accounts of the circumstances of a death to coroners, bereaved families and relevant public sector agencies.

The Queensland Act empowers coroners to require people to give them 'information, a document or anything else that is relevant to the investigation'. Persons must comply unless they have a 'reasonable excuse' which includes placing themselves at risk of self-incrimination: s16. The Victorian Act also gives power to coroners to demand statements with the proviso that a person must have a lawful excuse to refuse compliance: s 42. Lawful excuse includes a right not to give information if that would self-incriminate the person to whom the demand is made: s 50(1).

Members of the Bar with expertise in the coronial jurisdiction report that the issue of protection for witnesses giving statements arises regularly in medical inquests. It is constant source of anxiety and frustration for health practitioners and their legal representatives. Our experience is that health practitioners are usually keen to co-operate with investigations but are extremely conscious of placing themselves at potential risk of disciplinary action. Anecdotal evidence suggests that some health practitioners are more anxious about inquests than about being sued.

Because of the problems created by the 2009 Act, NSW Coroners have, on occasion, convened special hearings to have police officers who are involved in shootings and deaths give an account on oath with a s 61 certificate (as protection from self-incrimination). A transcript is then prepared for the hearing. This is expensive and takes up court space, time and resources. It fragments proceedings causing distress to families and the witness.

The Association submits that, to ensure coronial investigations are capable of collecting as much relevant evidence as possible, protection against self-incrimination for written statements is necessary.

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62 Coroners Act ss 84 & 85.

We submit that this would be in the public interest, in the interest of bereaved families who would receive full information and in the interest of witnesses who are seeking to assist coronial investigations. We do not, here, suggest a statutory form of words to resolve this problem. Rather, we say that it is a problem that needs to be addressed urgently and is but one of example of the need for comprehensive reform of the Act itself.

1.8.5 Section 78: Procedure in questions for dealing with indictable offences

Section 78 outlines the procedure for managing inquests when a person is charged with an indictable offence or evidence suggests a 'known person' may be guilty of an indictable offence in relation to a death or fire being investigated at inquest or in a fire inquiry.

Coronial inquests and fire inquiries are not bound by the rules of evidence. Yet s 78(1)(b) of the 2009 Act imposes a test for referral of cases to the DPP which mirrors the test in committal proceedings which existed until 2018. In that year, however, the *Criminal Procedure Act 1986* was amended. The committal process was radically changed – magistrates no longer make decisions about the sufficiency of evidence.[63] The Office of the Director of Public Prosecutions makes that decision based on its own guidelines. It is anomalous, therefore, that the test in the 2009 Act has not been amended to reflect this significant change in public policy. How coroners should proceed when evidence at inquests suggests that 'known persons' are guilty of indictable offences needs to reconsidered. Again, this suggests that reform of the Act is urgently needed.

The Association submits that the test for referral to the DPP should be the 'prima facie' case test (currently the first limb of the two-stage test set out in the Act: s 78(1)(b)(ii)). A coroner would then only have to determine whether there was admissible evidence capable at law, if accepted, of proving that a 'known person' had committed an indictable offence causing the death or fire under investigation.

It can be difficult for coroners (and Counsel Assisting) to assess the sufficiency of *admissible* evidence to give rise to a reasonable prospect of conviction when they have heard a mixture of admissible and inadmissible material. That requires judgments to be made about witness credibility, whether evidence will be excluded and other matters. The prima facie test is clearer for coroners, Counsel Assisting and others. Judging the prospects of conviction is a task for which the DPP is better suited than coroners.

Changing the test to a prima facie one would also reduce the potential for inquests to turn into 'mini-trials', perhaps causing unfair prejudice to 'known persons' in later criminal proceedings.

1.8.6 *The role of counsel assisting*

Counsel Assisting in inquests and inquiries have important public roles. The ACT Coroners Act emphasises this by providing that one of their functions is 'acting in the public interest and the interests of justice to assist the coroner to decide matters of fact or law relevant to the inquest or inquiry.'[64]

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63 See *Criminal Procedure Act 1986*, Ch. 3, Pt 2.

64 *Coroners Act 1997* (ACT) s 39A(1)(d).

Unlike the ACT Coroners Act,[65] the 2009 Act makes little mention of the role of Counsel Assisting.[66]. In NSW, however, coroners are invariably assisted by counsel and solicitors from the bar, the Crown Solicitors Office or the Office of General Counsel (Dept of Communities and Justice), or by specialist police advocates who are based at the Lidcombe Coroners Court. The NSW Bar Rules deal with aspects of the role of Counsel Assisting in investigative proceedings.[67] Specific reference to the role and functions of advocates (whether barristers, solicitors or police officers) assisting the coroner would enhance the public's and the legal profession's understanding.

1.8.7 *Search and seizure*

The 2009 Act is out of date in respect of powers to identify and seize evidence, especially electronic evidence. For example, 'coronial scene orders' (the coronial equivalent of a search warrant) make no mention of phones, the collection of electronic data from 'the cloud', or a power to demand passwords for electronic devices. Coroners cannot order a "sim swap" to gather relevant electronic evidence. This is another example of the obsolescence of this Act.

1.8.8 *Confidentiality of investigations*

In some cases it may be important for evidence gathered in the course of coronial investigations to be kept confidential until an appropriate time is reached to release it. Coroners can make non-publication orders in relation to evidence heard in court or documents tendered into evidence but their powers to maintain the confidentiality of documents or other evidence gathered into a coronial brief are unclear and not guided by statute. Similarly, their powers to disseminate information to parties subject to confidentiality undertakings are unclear. The 2009 Act should be amended to clarify coronial powers and to ensure both fairness and appropriate security in investigations.

A related issue arises given the Coroners Court is not constituted as a statutory court. Coronial investigations are often conducted in the shadow of related criminal or civil proceedings. Some coronial investigations are highly sensitive and may be jeopardised by the dissemination of material provided to coroners. At present, the 2009 Act provides for only vague and imprecise protection of sensitive coronial records.

Parties to civil litigation running in parallel with coronial proceedings sometimes attempt to subpoena documents in the coronial brief for their own purposes, potentially contaminating evidence in coronial investigations.[68] Given the present delays in finalising inquests and limitation dates for various civil causes of action, it is not uncommon for parties with sufficient interest in an inquest to commence, or be the defendant to, civil proceedings while a coronial inquest is ongoing. It is important to clarify the coroner's power to resist

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65 See *Coroners Act 1997* (ACT) ss 39, 39A which deal with the appointment and functions of Counsel Assisting coroners.

66 Assistance for coroners is mentioned in the NSW *Coroners Act* (ss 49(3)(d), 57(4)(f), 76(d)) but little can be gleaned as to the functions and role of Counsel Assisting or other legal assistants.

67 Legal Profession Uniform Conduct (Barristers) Rules 2015, Rules 97-100 in particular.

68 Cf the inter-court request procedure available where a party to civil litigation seeks documents held by a "court": Uniform Civil Procedure Rules 2005, r 33.3(2)(b), 33.13.

subpoenae issued in those proceedings seeking production of material obtained in the course of an ongoing coronial investigation.

1.8.9 *Privilege*

Legal professional privilege is a fundamental legal right that cannot be abrogated or curtailed unless such an intention is clearly manifested by unmistakable and unambiguous language in a statute. The position in coronial proceedings of other forms of privilege provided for in the *Evidence Act* is, however, less clear.

The *Evidence Act 1995* (NSW) provides for a number of other privileged or confidential forms of communication such as 'professional confidential relationship privilege', 'sexual assault communications privilege', 'journalist privilege', and religious confessions. Because the 2009 Act provides that the rules of evidence and procedure do not apply in inquests, communications that would be protected in criminal and civil litigation may not be similarly protected in inquests.

The public policy foundations for protection of these communications, we submit, apply just as much in coronial investigations and inquests as in other proceedings. This has been recognised elsewhere. The Victorian Coroners Act 2008 expressly provides that Part 3.10 of the Victorian *Evidence Act 2008* (Vic), which is in virtually the same terms as the *Evidence Act 1995* (NSW), applies in inquests (except for ss 128, 128A and 131A). In our submission, consideration needs to be given to a similar regime in the 2009 Act.

1.8.10 *Coroner's powers in respect of non-publication orders*

In *Commissioner of Police v Deputy State Coroner for NSW* [2021] NSWSC 398, the applicant, the NSW Commissioner of Police, sought judicial review of a number of decisions made by a Deputy State Coroner who had refused to make non-publication orders or suppression orders in respect of the NSW Police Force's "Safe Driving Policy" in an inquest she was conducting. The Coroners Court is not a "court" for the purposes of the *Court Suppression and Non-publication Orders Act 2010 (NSW)*[69] and lacks any statutory power to make a suppression order. It is necessary for coroners to rely on an implied incidental power to make such orders, which results in an undesirable lack of clarity for both coroners and parties seeking such orders, including as to the criteria for making any such order.

The Association submits that the proceedings in that case, together with the discussion of confidentiality in respect of coronial investigations above, demonstrate the need for clarification of the powers of coroner in respect to non-publication and suppression orders.

1.8.11 *Section 10: Co-ordination of the coronial system*

Section 10(1) of the 2009 Act provides that the functions of the State Coroner are:

(a) to oversee and co-ordinate coronial services in the State, and

[69] See s 3 of that Act; see also *Commissioner of Police v Deputy State Coroner for NSW* [2021] NSWSC 398 at [19]-[27].

(b) to ensure that all deaths, suspected deaths, fires and explosions concerning which a coroner has jurisdiction to hold an inquest or inquiry are properly investigated, and
(c) to ensure that an inquest or inquiry is held whenever it is required by this Act to be held or it is, in the State Coroner's opinion, desirable that it be held, and
(d) to issue guidelines to coroners to assist them in the exercise or performance of their functions, and
(e) to exercise such other functions as are conferred or imposed on the State Coroner by or under this or any other Act.

However, section 10(2) states that the State Coroner is 'in the exercise of a function under this section, subject to the control and direction of the Chief Magistrate'.

Section 10(2), as far as the Association is aware, is unique. The Association submits that it is inappropriate for a State Coroner, as an independent judicial officer with significant functions and responsibilities for managing the coronial system, to be subject to 'the direction and control' of anyone.

Secondly, as previously noted, neither the *Local Court Act 2007* (NSW) nor the 1999 Act vests coronial jurisdiction in the Local Court itself. It is anomalous, therefore, for the head of a court which has no statutory coronial jurisdiction, to 'control and direct' the State Coroner.

It would be more appropriate, as is the case in Queensland, for the control and direction of the coronial system to be vested in the State Coroner[70] but, while coroners remain under the umbrella of the Local Court, for the State Coroner to be required to consult with the Chief Magistrate in respect of coronial matters relating to or affecting the Local Court.

The Bar Association submits that s10(2) of the 2009 Act should be repealed or amended in terms similar to those of s 71(2) of the Queensland *Coroners Act 2003*[71] with the addition of a clause requiring the State Coroner to consult with the Chief Magistrate in respect of any matter that may affect the operations of the Local Court.

The statutory review was alerted to most of the issues mentioned above and many others. It is not clear why that review has not proceeded. It is, however, evident from these examples and numerous others raised during the statutory review that significant reform of the 2009 Act, which is demonstrably obsolete and unwieldy, is necessary.

2 Resources

Answering the question whether the coronial system has adequate resources requires consideration of the system's purposes and objectives, its current structure and resources, and the resources it would need if reformed as this submission suggests it should be. The resource question therefore is multi-faceted.

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70 *Coroners Act 2003* (Qld) s 71(2): The State Coroner has power to do all things necessary or convenient to be done for, or in connection with, the performance of the State Coroner's functions.

71 *Coroners Act 2003* (Qld) s 71(2) provides 'The State Coroner has power to do all things necessary or convenient to be done for, or in connection with, the performance of the State Coroner's functions.'

Members of the Bar practising in the jurisdiction report that inquests conducted by the State Coroner and Deputy State Coroners are becoming increasingly complex and sophisticated, commonly involving 4-5 separate interested parties and sometimes involving 10 or more. Although an inquest of the complexity of the Lindt Café inquest is unlikely to be repeated, coroners have, for a number of years, conducted inquests simultaneously investigating multiple deaths with a view to identifying fatal factors common to each death and making death preventive recommendations. Examples include inquests into deaths at music festivals, deaths in quad bike accidents, deaths due to drug overdoses, deaths following doctor-shopping for drugs, multiple rock-fishing deaths and others.

Apart from s 23 inquests into deaths in custody and deaths in police operations, the most common single category of deaths being investigated is health-related deaths. But for the question of damages, these cases are often as complex as medical negligence cases in the Supreme Court and can be even more so because they involve multiple parties and investigations not only of human error but of system failure and ways of preventing it.

Apart from the gradual increase in reports of deaths resulting from population growth, the coronial system has responsibility for investigating fires and explosions. An increasing number of catastrophic bushfires have been occurring over the past few years. The summer of 2019-20 was memorable for the number and size of catastrophic bushfires. The community expects them to be investigated with a view to identifying their causes and learning preventive lessons if possible. This is scientifically complex, time-consuming work.

As all are aware, the world is confronted by an unprecedented pandemic. The *Ruby Princess* deaths are being investigated by a senior coroner. Questions of accountability of state agents and agencies arise as well as potential lessons learned. There also appear to be an increasing number of high-profile cold cases being publicised and calls for fresh inquests into some past events such as the deaths in the Luna Park fire. The coronial system is the institution of state whose responsibility it is to investigate these matters. Yet, as its few publicly available data show, it is struggling just to meet its responsibilities to conduct s 23 inquests. (This is discussed in more detail below.)

In the Association's submission, the current resources of the NSW coronial system are inadequate and do not allow it to perform its proper functions in a timely or optimally effective way for the benefit of families and the wider community. Although the current coroners are exceptionally hard working, skilled and efficient and still work long hours outside of core business hours to produce findings and attend views, the inadequacy of its current resources can be inferred from its current performance. Its resources are insufficient to enable it conclude inquests within the time standards set by the Local Court and, more generally, to meet community expectations as expressed in the Inquiry into the High Level of First Nations People in Custody.

According to the Local Court's latest *Annual Review*,[72] coronial cases should be concluded within the following time frames:

[72] Local Court of NSW, *Annual Review 2020,* 41. https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html

- 95% of deaths by natural causes, (no brief of evidence ordered) – within 3 months.
- 100% of deaths by natural causes, (no brief of evidence ordered) – within 6 months.
- 95% of deaths dispensed with (a brief of evidence ordered) – within 6 months.
- 100% of deaths dispensed with (a brief of evidence ordered) – within 9 months.
- 95% of deaths proceeding to inquest – within 12 months.
- 100% of deaths proceeding to inquest – within 18 months.

As will be further discussed below when considering delay in the system, coroners can only meet some of these time standards. In relation to inquests, in a majority of cases, time standards are not being met.

Anecdotal evidence suggests that the system is very stressed and is struggling to keep up with its incoming s 23 deaths in custody and police operations work, let alone reducing s 23 backlogs and undertaking valuable discretionary inquiries. This Select Committee will be familiar with the evidence to that effect presented to the Select Committee on the High Level of First Nations People in Custody especially from First Nations family members and those, such as the Legal Aid Commission and Aboriginal Legal Service, who represent them.

Members of the Association, and the legal profession more broadly, with experience in the jurisdiction point to delay as one of the most significant triggers of increased distress and even re-traumatisation not only of family members but also of others, such as health workers, police officers and correctional staff.[73] Delay also has negative effects on the Coroners' capacity to make the statutory findings required under the 2009 Act, as further discussed in the section on delay below.

The empirical data support these claims by demonstrating that the Coroners Court is labouring even to meet its responsibilities under s 23 of the 2009 Act to investigate deaths in custody and police operations and other mandatory inquests (homicides, missing persons, unexplained deaths). This, in turn, has an obvious knock-on effect in relation to non-mandatory inquests into preventable deaths which may, if fully investigated, mitigate the risk of future deaths and injury. (See further discussion in the section on delay below).

The Coroners Court is also under-resourced in the sense that, as discussed above, it has inappropriate and inadequate structures for managing its work and its aspirational functions in an optimal fashion. As discussed above, it is also under-resourced in terms its death prevention function because it lacks the capacity to collect and analyse its data to make the contribution it could to public health and safety. Despite best efforts by the legal team assisting the Coroner, *ad hoc* research undertaken and evidence from individual expert witnesses who are at times instructed by lawyers assisting the Coroner cannot hope to match the research expertise of a properly resourced Coronial Prevention Unit dedicated to the task of collecting and analysing coronial data.

Statistics from the Productivity Commission appear to show that, compared with other Australian coronial systems, NSW spends relatively little on its coronial system. The Productivity Commission data show that in 2019-20, NSW coroners received 6506 reports of death. Victoria received 7323, Queensland 5631, WA 2573,

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[73] For an analysis of the counter-therapeutic effects of inquests, see Ian Freckelton "Minimising the Counter-Therapeutic Effects of Coronial Investigations: In Search of Balance", (2016) 16 *QUT L. Rev.* 4.

SA 2651, Tasmania 751, the ACT 347 and the NT 277. Thus, NSW accounted for almost 25% of all deaths reported to coroners in Australia that year.[74]

The Productivity Commission's data show that in 2019-20 (excluding autopsies and forensic sciences) recurrent expenditure on coroners courts in NSW was $6,908,000; in Victoria $21,549,000; $12, 437,000 in Queensland; $7,494,000 in WA; $4,317,000 in SA; $1,587,000 in Tasmania; $1,803,000 in the ACT; and $1,316,000 in the NT. The NSW share of total Australian recurrent expenditure on coroners courts was therefore slightly more than 12%.[75] On the Productivity Commission's figures, NSW recurrent expenditure on coroners courts therefore is only about 32% of the amount spent in Victoria. On these figures, NSW only spends about 55% of the amount spent in Queensland to maintain its coroners court but received 875 more reports of death (about 15% more reports).

Given that the number of reported deaths annually in NSW and Victoria is similar, the difference provokes questions about the comparative quality of the services being provided in NSW and Victoria. Comparison with Queensland also raises questions about why there is such a discrepancy in recurrent expenditure on coroners.
Other data in the Productivity Commission's 2021 Report on Government Services also supports the impression that the coronial system in NSW is insufficiently resourced. According to the Productivity Commission, real net recurrent expenditure per case finalised in NSW is the lowest of all Australian states and territories and is about half the Australian average. In the 2019-20 financial year it was reported as being $1026 in NSW; $3240 in Victoria; $2099 in Queensland; $2706 in WA; $1832 in SA; $2197 in Tasmania; $4814 in the ACT; and $3912 in the NT. The national average was $2214 per case.[76]

According to the Report on Government Services for 2021, the number of FTE staff involved per 1000 finalisation was 4.7 in NSW, 16.0 in Victoria, 12.3 in Queensland, 12.8 in WA, 10.4 in SA, 11.6 in Tasmania, 14.1 in the ACT and 21.0 in the NT with a national average of 11.2.[77] The number of judicial officers per 1000 finalisations shows a similar wide gap between NSW and other jurisdictions. The national average is 1.3, whereas in NSW it is 0.8. In Victoria it is 1.4, in Queensland 1.5, in WA 1.6, in SA it is 1.1, in Tasmania it is 4.2 and in the NT it is 4.4. Only in the ACT is it less than in NSW: 0.5.[78]

When the comparative clearance rates in the different jurisdictions are examined, NSW appears to show up well. In 2019-20, a clearance rate of 104.7% was achieved. This was only exceeded by WA with a clearance rate of 106.4%. Although output is high in NSW, this is not a measure of the *quality* of the outcomes being produced by the coronial system if death prevention, accountability of state agencies and other key functions of coroners are considered. In fact, the high clearance rate in a context of comparatively low numbers of FTE staff and judicial officers per finalisation, and the relatively low recurrent expenditure per case, suggests that, compared with other jurisdictions either NSW is exceptionally efficient or that other jurisdictions invest more resources in investigating deaths. We submit that the Productivity Commission data imply that, compared with other Australian jurisdictions, the NSW coronial system is significantly under-resourced and that the overall quality of coronial services being provided to members of the public, especially bereaved families, is

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74 Productivity Commission, Lodgements Table 7A.2 *Report on Government Services* 2021

75 Productivity Commission *Report on Government Services 2021* Table 7A.12.

76 Productivity Commission, *Report on Government Services 2021* Table 7A.32.

77 Productivity Commission, *Report on Government Services 2021* Table 7A.30.

78 Productivity Commission, *Report on Government Services 2021* Table 7A.29.

It may be argued that the Productivity Commission data, despite appearances, cannot be relied on as presenting an appropriate comparison of the resources being invested in the NSW system and in other states, especially Victoria and Queensland. It seems likely that the apparent gap is not as wide as appears because of the following factors:

(i) by dealing with approximately 46% of cases within NSW regional courts, the costs of managing those cases are not transparently revealed. They may be covered by the general Local Court recurrent expenditure;

(ii) the costs of providing legal assistance to coroners are carried by the Communities and Justice Department and NSW Police whereas the Victorian Coroners Court has in-house legal assistance for coroners. They appear to be covered by that court's budget;

(iii) a significant proportion of the Victorian Coroners Court costs result from operating its Coronial Prevention Unit to conduct data collection and analysis and research support for coroners. In NSW, in complex inquests, research support is carried out by Counsel Assisting and solicitors on an ad hoc basis. Expert reports are also frequently sought by fulltime coroners in the course of their investigations. Those costs, we understand, may not be counted towards the Productivity Commission's comparisons.

The Victorian Coroners Court is purpose-built and comparatively well-resourced. If the comparative costs were to be appropriately calculated, the cost differential is not as wide as appears, but if the Victorian system is markedly superior, as appears to be the case, the argument for adopting a model similar to Victoria's strengthens.

If, on the other hand, a proper comparison was to find that Victoria was spending significantly more in its system, the likely explanation would appear to be that its Coronial Prevention Unit and its other death preventive effort is the primary source of the cost differential.

The economic value of a life is an actuarial measure of the benefit of avoiding a fatality. An American estimate of the economic value of a human life in Australia is $10 million.[79] In 2014, the Australian Government estimated the economic value of an Australian life to be $4.2 million.[80] The potential economic and human benefits of reforming the system so that its death preventive potential is enhanced seem self-evident. If an increase in resources for the coronial system were to mitigate risk of death and serious injury, it could and should be considered not only a social benefit but an economic investment for the state of NSW.

Even if the comparative cost in Victoria is significantly greater than in NSW, the cost of the Victorian Coroners Court within the Victorian Government's overall expenditure on health and public safety is very small but the potential for development of death preventive recommendations and policy interventions derived from coronial

79 Kip Viscusi, "Pricing lives: International guideposts to safety", (2018) *Economic Record* 94, Special Issue, June 2018, 1-10. In 2014, the Australian Government estimated the value to be in the order of

80 Department of Prime Minister and Cabinet, "Best Practice Regulation Guidance Note: Value of statistical life" (December 2014), https://www.pmc.gov.au/sites/default/files/publications/Value_of_Statistical_Life_guidance_note.pdf .

data is much greater than in NSW.[81] This suggests that NSW should follow the Victorian lead (or even seek to improve on it) by maximising the death preventive use of coronial data.

The Association submits that the Select Committee should take appropriate steps to make an appropriate comparison of the relative costs of the NSW and Victorian coronial systems.

In conclusion, quantitative comparisons with other jurisdictions takes the resource issue only a limited distance. In our submission, the fundamental question the Select Committee must come back to is the sort of system NSW should have. Having crystallised the answer to that problem, it should ask what resources are required for the coronial system to provide consistently high quality death investigations, enable death preventive lessons to be learned and implemented, government agencies to be properly held to account, and restorative processes for bereaved families to be enhanced.

3 Timeliness and delay

The Association notes that in their annual reports to parliament concerning deaths in custody and police operations, State Coroners complained of 'unavoidable delays' in concluding s 23 investigations (deaths in custody and police operations) every year between 2000 and 2019.[82] (The 2020 report has not yet been published.) These complaints suggest that the coronial system (which includes the forensic medical staff and police officers who carry out investigations on behalf of coroners) has been chronically over-stretched for at least two decades.

Evidence presented to the Inquiry into High Level of First Nations People in Custody by Adjunct Professor Dillon shows that, in the decade 2010-2019, the Local Court managed an average annual clearance rate of about 100% per annum for general cases. But in respect of s 23 cases he found that an annual clearance rate of only about 80% per annum had been achieved over that period. He noted that 'Only twice in the past decade have NSW coroners been able to achieve an annual clearance rate of 100% in s 23 cases. This occurred in years in which there were an unusually low numbers of s 23 deaths reported.'[83]

In the period 2016-2020, the entire NSW Local Court (including regional magistrates) only averaged 109 inquests per year.[84] The Local Court's most recent data show that in 2020, 112 inquests were conducted, of which 45 were s 23 mandatory inquests. Only the State Coroner and Deputy State Coroners are vested with s

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81 The Victorian Coroners Court *Annual Report 2019-2020* lays great emphasis on its death preventive orientation and achievements. See https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019-20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf

82 These reports are required pursuant to the Coroners Act s 37. They can be found in the NSW Parliament's Tabled Papers and also on the Coroners Court website, https://coroners.nsw.gov.au/coroners-court/resources/publications/deaths-in-custody-and-police-operations-annual-reports.html

83 Supplementary Submission of Adjunct Professor Hugh Dillon to Select Committee Inquiry into High Level of First Nations People in Custody 5 November 2020. https://www.parliament.nsw.gov.au/lcdocs/submissions/69470/104b%20Adjunct%20Professor%20Hugh%20Dillon.pdf

84 See *Local Court Annual Review 2020,* 22.

23 jurisdiction. Although the overall clearance rate of cases was 110%, the Coroners Court was unable to reduce the backlog of s 23 cases of which 48 were reported in 2020.[85]

The senior coroners (and all those who work on s 23 investigations) are commended by the Association for the considerable effort put in to prevent the backlog of s 23 cases increasing. However, it appears obvious that significantly increased resources will be required to reduce the backlog which stands at about 130 cases.[86] Therefore the prospects of reducing this backlog in the foreseeable future, without significant additional resources being invested in the coronial system, are dismal. The adverse effects on families, and especially on First Nations families, due to chronic delays, were well-documented in the Inquiry into High Level of First Nations People in Custody.

A further consequence in the chronic backlog of s 23 cases is that any attempt to reduce it with the current resources available to the Coroners Court and other organisations involved in coronial investigations would inevitably consume resources that could be applied to discretionary inquests with potential to mitigate risk of future deaths. Examination of the 77 published inquests findings for 2020 shows that, of that sample of coronial findings, mandatory inquests constituted two-thirds of that work.[87] Relatively few discretionary inquests into other possibly preventable deaths are being conducted. As outlined above, of the 77 published findings, 13 inquests dealt with health-related matters (including 3 deaths of psychiatric patients), two with deaths in aged care facilities and one with two fatal equestrian accidents.

According to data from the National Coronial Information System, approximately 40% of reported deaths in NSW are due to non-natural causes (ie about 2500 deaths per annum).[88] For coroners to conduct such a small number of discretionary inquests into unnatural deaths suggests that the potential for death prevention is not being maximised in NSW, most likely as a result of the resource constraints discussed above. This impression is strengthened by the fact that almost half the reports of death are being made to regional magistrates who conduct very few inquests and make a negligible number of death preventive recommendations.

As noted above, the Local Court sets time standards and issues practice notes concerning the completion of most of its core functions. For inquests, the standard is that 95% will be complete within 12 months and 100% within 18 months.[89]

A 2019 study by Adjunct Professor Dillon considered delay in the NSW Coroners Court. He found that data were not publicly available concerning the performance of regional coroners. In respect of fulltime coroners, he

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85 *Local Court Annual Review 2020*, 22-23.

86 The most recent report to Parliament pursuant to s 37 of the *Coroners Act 2009* by the State Coroner, for the year 2019, revealed that as at 31 December 2019, 129 cases remained outstanding. 48 cases were reported in 2020 and 45 inquests were held.

87 Suspicious deaths and homicides (11), missing persons (13), deaths in custody (24), deaths in police operations (8), and unexplained deaths (5).

88 See NCIS *Annual Report 2018-19* Table 2, p.12. Curiously, although Victorian coroners receive approximately the same numbers of reported deaths, only about 40% are diagnosed as being due to natural causes. The explanation for this wide divergence between the jurisdictions is unclear.

89 See *Local Court Annual Review 2018*, Appendix 1, http://www.localcourt.justice.nsw.gov.au/Documents/Annual%20reviews/15608%20-%20Local%20Court%20Annual%20Review%202018%20v3%20accessible.pdf accessed 20/11/19.

found that reliable data were only available (at that time) for the period 2015-2018. Fulltime coroners conduct the great majority of inquests in NSW, therefore these data are more significant than any relating to regional magistrates. They show that fulltime coroners were only able to meet the time standards in a small minority of cases (see table below). When the date of death was compared with the date of completion of inquests, as recorded in the findings of coroners reported on the Coroners Court website, it was found that on average 4.3% per cent were completed within 12 months and only 16.5% within 18 months.[90]

Year	% within 12m	% within 18m
2015	3.2	22.6
2016	5.2	20.8
2017	5	13.8
2018	3.8	8.7
Averages	**4.3**	**16.5**

Table 4: Time standard performance for inquests – fulltime coroners 2015-18
Source: Department of Justice, "Coronial findings" webpage,
http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx

Dillon's study also showed that few inquests were completed within 12 months while the majority were taking between 18 months and 4 years to completion.

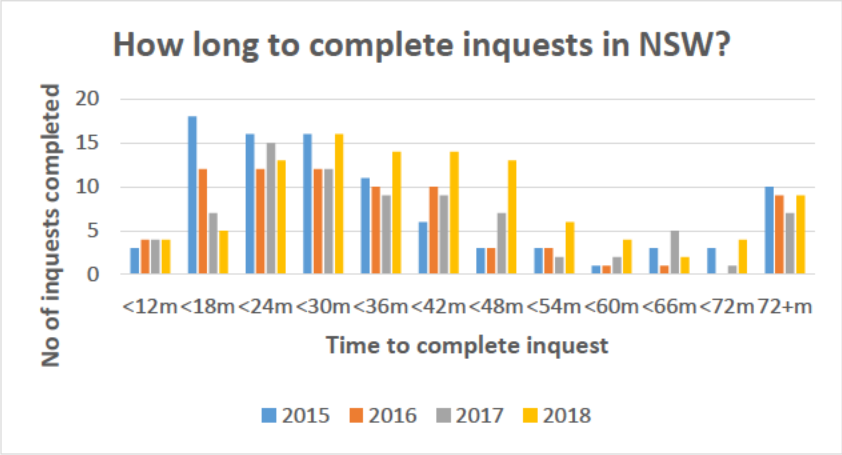

Table 5: Time standard performance for inquests – full time coroners 2015-18
Source: Department of Justice, "Coronial findings" webpage,
http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx

[90] Hugh Dillon, "Rethinking the NSW coronial system – why we need to and what it should look like", unpublished presentation to the Australian Academy of Forensic Sciences, Sydney, 20 November 2019. Paper is available from Hugh Dillon.

The COVID epidemic disrupted all courts, so it appears unlikely that this situation has improved.

It may be accepted that delay lessens the reliability of witness recall when called to give evidence about past events. In the coronial jurisdiction many (but not all) witness statements are taken relatively soon after the relevant events occurred with the assistance of investigating police. Delay in matters coming on for hearing however limits the ability to obtain reliable and important additional evidence on matters that may not have been included when statements were first taken, or from witnesses who may not have been identified by the officer in charge conducting the initial investigation. If, in the course of a coronial investigation, there is a need to hear further from witnesses to important events, such further evidence needs to be taken in a timely fashion before it is lost or its reliability is irreparably diminished.

Dillon additionally concluded:

> *Long delays in completing investigations and inquests are distressing for bereaved families, for other people affected by reported deaths, and reduce the effectiveness of coronial recommendations. They also 'undermine the integrity of vital statistics' concerning public health and safety.*[91] *Research based on National Coronial Information System data has found that delay is common in all Australian jurisdictions. This is also the international experience.*[92] *Finding solutions to the problem of delay in NSW could have nationwide and, indeed, international benefits. Inaction, on the other hand, will compound the growing problems.*

The Association acknowledges the current efforts being made to reduce delay. In particular, we note that the Coroners Court has been working exceptionally hard to reduce the backlog of s 23 inquests. The Association also acknowledges the work of the Inter-departmental "Improving Timeliness of Coronial Procedures" Taskforce in attempting to streamline the forensic medicine process in particular.

Delay, however, is sometimes the result of adjournments for other processes to complete – eg professional disciplinary proceedings/criminal proceedings. Therefore, even with hard working coroners and legal representatives, delay in some cases is inevitable unless those other processes are themselves conducted more quickly where an inquest is adjourned pending their completion.

For a variety of reasons, therefore, delay remains a significant concern. We submit that urgent action is needed to address what appear to chronic problems of delay in the NSW coronial system. The problems are likely to stem from multiple causes due to lack of integration of the coronial system and other structural issues. They are unlikely, therefore, to be cured by simple expedients within the State Coroner's or Chief Magistrate's capacity to control such as the issuing of Practice Notes or the holding of directions hearings or convening ad hoc taskforces. In our submission, more extensive systemic reform is needed over the system as a whole, including a commitment by government to the provision of additional financial resources to the coronial system.

The Queensland and Victorian approaches may hold some of the answers to the administrative friction that causes and amplifies delay in the system. Other answers, such as innovative processes and additional resources, appear to be required to reduce the backlog and to ensure the ongoing improvement, efficiency and effectiveness of the system in achieving its proper objectives. (In section (B) below, we discuss some interesting methods used in Ontario that may be adaptable to the NSW environment.)

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91 David M Studdert el al., "Duration of death investigations that proceed to inquest in Australia", *Injury Prevention,* (2016) 0: 1-7 at 1.

92 Studdert et al. (2016), 3.

4 Coronial recommendations and responses

The contribution of coroners and the coronial system to prevention of future death and injury is largely (but not solely) made through recommendations delivered at the conclusion of inquests. Under the 2009 Act, coroners are only empowered to make recommendations if an inquest is held.[93]

In practice, whether or not recommendations are ultimately made, in many cases the holding of coronial investigations is likely to prompt remedial action by agencies and organisations, often well before the inquest. It is the experience of the NSW Bar that, because inquests are frequently delayed even for years, remedial action often overtakes the coronial process, including in an effort by organisations to avoid being the subject of coronial recommendations. While it is obviously commendable that organisations take remedial action without waiting for coronial recommendations, delay reduces the effectiveness of coroners as agents of preventive action. In other cases, practitioners who act for interested parties report that organisations will sometimes want to delay implementing proposed recommendations until after a coroner has expressed an opinion about them in an inquest. Delay in these cases can compromise public safety.

A second question arising concerning coronial recommendations is their practicability. In this submission, we do not comment on the quality of recommendations made by NSW coroners.

Requiring responses to coronial recommendations, however, is only one aspect of this issue. An important New Zealand study found that the quality of recipients' responses also depended to a significant extent on the quality of coronial recommendations themselves.[94] Associate Professor Jennifer Moore, the author of that study, made a range of recommendations for improving the performance of New Zealand coroners in relation to their death preventive function. The Association notes that studies conducted in respect of the New Zealand and Victorian coroners have found that coronial recommendations are often less effective than they could be.[95] Improving the death preventive quality of recommendations, therefore, is one side of this question.

Improving the quality of the *response* to recommendations is the other. In NSW, unlike Victoria, for example, there is no statutory requirement for responses to be made to coronial recommendations. If coroners make recommendations, they are required to send them to the Attorney General and any relevant minister, as well as to persons or organisations to whom they are made. Premier's Memorandum M2009-12 "Responding to coronial recommendations" is an administrative direction to NSW Government ministers and agencies. It

93 *Coroners Act* s 82.

94 Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016), Chs 5, 6.

95 Freckelton and Ranson *Death Investigation and the coroner's inquest* (2006); Georgina Sutherland, Celia Kemp, David M. Studdert, "Mandatory responses to public health and safety recommendations issued by coroners: a content analysis" (2016) 40:5 *Australian and New Zealand Journal of Public Health* 451; Ray Watterson, Penny Brown and John McKenzie, "Coronial recommendations and the prevention of Indigenous death" (2008) 12 Special edition 2 *Australian Indigenous Law Review* 4; Lyndal Bugeja et al., "Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention" (2012) 18 *Injury Prevention* 326-333.

requires response from ministers and government agencies.[96] There is no response required, however, from non-government recipients of recommendations.

According to Premier's Memorandum M2009-12, government recipients of recommendations should acknowledge receipt within 21 days and, within 6 months, notify the Attorney-General of action taken or proposed in respect of recommendations, or reasons for not implementing the recommendations. A perusal of the responses of NSW government departments and agencies suggests that the deadlines set down in the Memorandum are frequently missed and sometimes no response is published at all.[97]

Unlike the Victorian Coroners Court, recommendations and responses are not published or linked together in one website. Coronial findings are published on the NSW Coroners Court website[98] with responses being published in batches many months later on the website of the Department of Communities and Justice.[99] The Association submits that this is an inefficient and incoherent system. It negatively affects the public's and government agencies' capacity to access and learn from the work of the Coroners Court. It is also contrary to concepts of access to justice if coroners, the legal profession, investigators, bereaved families, other members of the public, researchers, government agencies cannot obtain ready access to coronial recommendations and government responses. We submit that the more efficient system employed by the Victorian Coroners Court is to be preferred.

Coroners and those assisting them ought to be able easily to find recommendations made previously in similar cases. The inefficiency of the current NSW system is likely to hamper any such searches. It may result in coroners expending unnecessary effort 'reinventing the wheel' or making recommendations inconsistent with those made previously, causing recipients confusion and adding to the burden of responding to the fresh recommendations. For the benefit of coroners and recipients of recommendations, as well as the wider community, in our submission it is clear that a better system is needed.

In some other jurisdictions, a response to recommendations is required by statute. The Victorian *Coroners Act* mandates a written response from ministers and other public entities, outlining proposed action, within 3 months of receiving the recommendations. (No response is required under the Act from non-government persons or organisations). In Victoria, recommendations and responses must be published on the Coroners Court website.[100]

In England and Wales, coroners and coronial juries no longer have power to add 'riders' or recommendations to inquest verdicts. However, if coroners' investigations reveal anything that 'gives rise to a concern that circumstances creating a risk of death' exist, they must send a report to the relevant person or authority with a suggestion that 'action should be taken… to eliminate or reduce the risk'.[101] Recipients of Reports to Prevent

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96 See https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations

97 Dept of Communities and Justice, "Government response to coronial recommendations" webpage https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx accessed 3 June 2021.

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

99 See https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

100 *Coroners Act 2008*, s 72.

101 *Coroners and Justice Act 2009* (UK) Para. 7 of Schedule 5.

Future Deaths are required to respond within 56 days notifying the coroner of action taken or proposed, or reasons for taking no action.[102]

The *Coroners Act 1997* (ACT) provides for one of the most detailed statutory schemes dealing with recommendations and responses. Like the English statute, it requires coroners to 'comment' on any matter of public safety found to arise during an inquest.[103] In relation to deaths in care or deaths in custody, ACT coroners 'must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the cause of death.'[104] Coroners may report their findings, and may also make recommendations concerning matters of public safety, to the Attorney General.[105] If the report comments or makes recommendations about issues of public safety, the Attorney (or another minister) must present the report to the Legislative Assembly and present a response to the report.[106]

Reports of findings made in relation to deaths in care or custody must be made to relevant persons and bodies.[107] Recipient agencies are required to provide a response to the Attorney General within 3 months including action taken or proposed in relation to any of the coronial findings. The Attorney must provide a copy of the response to the coroner.

The *Coroners Act 1993* (NT) requires a coroner conducting an inquest into a death in custody to report on the care, supervision and treatment of the person while being held in custody and may report on any issues of public health or safety or the administration of justice relating to the death.[108] A coroner is also required to 'make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.'[109] In other inquests, coroners may report to the Attorney General and also make recommendations on any relevant matter connected with a death.[110] The Act requires responses to coronial reports or recommendations to be given to the Attorney General within 3 months.[111] The Attorney is obliged to report on the coroner's report or recommendations and the response by giving a report to the coroner and tabling that report in the Legislative Assembly.[112]

The Queensland Act also permits coroners to comment on matters of public health and safety and ways to prevent future deaths. Comments and recommendations must be provided to family members, interested parties, the Attorney and any other relevant minister.[113] In relation to deaths in care or custody or police operations, coronial findings and comments must also be made directly to relevant department chief

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102 Coroners (Investigations) Regulations 2013 (UK) r.29.
103 *Coroners Act 1997* (ACT) s 52 (4).
104 *Coroners Act 1997* (ACT) s 74.
105 *Coroners Act 1997* (ACT) s 57(1), (3).
106 *Coroners Act 1997* (ACT) s 57(4).
107 *Coroners Act 1997* (ACT) s 75.
108 *Coroners Act 1993* (NT) s 26(1)
109 *Coroners Act 1993* (NT) s 26(2).
110 *Coroners Act 1993* (NT) s 35(1), (2).
111 *Coroners Act 1993* (NT) s 46B(1).
112 *Coroners Act 1993* (NT) s 46B(3).
113 *Coroners Act 2003* (Qld) s 46(1), (2).

executives.[114] There is no statutory requirement for responses to recommendations. The Queensland Government website indicates a policy of responding to coronial recommendations within 6 months.[115]

The South Australian *Coroners Act 2003* empowers coroners to make recommendations at the completion of an inquest.[116] The Attorney General or the minister responsible for the agency or instrumentality concerned must, within 8 sitting days after a 6-month period since receiving the findings and recommendations, table a response in each house of parliament.[117]

Tasmanian coroners are empowered to make recommendations to the Attorney General.[118] The Tasmanian Act does not require responses to recommendations. The Tasmanian Magistrates Court website provides no information as to whether Tasmanian government ministers or entities are required to respond to recommendations. (Intriguingly, however, the court website suggests readers seek further information about how other states manage coronial recommendations).[119] We are informed, however, that it is the practice of the Coronial Division of the Tasmanian Magistrates Court to follow up coronial recommendations with recipients.

The Western Australian Act gives coroners power to 'comment' on relevant matters and requires them to comment on 'the quality of the supervision, treatment and care' of a person who has died in care or custody'.[120] The Act does not provide for mandatory response to coronial recommendations. As in the Tasmanian case, it is unclear what administrative arrangements, if any, are made by the WA Government to respond to coronial recommendations.

In our submission, the 2009 Act should require that coroners comment on the care and treatment of people who die in care or custody in the period prior to their death.

The Association submits that, because of its transparency and efficiency, the best of the current models is the Victorian approach. However, one deficit in that model is that coroners do not have statutory power to follow up recommendations. A second flaw in the Victorian approach is that non-government recipients of recommendations have no obligations to respond.

A lack of follow-up powers means that, once coroners have concluded inquests by making findings and recommendations, they have no statutory means of ensuring that recommendations are actively considered.

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114 *Coroners Act 2003* (Qld) s 47.

115 Queensland Government "Coronial recommendations" webpage https://www.qld.gov.au/law/legal-mediation-and-justice-of-the-peace/coronial-recommendations

116 *Coroners Act 2003* (SA) s 25(2).

117 *Coroners Act 2003* (SA) s 25(5).

118 *Coroners Act 1995* s 30(2).

119 Magistrates Court of Tasmania, "Findings, comments and recommendations" https://www.magistratescourt.tas.gov.au/about_us/coroners/coronial_practice_handbook/key_elements_in_the_process/findings_comments_recommendations . See also Rose Mackie, "The implementation of coronial recommendations in Tasmania: Two case studies on child deaths" (2018) 25:2 J of Law & Medicine 503 which argues for a mandatory response regime to implemented in Tasmania.

120 *Coroners Act 1996* (WA) s 25(2), (3).

Public sector recipients are required by law to respond to coronial recommendations within 3 months but it is not clear from the Victorian Coroners Court website what happens if a response is late or not forthcoming.

A better approach would be to adopt the Victorian model but, in the event that no response, or an inadequate response, is made to coronial recommendations, to give the State Coroner a statutory power to require that agencies provide a response within a fixed period of time and a power to report to the Attorney-General or, through the Attorney, to the Parliament in circumstances where no response, or no adequate response, is received within the time allowed.[121] In our submission, an adequate response is one that states what action (if any) will be taken in respect of a recommendation and the anticipated timeframe for carrying out that action. If no action is proposed to be taken, clear reasons should be given for rejecting the recommendations.

Consideration should also be given in NSW to requiring a response from all recipients of recommendations. If death and injury prevention is the objective of making recommendations, there seems no reason in principle why only government entities should be required to consider and respond to coronial recommendations.

In 2020, coroners made recommendations to the following non-NSW Government persons and organisations:

(i) Chief Executive, Therapeutic Guidelines Ltd (publishers of *Therapeutic Guidelines*)
(ii) Chief Executive, Nursing and Midwifery Board of Australia
(iii) Southern Cross Care NSW & ACT (aged care provider)
(iv) CEO, GEO Group Australia (Junee Correctional Centre)
(v) General Manager, Campbelltown Private Hospital
(vi) CEO, Scentre Group Pty Ltd
(vii) CEO Healthscope Ltd and Nepean Private Hospital.[122]

It is notable that they include private prisons, private hospitals and private aged care facilities. These facilities are, in effect, providing public services and are largely funded by government.

In our submission, consideration should also be given to whether there is an appropriate role for a standing committee of the State Parliament in regularly reviewing the adequacy of responses to coronial recommendations.

5 Coroners Court's capacity to respond to culturally diverse needs

As discussed above, the Association strongly supports all efforts made by the State Coroner and many other actors in the coronial system to provide recognition and support for bereaved First Nations families and communities.

One significant area of coronial work which requires cultural sensitivity is in respect of objections to autopsies and organ retention on cultural or religious grounds. Our understanding is that counsellors in the Department

121 The *Ombudsman Act 1974* (NSW) gives the Ombudsman a similar power: s 27, 31. See also the commentary of Sutherland, Kemp and Stoddard on the flaws in the Victorian mandatory response regime n.29 above.

122 https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx viewed 12/6/21.

of Forensic Medicine (NSW Health) and from the Coronial Information and Support Program team (Coroners Court) work well with coroners and families to ensure that family concerns about forensic medical investigations are dealt with sensitively.

Members of the Bar experienced in the coronial system report that applications to the Supreme Court for orders in respect of forensic medical examinations are rare because family concerns are listened to respectfully and weighed seriously.[123] The Coronial Information and Support Team and Forensic Medicine counsellors are able to negotiate with coroners and forensic pathologists to resolve most issues with families once objections are raised. In many cases, this is done by providing families with more information or negotiating a limited examination process with the forensic pathologists.

6 Operational arrangements – Coroners Court, NSW Health, NSW Police

The NSW coronial system appears to operate largely on the basis of good personal relations between the members of the three major participants – the Coroners Court, the Dept of Forensic Medicine (NSW Health) and the NSW Police. As noted above, such an arrangement was found in Queensland to result in less than optimal co-ordination and reduced performance by that coronial system. This is likely to be the case in NSW also.

The system is not fully integrated at a managerial level. This has led to difficulties in the past. The Queensland Auditor-General's report is relevant in that it identified lack of co-ordination within a system similar to the NSW system as a major problem. It seems very likely that the NSW system would work more efficiently and effectively with more formal arrangements for co-ordination.

A NSW Government task force is considering delay in the system up to the point of inquest. It has not yet reported but it was set up because of complaints concerning delays caused by operational arrangements.[124] It is an ad hoc task force only and is largely being driven by NSW Health which is, understandably, preoccupied at present with other more pressing matters especially the Covid pandemic and its ramifications.

While the Association is hopeful that some remedial measures will emerge to reduce delay, we submit that a more high-powered strategic body, as in Queensland, is required for the medium- to long-term strategic co-ordination and performance management. The Association submits that a high-level board or committee, similar to the Queensland Coronial Services Governance Board, should be established in NSW.

123 A perusal of the NSW Caselaw website supports this. Only 50 Supreme Court cases concerning the Coroners Act were found in a search using the term "Coroners Act". Only 2 concerned objections to forensic medical procedures.

124 The "Improving Timelines of Coronial Procedures" taskforce: see *Local Court Annual Review 2020*, 24.

(B) COMPARISON WITH OTHER JURISDICTIONS

Some comparisons with other jurisdictions have been made in the previous sections. In this section, we consider broader structural differences between the NSW system and others. We also consider some of the features of other systems that could be adapted to NSW needs.

The England & Wales model is *sui generis*.[125] It consists of 92 coronial districts, with coroners appointed by local government authorities. Many are part-timers. Until 2009, when a Chief Coroner was appointed, it was considered to be a 'cottage industry' with enormous variance in practice and consistency. Despite the appointment of a Chief Coroner and the institution of Chief Coroner's guidelines (or 'guidances')[126], anecdotal evidence suggest that it remains a highly variable and idiosyncratic system with coroners being poorly resourced and supported compared even with NSW coroners.

Perhaps the most attractive feature of the English system for NSW purposes is the explicit application of human rights standards in coronial inquests investigating deaths involving state agencies and agents has resulted in better guidance for coroners and more thorough inquests than had previously been the norm.[127]

While the New Zealand legislation has excellent features, including a particular emphasis on cultural respect and sensitivity. Approximately 25% of NZ coroners are Maori. However, except in numbers of coroners, the New Zealand system is not well particularly well resourced and is also quite decentralised.

The Queensland Coroners Court sits within the structure of the Queensland Magistrate's Court. It is headed by the State Coroner who has the status of a Deputy Chief Magistrate. Including the State Coroner, it has 8 specialist coroners, 5 based in Brisbane covering the city and South-East Queensland and 2 regional coroners in Cairns and Mackay. As in NSW, coroners are magistrates and all magistrates are coroners *ex officio*. However, by administrative fiat, Queensland no longer uses local magistrates for coronial work.

The Queensland system has four particular strengths:

(i) It has recognised coronial work as specialist work;
(ii) It has developed what is, in practice, a specialist court;
(iii) The Queensland State Coroner's Guidelines are a comprehensive and intelligent guide to the underlying modern principles and practice of coronial work;[128]

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125 Scotland has its own system which is quite different from that which operates in England, Wales and Northern Ireland.

126 See Chief Coroner's Guidance, Advice and Law Sheets https://www.judiciary.uk/related-offices-and-bodies/office-chief-coroner/guidance-law-sheets/coroners-guidance/

127 See Paul Matthews, *Jervis on Coroners* 13th ed, (London: Sweet & Maxwell, 2014), 123-125. See also *R (Middleton) v West Somerset Coroner* [2004] AC 184; *R (Amin) v. Secretary of State for the Home Department* [2003] UKHL 51.

128 State Coroner's Guidelines https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation#state

(iv) The system as a whole is in the process of being reformed and better integrated by the Queensland Coronial Services Governance Board.

The Ontario death investigation system is based on a medical model (350 local GP coroners overseen by 11 regional specialist physicians all managed the Chief Coroner and Chief Forensic Pathologist). Historically, the Ontario coronial system has been noteworthy for two reasons. First, earlier than many other coronial systems around the world, it orientated itself towards death prevention. This influenced later developments in other jurisdictions, notably Victoria.[129]

Secondly, in the 1990s, because of his frustration with the delays and cumbersome nature of inquests, the Chief Coroner of Ontario, Dr James Young, developed a method of informal inquiries, using techniques similar to those used in restorative justice conferences. In evidence to the 1997 Queensland review of its coronial services, he described the process as follows:

> *Both the Regional Coroner and the Local Coroner meet with the relevant institutions. Institutions sometimes bring their lawyers. No minutes are kept of the meeting. 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 available about the death is only preliminary and that more information may be later provided, and that this may change the case's direction. When a meeting with an institution 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 measures to overcome a similar death occurring.*[130]

Coroners also met with families. Dr Young told the Queensland review that initially both families and institutions were suspicious of this informal process. Families initially preferred inquests. After some experience had been developed, however, families developed confidence in it and felt empowered because they were integrally involved in the outcomes.[131] Our understanding is that the processes in Ontario have since taken on greater formality in that discussions are recorded but that these flexible methods are still employed regularly in that province.[132]

Apart from its emphasis on non-adversarial, restorative approaches to death investigation, Ontario has four particular features that could be adopted with advantage in NSW:

(i) It has a Death Investigation Oversight Council to provide strategic direction and advice to the Chief Coroner and Chief Forensic Pathologist;

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129 See Graeme Johnstone, "An avenue for death and injury prevention" in Hugh Selby (ed), *The Aftermath of Death,* (Sydney: Federation Press, 1992).

130 James Young statement to Queensland Review of Coronial Laws (1997) quoted in Justin Malbon, "Institutional responses to coronial recommendations", (1998) 6 *J of Law & Medicine* 35, 46-47.

131 Young, (1997), 47.

132 Dr Dirk Huyer, Key note speaker, UNSW Law School Coronial Workshop, 13 February 2020 (unpublished report of workshop).

(ii) It has a range of expert death review panels concerning relating to domestic violence deaths, patient safety, maternal and perinatal deaths, paediatric and geriatric deaths to provide expert advice to coroners and also to examine systemic issues;

(iii) The Ontario system has embarked on a data collection and analysis program that, it is hoped, will identify patterns and trends of unexpected deaths and will support public health and safety research and programs in the province;

(iv) It has a 169-point Strategic Plan to improve coronial services in Ontario.[133] (The current work plan was scheduled to be completed by 2021 when a further 5-year plan would commence.)

In the view of Dr Dirk Huyer, the Ontario Chief Coroner, the combination of coronial investigations and systemic reviews is much more efficient and effective than the inquest approach.[134] Apart from providing advice to coroners, the panels are better than individual coroners at discerning patterns and trends and systemic issues. They are also able to meet with families in some cases.

Despite its considerable strengths, however, the Ontario model is unsuitable for adoption in NSW for a variety of reasons. Its most obvious point of incompatibility is that it is highly decentralised and difficult to manage.

The Victorian model appears for a number of reasons to be the most attractive current alternative to the present NSW regime:

(i) It has a specialist court headed by a County Court judge as State Coroner;

(ii) As a stand-alone court it has been able to develop its own unique culture, rather than seeking to adapt, or adapt to, the culture of an umbrella court;

(iii) It has a well-developed culture of therapeutic jurisprudence;

(iv) It is integrated well with the Victorian Institute of Forensic Medicine;

(v) It has a clear set of statutory objectives and an historical philosophy and practice oriented towards death prevention;

(vi) Its Coronial Prevention Unit collects and analyses coronial data, and provides professional research support to coroners (and also on occasions ad hoc advice to other agencies);

(vii) The Coronial Prevention Unit is well-connected with Monash University injury prevention researchers and other public health and safety organisation;

(viii) It has been innovative in instituting support for First Nations families and developing protocols for investigating deaths in custody.

Desirable changes to the NSW coronial jurisdiction, having regard to those comparisons, have also been outlined above. The Association reiterates its submission that a root-and-branch revision of the 2009 Act is

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133 The plan was largely developed from the recommendations of the Goudge Inquiry into Ontario forensic services (2008). See Inquiry into Pediatric Forensic Pathology in Ontario, Canada. https://www.attorneygeneral.jus.gov.on.ca/inquiries/goudge/report/v1_en_pdf/Vol_1_Eng.pdf For Strategic Plan, see https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Ourcommitment/DI_Strat_plan_15_20.html

134 Dr Dirk Huyer, Key note speaker, UNSW Law School Coronial Workshop, 13 February 2020 (unpublished report of workshop).

required and would be pleased to contribute to the work of any inquiry or consultation process in relation to the drafting of such revisions.

(C) MOST APPROPRIATE INSTITUTIONAL ARRANGEMENTS FOR NSW

As discussed above, the Association submits that significant reform of the NSW coronial system is needed to meet the current and future needs of the community.

If history is any guide, the institutional arrangements that follow from this inquiry are likely to subsist for many years. This inquiry is likely to present a once-in-a-generation opportunity for the NSW Government and the Parliament to create a modernised coronial system.

The coronial system should not be regarded as a minor add-on to a major criminal court but should be recognised as an historically unique public institution with specialist responsibilities for caring for the dead, for those affected by reported deaths (especially families), for the mitigation of risk of future death and for enhancing the legitimacy of the state by holding its agents and agencies to account against appropriate human rights standards when they cause or contribute to causing a death.

A reformed system should:

- Have real potential to mitigate the risk of future death.
- Apply innovative methods which are therapeutic and restorative for bereaved families and the wider community.
- Enhance the legitimacy of investigations of deaths involving government agencies and agents by eliminating unnecessary delay and counter-therapeutic effects of coronial investigations for families and others affected by such deaths.

To achieve those ends, it must be recognised as a multi-disciplinary system or complex; the intersecting elements should be arranged and co-ordinated efficiently; and the system should be designed to achieve the objectives, not tacked onto another specialist system.

Taking into account lessons that can be learned from other jurisdictions, the Bar Association submits that the most appropriate institutional arrangement for NSW would be to establish a system consisting of:

- A new Act adopting the best features of the Victorian and New Zealand Acts, especially the statutory objects. The statute should expressly declare its basic purposes;
- Statutory objects that specifically recognise the unique and honourable place of First Nations people in the Australian community as the First Nations of the land; and the unique needs of First Nations people in the coronial system given the impact of colonisation, dispossession and systemic discrimination upon First Nations people;
- A requirement for the urgent appointment of First Nations coroners and further First Nations commissioners (or similar title) to sit on all inquiries relating to the death of a First Nations person;
- A specialist court, clearly constituted with specialist jurisdiction, to stand as the hub of the coronial death investigation system;
- The system should be co-ordinated and, as far as reasonably practicable, integrated with a view to achieving maximum efficiency of its operations and optimal outcomes for bereaved families and others affected by

reported deaths. A strategic oversight board or committee along the lines of the Queensland Coronial Services Governance Board to co-ordinate the system and strategically plan it;

- A series of standing death review committees similar to the Ontario model to work within the coronial system in a co-ordinated fashion;
- A coronial public health and safety research unit to collect and analyse coronial data with a view to (a) contemporaneous identification of patterns and trends of risk; (b) alerting appropriate public agencies to the emergence of such trends; (c) supporting the coronial system more broadly in its preventive function;
- Co-ordinated connections between the coronial public health and safety research unit and public health and safety organisations and research units in universities and government agencies;
- The system should be resourced sufficiently to enable it to complete all s 23 inquests within 12 months of a death being reported and to complete investigations into all preventable deaths within 18 months (accepting that, as discussed above, in practice there will sometimes be good reasons relating to other disciplinary or curial processes which mean that these time frames will not be achievable in every single case);
- A statutory mandatory response regime for coronial recommendations, similar to that provided in the Victorian Act but with the additional elements that (a) non-government persons and agencies would also be required to respond; (b) that the State Coroner could require a further response if a response was not filed within a particular timeframe or did not adequately explain what action had been taken or, if the recommendation had been rejected, did not provide satisfactory reasons; and (c) that the State Coroner could, through the Attorney-General, provide a report to the Parliament in circumstances where no response, or no adequate response, is received within the time allowed;
- The State Coroner or strategic oversight board should be required to produce an annual report to Parliament on the performance of the coronial system.

It may be thought that NSW already has a de facto Coroners Court. In some respects, this impression is correct. However, as we noted at the beginning of this submission, there is no statutory foundation for this 'court'. And that creates a range of practical problems:

First, as we have noted above, the Chief Magistrate, not the State Coroner, is effectively the head of the coronial jurisdiction because the State Coroner is subject to the Chief Magistrate's "control and direction" in respect of any of the State Coroner's functions and responsibilities.[135] Yet the 2009 Act imposes statutory responsibility for co-ordinating the coronial system on the State Coroner. Within the Local Court, the largest criminal court in Australia, the coronial jurisdiction is a minor element. The 'Coroners Court' can only draw its resources from the Local Court so there is always a tension and competition for resources.

Secondly, country magistrates are doing coronial work but not within a single court structure and coronial culture. Nor are they resourced for this specialist work. In essence, NSW has an awkward hybrid structure with some of the characteristics of the English local coronial system and some of the features of the Queensland system and some unique features of its own.

Thirdly, the Inquiry into High Levels of First Nations people in gaol unearthed what some may consider to be an important ethical problem. The Local Court deals with 27,000 cases brought against First Nations

135 *Coroners Act* s 2009 (NSW) s 10(2).

defendants per annum. The Local Court is responsible for sentencing many of them to terms of imprisonment. Yet when they die in custody, the Local Court – though its magistrates acting as State Coroner and Deputy State Coroners -- is also responsible for investigating their deaths. Some part-time Deputy State Coroners also work as local magistrates.

It is well known that an enormous trust gap lies between the courts and First Nations communities. Establishing a separate statutory Coroners Court, the members of which have nothing to do with sentencing, would be a small but important step towards eliminating First Nations apprehensions of bias by coroners towards police and correctional officers and may create greater trust between First Nations people and the coronial system. So, too, would the appointment of First Nations coroners and commissioners.

The Association anticipates, therefore, that one of the issues that the Select Committee will consider is whether to recommend a stand-alone court based on the Victorian model or a specialist court attached to the NSW Local Court along the lines of the NSW Children's Court.

Each model has particular strengths. Attaching a specialist court to the Local Court would enable magistrates to move between the courts, always with the proviso that this was a mutually agreed process by the Chief Magistrate and the State Coroner. For the Coroners Court to be able to recruit from the Local Court is a significant advantage.

On the other hand, the purposes and cultures of criminal courts and coronial courts are very different. When two different courts are joined in an arranged marriage, tensions can arise. For that reason, a stand-alone court may be preferable.

The major argument sometimes made against stand-alone courts is that performance management of individual members of their benches is sometimes difficult. Put frankly, it is easier to 'hide' a poor performer in a large court than in a small one. In our view, however, this putting the cart before the horse. Speculation about potential performance management issues should not be determinative of the structure of the coronial system. Confidence should be placed in a merit-based selection process for coroners and the management skills and integrity of the State Coroner to ensure that the coronial system and specialist Coroners Court work optimally.

APPENDICES

Appendix A: Statutory Objects and Purposes – New Zealand and Victorian Acts

Coroners Act 2006 **(NZ)**

3 Purpose of this Act

(1) The purpose of this Act is to help to prevent deaths and to promote justice through—

(a) investigations, and the identification of the causes and circumstances, of sudden or unexplained deaths, or deaths in special circumstances; and

(b) the making of recommendations or comments that, if drawn to public attention, may reduce the chances of further deaths occurring in circumstances similar to those in which the deaths occurred.

(2) To help to achieve its purpose, this Act—

(a) identifies deaths that must be reported to a coroner and the process for reporting and investigating those deaths:

(b) recognises both—

(i) the cultural and spiritual needs of family of, and of others who were in a close relationship to, a person who has died; and

(ii) the public good associated with a proper and timely understanding of the causes and circumstances of deaths:

(c) provides for an independent coronial system for investigations of deaths by coroners liaising with other authorities permitted or required by law to investigate those deaths:

(d) repeals and replaces the Coroners Act 1988.

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Coroners Act 2008 **(Vic)**

1. Purposes

The purposes of this Act are—

(a) to require the reporting of certain deaths; and

(b) to provide for coroners to investigate deaths and fires in specified circumstances; and

(c) to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners; and

(d) to establish the Coroners Court of Victoria as a specialist inquisitorial court; and

(e) to establish the Coronial Council of Victoria; and

(f) to amend the **Coroners Act 1985** —

(i) to repeal the provisions relating to coroners; and

(ii) to rename that Act as the **Victorian Institute of Forensic Medicine Act 1985** ; and

(g) to make consequential amendments to other Acts.

8. Factors to consider for the purposes of this Act

When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following—

(a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;
(b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;
(c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
(d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;
(e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;
(f) the desirability of promoting public health and safety and the administration of justice.

Appendix B: Protocol for hearing of inquests – April 2010

Protocol for Hearing of Coronial Inquests

The following protocol is applicable for the hearing of all coronial matters in New South Wales.

The establishment of time standards for hearing of coronial matters inquests remains as set out below:

95% of deaths by natural causes, (no brief of evidence ordered), - within 3 months.
100% of deaths by natural causes, (no brief of evidence ordered), - within 6 months.
95% of deaths dispensed with (a brief of evidence ordered) - within 6 months.
100% of deaths dispensed with (a brief of evidence ordered) - within 9 months.
95% of deaths proceeding to inquest - within 12 months.
100% of deaths proceeding to inquest - within 18 months.

The State Coroner and Deputy State Coroners are to continue the responsibility for the management and hearing of all coronial matters in the Metropolitan Area.

With the commencement of the *Coroners Act* 2009 there are no longer Registrar Coroners in Regional NSW. Magistrates in Regional areas will now have the responsibility of the following:

- Examination of all reports of deaths pursuant to the *Coroners Act*;
- Consideration of all objections to post mortems and applications under the *Human Tissue Act 1983*;
- Determinations regarding the holding of and dispensing of inquests; and
- The conduct of all conferences with interested parties (at the discretion of the coroner).
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Registrars of the Local Court are to retain the administrative functions of the Assistant Coroner.

Magistrates are to determine appropriate matters in which an inquest can be dispensed with. Where it is determined that an inquest is to be held the Circuit Magistrate is to determine whether a conference with interested parties should be held.

Where it has been determined by the Magistrate that an inquest is to be held, Inquests of less than five days are generally to be heard by the Circuit Magistrate.

The State Coroner and Deputy State Coroners remain responsible for the following inquests arising in country locations:

- those they are required to conduct due to the relevant legislation, i.e. deaths in custody, and matters involving police activities.
- those inquests of a complex nature and/or listed in excess of five days.
-

Magistrates in Newcastle and Wollongong have been appointed Deputy State Coroners for these cities.

Magistrates seeking assistance for the conduct of lengthy or complex coronial matters should send the following advice to Mr Don McLennan, Executive Officer, Coroner's Court:

1. The date the matter was commenced;
2. Estimated length of hearing with reasons for the complexity or length;
3. Any urgency or other factors to be taken into account in according priority;
4. Available courtroom dates (if relevant);
5. Any additional criteria eg Interpreters, CCTV (remote witness).

This protocol is to commence on Monday 12 April 2010.

Graeme Henson
Chief Magistrate

Mary Jerram
State Coroner

Appendix C: State Coroner's Draft Protocol

Case management of mandatory inquests involving deaths of First Nations People

Part 1: Background

1.1 The final report of the Royal Commission into First Nations Deaths in Custody (**RCIADIC**) was published in 1991 and made 339 recommendations across a wide range of areas, including in relation to improvement of coronial processes.

1.2 The New South Wales Coroners Court recognises that, while the RCIADIC recommendations were handed down 30 years ago, there are still significant improvements that can be made to enhance the investigation of deaths of First Nations People in custody. The Coroners Court is committed to fully implementing the RCIADIC recommendations as they relate to coronial processes, and recognises the importance of maintaining cultural appropriateness at every stage of the investigation into the death of First Nations persons in custody, particularly in ensuring that the impact of the work of the Coroners Court on First Nations families does not perpetuate cycles of grief and loss.

1.3 The State Coroner's Protocol aims to enhance the implementation of, amongst others, Recommendation 8 of the RCIADIC *(Recommendation 8)*:

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

1.4. The Coroners Court has previously issued Coronial Practice Note 2, which addresses the case management of deaths or suspected deaths occurring in the following circumstances:

- While in custody of a police officer, section 23(1)(a) of the *Coroners Act 2009* (**the Act**);
- While escaping or attempting to escape from the custody of a police officer, s 23(1)(b); and
- As a result of police operations, s 23(1)(c).

1.5. However, given the focus of the RCIADIC, it is appropriate to implement Recommendation 8 through a Practice Note that specifically addresses deaths in custody of First Nations People, rather than taking a whole-of-population approach. The Protocol will not only provide directions regarding cultural considerations and standards in the investigation of deaths of First Nations People in custody in New South Wales, but, where applicable, will be relevant to the coronial processes relating to all reportable deaths of First Nations People that fall under the Act.

Part 2: Object and purpose of this Practice Note

2.2 This Protocol applies to all deaths or suspected deaths of First Nations People that enliven jurisdiction under s 23 of the Act.

2.3 The Protocol sets out the procedural requirements for the early listing and case management of reported deaths falling within [2.2].

2.4 The object of this Protocol is to ensure that:

2.4.1 All coronial investigations and mandatory inquests into deaths in custody of First Nations People are conducted in a timely and culturally appropriate manner, and

2.4.2 Families of First Nations People who have died in custody are provided with appropriate information and material regarding the status of the investigation into the death and the coronial process in a timely manner.

2.5 The Protocol will commence on XX XX 2021.

Part 3: Definitions

3.1 *Coronial brief:* refers to the brief of evidence compiled by the Officer in Charge.

3.2 *Officer in Charge:* refers to a member of the NSW Police Force nominated by the Chief Commissioner of Police or any other person nominated by the senior coroner to assist the senior coroner with his or her investigation into a reportable death. The Officer in Charge takes instructions directly from a senior coroner and carries out the role subject to the direction of a senior coroner.

3.4 *Family legal representative*: refers to the solicitor with carriage from the First Nations Legal Service NSW/ACT (**ALS**) or Legal Aid NSW (**Legal Aid**) who advises the senior next of kin (see [5.3]) or other legal representative(s) nominated by the family of the deceased person.

3.5 *First Nations People:* The term 'First Nations People' is used to refer to all First Nations and Torres Strait Islander people in Australia.

3.6 *Solicitor assisting the senior coroner:* refers to the solicitor from the Crown Solicitor's Office (**CSO**) or DCJ Legal (formerly, the Office of the General Counsel) who is instructed by the senior coroner to assist in relation to the conduct of the coronial proceedings following a determination of jurisdiction under s 23 of the Act (see [5.1]).

Part 4: Factors to be considered in the investigation into the death of a First Nations person in custody

4.1 The senior coroner will consider, when investigating the circumstances of the death of a First Nations person in custody, the quality of care, treatment and supervision of the deceased prior to death *(see RCIADIC Recommendations 12 and 35).* This will entail making specific directions to the Officer in Charge to provide a comprehensive coronial brief that includes statements from persons that can give evidence in relation to these factors.

4.2 The solicitor assisting the senior coroner will ensure that the family of the deceased, or if applicable their legal representative, are kept apprised of the progress of the investigation, including being consulted on proposed dates of hearings to ensure the family is able to attend *(see also RCIADIC Recommendations 21 and 22).*

Part 5: Stage One – Determination of jurisdiction and instructions

5.1 Upon receiving the report of a death or suspected death of a First Nations person in custody, a senior coroner is to:

5.1.1 Determine whether there is jurisdiction under s 23 of the Act, and if so, to instruct the CSO or DCJ Legal to assist in relation to the conduct of the coronial proceedings;

5.1.2 Ensure the Officer in Charge is contacted at the earliest possible opportunity to determine appropriate arrangements for:

- Obtaining statements (such as to facilitate witness interviews being held in a location other than a police station, or for the presence of support persons at interviews with family members where requested),
- The collection of time-critical evidence (such as CCTV footage), and
- Any other relevant issue that requires early direction.

5.2 A senior coroner is required to take the steps outlined in [5.1] within 48 hours of determining that a death or suspected death of a First Nations person comes within s 23 of the Act.

5.3 Within 24 hours of receiving instructions from a senior coroner in accordance with [5.1], the solicitor assisting the senior coroner will make contact with the ALS or Legal Aid to facilitate legal advice being provided to senior next of kin on their rights in relation to the coronial process.

Part 6: Process around post mortem and release of the body

6.1 In accordance with sections 88, 89 and 96 of the Act, the senior next of kin of a First Nations person who has died in circumstances set out in [2.2] will be consulted in relation to any cultural considerations around the proposed post mortem examination and release of the body (*see also RCIADIC Recommendation 38*).

6.2 It is expected that the final post mortem report will be available within 8 weeks of the death being reported to the senior coroner. If there is a delay for a post mortem report relating to the death of a First Nations person in custody, the solicitor assisting the senior coroner will ensure that the family is kept informed and the reason for any delay is explained.

Part 7: Stage Two - Preliminary report of the Officer in Charge

7.1 No later than two weeks after a senior coroner has determined jurisdiction under s 23 in accordance with Stage One, the forensic pathologist who conducted a post mortem examination, together with a Forensic Medicine social worker, is to meet with the solicitor assisting the senior coroner and the Officer in Charge to inform them of the forensic pathologist's findings from the examination.

7.2 No later than four weeks after a senior coroner has determined jurisdiction under s 23, the Officer in Charge is to provide a preliminary report of no more than five pages to the senior coroner and the Crown Solicitor's Office. This report is to outline and address the following:

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

7.2.2 The current status of the investigation,

7.2.3 Identified issues arising from the investigation,

7.2.4 The status of the brief of evidence including items outstanding,

7.2.5 The proposed date when the brief of evidence will be complete, and

7.2.6 A summary of the meeting with the forensic pathologist (outlined at [7.1]).

Part 8: Stage Three – Meeting with the family

8.1 **First family meeting**: within four weeks of a determination being made under s 23 in accordance with Stage One, a family meeting will be held.

8.2 The first family meeting is to be attended by:

- The senior next of kin (and other family members of the deceased person as appropriate in the circumstances),
- The family legal representative(s),
- The solicitor assisting the senior coroner,
- The Officer in Charge,
- A Coronial Information and Support Programme (CISP) social worker, and
- A Forensic Medicine social worker.

8.3 The purposes of the first family meeting are:

- To discuss the coronial process including timeframes,

- To demonstrate to families that the process will be aimed at being culturally appropriate, including through adherence to this Practice Note, and
- To discuss the initial findings of any post mortem examination

8.4 **Senior coroner's conference**: Upon receipt of the preliminary report the senior coroner will conduct a conference with the solicitor assisting the senior coroner and the Officer in Charge.

8.5 **Second family meeting**: Following the conference outlined in [8.3], the solicitor assisting the senior coroner will conduct a conference with the family of the deceased person and the family legal representative(s), if applicable. The forensic pathologist, Forensic Medicine social worker and CISP social worker are to attend.

8.6 The final post mortem report is to be available at the second family meeting, unless exceptional circumstances exist (for example, where there are complex forensic issues to be resolved and/or where an expert opinion is required). If a final post mortem report is not available at the second family meeting, the senior coroner must set a date by which it is to be provided at the first directions hearing (see [9.2]).

8.7 The senior coroner's conference and the second family meeting are to occur no later than 8 weeks after a senior coroner has determined jurisdiction under s 23 in accordance with Stage One.

Part 9: Stage Four – Directions Hearing

9.1 The case is to be listed in Court no later than 12 weeks after a senior coroner has determined jurisdiction under s 23 in accordance with Stage One for a directions hearing before the senior coroner. The case will then be case managed in accordance with s 49 of the Act.

9.2 At the first directions hearing:

9.2.1 The solicitor assisting the senior coroner is to advise the parties of likely witnesses and issues to be raised in the inquest. Any comments regarding the proposed witnesses and issues are to be provided to the solicitor assisting the senior coroner by interested parties no later than 4 weeks after the first directions hearing.

9.2.2 The senior coroner must set a timetable for the provision of statements from involved officer/s and/or correctional officers.

9.2.3 The senior coroner must set a date for provision of the final post mortem report, if it has not yet been made available.

9.4 At the second directions hearing, no later than 24 weeks after a senior coroner has determined jurisdiction under s 23 in accordance with Stage One, the matter should be listed for hearing.

Part 10: Court hearings – cultural considerations

10.1 Hearings will be convened in a culturally appropriate manner in consultation with family.

Teresa O'Sullivan
State Coroner
March 2021

ANNEXURE A: PRACTICE NOTE 3 - TIMELINE and OBLIGATIONS

	TIMELINE	OBLIGATION
STAGE 1 - [redacted]	48 hours after report of death	• Senior coroner to: – Determine whether death falls within s 23, *Coroners Act 2009* – If so, instruct CSO or OGC ('solicitor assisting') – Ensure OIC contacted to provide early direction re statements/CCTV.
	24 hours after senior coroner instructs solicitor assisting	• Solicitor assisting to contact ALS or Legal Aid to facilitate legal representation for SNOK
STAGE 2 – OIC [redacted]	2 weeks after s 23 determination	• Forensic pathologist and FM social worker to meet solicitor assisting and OIC to brief re forensic examination
	4 weeks after s 23 determination	• **OIC preliminary report** provided to senior coroner and solicitor assisting re – Status of investigation – Early identified issues – Status of brief – Proposed date for completion of brief – Summary of forensic examination briefing meeting
STAGE 3 – [redacted]	4 weeks after s 23 determination	• **First family meeting** to: – Explain coronial process – Discuss initial forensic findings
	8 weeks after s 23 determination	• **Senior coroner's conference** with solicitor assisting and OIC
		• **Second family meeting:** – To discuss OIC's preliminary report – Final post mortem report to be available
STAGE 4 – [redacted]	12 weeks after s 23 determination	• **First directions hearing:** – Solicitor assisting to advice of likely issues and witnesses – Senior coroner to set timetable for provision of statements and involved officers
	24 weeks after s 23 determination	• **Second directions hearing:** – Senior coroner to list matter for hearing

Appendix D: State Coroner Barnes's submission to Statutory Review (2014)

STATE CORONERS COURT

Review of the *Coroners Act 2009*

Submission by the State Coroner

[November 2014]

Contents

This submission is made on behalf of the state coroner and the deputy state coroners presiding at the Glebe Coroners Court.
It is in two parts: Part A details the structural and thematic issues of the *Coroners Act 2009* which, in our view, warrant reform. Generally, these are the more high-level issues. Part B contains the more precise or particular changes recommended.

Part A

1. Structure of the Act

It is submitted the structure of the Act should be reordered so that it follows the natural sequence of most coronial cases thus making the law more accessible. The following structure would achieve this.

- Preliminary – the objects of the Act; commencement date; reference to the dictionary.
- Reportable deaths defined, including locality jurisdiction.
- Obligation to report
- Coroners' jurisdiction to investigate
- Autopsies, orders and objections
- Powers of investigation
- Findings
- Inquests and inquiries
- Fresh inquests and inquiries, appeals
- Access to coronial documents and physical evidence
- Appointment of state coroner, deputy state coroners, local coroners, administration
- Miscellaneous

2. Coronial focus

In our submission, each step during the course of a coronial investigation should advance a legitimate coronial purpose and should be informed by all readily available information. This approach can be facilitated by amendments that enable the gathering of information from the scene, the family and the deceased's body prior to a coroner considering whether an autopsy is necessary. Similarly, amendments that ensure inquests are only convened when necessary enable a better use of limited resources.

3. Powers of investigation

A coroner's powers of investigation are extensive but incomplete and unclear in certain respects.

For example:-

- A coroner can authorise a police officer to enter, secure and search premises if the coroner considers it necessary for the purposes of an inquest, but not to establish whether there is in the premises a deceased person whose death is reportable to a coroner.

- A coroner can require a person to produce a document or thing relevant to an investigation but not to provide information by way of a statement.
- A coroner can make a non-publication order in relation to evidence heard in court or documents tendered into evidence but it is unclear whether a coroner can maintain confidentiality of material during the course of the investigation or release information to parties subject to a condition that it not be further disseminated.

It is submitted the investigative powers of coroners should be reviewed and rationalised so that coroners have ready access to the information they need to discharge their role while the interests of those who may be compelled to provide it are appropriately protected.

4. Inquest or dispense

The Act requires a coroner to hold an inquest into all reportable deaths unless an inquest is dispensed with. In NSW, as in all other Australian jurisdictions, less than 5% of deaths reported to a coroner go to inquest.

It is submitted it is illogical and unhelpful for the general rule and the exception provided for in the Act to be reversed in practice. It creates unrealistic expectations for family members and requires coroners to frame a principal case management decision in the negative.

Currently, inquests cannot be dispensed with unless the manner and cause of a death or a suspected death have been sufficiently ascertained by the investigation. This means that in numerous cases inquests must be held even though there is a very low likelihood that any further relevant information will be revealed. For example, every missing person case can only be finalised by an inquest.

These undesirable characteristics could be addressed if inquests were mandatory in particular categories of deaths – such as unnatural deaths in custody - and there was a general discretion to convene an inquest to be exercised with reference to stipulated criteria in all other cases.

In our view, inquests should be held only when there is a forensic or policy purpose. Accordingly, inquests should be held if a hearing is needed to attempt to resolve factual uncertainties in the circumstances of the death; to resolve differences among the opinions of relevant experts; or to explore possible changes to improve public health and safety.

5. Findings

Unless an inquest is held, a coroner can make no finding as to the manner of a death - i.e. whether the death was accidental, deliberate or self-inflicted - nor make findings as to any of the surrounding circumstances or issues. As a result, family members and other interested parties are deprived of a coroner's determination in relation to this central and primary focus of coronial investigations in all but a small percentage of cases.
It is submitted that coroners should be required to make finding in relation to the manner and cause of death in all cases, with or without an inquest, perhaps with the exception of natural causes deaths when the facts are not in dispute. The provision of comprehensive findings detailing the circumstances of the death would

complement a move away from mandatory inquests: families would get the information they deserve without the expense and delay of participating in a public hearing.

6. Interface between coronial and criminal

Coroners seek to establish facts about sudden and unnatural deaths, criminal courts determine criminal responsibility for them but the two jurisdictions cannot be completely separated, looking as they do at many of the same issues. The Act needs to more clearly provide for the articulation between the two and transmission back and forth between them.

7. Right of review

A coronial investigation sequences through clearly defined decisions points each of which impact upon interested parties: is the death reportable; should a cause of death certificate be issued; who is the ranking family member; what level of autopsy is warranted; should organs be retained; who is entitled to receive the body, etc? At each point those with sufficient interest should have access to a speedy and inexpensive right of review of the decision made by the case coroner.

It is submitted that right of review should at first instance be to the state coroner who should be obliged to provide reasons and then to the Chief Magistrate.

Part B

This part of the submission contains recommendations aimed at ensuring the objectives outlined in Part A can be achieved.

8. Objects of the Act

Although s3 as currently framed envisages coroners making recommendations, no purpose of those recommendations are articulated. Death prevention and improvements in public health and safety and the administration of criminal justice are now widely accepted as key coronial functions. In our submission the objects clause of the Act should give due prominence to this role. See s1(d) of the *Coroners Act 2008* (Vic) and s3(d) of the *Coroners Act 2003* (Qld) for examples.

9. Reportable death

The definition in s6 should be expanded to include all deaths which enliven a coroner's jurisdiction including a death in a police operation and a death in custody (s 23) and a death of a child known to FaCS and a disabled person receiving state funded residential services (s24).

The definition of a health care related death should be clarified to make clear that the assessment of whether a death was unexpected should focus on what was known before the procedure that led to death was undertaken and relate to what an independent, properly informed clinician would expect – see the provisions in Victorian Queensland coronial legislation.

Death in custody and death in police operation should explicitly include deaths associated with Commonwealth agencies.

"Custody" should be more clearly defined to make clear whether it includes a person being held in protective custody. For example, in our submission it should include when a person is being held in a mental health facility under an involuntary treatment order.

The definition of death in a police operation should be clarified to stipulate that there needs to be some causal connection between the actions or inactions of the involved police officers and the death. Currently, it is unclear whether concerns about a person's welfare coming to police attention before the person dies the death necessarily results in the death being a death in a police operation.

There should be added to the definition of reportable death, a death where a cause of death certificate has not issued and is unlikely to issue in the near future.
Consideration should be given to including the locality jurisdiction within the definition of reportable death so that a death is not reportable unless it is of the type or occurs in the circumstances described in s6 and it has the requisite connection with NSW.

10. Senior next of kin

A mechanism for resolving competing claims to be recognised as the senior next of kin by relatives on the same level in the hierarchy of consanguinity provided for in the Act would spare blended and fragmented families added distress. For example, who is the ranking relative when a person is married to one person but living in a de-facto relationship with another and why should either have to initiate proceedings in the Supreme Court to clarify the issue?

In our submission the Act should explicitly give the power to the case coroner to decide this question with a right of review by the state coroner and chief magistrate as necessary.

11. Jurisdiction to investigate

A coroner should be authorised to investigate whether a particular death is a reportable death and a person dissatisfied with the coroner's ruling in that regard should be entitled to have it reviewed, initially by the state coroner, if the ruling was made by another coroner, and the chief magistrate if the person remains dissatisfied or if the initial ruling was made by the state coroner.

In our submission, the jurisdiction should be framed in terms of a coroner being authorised to investigate the death with a view to determining whether it is reportable and/or, if so, to make findings as to the manner and cause of the death, rather than jurisdiction to convene an inquest. As detailed below, an inquest should be seen as part of an investigation to be utilised when necessary or otherwise appropriate.

12. Powers of investigation

Notice to produce a thing

Currently, the power to require production of a thing to the coroner is provided for in s 53 and s 66 in terms that are not identical or mutually exclusive. This should be rationalised. A coroner should be authorised to require production of anything relevant to the death investigation, subject to a claim of client privilege, privilege against self-incrimination or public interest immunity.

Notice to produce a statement

In our submission, a person whom a coroner considers his likely to have information relevant to an investigation should be required to create and produce a statement detailing his or her knowledge of the issues identified in a notice requiring the statement. The recipient of such a notice should be able to claim privilege against self-incrimination and the coroner should in response be able to utilise the s 61 certificate provisions as modified to suit these circumstances.

Self-incrimination

In our submission s 61 is unnecessarily complicated in its current form and unclear in its application as a result of the recent decisions of the NSW Court of Appeal *in Rich v AG of NSW* and the High Court in *X7* and *Lee*.

There seems little utility in offering to allow a witness to give oral evidence with the protection of a certificate after they have objected to doing so on the basis that they may incriminate themselves.
Further, doubts about the legitimacy of "global" objections should be clarified and the uncertainty about the factors which should be considered when determining whether the interests of justice require the witness to give the evidence of concern should be resolved.

In our submission, the scheme could be simplified as follows: the witness raises the objection; the coroner indicates whether he/she accepts there are reasonable grounds; if the objection is accepted, the coroner indicates whether he/she considers the giving of the evidence is nonetheless in the interests of justice; if so, the coroner indicates a certificate will be provided and directs the witness to answer the questions in relation to specified topics.

In our submission the risk of compromising an accused's right to a fair trial as discussed in *X7* and *Lee* is slight provided the coroner focusses on matters connected with the death: in almost all cases the witness will have given a detailed account when being interviewed, either voluntarily or under direction, and that account will usually have exculpated the witness (they would have been charged otherwise and the inquest would not have proceeded.) Further, it is usual to first call the witnesses less involved in the death than the "principal actors" so by the time the objection is made the coroner will have a good understanding of all of the available evidence and the risk the objecting witness might face if required to give evidence.

The family of the deceased and the public generally, have a significant interest in being apprised of all of the circumstances of a violent or unnatural death. Frequently, the person most involved in the death is best placed to provide that information. It should not be supressed when there is little or no chance of the information being used to prevent a witness obtaining a fair trial.

In view of the authorities referred to above, the Act should expressly authorise a coroner to direct a witness with the benefit of a certificate to answer questions about the death in question unless there is a real likelihood that the witness could be charged with causing the death.

13. Autopsies

In our submission an autopsy examination should be the least invasive necessary to serve coronial purposes; should be based on consideration of all relevant information; and should take account of the deceased person's family's view about autopsies. The following recommendations seek to increase the likelihood of that occurring.

Preliminary examination
Officers of the NSW Police Force, and staff employed by the Department of Forensic Medicine (DoFM) and NSW Health should be authorised to undertake a number of steps in relation to a reportable death without a coroner needing authorise them so as to minimise the delay before the body can be returned to the family by ensuring all necessary information is available to the coroner in a timely manner. Currently, very little is done before the coroner first assesses a new matter as no power exists to do so.

In particular, it is submitted:-

- A police officer who reasonably suspects there may be a deceased person in any place should be authorised to enter and search the place in order to report the death to a coroner and to commence the coronial response.
- A police officer who discovers a deceased person whose death he or she believe must be reported to a coroner should be authorised to search the place where the body is found and seize anything he or she believes will be relevant to the investigation of the death by the coroner.
- A police officer should be authorised to direct that a body be transported to a place where a coronial autopsy can be undertaken.
- A police officer should be entitled to require a hospital or medical practitioner to provide medical records relating to a deceased whose death has or is to be reported to a coroner.
- DoFM staff members should be authorised to:-
-
    - receive and peruse the initial report by police to the coroner (the form P79A);
    - undertake a non-invasive external examination of the body;
    - receive and peruse medical records relating to the deceased;
    - take samples of bodily fluid including blood, urine, saliva and mucus from the body (which may require an incision to be made) and the testing of those samples;
    - take images of the body including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography;
    - take samples from the surface of the body including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin and the testing of those samples;
    - take sample of fingerprints of the body; and
    - undertake any other procedure that is not a dissection or the removal of tissue.

Tissue donation
Coroners' cases are a major source of tissue used by the various tissue banks – heart valves; skin; retinas; bone sections etc. Pursuant to the *Human Tissue Act* retrieval of such material from the body of a deceased person whose death is reportable requires the consent of the family of the deceased, the forensic pathologist who will undertake the autopsy and the coroner. Retrieval of this material is time critical. In order to determine whether

the deceased person is a suitable donor tissue bank staff need to view the body and review medical records and any available social history of the deceased.

In our submission the Act should authorise tissue bank staff members to access documentary material in possession of the coroner and the DoFM and to make an external examination of the body, provided they comply with any limitations the case pathologist may stipulate.

Type of autopsy – least invasive

In our submission, the Act should require a coroner to specify whether a medical records review, an external, partial internal or full internal autopsy should be undertaken. The obligation on the person undertaking the examination to use the least invasive procedure (s 88(2)) should be maintained and extended to coroners.
A coroner should whenever practical be required to consult with a forensic pathologist when determining whether an autopsy should be ordered and if so the extent of the autopsy.

Family concerns

The current provision enabling the senior next of kin to make a written request that a coroner not make an autopsy order (s 96) is impractical and fails to provide effective in-put by the family. In practice, it has been circumvented by requiring the police officer who reports the death to ascertain whether the family objects to an autopsy. When this isn't done, staff from the coroners' office contact the senior next of kin by telephone.
In our submission this should be regularised by amending the Act to require the coroner to have regard to any concerns the family may have about an internal autopsy, whenever it is practical* to do so, if the coroner is inclined to order an internal examination. The mechanism for ascertaining the family's views should be provided for by a practice note or direction by the State Coroner.

If the family objects to an internal examination and the coroner considers it necessary having regard to advice received from a forensic pathologist, a speedy and informal resolution mechanism is necessary. This should be a review by the state coroner unless he/she has made the initial decision, in which case the review should be by the chief magistrate.

Families' concerns, if any, about the retention of whole organs after autopsy should also be considered, if practical,* when the coroner is determining whether to authorise the retention.

*In both cases, "if practical" should be defined to exclude cases where seeking the family's views, or alerting the family to the reason for the internal autopsy or retention of organs is likely to unduly delay or otherwise compromise the investigation.

Pathologist to report to BD&M

When an autopsy is ordered, the medical practitioner undertaking it should be required to provide to the Registrar of Births Deaths and Marriages sufficient information to enable the death to be registered, including the cause of death if it is known. This would significantly reduce delays in the provision of a death certificate to the family. If the subsequent coronial investigation leads to the coroner coming to a different conclusion as to any of the particulars of the death, the register can be amended when the coroner's file is finalised.

Second or subsequent autopsies

The Act in s 89(1)(d) provides that a coroner may order another examination of the deceased person's body but only *"if it appears to the coroner that the cause of death of the deceased person has not been satisfactorily explained by a report given pursuant to a previous post mortem examination direction"* . In practice, second or subsequent autopsies are usually conducted at the request of the family of the deceased person because they lack confidence in the independence of state government pathologists and wish to engage a pathologist themselves.

In our submission, coroners should have a general power to order a second or subsequent autopsy when it is in the public interest to do so and subject to consideration of any objection by the senior next of kin.

14. <u>When to inquest?</u>

In our submission an inquest should be mandatory if:

- a person dies an unnatural death while in custody;
- a person dies a natural death while in custody and the coroner has concerns about the quality of the health care provided to the deceased;
- a person is known or whose family is known to FaCS in the s 24 sense and the coroner has concerns that the quality of the health care or supervision provided to the deceased may have contributed to the death;
- a disabled person, in the s24 sense, dies and the coroner has concerns that the quality of the health care or supervision provided to the deceased may have contributed to the death; and
- an unnatural death occurs in the course of a police operation and the coroner considers that police action or inaction may have contributed to the death.

In all other cases, an inquest should be at the discretion of the coroner, having regard to whether it is likely a hearing could better ascertain the manner and cause of death or it is in the public interest because it is likely to facilitate the making of preventative recommendations.
Any person with sufficient interest should be entitled to request an inquest be convened and the coroner to whom it is made must either grant the application or provide details as to why he/she is not prepared to do so. The applicant should be entitled to have that decision reviewed by the state coroner. If the person remains dissatisfied or if the initial ruling was made by the state coroner, the review or further review should be undertaken by the Chief Magistrate.

15. <u>Chamber findings</u>

Currently, unless an inquest is held, a coroner makes no findings as to the manner of death. This means the family and other interested parties receive no considered information about how the death occurred or the circumstances in which it occurred.

In our submission a coroner should make findings in relation to identity, date, place, cause and manner of death in all cases, whether or not an inquest is held.

Following consultation with the family, and in-put from the reporting police and a pathologist, a coroner should be authorised to make findings without an autopsy if there is sufficient information to do so. Further, if the

family does not request an autopsy be undertaken, in cases that are not suspicious and do not raise issues of public interest, a coroner should be authorised to find that a person died from unascertained natural causes. The Act currently seems to authorise these procedures in s 25, s 35(2) and s 89 but it is far from clear.

16. Re-opening investigations and fresh inquests

Currently, the Act provides in s29 that the State Coroner can direct a coroner who has dispensed with an inquest to hold an inquest. Pursuant to s 83(4), the State Coroner can also order that a fresh inquest be held if an application is made by a police officers or a party to a previous inquest and the state coroner is of the opinion the discovery of new evidence makes it desirable to hold a fresh inquest.

In our submission these provisions do not provide sufficient flexibility to meet the reasonable needs of interested parties and the community. Further, if the recommendations for chambers findings are accepted a mechanism for setting such findings aside would be necessary.

Accordingly we submit that a coroner who has conducted an investigation and made findings should be authorised to re-open the investigation if he/she concludes the circumstances of the death warrant further investigation or new evidence casts doubt on the findings.

On his or her own initiative or on application of any person with sufficient interest, the state coroner should be authorised direct the coroner who has investigated a matter and made findings to re-open the investigation.
If an inquest has been held the coroner who conducted it should be authorised to re-open it if satisfied that new evidence casts doubt on the findings or re-opening is otherwise in the public interest. The state coroner should be authorised to direct that an inquest be re-opened on the same grounds.

17. Referral to prosecution and disciplinary authorities

Although for hundreds of years coroners played a central role in transitioning suspects into the criminal justice system, in the latter part of the 20thC, what we consider to be undue sensitivity led to a winding back of this aspect of a coroner's role.

In NSW, the 1980 Act provided that a coroner was required to terminate an inquest when a prima facie case was made out and to refer the matter to the DPP. Amendments to that Act have been carried forward in the 2009 legislation so that there is no longer an obligation to terminate, but rather an inquest *may* be suspended if the current committal test (prima facie case and reasonable prospects of a conviction) is reached.

Alternatively, the coroner may complete the inquest and make findings in relation to all matters before referring the matter to the DPP.

In our view, having regard to the prohibition on a coroner making a finding suggesting that an offence has been committed – s 82(3) - there is little basis for concern that an inquest will undermine a person's right to a fair trial, should one eventuate. Coroners find facts, juries determine questions of guilt. The two are easily kept separate.

In our submission the Act should require a coroner to refer cases for the consideration of prosecuting authorities whenever it appears a prosecution might be warranted. This function can be exercised independently of a coroner's duty to make findings, either with or without an inquest.

Equally, if as a result of considering the evidence gathered during an investigation or inquest, a coroner concludes disciplinary or remedial action may be warranted in relation to a government employee or the member of a profession the coroner should, in our submission, have explicit authority to refer the material to the person's employer or professional regulatory body for consideration of such action.

18. Release of coronial documents

People seek access to documents or things in the possession of a coroner for a variety of reasons. In our submission the response of a coroner to such requests should depend upon the nature of the document or thing sought, the interest of the requester and the purpose for which it is proposed the accessed document or thing will put.

During the course of an investigation, a person should only be granted access to a document or thing in the coroner's possession if:

- the coroner is satisfied the person has sufficient interest;
- the granting of access will not prejudice the investigation, undermine a person's right to a fair trial; or
- there appears no basis on which the person or organisation who prepared or supplied the document or thing might claim public interest immunity or some other privilege in relation to it.
- In these last category of cases the document or thing should not be released without allowing that person or organisation to be heard on whether the release should proceed.

If an applicant for access does not have sufficient interest in the thing sought in the legal sense but seeks it to utilise for research the coroner should be required to satisfy him or herself that the researcher has ethics approval from a recognised research institution and that there are in place appropriate mechanisms to protect the confidentiality of the material.

The coroner should be authorised to release the material subject to conditions. For example, it will usually be appropriate to release material to parties participating in an inquest on the condition that it be used for that purpose only and not further disseminated.
Generally, once a document or thing has been tendered into evidence in an inquest it should be freely available, subject to the coroner being able to make non publication orders in relation to any material or part of it.

19. Control of the body

The Act should make explicit that the coroner has control of the body from the time the death is reported to the coroner until he/she rules that the death is not reportable or determines that possession of the body is no longer necessary for the purposes of the coronial investigation and orders its release to the senior next of kin.

That control should extend to directing the body remain in a particular mortuary while the coroner makes an informed decision as to whether an autopsy is necessary. Unnecessary removal of bodies from their communities of residence adds to the distress of the bereaved and a significant waste of public resources.

20. A Coronial Council

It is trite to observe that coroners deal with very sensitive matters and make determinations about matters which are highly subjective and may involve complex cultural issues. Coroners are lawyers, not necessarily knowledgeable in these matters.

Of course they receive assistance in individual cases from the various disciplines that participate in the coronial processes but more general advice from a policy perspective is not readily available.

In our submission a body of relevant experts: pathologists; clinicians; lawyers; police; and representative from the larger ethnic communities could make a valuable contribution and reassure coroners that their decisions are consistent with informed community expectations. The Coronial Council of Victoria, established by s109 of that state's Coroners Act, is an apposite example.