Submission No 18

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: NSW Government

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The Hon Adam Searle, MLC
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Dear Mr Searle

Select Committee on the coronial jurisdiction in New South Wales

I write in relation to the Legislative Council Select Committee on the coronial jurisdiction in New South Wales and enclose a submission to the inquiry on behalf of the NSW Government.

Thank you for your consideration of this matter. I look forward to the Committee's report.

If you have any questions or would like to discuss, please do not hesitate to contact me on or at

Yours sincerely,

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NSW Government Submission

Select Committee on the coronial jurisdiction in New South Wales

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Overview of the coronial jurisdiction

The coronial jurisdiction aims to ensure that all sudden, unexpected or unexplained deaths, suspected deaths, fires and explosions are properly investigated. The *Coroners Act 2009* (the Act) provides the legislative framework for the coronial jurisdiction in New South Wales (NSW).

The NSW Government recognises that the sudden, unexpected or unexplained death of a loved one can result in significant emotional, health, financial and/or social impacts for families and communities. The coronial jurisdiction must not add to this burden. It is critical that services are delivered in a professional and timely manner, which upholds the dignity of the deceased person and ensures respect for their family and friends.[1]

In NSW, the coronial pathway involves three NSW Government agencies: the Department of Communities and Justice (DCJ), NSW Health Pathology (NSWHP) and the NSW Police Force (NSWPF). Several stakeholder groups are also involved, including hospital and residential care facilities, transport services, funeral directors and primary and specialist clinicians.

The Coroners Court forms part of the NSW Local Court. All Magistrates, by virtue of their office, are coroners. The State Coroner is responsible for the oversight and coordination of coronial services across NSW, with the assistance of those Magistrates who are appointed as Deputy State Coroners. Other Magistrates may also perform coronial functions in relation to regional deaths. The jurisdiction's state headquarters are located at the Forensic Medicine and Coroners Court Complex in Lidcombe, Sydney.

Once a death has been reported to the coroner, the coroner is required to confirm the death occurred and make findings as to the identity of the deceased, the date and place of death, and the cause and manner of death. The coroner may also make recommendations in relation to matters connected with the death, such as public health and safety issues.

The NSWHP Forensic Medicine Service (Forensic Medicine) supports the coroner by providing a highly specialised coronial post-mortem examination service. Forensic Medicine has dedicated facilities in Sydney, Newcastle and Wollongong.

The NSWPF is responsible for investigating all reportable deaths at the coroner's direction, some of which may lead to an inquest (a court hearing to explore any unresolved issues) and a coronial brief of evidence being compiled. Specialist Police Prosecutors may assist the coroner during inquests and inquiries.

The three key agencies in the coronial pathway are interdependent. The quality and timeliness of the coronial process relies on complex workflows, processes and procedures, as outlined in the coronial pathway roadmap at **Tab A**.

[1] The core values underpinning the work of the Coroners Court are set out on its website at the following link: https://www.Coroners.nsw.gov.au/Coroners-court/history-and-values/values.html.

Context to assist this inquiry

The Improving the Timeliness of Coronial Procedures Taskforce

In July 2019, the NSW Government established the Improving the Timeliness of Coronial Procedures Taskforce (the Taskforce) to identify ways to reduce delay in coronial procedures and improve the experiences of families and loved ones.

Members of the Taskforce include senior representatives from the NSW Ministry of Health (NSW Health), NSWHP, NSWPF and DCJ. The Taskforce's work plan aims to achieve four objectives:

1. Reduce the over reporting of natural deaths;
2. Reduce delays in the release of deceased persons;
3. Reduce delays in finalising post-mortem reports; and
4. Improve communication with families.

The Taskforce has identified and begun implementing a range of initiatives intended to improve the timeliness of the coronial system. These initiatives include:

- education and support for general practitioners on issuing Medical Certificates of Cause of Death (MCCDs);
- increased forensic pathologist, social work and clinical nurse consultant resources;
- extensive engagement with external stakeholders, including funeral directors;
- statutory reforms to the Act; and
- process and workflow improvements.

The Taskforce has also overseen the implementation of centralised coronial decision-making for regional deaths, which was introduced by the State Coroner in March 2020 in response to the COVID-19 pandemic. Under this model, the function of making coronial directions for regional deaths has been centralised and allocated to a Deputy State Coroner at the Lidcombe Coroners Court. This is intended to streamline the initial triage process and enable coroners to make informed, timely decisions. The model has resulted in reduced delays in the return of deceased persons for regional families.

The Taskforce is expected to conclude by the end of 2021, as many of its initiatives are now either in the implementation phase or complete. It is proposed that the Coronial Services Committee, an interagency committee chaired by the State Coroner, will have oversight of the implementation of Taskforce initiatives beyond 2021.

The Taskforce is currently preparing a progress report. As the Taskforce's ongoing work bears on the question of whether the Act's policy objectives 'remain valid' and its terms 'remain appropriate for securing those objectives' (see s 109(1) of the Act), DCJ intends to progress the statutory review of the Act once the Taskforce has concluded, with the benefit of the Taskforce's findings.

DCJ has actively considered issues raised during stakeholder consultation and progressed several amendments to the Act, including:

- An amendment to remove the requirement to report a death to the coroner where the only basis for reporting was that the deceased person had not seen a medical practitioner in the six months prior to death. The amendment was intended to reduce the overreporting of natural cause deaths and ensure coronial resources are appropriately focused on deaths that warrant coronial scrutiny;
- An amendment to allow forensic pathologists to undertake preliminary examinations of deceased persons without the need for a direction from the coroner. This amendment was intended to reduce delays in the return of deceased persons to their families.

These amendments were progressed as Sch 1.4 of the Justice Legislation Amendment Bill 2019, which received assent on 26 September 2019 and commenced on 20 January 2020.

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

The Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody has made five recommendations related to the coronial jurisdiction (Recommendations 30-34).

The NSW Government will carefully consider the findings and recommendations of the Select Committee and prepare a final response in due course.

The Special Commission of Inquiry into the Drug 'Ice'

The Special Commission of Inquiry into the Drug 'Ice' has made one recommendation related to the coronial jurisdiction (Recommendation 106).

The NSW Government is committed to developing a meaningful and substantial response to the Special Commission. This recommendation is being considered in this context.

The National Coronial Information System

The National Coronial Information System (NCIS) is the national database of mortality data reported to a coroner in Australia and New Zealand. The NCIS supports the work of coroners, death investigators, researchers and the broader community.

The NCIS relies on financial contributions from all Australian states and territories, and New Zealand and Commonwealth agencies for core funding. In FY2020/21, the NSW annual contribution was $165,008.

The NCIS provides bespoke reports at the request of coroners on specific issues to assist the conduct of inquests, as well as regular data reporting to support court governance and caseload management.

Terms of Reference

(a) The law, practice and operation of the Coroners Court of NSW, including:

(i) the scope and limits of its jurisdiction

Coroners have jurisdiction to investigate certain categories of deaths prescribed under the Act. These include:

- reportable deaths (s 6);
- deaths in custody or as a result of police operations (s 23);
- deaths of children and persons with disability (s 24); and
- deaths that are subject to mandatory inquests (s 27).

A particular death may fall within one or more categories.

Reportable deaths

Section 21 of the Act provides that a coroner has jurisdiction to hold an inquest regarding a 'reportable death' as defined in s 6, or where a death certificate is not issued by a medical practitioner. Reportable deaths are:

- violent or unnatural deaths;
- sudden deaths the cause of which is unknown;
- deaths in unusual or suspicious circumstances;
- deaths that are not the 'reasonably expected outcome of a health-related procedure'; and
- deaths of patients who were resident in mental health facilities, including patients who were temporarily absent.

Where a death is reported to the coroner under s 6, the coroner decides what kind of investigation is necessary. This decision-making process is supported by the interagency triage model discussed below. Most coronial proceedings can be finalised by the coroner without the need for an inquest. In 2020, less than 2% of all matters (112 matters) were subject to inquest.[2]

Mandatory inquests

A coroner (or, where required, a Senior Coroner) is required to hold inquests in certain circumstances (i.e. mandatory inquests) under s 27 of the Act. These circumstances include:

- suspected homicides (not including suicides);
- deaths in custody or police operations as prescribed under s 23; and
- cases in which the evidence presented to the coroner does not sufficiently disclose any of the following: whether the person has died, the identity of the deceased person and the date and place of death, or the manner and cause of death.

Deaths in custody or as a result of police operations

A Senior Coroner (the State Coroner or a Deputy State Coroner) has jurisdiction under section 23 of the Act to hold an inquest concerning the death or suspected death of a person:

[2] 2020 Local Court of New South Wales Annual Review.

- while in the custody of a police officer or in other lawful custody;
- while escaping, or attempting to escape, from the custody of a police officer or other lawful custody;
- as a result of police operations;
- while in, or temporarily absent from, any of the following institutions or places of which the person was an inmate—
    - a detention centre within the meaning of the *Children (Detention Centres) Act 1987*
    - a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*;
    - a lock-up; and
- while proceeding to an institution or place referred to above for the purpose of being admitted as an inmate of the institution or place and while in the company of a police officer or other official charged with the person's care or custody.

Inquests into deaths in custody and police operations have been mandatory since the 1991 Royal Commission into Aboriginal Deaths in Custody, which recommended that:

- all deaths in custody be required to be the subject of a coronial inquiry that culminates in a formal inquest. Such inquests should be conducted in public hearings 'unless there are compelling reasons to justify a different approach'; and
- a coroner inquiring into a death in custody must investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased person prior to death.

Since the Royal Commission into Aboriginal Deaths in Custody, the definition of a death in custody has been expanded to cover situations in which a person dies during an attempt to escape custody, or during a police operation. This expansion was to provide for a mandatory inquest into all cases involving police or correctional staff, codifying coronial practice and to satisfy concerns raised by the Royal Commission.

Inquests into deaths in custody or as a result of police operations must be conducted by a Senior Coroner, which is defined to include the State Coroner and Deputy State Coroners (s 22(1)).

Other inquests which may only be conducted by a Senior Coroner

Section 24 provides that only a Senior Coroner has jurisdiction to conduct an inquest into certain deaths of children and persons with disability. This includes the death of:

- a child in care, or a child whose death is or may be due to abuse or neglect or that occurred in suspicious circumstances; and
- a person who was living in, or temporarily absent from, supported group accommodation or an assisted boarding house.

The overreporting of natural cause deaths

Medical professionals can issue a MCCD if they are 'comfortably satisfied' as to the likely underlying cause of a natural death. There are limited circumstances in which a medical professional should not issue a MCCD and should instead report a death to the coroner. These include violent or unnatural deaths, a sudden death the cause of which is unknown, or deaths under suspicious or unusual circumstances.

Despite this, natural cause deaths account for approximately 60% of deaths reported to the coroner each year. In 2019, this represented approximately 3,980 cases out of a total of 6,525 deaths (or 61% of cases) reported to the coroner.

To ensure that coronial resources are appropriately focused on deaths which warrant the scrutiny of the coroner, the Taskforce has identified a need to reduce the overreporting of natural cause deaths. This objective is also expected to improve timeliness by alleviating pressures across the coronial system.

The Taskforce has progressed numerous initiatives intended to achieve this objective. As discussed above, this included working with DCJ to progress an amendment to the meaning of 'reportable death' in s 6 of the Act to remove the requirement to report a death on the basis that the deceased person had not seen a medical professional in the six months prior to their death. This amendment commenced on 20 January 2020 and appears to have resulted in a modest reduction in the overreporting of natural deaths to the coroner, according to a survey of general practitioners undertaken by NSW Health.[3]

Qualitative and quantitative reviews of certain categories of death

A central tenet of the coronial jurisdiction is the prevention of future loss of life. The coronial jurisdiction is engaged in a number of initiatives intended to identify systemic issues arising across particular categories of death. This contributes to policy developments aimed at improving service responses to prevent future loss of life.

The Domestic Violence Death Review Team

The Domestic Violence Death Review Team (DVDRT) reviews deaths occurring in the context of domestic violence, in order to identify opportunities for intervention or prevention.

The DVDRT was established in 2010 under Part 9A of the Act. It is convened by the State Coroner and brings together representatives from key government agencies as well as non-government service providers and sector experts. The DVDRT reports to the NSW Parliament biennially, setting out findings and recommendations for reform.

In its 2017-2019 report, the DVDRT recommended that its remit be expanded by amending the definition of 'domestic violence death' in s 101B of the Act (Recommendation 33). The intention of this recommendation was to ensure that the DVDRT has power to review all deaths which occur within the context of domestic violence, including deaths due to the acts of an intervening third party (such as police), deaths by suicide, and deaths where an incident of domestic violence was one of multiple contributing factors.

The NSW Government has responded to the report and indicated in principle support for this recommendation.[4] DCJ is consulting with stakeholders about possible options for reform.

Deaths in custody or as a result of police operations

As noted above, s 23 of the Act stipulates that if a person dies during the course of a police operation or while in custody, the death must be reported and an inquest must be conducted by the State Coroner or a Deputy State Coroner into the circumstances of the death.

Section 37 requires that the State Coroner make a written report to the Attorney General containing a summary of such deaths for each twelve-month period. The Attorney General is required to table the report within 21 days. The 2020 report was tabled on 21 May 2021.

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[3] This amendment was progressed as Sch 1.4 of the *Justice Legislation Amendment Bill 2019.*
[4] The NSW Government Response to DVDRT 2017-2019 Report Recommendations, available at: https://Coroners.nsw.gov.au/documents/reports/NSW_Government_Response_to_the_DVDRT_2017-19_Report_Recommendations.pdf.

This year, the State Coroner presented to the Attorney General an additional report regarding First Nations People's Deaths in Custody in NSW over the period from 2008 until 2018. The First Nations People's Deaths in Custody in NSW report was tabled on 21 May 2021.

Deaths by suicide

The NSW Suicide Monitoring System (the System) was established as a joint project between DCJ, NSW Health, the State Coroner and the NSWPF. The System is a database which collects and reports information on confirmed and suspected suicides, using data collected by NSWPF and the State Coroner. The objective of the System is to contribute to policy development and service responses aimed at reducing the suicide rate in NSW.

Stage 1 of the System was launched in November 2020 and facilitates the collection of basic demographic information about the deceased person and the event. Stage 2 of the System, which is currently under development, will include an enhanced set of data including more detailed information about the psychological stressors a person may have been experiencing in the lead up to the event, such as medical reports, witness statements, and information about contacts with government and non-government services.

System reports have been published and are available on the NSW Health website at: https://www.health.nsw.gov.au/mentalhealth/Pages/suicide-monitoring-system.aspx .

Defence and Veteran Suicides

On 19 April 2021, the Prime Minister, the Hon Scott Morrison MP, announced the establishment of a Royal Commission into Defence and Veteran Suicide.

The Australian Government has also committed to establishing the National Commissioner for Defence and Veteran Suicide Prevention (the National Commissioner) as an independent statutory office holder. The National Commissioner will work to identify and understand the factors and systemic issues that may contribute to suicide risk among serving and former Australian Defence Force (ADF) members, and make recommendations to government about actions and strategies relevant to ADF member or veteran deaths by suicide.

The NSW Government is committed to supporting the work of the Royal Commission into Defence and Veteran Suicide and the National Commissioner, including through the work of the coronial jurisdiction.

The coronial jurisdiction has already made adjustments to improve its capacity to collect relevant data on Defence and veteran suicides. In March 2021, DCJ updated the JusticeLink case management system to enable an individual's ADF status to be recorded. This information is also collected in the System.

(ii) the adequacy of its resources,

Current resourcing of the coronial jurisdiction

The coronial jurisdiction is jointly funded by DCJ, NSW Health and the NSWPF.

Resourcing for the Local Court will receive a boost in the 2021-22 Budget, which will provide funding for eight additional Magistrates. As noted above, all Magistrates, by virtue of their office, are coroners. One of the eight new magistrates has been assigned exclusively to the coroner's jurisdiction.

Additional resources for the coronial jurisdiction include the enhancement of the Coronial Case Management Unit (CCMU), which will improve coronial services for grieving families by reducing

delays in the return of the deceased to their family, minimising the numbers of intrusive post-mortem examinations, and improving the quality and timeliness of information and support for family members.

In FY2019/20, according to data from the Report on Government Services (RoGS) 2020:

- The real recurrent expenditure of the NSW Coroners Court was $7,161,000 (Table 7A.12);
- An additional $8,311,000 was expended on autopsy and forensic science, which includes the costs for autopsy, forensic science, pathology tests and body conveyancing fees (Table 7A.12); and
- There were 5.3 FTE judicial resources allocated to the NSW Coroners Court (Table 7A.28). This includes:
    - five FTE Senior Coroners (the State Coroner and Deputy State Coroners) located at the Forensic Medicine and Coroners Court Complex in Lidcombe, Sydney; and
    - two Magistrates, who hold commissions as Deputy State Coroners and perform coronial duties on a part-time basis in addition to their usual judicial duties. Each is allocated to carry out coronial duties approximately one day per week, which is recorded as equivalent to 0.3 FTE judicial resources.

DCJ has indicated that in addition to judicial resources, there are currently 20 FTE registry staff and 6 FTE other court staff at the Forensic Medicine and Coroners Court Complex in Lidcombe. This includes the Manager of Coronial Services, Registrar, Deputy Registrar, Registry officers, CCMU and the DVDRT.

RoGS 2020 data for the NSW Coroners Court does not capture the full expenditure of the coronial jurisdiction. For example, the reported expenditure does not include:

- the costs of government assisted burials/cremations;
- legal fees incurred in briefing counsel assisting for inquests;
- the costs of representation in related legal matters, such as Senior Next of Kin disputes; or
- the costs of preparing matters for inquest, including the costs of obtaining independent expert reports.

This differs from data reported by other jurisdictions such as Queensland and Victoria, which do include such costs within their expenditure figures (Table 7A.12, footnote (d)).

Because the NSW Coroners Court forms part of the Local Court structure, it is able to draw to some extent on general resourcing for this jurisdiction. For example, the NSW Coroners Court may take advantage of judicial education resources and administrative functions and costs which are shared across the Local Court jurisdiction. While coroners located in Lidcombe perform the majority of the state's coronial work, Local Court Magistrates offer an important supplement by carrying out a proportion of coronial investigations and inquests for regional deaths.

The 2020 Local Court of New South Wales Annual Review includes data that demonstrates how coronial work is divided between metropolitan Senior Coroners and regional Magistrates, acting in their capacity as coroners:[5]

	Lidcombe	**Other State-wide**	**Total**
Deaths reported	3540	2834	**6374**
Investigations finalised	3829	3211	**7040**
Inquests/inquiries	94	18	**112**
Fires reported	148	54	**202**

Efficiency and finalisation rates

RoGS 2020 data provides the following clearance data for the NSW coronial jurisdiction, as compared with Queensland and Victoria:

RoGS 2019/20 – Coroners Court	**NSW**	**Vic**	**Qld**
Finalisations, deaths reported	6 862	6 841	5 744
Cases finalised < 12 months (Table 7A.23)	83.6%	81.8%	80.4%
Cases finalised < 24 months (Table 7A.23)	97.0%	94.5%	93.1%
Clearance indicator (Table 7A.26)	104.7%	93.4%	102.0%

The Taskforce and Coronial Services Committee continues to monitor the impact of changing workloads on the quality and timeliness of outcomes

Over the previous five financial years, RoGS data shows that the coronial jurisdiction caseload has increased by 19% with a corresponding increase in the pending caseload.

However, RoGS 2020 data demonstrates that in FY2019/20 there was a small reduction in the coronial workload. For example:

- The number of deaths reported reduced from 6,723 in FY2018/19 to 6506 in FY2019/20 (Table 7A.2);
- The pending caseload[6] reduced from 3,544 in FY2018/19 to 3,176 in FY2019/20 (Table 7A.21); and
- The clearance indicator (finalisations/lodgements) increased from 91.9% in FY2018/19 to 104.7% in FY2019/20 (Table 7A.26).

The Coroners Court has noted that inquests are becoming increasingly lengthy and complex. In 2021, for example, the State Coroner will conduct several inquests into the deaths in custody of

[5] As noted above, in addition to the Senior Coroners located in Lidcombe, there are two part-time Deputy State Coroner roles located in Newcastle and Wollongong, whereby the allocated Magistrate performs coronial duties one day per week. Investigations and inquests managed by these coroners are captured in the 'Other State-wide' figures.

[6] As noted above, the timeliness of coronial processes is reliant on a range of complex and interdependent workflows, shared across each of the three key agencies involved (**Tab A**). As such, the pending caseload may reflect delays across each stage of the coronial process. This includes delays which are outside of the

First Nations people, as well as two significant inquests emerging from the COVID-19 pandemic. The first involves deaths arising from the COVID-19 outbreak at the Newmarch House Nursing Home. The second involves the deaths arising from the outbreak of COVID-19 on board the Ruby Princess cruise ship.

As outlined above, the Taskforce has put in place initiatives intended to improve timeliness in the coronial process, including reducing resourcing pressures during the early stages of the coronial process that result from the overreporting of natural cause deaths.

The Taskforce, and subsequently the Coronial Services Committee beyond 2021, will continue to monitor the impact of changes in workload on the quality and timeliness of coronial outcomes.

The challenge of responding to the shortage of forensic pathologists

There is a worldwide shortage of forensic pathologists. Forensic Medicine has undertaken extensive national and international searches to source forensic pathologists to provide services at its three facilities in Sydney, Newcastle and Wollongong. These efforts have resulted in additional forensic pathologists being recruited to maintain current workforce capacity.

To ensure efficient use of the available forensic pathologist workforce, Forensic Medicine has:

- expanded its forensic pathology training program;
- established a program to further develop the neuropathology skills of its forensic pathologists;
- begun development of the Forensic Medicine Information System;
- established the role of Clinical Training Coordinator;
- recruited five forensic pathology trainees; and
- committed to ongoing efforts to recruit additional forensic pathologists to meet current and future service demand.

Improved coronial facilities

In December 2018, the NSW Government completed a $91.5 million state-of-the-art Forensic Medicine and Coroners Court Complex in Lidcombe, Sydney. The Lidcombe complex replaced the 40-year old facility at Glebe and is double the size of the previous building.

The high-tech facility enables more comprehensive coronial investigations, creates a respectful and calm environment for people dealing with unexpected losses, and supports staff carrying out vital services with a more modern and spacious environment.

Key features include:

- four large, state-of-the-art courtrooms;
- increased capacity to host large and complex inquests, including mass casualties;
- multi-purpose rooms with giant high-definition monitors capable of screening inquests for the media and general public if a courtroom is full;
- audio-visual technology that allows witnesses to give evidence remotely;
- increased capacity for collaboration and coordination of services across agencies;
- private viewing rooms with dedicated facilities to support large family groups with dignity, including a multi-faith room;
- modern and expanded clinical facilities for NSW Health Pathology's Forensic and Analytical Science Services;

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direct control of the coroner, such as delays in the finalisation by Forensic Medicine of a post-mortem report, and delays in the preparation by NSWPF of the coronial brief of evidence.

- advanced additional clinical equipment to help provide cause-of-death answers in the least invasive manner; and
- advanced teaching suites.

(iii) the timeliness of its decisions,

The interagency triage process

Where a death is reported to the coroner, it is generally for the coroner to decide what kind of investigation is necessary (except where the death is subject to a mandatory inquest).

This decision-making is supported by a multi-disciplinary, inter-agency triage process, intended to support the coroner to make timely and appropriate directions. The triage process is important, as it can help avoid the need for a deceased person to be transferred to a forensic medicine facility, thereby reducing the number of natural deaths entering the coronial pathway.

Key responsibilities in the triage process are shared by the coroner, staff from the NSW Coroners Court, the NSWPF, forensic pathologists, clinical nurse consultants, a case coordinator and Forensic Medicine social workers. As part of this process:

- Forensic Medicine may review the person's medical history and circumstances of death and provide support for either a medical professional to issue a MCCD or a coroner to issue a coroner's certificate, or alternatively advise the coroner where a post-mortem examination may be required;[7]
- Where appropriate, the coroner may direct Forensic Medicine to perform post-mortem examinations, ensuring these are conducted in the least invasive manner possible;
- When a post-mortem examination is directed by the coroner, the Forensic Medicine team schedules all activities in a way that minimises the time from admission of the deceased person to their release into the care of an appointed funeral director;
- The NSWPF may conduct investigations into the circumstances of death, including by seeking specialist reports from experts and statements from witnesses, including family and friends;
- A Coronial Information and Support Program social worker may consult with the family of the deceased person and report any stated wishes or concerns to the coroner.

Once the investigation is complete, the coroner will review all of the evidence that has been gathered in order to determine whether or not an inquest is necessary.

Most coronial proceedings can be finalised by the coroner without the need for an inquest. In cases where the cause and manner of death are clear, the coroner will usually dispense with the need for an inquest and finalise the matter. If, at the conclusion of the investigation, the cause or manner of death remains unclear, the coroner will usually direct that an inquest be conducted.

The CCMU model

The triage process described above occurs in the Coronial Case Management Unit (CCMU) located at the Forensic Medicine and Coroners Complex in Lidcombe. The CCMU was established in 2017 and co-locates staff from DCJ, NSW Health and the NSWPF to collectively manage the early stages of the coronial process, for deaths referred from the greater Sydney

[7] A coroner's certificate may be issued under s 25(2) of the Act where the coroner is satisfied, after obtaining relevant advice from police officers and medical practitioners and consulting with the deceased person's Senior Next of Kin, that the deceased person died of natural causes and the deceased person's family do not wish for a post mortem examination to be conducted to determine the precise cause of death.

metropolitan area. The CCMU model supports the coroner to make timely, consistent and appropriate directions.

Key advantages of this model for metropolitan coronial matters include that:

- the co-location of key staff from each agency facilitates real-time information sharing and fast resolution of issues;
- the availability of the State Coroner and other full-time Deputy State Coroners enables the making of prompt and consistent coronial decisions, which is especially important where decisions are time-sensitive due to body deterioration or cultural/religious concerns;
- standardised assessment processes promote greater consistency in coronial decision-making and greater adherence to legislative requirements and principles, for example, that post-mortems be conducted using the least invasive procedures appropriate in the circumstances;
- the streamlined processes facilitate improved communication to families; and
- the increased oversight of the State Coroner creates enhanced capacity to detect state-wide trends.

The CCMU triage model has facilitated a greater proportion of matters being finalised through either a MCCD or coroner's certificate.

The CCMU model has also resulted in reduced delays in the return of deceased persons to their families, less intrusive post-mortem examinations, and improvements in the quality and timeliness of information being provided to families. This is important as a post-mortem can be a distressing process for loved ones, delaying the return of a deceased person to allow for funeral arrangements.

The Rural Triage Centre

The Rural Triage Centre was established to avoid the unnecessary transfer of deceased persons away from their communities, promote timely liaison with Local Court Magistrates exercising coronial jurisdiction and provide access to Forensic Medicine social work support for the deceased person's family and loved ones. The Rural Triage Centre also implements the triage process described above.

In response to the COVID-19 pandemic, the function of making coronial decisions for regional deaths was centralised and allocated to a Senior Coroner at the Forensic Medicine and Coroners Court Complex in Lidcombe. This was possible due to the temporary cessation of inquest work, which created additional judicial capacity.

This centralisation of coronial decisions has assisted regional families by reducing the timeframe for the coroner to make a direction regarding the need for a post-mortem examination. It has also improved the average time to obtain a MCCD, or coroner's certificate, for deaths confirmed as being of natural causes, enabling families to access death certificates more quickly for estate finalisation.

The Taskforce

Since the Taskforce was established, there have been notable performance improvements to coronial timeliness.

In 2019/20, 90 fewer deceased persons from rural or regional NSW were transported to a Forensic Medicine facility as a result of improved triaging procedures (from 882 persons in 2018/19 to 792 persons in 2019/20).

In 2018/19, 37% of post-mortem examinations from rural and regional NSW performed at Forensic Medicine Newcastle were undertaken in three days or less. As of March 2021, 65% of post-

mortem examinations of deceased persons from rural and regional NSW were taking place within three days of admission.

During the same period, the median time from admission to release for rural and regional deceased persons who undergo post-mortem examination decreased by 25%, down from eight days to six days. This has enabled grieving families to progress funeral arrangements for their loved ones in a more timely manner.

The average number of post-mortem reports finalised per month (i.e. comparing data for 2018/19 to March 2021) has increased by 10%, resulting in about 24 additional reports finalised per month. This trend is expected to continue due to a range of initiatives, including additional resourcing and enhanced specialist capacity, system improvements and standardised template reports.

Improved timeframes significantly assist the community by resulting in more timely resolution for grieving families. Over the last 18 months, there has been a 45% reduction in the number of post-mortem reports waiting to be finalised for longer than six months. In March 2021, 81% of post-mortem reports relating to rural and regional deceased persons were completed within six months, with a median completion time of four months.

The development of a Forensic Medicine Information System

Forensic Medicine is developing a new Forensic Medicine Information System (FMIS), which is expected to go live in December 2021. The FMIS will capture all workflow, clinical information, case management and reporting requirements for Forensic Medicine. It is anticipated the FMIS will contribute to improving timeframes for the coronial system and improving support for families by:

- facilitating the efficient receipt of information through electronic systems;
- improving Forensic Medicine social workers' engagement with families by assigning automated tasks; and
- eliminating manual processes and enabling improved communications with the coroner, Local Court Magistrates exercising coronial jurisdiction, NSW police officers and other key parties.

A pilot of direct admissions for certain types of deaths

A pilot will commence in the Wagga Wagga Police District in mid-2021 to provide direct admissions for certain types of deaths in rural and regional areas to enable deceased persons to be returned to their families sooner. Currently, triage must occur and a coronial direction be made before transfer can be arranged for a rural or regional unexpected or unexplained death. Under the proposed model, the NSWPF would arrange for the deceased person to be transferred to a Forensic Medicine facility as soon as possible if satisfied that the death meets the criteria.

The development of timeliness standards and ongoing monitoring

The Taskforce is developing timeliness standards for the key steps in the coronial process to support monitoring of performance, including the impact of Taskforce initiatives. These timeliness standards, in combination with clinical standards being developed, will form the basis against which each agency will monitor compliance against the standard and the key performance indicators. The Coronial Services Committee will monitor compliance with the timeliness standards into the future.

(iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,

Section 82 of the Act provides that coroners may make recommendations in relation to public health and safety, and that a matter be investigated or reviewed by a specified person or body. The coroner is required under s 82 to provide a copy of the recommendations to any person or body to which a recommendation is directed, including Ministers where relevant.

Premier's Memorandum M2009-12

The Premier's Memorandum M2009-12 Responding to Coronial Recommendations sets out the process for responding to coronial recommendations directed at Ministers and NSW Government agencies. This provides that a Minister or NSW Government agency which receives a coronial recommendation should acknowledge receipt of the recommendation within 21 days and provide a substantive response to the Attorney General within six months. This response should outline any action being taken to implement the recommendation, or provide reasons if a recommendation is not proposed to be implemented.

As prescribed under the Premier's Memorandum, the Attorney General receives and publishes the responses received from Ministers and NSW Government agencies on the DCJ website. These are accessible at the following link: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

NSW Government agency processes for responding to coronial recommendations

Many NSW Government agencies have established mechanisms to review and monitor the implementation of coronial recommendations. Often, these processes operate alongside internal review mechanisms for investigating incidents involving a death.

Corrective Services NSW

The Corrective Services NSW (CSNSW) Management of Deaths in Custody Committee, and where relevant the Oversight Review Committee, review and monitor the implementation of coronial recommendations. CSNSW provides updates on the implementation status of the coronial recommendations to the Minister for Corrections and reports on this to the Attorney General and the State Coroner.

The Corrective Services Management of Deaths in Custody Committee

The CSNSW Management of Deaths in Custody Committee was established in 2009. This Committee provides a centralised point for consideration, management and reporting of all inmate deaths in custody. It is also responsible for responding to, and actioning, the findings and recommendations made during coronial inquests and arising from internal investigations.

The Committee meets quarterly and is chaired by the Assistant Commissioner, Governance and Continuous Improvement, and comprises of senior executives from CSNSW and the Justice Health and Forensic Mental Health Network. Meeting invitations are also extended for a representative of the NSW coroner to attend as an observer.

The Corrective Services Oversight Review Committee

The CSNSW Oversight Review Committee was established in November 2016 following a recommendation from the Auditor-General's Performance Audit Report – Performance Frameworks in Custodial Centre Operations, that CSNSW establish an Operations Oversight Committee to monitor the effectiveness of remedial actions.

The purpose of the Committee is to provide assurance to the CSNSW Executive and the Minister for Corrections that, where critical reviews, investigations or findings are made by external agencies and internal governance processes, they are actioned and implemented accordingly.

The Oversight Review Committee comprises high level representation from across CSNSW and the secretariat function is administered by the Governance and Continuous Improvement Division. The Committee meets bi-monthly and takes a proactive approach to the implementation, monitoring and reporting of recommendations and findings.

NSW Health

The System Management Branch (SMB) within NSW Health is responsible for coordinating the NSW Health responses to coronial recommendations directed to NSW Health for implementation.

NSW Health has a robust process for responding to recommendations made by the coroner, in line with the NSW Premier's Memorandum M2009-12. SMB reports to the Secretary of NSW Health on a monthly basis to advise of any coronial recommendations received in the previous month which are directed to NSW Health for implementation.

In addition, NSW Health has processes in place to ensure that any recommendations with statewide implications are identified and shared. This process involves a bi-monthly meeting held between the SMB and the Clinical Excellence Commission to discuss statewide coronial recommendations. At this meeting, representatives conduct a high-level analysis of recommendations to local health districts and specialty health networks to identify cases that may have potential statewide implications and possible adverse effects on the delivery of quality patient care. Any initiatives to progress statewide system changes are co-ordinated through NSW Health and the pillar organisations.

Justice Health and Forensic Mental Health Network

In the Justice Health and Forensic Mental Health Network (the Network), a Serious Adverse Event Review (SAER) is conducted for all deaths with a Harm Score assessed as "1". This is in compliance with the NSW Health PD2020_047 Incident Management Policy and Part 2A of the *Health Administration Act 1982*. The Network conducts a death review for all other deaths that do not fall under the SAER.

The Network Close the Loop Committee provides oversight of all coronial and SAER recommendations and reviews evidence to demonstrate the completion of a recommendation.

The Network also participates in the CSNSW-led Death in Custody Committee for shared governance of Coronial findings and recommendations.

NSWPF

The NSWPF has established systems and processes to ensure compliance with Premier's Memorandum M2009-12 to report to the Attorney General on responses to Coronial recommendations and to progress implementation of those that are supported.

Following acknowledgement of receipt of recommendations, the NSWPF Executive approves an organisational response which is sent to the Attorney General to meet the six month timeframe. For those recommendations that are supported, Action Items are created which set out the steps

necessary to implement the recommendation, with responsibility allocated to relevant commands. These are then reported on at regular intervals and updates are provided to the Attorney General via the DCJ Legal Services Branch.

Youth Justice NSW

Where coronial recommendations are directed to Youth Justice NSW (YJNSW), the YJNSW Executive Leadership Team is responsible for implementation, oversight and periodic reporting against these recommendations.

(v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,

Improving the ability of the coronial jurisdiction to respond to the needs of First Nations families

First Nations people continue to be overrepresented in almost every category of death which is reported to the coroner in NSW. The NSW Government is committed to improving the coronial jurisdiction to ensure processes are culturally safe and respectful, and contribute to preventing future loss of life for First Nations people.

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

As noted above, the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody has made five recommendations related to the coronial jurisdiction. The NSW Government will carefully consider these recommendations and publish a response in due course.

The creation of Aboriginal Family Engagement officers

The Coroners Court recently established two Aboriginal Family Engagement officer roles, which are expected to be filled in the next few months.

The Aboriginal Family Engagement officers will sit within the Coronial Information and Support Team at the Lidcombe complex. Their primary role will be to provide support to the families of First Nations people whose deaths have been reported to the coroner. This support will extend throughout the course of the coronial process, from the time that the death is reported until the time that the matter is finalised. The officers will also assist with the development of policies and procedures for engaging with First Nations people who are involved with the coronial jurisdiction.

Through improved engagement with First Nations families, the Coroners Court seeks to ensure that all relevant issues are ventilated and relevant material put before the Court. Thorough investigation of First Nations people's deaths is essential to contribute to the prevention of future loss of life.

Improved processes for deaths in custody and deaths which occur as a result of police operations, including deaths of First Nations People

The Chief Magistrate and State Coroner are in the final stages of drafting a revised Practice Note which sets out guidelines for Senior Coroners for the case management of deaths in custody or as a result of police operations (s 23 deaths).

The Practice Note will also refer to the State Coroners Protocol for the case management of s 23 inquests involving First Nations people. It is hoped that the Practice Note and the Protocol will commence in the next few months.

The Local Court plans to conduct targeted consultations with key legal and First Nations stakeholders once the draft Practice Note and Protocol are finalised. This will likely include face-to-face discussions where the draft Practice Note and Protocol will be used as a talking point, as well as an opportunity to provide written comment.

Forensic Medicine initiatives to improve its capacity to respond to the needs of First Nations families

All NSWHP staff undertake a combination of face-to-face and online mandatory Respecting the Difference - Aboriginal Cultural Training eLearning.

In December 2020, NSWHP launched its first Reconciliation Action Plan (RAP). Forensic Medicine has developed a RAP implementation plan and is conducting extensive outreach to Aboriginal communities and services to discuss ways to improve the experience of the coronial process for First Nations people. These efforts include shared newsletter distribution, invitations for Aboriginal community leaders and other representatives to visit Forensic Medicine facilities, and direct communication and engagement with Aboriginal Hospital Liaison Officers who work with local communities.

Every effort is made to respect cultural and individual family requests, such as supporting smoking ceremonies, memory collation, painting, and the placing of important possessions with the deceased person. With the support of NSWHP's Aboriginal Workforce Development Unit, Forensic Medicine is actively engaged in providing culturally safe and appropriate facilities.

NSW Health is committed to increasing the Aboriginal workforce to a minimum of a 3% overall, with sub targets of 3% by both salary band and occupation. The NSW Health Aboriginal workforce increased from 2.4% in 2014-15 to 2.9% in 2019/20. A strong and capable Aboriginal workforce is fundamental to building inclusive organisational culture, and better enabling culturally safe service delivery to Aboriginal people, their families and community.

Engaging with culturally and linguistically diverse communities

The Coroners Court meets annually with the president of the Muslim Association and with the Jewish Board of Directors to discuss and agree on protocols for the appropriate early release of deceased persons of those faiths to allow funerals to be conducted in accordance with religious requirements. Channels have been established so that representatives can contact the Court directly in between these periodic meetings should an issue arise.

Engagement between Forensic Medicine and the Muslim community in Sydney and Newcastle has identified a range of concerns for bereaved families. These include a need to better understand what a post-mortem examination involves, how to lodge an objection, the timeframes of a post-mortem examination, the role of the Senior Next of Kin, and for communication materials with a specific cultural/religious focus. Engagement is continuing with funeral directors and the Australian National Imams Council about hosting information sessions in the community and providing input into culturally appropriate material.

Forensic Medicine will conduct outreach and engagement with other culturally and linguistically diverse communities in 2021 to improve the experience for bereaved families who may feel confused, distressed or excluded as a result of sensitivities related to cultural, religious or linguistic diversity.

(vi) the operational arrangements in support of the Coroners Court with the NSW Police Force and the Ministry of Health,

The role of Forensic Medicine in the coronial system

Forensic Medicine is responsible for conducting medical investigations into reportable deaths, as directed by the coroner.

Coronial post-mortem examinations can only be performed by qualified and credentialed forensic pathologists who are supported by a specialist team of forensic mortuary technicians, forensic radiologists and radiographers, clinical nurse consultants and forensic medicine social workers and specialised equipment.

Forensic Medicine has dedicated facilities in Sydney, Newcastle and Wollongong with specialist equipment to help determine the cause of death in the least invasive way possible.

Forensic Medicine has triage and case management functions for all deaths reported to the coroner in NSW. Statewide triage of coronial referrals is managed by the:

- CCMU located at the Forensic Medicine and Coroners Complex in Lidcombe, Sydney; and
- the Rural Triage Centre located at Forensic Medicine Newcastle.

The triage function is an inter-agency partnership with key responsibilities in the coronial process shared by NSW Coroners Court staff, NSWPF officers, forensic pathologists, clinical nurse consultants and forensic social workers.

The CCMU triages cases from the metropolitan Sydney police local area commands.

The Rural Triage Centre consists of Forensic Medicine staff who coordinate the triage of new cases for regional areas of NSW. It was established to:

- avoid the unnecessary transfer of deceased persons away from their communities;
- ensure timely liaison with coroners who service rural and regional areas; and
- provide access to Forensic Medicine social work support for the deceased person's family and loved ones.

In response to the COVID-19 pandemic, since March 2020, the function of making coronial decisions for regional deaths has been centralised and allocated to a Senior Coroner at the Forensic Medicine and Coroners Court Complex in Lidcombe.

The role of the NSW Police Force in the coronial system

The NSWPF is responsible for investigating all reportable deaths to the coroner, some which may lead to an inquest and the compilation of a coronial brief of evidence. These investigations are ultimately under the direction of the coroner.

The NSWPF is responsible for conducting a thorough investigation and compiling briefs of evidence for all mandatory inquests. The NSWPF is required to comply with strict timeframes and protocols as outlined in existing Practice Notes.

The Coronial Law Unit (CLU) consists of specialist Police Prosecutors who work as 'coronial advocates' for the NSW State Coroner and Deputy State Coroners, and on request for regional and rural Magistrates exercising their coronial jurisdiction. Police coronial advocates are otherwise known as Advocates Assisting the Coroner during Inquests and Inquiries.

The CLU is based in the NSW Coroners Court in Lidcombe, but assist with Coronial proceedings state-wide when required. The CLU is funded by the NSWPF.

The police coronial advocates at the CLU act as a conduit between the coroners and the Officers in Charge of the Coronial investigations. In 2020, police coronial advocates provided 684 case updates for coroners.

Police coronial advocates perform a variety of duties including:

- identifying issues and further avenues of coronial investigation;
- liaising with family members (including preparation of "30 day letters"[8]);
- liaising between investigating police and the coroner, generating and issuing formal documents such as subpoenas;
- identifying witnesses;
- engaging expert evidence; and
- preparing a matter for inquest and conducting coronial inquests.

Police coronial advocates also provide training to operational police on the coronial jurisdiction at Command training days, as well as running coronial training days for investigators.

The role of the Crown Solicitor in the coronial system

The Crown Solicitor assists the coroner in any coronial inquest or inquiry which falls within the following categories:

a) the proceedings raise complex issues (including significant legal, procedural, technical or evidentiary issues); or
b) multiple agencies are involved; or
c) there is likely to be a significant public interest in the proceedings; or
d) it would be inappropriate for the Police Coronial Advocate to act because of an actual or perceived conflict of interest.[9]

Police coronial advocates will generally assist a coroner in a coronial inquest or inquiry that does not meet the threshold outlined in (a) to (d) above.

The Crown Solicitor will accept instructions to assist a coroner in a coronial inquest or inquiry falling within categories (a) to (d) above unless a conflict of interest arises. Where there is a conflict precluding the Crown Solicitor from accepting instructions, the Inquests, Inquiries & Representation team within DCJ Legal will generally assist the coroner in the inquest or inquiry.

Presently, the Crown Solicitor is assisting the State Coroner and her deputies in approximately 200 inquests and inquiries.

In some circumstances, the Crown Solicitor represents NSW Government agencies that are identified as parties with a sufficient interest in a coronial inquest or inquiry. DCJ Legal generally assists the coroner in the inquest or inquiry in these circumstances. Presently, the Crown Solicitor represents NSW Government agencies in approximately 50 inquests and inquiries.

(b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary,

The NSW Government is committed to continually identifying and implementing opportunities for reform to improve the quality and timeliness of the coronial system. This is evident in the following ongoing projects, mentioned throughout this submission:

[8] A "30 day letter" is sent where the deceased's family has sought an inquest, but the coroner proposes to dispense with an inquest on the preliminary view that the evidence satisfactorily discloses the deceased's identity and the date, place, cause and manner of death, and does not identify any public interest issues which should be investigated. The letter invites the family to provide a response within 30 days outlining any further concerns that they believe require an inquest to be held.
[9] See footnote 9 to PM2016-04-NSW Government Core Legal Work Guidelines.

- The NSW Government is carefully considering relevant recommendations emerging from the following recent inquiries:
    - the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody; and
    - Special Commission of Inquiry into the Drug 'Ice'.
- The Taskforce has identified and commenced implementation of a range of initiatives intended to improve the timeliness of the coronial system. When the Taskforce concludes, it is proposed that the Coronial Services Committee will continue to oversee the implementation of Taskforce initiatives and monitor the timeliness of coronial procedures.

(c) the most appropriate institutional arrangements for the coronial jurisdiction in New South Wales, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement

The structure of the Coroners Court

The NSW Coroners Court forms part of the NSW Local Court and is headed by the State Coroner, who is responsible for the oversight and coordination of coronial services across the State. The State Coroner is subject to the control and direction of the Chief Magistrate and has the same status as a Deputy Chief Magistrate (ss 7 and 10 of the Act).

The Coroners Court is composed of Local Court Magistrates who are coroners by virtue of their office (s 16) and are subject to the Chief Magistrate's triennial rotation program. The Chief Magistrate is responsible for the allocation of Magistrates to the coronial jurisdiction.

The Act does not expressly recognise the Coroners Court as a court of record. However, it is recognised as a court of record under case law (see *Decker v State Coroner* (1999) 46 NSWLR 415 at [6]).

As at 8 June 2021, there were five full time coroner positions located at the Coroners Court complex in Lidcombe. One of these positions is shared between two Magistrates. In addition, there are two part-time coroner roles located in Newcastle and Wollongong, whereby the allocated Magistrate performs coronial duties one day per week. All eight Magistrates appointed in full and part-time Coroner positions are appointed as Deputy State Coroners.

As a result of the funding boost included in the 2021-22 Budget, one additional Magistrate has been assigned exclusively to the coronial jurisdiction.

Local Court Magistrates in regional areas also hear coronial matters, in addition to their usual criminal and civil workload. Certain regional coronial matters are referred to Senior Coroners (the State Coroner and Deputy State Coroners). This include:

- deaths within the exclusive jurisdiction of Senior Coroners; and
- particularly complex inquests, including where the inquest is likely to run for longer than five days.

Advantages of the current structure

The current structure, where the NSW Coroners Court forms part of the NSW Local Court, has several advantages.

These include:

- Increased flexibility in managing judicial resources across each jurisdiction. For example, where vacancies in office arise, the Chief Magistrate may appoint a Local Court Magistrate to meet any sudden need in the coronial jurisdiction;
- Increased access for coroners to judicial resources and training;
- Reduced risk of vicarious trauma, as Magistrates may be rotated to avoid excessive exposure to traumatic coronial material; and
- Reduced duplication of administrative functions and costs.

NSW GOVERNMENT Health Pathology

CORONIAL PATHWAY

	Death Event or Scene (Stg 1)	Mobilize and Report (Stg 2)	Examination and Investigation (Stg 3)	Coronial Findings (Stg 4)	Case Management (Stg 5)
Function	Death Notification Coordination of coronial investigation scene Verification of death Clinical consultation Transportation	Police Report to the Coroner (P79a) Transportation Forensic Medicine Admission LHD Admission Client Registration (coronial referral) Triage, Forensic Medicine Coronial Direction Orders ID/SNOK Follow Up Objection Clarification	Medical Examination & Investigation Manner of Death Investigation Release of deceased Transport Whole Organ Early Appropriate Guilty Plea	Coronial documents Test Results Sub-specialty reports Autopsy Reports Inquest Dispensing of matter Coronial Findings	Viewings/ID's SUDI protocol Peer Review Court Preparation & Attendance Compliments/Complaints management Genetic Referrals

Workflow Processes