Submission No 39

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Gilbert and Tobin

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Legislative Council

Select Committee on the coronial jurisdiction in New South Wales

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1 Introduction

The Select Committee on the coronial jurisdiction in New South Wales (**Committee**) has been tasked with inquiring into and reporting on the coronial jurisdiction in New South Wales and considering, among other Terms of Reference, the law, practice and operation of the Coroners Court of NSW (**Coroners Court**), whether any changes to the jurisdiction are desirable or necessary and the most appropriate institutional arrangements for the coronial jurisdiction.

This review is important and necessary. There has been no thorough review of coronial legislation in New South Wales since the *Coroners Act 1980* (NSW) (**Coroners Act**) was passed.

Gilbert + Tobin's submission focuses on the following terms of reference:

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

  (i) the scope and limits of its jurisdiction,

  (ii) the adequacy of its resources,

  (iii) the timeliness of its decisions, and

  (iv) the outcomes of recommendations made, including the mechanisms for oversight of implementations of recommendations of the Court;

(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; and

(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.

Our submissions reflect the experience of Gilbert + Tobin's clients in our pro bono practice and include case studies illustrating their experiences and the impact of their engagement with the Coroners Court on them.

A number of the recommendations in this submission are consistent with the recommendations of the NSW Select Committee into the high level of First Nations people in custody and oversight and review of deaths in custody which released its report on 15 April 2021 and recommended the establishment of this Committee.[1] Given the importance of the issues examined by that Committee, any recommendations made by the Committee in this review should be considered in light of its report.

[1] Recommendation 30, Legislative Council, Report No 1 - First Nations People in Custody and Oversight and Review of Deaths in Custody, 15 April 2021, p 150. Available at https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=266.

2 Recommendations

Recommendation 1: That the *Coroners Act 2009* (NSW) be amended to establish the Coroners Court of NSW as a standalone specialist inquisitorial court

Recommendation 2: That the jurisdiction and functions of a coroner no longer be conferered on all magistrates

Recommendation 3: That the Coroners Act be amended to include the factors to be taken into account in determining whether or not a post mortem is required and if so, any limits on that examination

Recommendation 4: That where a post mortem examination is ordered, families be provided with adequate and sensitive information to understand the procedures to be undertaken on the deceased and to prepare for the appearance of the deceased and that materials be developed for that purpose for common forms of post mortem examination

Recommendation 5:That coroners be required to give great weight to the views of the family of the deceased in determining whether or not to order a post mortem where it appears a person died of natural causes

Recommendation 6: That the material on which the coroner relies when considering ordering a post mortem examination over the objection of the senior next of kin be made available to the senior next of kin for comment prior to the coroner making his or her decision

Recommendation 7: That *State Coroners Circulars*, including Circulars Nos 30 and 36, be made publicly available and accessible, including digital copies being made available online to ensure greater transparency of the operations of the court

Recommendation 8: That a family's advocate be appointed whose role is to assist families to assist families to navigate the processes and procedures of a coronial investigation and inquest and to understand and exercise the rights of the senior next of kin and family of the deceased

Recommendation 9: That the senior next of kin be given the opportunity to choose the gender of the pathologist where there are relevant cultural considerations

Recommendation 10: That the Coroners Court review and adjust, where necessary, their policies, procedures and protocols to ensure senior next of kin are able to make a free and informed decision whether or not to consent to a post mortem examination (including an autopsy or partial autopsy) including that:

- they are advised of the reasons the examination is sought and are given the opportunity to put their view on the necessity of the examination;
- they are provided with the material on which the coroner relies in determining whether or not to order an autopsy and are given an opportunity to comment on that material;
- they understand what is involved in the autopsy and the impact of the autopsy on the body of the deceased;
- they are advised of their right to appeal against a decision of a coroner to order an autopsy; and

- they are not pressured by the Court to consent to an autopsy or partial autopsy

Recommendation 11: That employees of the Coroners Court be provided with cultural awareness training on Aboriginal beliefs, culture and practices in relation to death (noting the diversity of Aboriginal cultures) that may impact on the attitude of Aboriginal people to aspects of the Coroners Court processes including post mortem investigation

Recommendation 12: That a protocol be developed for taking into account cultural considerations in the processes of and decision-making by the Coroners Court when the deceased identified as or has family who identify as First Nations

Recommendation 13: That the Coroners Act be amended to enable the coroner to order to whom remains are to be released, to authorise that person to dispose of the remains to the exclusion of others and to make such ancillary orders as the coroner considers necessary, with an appeal against the order/s to the Supreme Court

Recommendation 14: That where there is a dispute about the disposal of the remains of the deceased, the Coroner be empowered to order compulsory mediation

Recommendation 15: That the Coroners Court be resourced to provide culturally appropriate mediation services at no cost in disputes over the disposal of the remains of the deceased

Recommendation 16: That an evaluation be undertaken to determine the level of funding required for the NSW Coroners Court to adequately fulfil its role and to fulfil its role in a timely manner

Recommendation 17: That the NSW Coroners Court be funded in accordance with the outcomes of the evaluation recommended above

Recommendation 18: That Legal Aid be funded to provide assistance to all applicants in inquests raising matters in the public interest, and to increase the means test for families in other coronial inquests, particularly where the inquest involves government agencies or corporate or not for profit entities that are legally represented

Recommendation 19: That Legal Aid be provided with funding to be granted to families meeting an extended means test to enable them to brief appropriate experts in coronial inquests

Recommendation 20: That the State Coroner work with the ODPP to develop a protocol to enable faster decisions on prosecution and more transparent, frequent and useful communication with the family of the deceased about the investigation, the decision to prosecute and timing

Recommendation 21: That the Coroners Act should be amended to include a provision setting out the factors to be taken into account in exercising functions under the Coroners Act in similar terms to s8 of the Victorian Coroners Act

Recommendation 22: That the Coroners Court implement a process for providing families of the deceased with regular updates about the progress of the deceased's case and timing of next steps

Recommendation 23: That the Coroners Act be amended to require the following:

(a) That a person, agency or legal entity to whom a coronial recommendation is addressed must, within 21 days of receiving a coronial recommendation, acknowledge receipt of the recommendation in writing to the State Coroner;

(b) That a person, agency or legal entity to whom a coronial recommendation is addressed must, within six months of receiving the recommendation, or such other time as agreed with the State Coroner, provide a written response to the State Coroner stating what action has been, is being or will be taken in relation to the recommendation and responding to any specific questions concerning the recommendations directed to the entity by the State Coroner; and

(c) That, unless otherwise ordered by the State Coroner, as soon as reasonably practicable upon receipt of the written response from the person, agency or legal entity, the State Coroner must publish the response on its website

Recommendation 24: That the Committee consider whether the effectiveness of coronial recommendations should be assessed and reported on and if so, amend the Coroners Act to incorporate a mechanism for doing so

3 About Gilbert + Tobin

Gilbert + Tobin is a leading independent corporate law firm and a key player in the Australian legal market.

Through our pro bono program, we assist people who are marginalised and disadvantaged and the organisations working with them. We have a particular focus on working with First Nations people and organisations, people with disability, refugees and in human rights matters.

We have represented families pro bono in coronial inquests in NSW, Victoria and the Northern Territory. The majority of our clients in coronial matters are First Nations people and all have limited financial resources.

Through our work acting for families in burial disputes, we have also engaged with the Coroners Court in relation to its determination of senior next of kin and in seeking the release of the body of the deceased.

4 Advantages of establishing a standalone court

Term of Reference 1(c) requires the Committee to consider the most appropriate institutional arrangements for the coronial jurisdiction in NSW, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement.

The Coroners Act does not create a "Coroners Court". Rather, powers are conferred on the State Coroner, the Deputy State Coroner and other coroners who are appointed by the Attorney-General.[3] To be appointed as a coroner a person must be a magistrate of the Local Court. The Coroners Act also confers the jurisdiction and functions of a coroner on all magistrates by virtue of their office.[4] As a consequence of this structure, in regional areas the coronial jurisdiction is ordinarily exercised locally by a magistrate. The Coroners Court therefore has somewhat uncertain status being neither a standalone court, nor a formal division of the Local Court from which coroners are drawn.

[3] *Coroners Act 2009* (NSW) s 7.

[4] *Coroners Act 2009* (NSW) s 16.

We submit the Coroners Court should be a standalone court. The coronial function differs significantly and materially from the functions of other Courts. The Coroners Court is investigative as much as it is determinative. Its process is inquisitorial not adversarial. As such, coroners require both a skill set and mind set different from that of judicial officers in the adversarial court system. The court requires processes and procedures that support the unique work of the court, the subject matter with which it deals and the circumstances of the families of the deceased who are not parties to the inquest and whose participation in the inquest is almost entirely at the discretion of the coroner.

Implementing a standalone, specialist coroners court would bring NSW into line with other states including Victoria, Queensland, South Australia and Western Australia. It would also be consistent with practice in comparable jurisdictions internationally. Both New Zealand and Canada, for example, have standalone coroners courts.

Benefits of a standalone court include:

- enabling coroners to be drawn from a wider pool than just the magistracy. Given the nature of the coronial process, the skills required are not necessarily and not only found on the Local Court bench. Judicial officers would be appointed to a standalone court on the basis of their ability to exercise the functions of a coroner;

- the development of expertise in the coronial process among court staff. Many of our clients have received misinformation about the jurisdiction and operation of the Coroners Court from staff, particularly from court staff in regional Local Courts and but also from staff at the Coroners Court. See for example Case Studies 1 and 2;

- a focus on the development of practices and procedures appropriate to the coronial process; and

- increased opportunities for coroners to undertake specialised training and professional development – opportunities not always available to magistrates exercising their coronial function in addition to their Local Court work.

In the event the Coroners Court is established as a standalone court, we submit magistrates should no longer have the jurisdiction and functions of a coroner conferred on them. It should not fall to magistrates to exercise the functions of this increasingly specialised jurisdiction.

Recommendation 1: That the *Coroners Act 2009* (NSW) be amended to establish the Coroners Court of NSW as a standalone specialist inquisitorial court

Recommendation 2: That the jurisdiction and functions of a coroner no longer be conferred on all magistrates

5 Post mortem investigations

Term of Reference 1(a)(i) requires the Committee to consider the law, practice and operation of the Coroners Court of NSW, including the scope and limits of its jurisdiction.

5.1 Issues

There is insufficient guidance in the Coroners Act and the common law for coroners on the factors to be taken into account in determining the extent of a post mortem examination and when a post

mortem examination may be dispensed with. There is no guidance on how those factors should be weighed.

Where the decision to conduct a post mortem is objected to by family, families feel they do not understand the decision-making process for ordering a post mortem examinations, their rights nor what will be involved in any post mortem.

5.2 Limits on guidance

Section 89 of the Coroners Act empowers a coroner or assistant coroner to order a full post mortem examination on the remains of the deceased, a limited or specified post mortem examination or to dispense with a post mortem examination.

Ordering and limiting post mortem examinations

While s 88 of the Coroners Act provides guidance to the person conducting a post mortem examination (being to respect the dignity of the deceased and to use the least invasive procedure) the Coroners Act provides no such guidance to a coroner in deciding whether or not to order a post mortem examination and any limits to be placed on the examination. The only matter the coroner is required to take into account is whether or not they consider the examination 'necessary or desirable … for the purpose of assisting in the investigation' of the death.

We submit that the Coroners Act should be amended to explicitly state the factors to be considered in determining whether or not a post mortem examination is necessary or desirable and the limits to be placed on a post mortem examination.

Those factors should not be limited but should include:

(a) Whether or not a post mortem examination is necessary to establish the cause of death;

(b) Whether or not the cause of death can be established by a limited post mortem examination, and if so, the post mortem examination should be so limited;

(c) Respect for the dignity of the deceased;

(d) The post mortem directions should be limited to the least invasive alternative;

(e) Whether or not the death occurred in suspicious circumstances;

(f) If the deceased died from natural causes but the exact cause is unkown, whether or not there is a public interest or benefit from identifying the exact cause of death;

(g) The likelihood of identifying the exact cause of death from post mortem examination;

(h) The views of the senior next of kin of the deceased and/or other appropriate family members as to whether or not a post mortem examination should be conducted and any limits on that post mortem examination; and

(i) Any relevant cultural or religious concerns arising from the culture and/or religion of the deceased and/or his or her family.

We acknowledge that some of the above considerations are included in the guidance for coroners in the Local Court Bench Book, however the Bench Book provides guidance only and does not have the force of law. [8]

When a decision is made to conduct a post mortem examination, the family of the deceased should be provided with a clear (but sensitive) description of the procedure to help them understand and prepare for how the deceased's body may look after the post mortem examination has been completed. The information should be provided as early as possible in the process and well before the senior next of kin and family view the deceased's body. A major cause of the trauma occasioned to our client in Case Study 1 was the shock of seeing the type and extent of stitching across her daughter's neck and chest from the post mortem when she saw her daughter for the first time after her death.

Dispensing with a post mortem examination

The only guidance given to a coroner on whether or not to dispense with a post mortem is that the coroner must be satisfied, after obtaining relevant advice from police and medical practitioners and consulting with the senior next of kin and any other person the coroner considers appropriate, that:

- the deceased died from natural causes (whether or not the precise cause of death is known); and
- the senior next of kin indicates the deceased's family does not wish for a post mortem examination to be conducted to determine the precise cause of death.[9]

We submit that, as illustrated in Case Study 1, there can be inadequate investigation into and oversight of the investigation into the cause of death and limited transparency of that examination for families.

We submit that the Committee should consult with appropriate experts to develop either factors to be considered in determining whether or not to dispense with a coronial inquest to be included in the Coroners Act, or a Practice Note setting out the steps to be taken in investigating whether or not a person died of natural causes. That investigation, at a minimum, should include obtainin the person's medical records for the last five years from all identified service providers, and where there is doubt about the cause of death, an opinion from an appropriately qualified expert.

Coroners should be reminded, either in the amendment to the Coroners Act or in other guidance of the the intention of the legislature that greater weight should be given to the views of the family where a person has apparently died of natural causes. In the second reading speech of the Coroners Bill (2009) NSW, the Attorney General said:[17]

> *The conduct of a post-mortem examination when the death is due to unsuspicious natural causes has little public benefit. The real benefit of conducting a post-mortem would be for family members who may wish to obtain information on how their relative died. The post-mortem can provide information on co-existing conditions, including inheritable conditions where early detection may be advantageous for the future treatment of a family member. Families should*

[8] Judicial Commission of New South Wales, *Local Court Bench Book* [44.060]. Available at https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html.

[9] See *Coroners Act 2009* (NSW) s 89(6).

[16] Judicial Commission of New South Wales, *Local Court Bench Book* [44.060]. Available at https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html.

[17] New South Wales, *Parliamentary Debates*, Legislative Council, 4 June 2009.

therefore have a greater involvement in the decision of whether to have a post-mortem examination when a relative dies of natural causes, and the only purpose of the post-mortem is to distinguish between more than one possible natural cause of death.

In some instances the conduct of a post-mortem will provide family members with certainty, closure and peace of mind. In other instances families will feel that the death of a sick relative should not require a full post-mortem examination. The bill recognises that greater weight should be given to the views of the family on the issue of conducting post-mortems. The coronial process should not be a source of greater distress to the families of people who have died. Giving a greater role to families in the decision-making process in these circumstances will ensure that coroners act in a manner that is sensitive to the needs of grieving families.

Recommendation 3: That the Coroners Act be amended to include the factors to be taken into account in determining whether or not a post mortem is required and if so, the limits on that examination

Recommendation 4: That when a post mortem examination is ordered, families be provided with adequate and sensitive information to understand the procedures to be undertaken on the deceased and to prepare for the appearance of the deceased and materials be developed for that purpose for common forms of post mortem examination

Recommendation 5:That coroners be required to give great weight to the views of the family of the deceased in determining whether or not to order a post mortem where it appears a person died of natural causes

The senior next of kin has a right to object to a post mortem.[23] However, a coroner may order that a post mortem investigation be carried out notwithstanding the objection.[24]

We note that in Case Study 1 and in at least one other matter, if a written opinion was provided by a medical practitioner explaining why a post mortem examination was necessary, it was not provided to our client.

The Coroners Court website states that the Coronial Information and Support Program team (**CISP**) facilitates communication between the coroner and the senior next of kin where an objection has been made to a post mortem examination.[27] However, the Bench Book states that where an objection to a post mortem examination is raised by the senior next of kin, but a coroner considers that a post-mortem examination is or may be required, the CISP team negotiate with the family on behalf of the coroner with the goal of coming to an agreement with the family of the deceased.[28]

The experience of our client in Case Study 1 was that the person from the Coroners Court who contacted her about the objection, who she assumes was from the CISP team, put her under significant pressure to agree to a limited autopsy. She did not feel supported by the CISP team nor

[23] *Coroners Act 2009* (NSW) s 96.

[24] *Coroners Act 2009* (NSW) s 96(3).

[26] Judicial Commission of New South Wales, *Local Court Bench Book* [44.060]. Available at https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html.

[27] Coroners Court, Guidance and Information (website) <https://www.coroners.nsw.gov.au/coroners-court/help-and-support/guidance-and-information.html>.

[28] Judicial Commission of New South Wales, *Local Court Bench Book* [44.060]. Available at https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html.

that they were there to provide her with information and support. The role of the CISP team in assisting and providing guidance to the next of kin would seem at odds with a role negotiating on behalf of the coroner where there is an objection to an autopsy.

As discussed further at 6, First Nations clients have told us that, in their communications with coronial staff, there was a lack of understanding of the cultural sensitivities in relation to the treatment of bodies of deceased First Nations peoples. This, in turn, led to acute distress and heightened grief for our clients when they later realised that their deceased family member's body had been treated in ways that they considered culturally inappropriate. Our clients did not understand that they were consenting to this type of treatment. Further, after communicating their distress, there was little or no acknowledgment of the impact of this disregard of cultural considerations, until the involvement of our firm. Even then, our client considereda the acknowledgment was limited and lacked ongoing accountability for change.

Recommendation 5: That the material on which the coroner relies when considering ordering a post mortem examination over the objection of the senior next of kin be made availabe to the senior next of kin for comment prior to the coroner making his or her decision

Recommendation 6: That *State Coroners Circulars*, including Circulars Nos 30 and 36, be made publicly available and accessible, including digital copies being made available online to facilitate greater transparency of the operations of the Court

Recommendation 7: That a family's advocate be appointed whose role is to assist families in navigating the processes and procedures of the coronial investigation and inquest and to understand and exercise the rights of the senior next of kin and family of the deceased

Recommendation 8: That the senior next of kin be able to choose the gender of the pathologist where possible, particularly where there are cultural considerations

Recommendation 9: That the Coroners Court review and adjust, where necessary, their policies, procedures and protocols to ensure senior next of kin are able to make a free and informed decision whether or not to consent to a post mortem examination (including an autopsy or partial autopsy) including that:

- they are advised of the reasons the examination is sought and are given the opportunity to put their view on the necessity of the examination;
- they are provided with the material on which the coroner relies in determining whehter or not to order an autopsy and are given an opportunity to comment on that material;
- they understand what is involved in the autopsy and the impact of the autopsy on the body of the deceased;
- they are advised of their right to appeal against a decision of a coroner to order an autopsy; and
- they are not pressured by the Court to consent to an autopsy or partial autopsy

[31] *Morris v Hand* (unrep, 27/2/97, NSWSC) per Dowd J.

6 First Nations families

Our clients who identify as Aboriginal have almost uniformly found dealing with the Coroners Court difficult, confusing and alienating. They have advised us that it is difficult to speak with a person at the Court able to explain the process and answer their questions and they seldom speak with the same person when they follow up with the Court seeking further information. When they are able to speak with someone at the Coroners Court, they advise that the information they are provided with is confusing and it is sometimes wrong. Our First Nations clients advise they feel pressured to make decisions in a hurry and without enough information and that they do not find they can interact with the Court in a manner that feels culturally safe. Our clients advise they feel that their cultural beliefs are not taken into account in the processes and decisions of the Court and the Coroners.

Case study 1 illustrates a number of the issues for Aboriginal families.

We submit that consideration should be given to employing First Nations people to provide information, support and as a point of contact for First Nations clients. We further submit a protocol should be developed for taking into account cultural considerations in the processes of and decision-making by the Coroners Court when the deceased identified as or has family who identify as First Nations.

Recommendation 10: That the Coroners Court employ specialist Aboriginal officers to work with family members of the deceased who are Aboriginal to:

-provide information about the coronial process and the progress of the investigation and/or inquest;

-support families in the investigation, inquest and generally with their interactions with the Coroners Court;

-support families to obtain legal or other assistance;

-to be the primary, consistent point of contact for families with the Coroners Court; and

-to assist staff to interact with Aboriginal families and to apply the Coroners Court's policies and procedures in culturally appropriate ways.

Recommendation 11: That employees of the Coroners Court be provided with cultural awareness training on Aboriginal beliefs, culture and practices in relation to death (noting the diversity of Aboriginal cultures) that may impact on the attitude of Aboriginal people to aspects of the Coroners Court processes including post mortem investigation

Recommendation 12: That a protocol be developed for taking into account cultural considerations in the processes of and decision-making by the Coroners Court when the deceased identified as or has family who identify as First Nations.

7 Disputes regarding release of the body of the deceased

7.1 Issues

Term of Reference 1(b) requires the Committee to consider 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.

We submit the Coroners Act should be amended to clarify the power of the coroner to release the body where there is a dispute about its release and to empower coroners to determine such disputes at first instance.

Disputes may arise between family members about where, how or by whom the deceased should be buried or cremated, with Aboriginal families disproportionately represented in such disputes, often for cultural reasons. Where there are competing claims to possession of the body for the purpose of burial or cremation it is not uncommon for both parties to request that the coroner release the body to them. However, there is no provision in the Coroners Act for resolution of such a dispute.

Under s 100(1) of the Coroners Act, a person must not bury or cremate human remains unless the person has been given, or has in their possession, an authorisation for the disposal of the remains. Section 101 of the Coroners Act provides that the coroner may, by order in writing, authorise the disposal of human remains. However, only the Supreme Court has original jurisdiction to determine disputes about how and by whom a person's remains are disposed of.

In our experience, when a dispute arises, coroners take one of the following approaches:

(i) the coroner uses the definition of senior next of kin as a proxy to determine to whom the body should be released;

(ii) the coroner requires the parties to come to an agreement before the body will be released; or

(iii) the coroner requires an order of the Supreme Court directing the body to be released to a particular person.

Each of the above approaches are problematic at law and/or in practice.

Section 6A of the Coroners Act defines the 'senior next of kin'. However, the senior next of kin as defined by the Coroners Act does not have the legal right to custody of the remains under the Coroners Act or otherwise at law. The senior next of kin may also be different from the person with the priority at law to custody of the remains.

Under the widely adoptedprinciples in *Smith v Tamworth City Council* (1997) 41 NSWLR 680), the hierarchy of the right to bury is as follows:

> "1. If a person has named an executor in his or her Will and that person is ready, willing and able to arrange for the burial of the deceased's body, the person named as executor has the right to do so.
>
> …
>
> 4. Where no executor is named, the person with the highest right to take out administration will have the same privilege as the executor in proposition 1.
>
> 5. The right of the surviving spouse or de facto spouse will be preferred to the right of children.
>
> 6. Where two or more persons have an equally ranking privilege, the practicalities of burial without unreasonable delay will decide the issue."

Section 6A of the Coroners Act, however, provides that the executor will only be considered senior next of kin if the deceased person did not have a spouse, child, living parent or sibling or if these

persons are unavailable to act. It is therefore not appropriate for the coroner to use senior next of kin as a proxy to determine to whom the deceased's body should be released.

Confusion about the role of senior next of kin also exists at staff level. On a number of occasions, our clients or the other party have been advised by Court staff that the senior next of kin is entitled to custody of the body and they have applied to be appointed senior next of kin on that basis. As set out in Case study 2, coronial staff have also provided our clients with incorrect information concerning the process of applying for remains to be released.

In cases where the coroner refuses to release the body without agreement, the Coroners Court does not assist the parties to resolve the dispute. Given the short timeframes and limited resources of the families involved, clients are generally unaware of or cannot find mediation services that can assist. Parties feel they have no option but to seek an order in the Supreme Court for the release of the remains. Supreme Court proceedings are costly, time consuming for both the Court and parties, can be culturally problematic for disputes involving Aboriginal families, and, due to the nature of adversarial proceedings, result in further deterioration of family relationships in a time of grief and crisis. This is consistent with the experience of our client detailed in Case study 2.

We submit the Coroners Court should have a greater role in determining to whom the body should be released. This could be achieved by way of legislative amendments empowering the coroner to determine burial disputes, at the least in circumstances where the Court has custody of the body of the deceased. This legislative power could be supported by resourcing compulsory, culturally appropriate mediation prior to the hearing of a burial dispute.

7.2 Specific legislative power

Section 48 of the Victorian *Coroners Act 2008* explicitly empowers coroners to determine to whom the body is to be released and the order of ranking reflects the common law. Section 48 provides:

> *(1) A person (the applicant) may apply to a coroner for a body to be released to the applicant.*
>
> *(2) If 2 or more applicants apply for release of the body, the coroner must determine the person to whom the body is to be released on the basis of who has the better claim.*
>
> *(3) In determining who has the better claim, the coroner must have regard to the following principles—*
>
> > *(a) if the person named in the will as an executor is an applicant, the body of the deceased should be released to the executor;*
> >
> > *(b) if a person specified under paragraph (a) is not an applicant, the body should be released to the senior next of kin;*
> >
> > *(c) if there appear to be 2 or more applicants who are the senior next of kin of the deceased, the coroner should determine to whom the body is to be released having regard to any principles of common law relating to the release and disposal of a body of a deceased person;*
> >
> > *(d) if no person referred to in paragraph (a) or (b) is an applicant, the coroner should determine to whom the body is to be released having regard to the principles of common law relating to the release and disposal of a body of a deceased person.*

We submit that a provision similar to s 48 of the Victorian Act should be inserted into the NSW Coroners Act, with a right of appeal against the decision to the Supreme Court.

Such a provision would:

(a) clarify the role of the Coroners Court;

(b) reduce the time and expense of negotiating with the Coroners Court, then applying to the Supreme Court if the Coroners Court does not make a decision;

(c) utilise the less adversarial processes of the Coroners Court in determining the dispute; and

(d) if the Coroners Court is properly resourced to provide this function, support the provision of just, quick and cost-effective resolution of the dispute.

In the event a party disagreed with the decision of the coroner, an appeal should still lie to the Supreme Court.

Recommendation 13: That the Coroners Act be amended to enable the coroner to order to whom remains are to be released, to authorise that person to dispose of the remains to the exclusion of others and to make such ancillary orders as the coroner considers necessary, with an appeal against the order/s to the Supreme Court

7.3 Role of mediation in resolving disputes

Given the nature of disputes over the disposal of human remains and the likely ongoing relationships between those in dispute, if the Coroners Court is given power to determine such disputes, we submit consideration should be given to resourcing the Court to provide a free mediation service to the parties. We further submit that coroners should be empowered to make compulsory mediation orders in such disputes where they consider compulsory mediation necessary or appropriate.

A mediation early in the dispute would often be a cost-effective option for both families and the Court. It could reduce the length of the dispute in circumstances where a quick outcome is desirable. It would reduce the need for legal representation early in the dispute. Importantly, done well mediation can better ensure that cultural considerations are properly taken into account and family relationships preserved.

Options for free or low-cost mediation are limited. Given that so many disputes involve Aboriginal families, it is also imperative that any service be culturally appropriate. While Community Justice Centres do provide mediation services tailored for Aboriginal and Torres Strait Islander people, the timing for accessing these services can present an issue in time sensitive disputes regarding the custody of remains.

Recommendation 14: That where there is a dispute about the disposal of the remains of the deceased, the Coroner be empowered to order compulsory mediation

Recommendation 15: That the Coroners Court be resourced to provide culturally appropriate mediation services at no cost in disputes over the disposal of the remains of the deceased

8 Adequacy of Coroners Court resources

Term of Reference 1(a)(ii) requires the Committee to consider the law, practice and operation of the Coroners Court of NSW, including the adequacy of its resources.

We submit that the NSW Coroners Court is inadequately resourced and that inadequate resourcing of the Coroners Court impacts the court's ability to carry out its functions effectively and in a timely manner. That, in turn, impacts the families of the deceased, compounding their grief and trauma. Further, the resources available to families who wish to participate in coronial proceedings are negligible, particularly where the family is ineligible for Legal Aid and does not have the financial means to engage legal representation or experts to provide evidence in the proceedings.

8.1 Funding of the Coroners Court

In 2018-2019, the total expenditure for the Coroners Court in NSW was $6,644,000.[32] This is substantially less than other jurisdictions and is insufficient. While NSW's expenditure on other state courts such as the Local or District Court is generally in line with other States, NSW's expenditure on the Coroners Court is substantially less.[33] For example, in the same period NSW spent $6,644,000 on the Coroners Court, Victoria's Coroners Court received funding of $20,166,000, Queensland's $11,245,000 and Western Australia's $7,004,000.[34] On a per head of population basis the funding differential is even more stark.[35] The funding differential is reflected in the number of coroners appointed in NSW. It appears NSW has 9 coroners,[36] while Victoria has 12[37] and New Zealand has 17.[38]

One of the key concerns of our clients is the delays in the decision whether or not to hold an inquest, and, if an inquest is held, the time to hearing. The delays cause the circumstances of the death to remain front of mind for families, make it hard for families to begin to heal and compound the trauma of the death (see, for example, Case Studies 3-5). We assume these delays are attributable to the inadequacy of the funding the Coroners Court receives.

The delay in hearing also reduces the quality of evidence before the inquest where people are giving evidence largely from memory. An example of this is in Case Study 4 where the evidence of multiple eyewitnesses of the restraint preceding the death the subject of the inquest was of limited utility due to their difficulty remembering events four years after they occurred.

The inadequacy of funding also impacts on the resources available to the Court. For example, the Victorian coronial jurisdiction is supported by the Coroners Prevention Unit, a specialist service for coroners created to strengthen their role in prevention of harm and to provide them with expert assistance.

We are aware of the State Coroner reaching out to organisations and universities to establish programs for research support in coronial cases due to the limited resources of the Coroners Court. This dependence on the goodwill of external agencies impacts the timeliness of proceedings and may impact on the nature and quality of the evidence and of the recommendations that are made.

Recommendation 16: That an evaluation be undertaken to determine the level of funding required for the NSW Coroners Court to adequately fulfil its role and to fulfil its role in a timely manner

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[32] Productivity Commission, *Report on Government Services 2020*, 29 January 2020.

[33] See Coroners Court New South Wales, *Coroners*, 25 August 2020. Available at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/courts.

[34] See Coroners Court New South Wales, *Coroners*, 25 August 2020. Available at https://www.pc.gov.au/research/ongoing/report-on-government-services/2020/justice/courts.

[35] NSW has a population of 8.166 million, Victoria 6.681 million, Queensland 5.185 million, and Western Australia 2.667 million.

[36] Coroners Court New South Wales, *Coroners*, 25 August 2020.

[37] Coroners Court of Victoria, *Annual Report*, December 2020.

[38] Coronial Services of New Zealand, About Coroners & Coronial Services, 2 July 2021.

Recommendation 17: That the NSW Coroners Court be funded in accordance with the outcomes of the evaluation recommended above

8.2 Legal support for families in the coronial proceedings

There are various support services available for families who are involved in coronial proceedings in NSW, such as the Coronial Information and Support Program (**CISP**) which states that it is available to provide information and support to persons affected by deaths reported to the Coroner, as well as services such as counselling.[39] There is, however, no general provision of legal assistance.

Legal Aid only provides assistance in coronial inquests in limited circumstances. Legal aid may be available for a coronial inquest matter if:[40]

- it is a preliminary step to civil proceedings for which legal aid is available, subject to the family member meeting the Legal Aid means test, or
- the public interest would be advanced if the applicant was represented at the inquest, again subject to the means test, or
- the inquest relates to the death of an Aboriginal or Torres Strait Islander person in custody.

As a consequence of the limitations on eligibility for assistance from Legal Aid in coronial proceedings in NSW, many families without the financial means to engage a lawyer will not have the opportunity to obtain legal advice or have legal representation.

In principle, the inquisitorial nature of the coronial process reduces the need for legal representation and if a senior next of kin wishes to question a witness in the proceedings, a "legal officer assisting the coroner can ask questions of witnesses on their behalf".[41] However, it can be very difficult for vulnerable clients to effectively engage with the evidence, engage with Coroners Court staff and advocate for their concerns to be addressed by the Coroner, particularly where complex legal or medical issues are involved. This issue is highlighted in Case study 4.

In addition, some coronial inquests which involve organisations that may be seeking to limit their civil or criminal liability or reputational damage can naturally tend towards a more adversarial approach, despite best efforts of the coroner. If families cannot find accessible legal representation at inquests, there is a power imbalance in the inquest that cannot be easily remedied, even with the best efforts of a diligent counsel assisting the coroner. If families come from a disadvantaged group or English is not their first language, this imbalance is amplified.

Families are also often prevented from effectively testing the evidence in an inquest and advancing the investigation of their concerns by their inability to brief and call evidence from their own experts due to the cost in doing so. They are reliant on the experts called by others who may lack expertise in the matter of concern or who may form their opinion based on a particular paradigm or set of biases that are difficult to challenge without calling evidence yourself.

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[39] Coroners Court New South Wales, *Help and Support*. Available at https://www.coroners.nsw.gov.au/coroners-court/help-and-support.html.

[40] Legal Aid New South Wales, *Policies* [6.12.1]. Available at https://www.legalaid.nsw.gov.au/for-lawyers/policyonline/policies/6.-civil-law-matters-when-legal-aid-is-available/6.12.-coronial-inquests-into-deaths.

[41] Coroners Court New South Wales, *Where to get legal advice and information* 31 March 2020. Available at https://www.coroners.nsw.gov.au/coroners-court/help-and-support/where-to-get-legal-advice-and-info.html.

Case study 4 is an example which illustrates the need for the family of the deceased to engage their own experts.

We submit a pool of funding be set aside by Legal Aid to enable families to engage appropriate experts in coronial inquests and that a more generous means test be applied to the grant of aid for that purpose.

Recommendation 18: That Legal Aid be funded to provide assistance to all applicants in inquests raising matters in the public interest and to increase the means test for families in other coronial inquests, particularly where the inquest involves government agencies or corporate or not for profit entities that are legally represented

Recommendation 19: That Legal Aid be provided with funding to be granted to families meeting an extended means test to enable them to brief appropriate experts in coronial inquests

9 Timeliness

9.1 Concern

Term of Reference 1(a)(iii) requires the Committee to consider the timeliness of coronial decisions.

In our experience, and as discussed at 8.1, families involved in the coronial process often face extensive delays waiting for a decision whether or not to hold an inquest, for the inquest itself to be held and for the findings and recommendations to be handed down. Those delays make it difficult for our clients to properly begin rebuilding their lives and result in ongoing grief and trauma.

As set out in Case studies 3 to 5, the negative impact the delays have on families is compounded by a lack of information from coronial staff regarding the progress of matters, the reasons for any delay, the anticipated next steps and timing of those steps.

Our clients' experience of delays is supported by the publicly available data included in Productivity Commission's Annual Report on Government Services 2020 (**PC 2020 Report**).[42] The PC 2020 Report sets out national benchmarks on timing of matters for all courts.

The 2020 PC Report sets out the following backlog benchmarks for the Coroners Court:

- no more than 10 per cent of lodgements pending completion are to be more than 12 months old; and
- no lodgements pending completion are to be more than 24 months old.[43]

Data from the PC 2020 Report show that of all the lodgements pending completion in the NSW Coroners Court in the 2018-19 reporting period, 776 cases (21.9%) were more than 12 months old, and 365 cases (10.3%) were more than 24 months old. [44]

As illustrated by Case study 4, delays in coronial hearings may also impact on the effectiveness of the investigatory function of the coronial process. A study by Dartnall, Goodman-Delahunty and Gullifer into the experiences of family and friends of missing people as the subject of a coronial investigation,

[42] Productivity Committee, *Report on Government Services 2020*, 29 January 2020.

[43] See Productivity Committee, *Report on Government Services 2020*, 29 January 2020 p 7.12.

[44] See Productivity Committee, *Report on Government Services 2020 – Courts data tables*, 29 January 2020, Table 7A.21.

found that after waiting significant periods for an inquest to commence, information and files were lost, witnesses could no longer recall details, and the protracted investigation created stress for some people retelling their stories.[45]

Recommendation 20: That the NSW Coroners Court is funded at a level that enables it to meet the backlog benchmarks for the Coroners Court

9.2 Interface with the Office of the Director of Public Prosecutions NSW (ODPP)

Our experience is that proceedings in the Coroners Court can be significantly delayed awaiting a decision by the NSW Office of the Director of Public Prosecutions (**ODPP**) whether or not to prosecute a person of interest.

As set out in Case study 5, one of our clients has been waiting for over 3 years for a decision from the coroner about whether or not there will be an inquest as there has been no decision from the ODPP about whether or not they will prosecute. The frustration arising from the delay is enhanced by the lack of information about when a decision might be received from the ODPP.

Recommendation 21: That the State Coroner work with the ODPP to develop a protocol to enable faster decisions on prosecution and more transparent, frequent and useful communication with the family of the deceased about the investigation, the decision to prosecute and timing

10 Communication with families

Families involved in the coronial process are generally the people most deeply affected by its procedures and investigations. Despite this, the NSW Coroners Act contains limited provisions which relate to families and generally only requires the coroner to consider the view of the senior next of kin, in very limited circumstances (usually relating to a post-mortem).

As demonstrated by a number of the Case Studies in this submission, our clients have been significantly impacted by failures of the Coroners Court staff and others involved in the process to adequately explain a family's role in the coronial process, the family's rights, the coronial process itself, the reasons for delay and to give useful information about the timing of the next steps in the process. These experiences are consistent with a 2006 study of the experience of Victorian families involved in a coronial investigation, which found that families were unclear on the roles, functions and processes of the coroner and there was a need for improvement in the frequency of communication from the Coroner's Office.[46]

Section 8 of the Victorian *Coroners Act 2008* sets out the factors to be taken into account in exercising functions under the Act. Those factors are largely focussed on the families of the deceased and include the impact of delays on the family and the need to keep families informed. We submit it would be beneficial for the NSW Coroners Act to be amended to insert a similar provision.

In addition to this general provision, families would also benefit from the NSW Coroners Court implementing a process for ensuring families are updated regularly about the progress of the coronial investigation and the decision whether or not to hold an inquest. Currently, our experience is that in the event of delays, the onus is almost entirely on the family to make enquiries with the coroner regarding the cause and extent of any delay and timing of next steps. We understand that coroners

[45] S Dartnall, J Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' *Frontiers in Psychology*, 10 November 2019.

[46] Myndscape Consulting, Review of the Coroner's Act 1985: Final Report, March 2006.

conduct semi-regular reviews of matters, there does not appear to be a requirement or practice of communicating the outcome of the reviews to families.

Recommendation 22: That the Coroners Act should be amended to include a provision setting out the factors to be taken into account in exercising functions under the Coroners Act in similar terms to s8 of the Victorian Coroners Act

Recommendation 23: That the Coroners Court implement a process for providing families of the deceased with regular updates about the progress of the deceased's case and timing of next steps

11 Implementation of recommendations

11.1 Current position

Term of Reference 1(a)(iv) requires the Committee to consider the outcomes of recommendations made by the Coroners Court, including the mechanisms to oversee whether recommendations are implemented.

If a coroner in NSW makes a recommendation in relation to a person, organisation or agency, there is currently no requirement under the Coroners Act for that person, organisation or agency to report on whether or not the recommendation was implemented, if not why not and whether or not the recommendation has addressed the problem it was intended to solve.

Premier's Memorandum 2009-12, Responding to Coronial Recommendations sets out a process for NSW Government agencies to respond to recommendations made by the coroner.[50] A Minister or NSW Government agency that receives a coronial recommendation should, within 21 days, acknowledge receipt of the recommendation, and within six months write to the Attorney General outlining any action being taken to implement the recommendation and provide reasons if a recommendation is not proposed to be implemented.

The limits on the Memorandum as a mechanism for overseeing the outcomes of recommendations made by the Coroners Court include that:

- it lacks the force of law;
- it provides limited transparency. The public and the coroner are only provided with the Attorney General's report summarising the responses of the agencies and not the responses themselves;
- it only applies to NSW Government agencies; and
- there is no consideration of whether or not the agency (or anyone else) considers the mechanism in fact addressing the failing it was intended to address.

[50] Premier Nathan Rees, *M2009-12 Responding to Coronial Recommendations*, 6 April 2009. Available at https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.

An indication of the limited utility of the Premier's Memorandum is the number of responses that are still outstanding for recommendations made during the period January 2020 - December 2020. For that period, of the 22 recommendations all but five are listed as 'awaiting response'.[51]

There is very limited research and data on the implementation rates and effectiveness of coronial recommendations in NSW, and that which does exist is outdated. The only study we have been able to identify was conducted in 2008 and found that only 48% of coronial recommendations in the inquests examined were implemented.[52]

The study considered 24 inquests from 2004. Those inquests resulted in 93 recommendations. In the absence of mandatory reporting of the implementation of recommendations, the authors of the study wrote to the relevant bodies to whom the recommendations were directed, asking whether the recommendations had been implemented. Responses were received in relation to 47 of the recommendations. Of those 47, 22 (48%) were implemented. This study itself demonstrates the difficulty overseeing the implementation of recommendations in the absence of a requirement to report on their implementation.

11.2 Benefits of a legislated mandatory reporting requirement

A number of other States and Territories have a legislative requirement for public authorities and/or entities to provide written responses to the recommendations of a coroner within a certain time frame, typically 3 months after the publication of the findings.[53]

The study cited in 11.1 found that the NT, SA and ACT had the highest implementation rates across all jurisdictions. At the time of publishing the study, those were the only jurisdictions that had mandated response requirements. There is a correlation, then, between mandatory reporting requirements in Australia and higher implementation rates. Victoria was found to the have the lowest implementation rate in the study. It has since adopted a mandatory response requirement.

Without a mandatory response requirement, coronial recommendations may be lost in the 'bureaucratic process'.[54] As stated in the study cited at 11.1, some government agencies were unaware that coronial recommendations had been made in relation to their agency and only became aware of the recommendations once the authors of the study made inquiries into the status of the recommendations. By requiring a response, the recommendations would at the very least come to the attention of department heads.

In order to ensure oversight of the implementation of coronial requirements, to address the lack of transparency in relation to implementation and potentially to increase the rate of adoption of coronial recommendations, we submit that a mandatory reporting regime be legislatively implemented in NSW through amendments to the Coroners Act.

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[51] See NSW Government, Government Responses to Coronal Recommendations, 5 August 2021. Available at https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

[52] R Watterson, P Brown and J McKenzie, *Coronial Recommendations and the Prevention of Indigenous Death*, January 2008.

[53] *Coroners Act 2008* (Vic) s 72; *Coroners Act 1997* (ACT) s 76, however the reporting requirement is restricted to deaths in care and deaths in custody; *Coroners Act 2003* (SA) s 25(5); *Coroners Act 1993* (NT) s 46B, requirement is restricted to deaths in custody.

[54] R Watterson, P Brown and J McKenzie, *Coronial Recommendations and the Prevention of Indigenous Death*, January 2008. p 2.

11.3 What the reporting requirement should include

We submit reporting on the implementation of the recommendations made in an inquest should be required and should include the following features:

(a) The reporting requirement should be legislatively mandated in the Coroners Act.

(b) Anyone in relation to whom a recommendation is made should be required to report on the implementation of the recommendation, not just government agencies.

The majority of mandatory reporting regimes currently in force require only public authorities to respond to recommendations. Given the important role public authorities play in preventable deaths, this is an important requirement. However, in light of the increasing privatisation of public functions, we also recommend that at a minimum the Committee consider whether it is appropriate to require private entities which perform public functions to also respond to recommendations.

(c) Given the coroner's role in ensuring public health and safety, responses should be required for all recommendations, not just recommendations relating to deaths in care and/or custody.

(d) The objectives of a mandatory response regime can be undermined if there is no incentive to respond or if responses lack clarity. These issues were raised in an evaluation of the Victorian mandatory reporting regime conducted by Sutherland, Kemp and Studdart, which found that "the objectives of Victoria's innovative mandatory response regime are being compromised by the opacity of many response letters".[56] In order to address this issue, we suggest that the request for responses be provided in the format suggested by Sutherland, Kemp and Studdart, that is, a series of structured questions designed to elicit the precise nature of the response and the entity be required to respond to these questions.

(e) Responses should be published online in addition to being provided to interested parties in line with the Victorian legislation.[57]

Recommendations are not made for recommendations' sake. The purpose of recommendations at the conclusion of an inquest is to address problems or failures that have led to a person's death. While it is hoped a recommendation will effectively address the problems or failures, they may not. We submit the Committee should consider whether or not the effectiveness of recommendations should be assessed in certain circumstances and if so, by whom.

Recommendation 24: That the Coroners Act be amended to require the following:

(a) That a person, agency or legal entity to whom a coronial recommendation is addressed must, within 21 days of receiving a coronial recommendation, acknowledge receipt of the recommendation in writing to the State Coroner;

(b) That a person, agency or legal entity to whom a coronial recommendation is addressed must, within six months of receiving the recommendation, or such other time as agreed with the State Coroner, provide a written response to the State Coroner stating what action has been, is being or will

[56] G Sutherland, C Kemp, D Studdert, Mandatory responses to public health and safety recommendations issued by coroners: a content analysis, Australian and New Zealand Journal of Public Health, 2016, p 451.

[57] *Coroners Act 2008* (Vic) s 72(5)(b).

be taken in relation to the recommendation and responding to any specific questions concerning the recommendations directed to the entity by the State Coroner; and

(c) That, unless otherwise ordered by the State Coroner, as soon as reasonably practicable upon receipt of the written response from the person, agency or legal entity, the State Coroner must publish the response on its website

Recommendation [x]: That the Committee consider whether the effectiveness of coronial recommendations should be assessed and reported on and if so, amend the Coroners Act to incorporate a mechanism for doing so

12 Case studies

The case studies below demonstrate many of the issues we have raised in our submission. Most of the issues arose in multiple matters we have acted in. Our clients have generously agreed to their experiences being the subject of a case study, however, to maintain their privacy the names of our clients have been changed.

Case study 1

Our client, Caitlyn, was the senior next of kin of her daughter Abigail, who passed away in 2013 from heart failure brought on by an asthma attack. Abigail had suffered from severe asthma all her life. Her asthma attack was witnessed by her friends who called the ambulance for Abigail. There were no suspicious circumstances surrounding Abigail's death.

Both Caitlyn and Abigail identify as Aboriginal women.

The Coroners Court contacted Caitlyn and advised that an autopsy would be performed on Abigail. Caitlyn objected to the autopsy in both telephone calls and in writing to the Coroners Court. Caitlyn's objections were for cultural reasons and because she did not consider an autopsy was necessary in the circumstances.

Caitlyn advised the Coroners Court of Abigail's lifelong history of asthma, and, for the three years leading to Abigail's death, the hospitals to which Abigail had been admitted for asthma and the medical services from which Abigail had received treatment for asthma. However, the Coroners Court only contacted one medical service and none of the hospitals. That medical service could not find a record of having treated Abigail for asthma in the previous three years. It was on that basis the Coroner decided an autopsy was required. Abigail had been hospitalised for severe asthma three times in the fourteen months before her death. Had the Coroners Court administration properly followed up on the information provided by Caitlyn and confirmed Abigail's hospital admissions and other treatment, it is unlikely that an autopsy would have been ordered.

Caitlyn felt under significant pressure from Coroners Court staff to withdraw her objection to the autopsy. She was contacted by the Court multiple times a day for several days following her daughter's death. When she maintained her objection to the autopsy she was advised by Coroners Court staff that despite her objection, the Coroner intended to order a full autopsy if Caitlyn did not agree to a partial autopsy. The Coroners Court failed to fulfil its statutory obligation to notify Caitlyn of her right to appeal to the Supreme Court against any order by the Coroner to conduct a post mortem examination.

Caitlyn was advised that the partial autopsy would only involve a small incision between the breasts to check Abigail's lungs. In order to avoid a full autopsy Caitlyn agreed to the partial autopsy.

The partial autopsy went well beyond a small incision between Abigail's breasts. Caitlyn suffered Post Traumatic Stress Disorder as a result of seeing her daughter's disfigured body after the autopsy and from discovering the extent and nature of the examination that took place.

Cutting a person open goes against Caitlyn's culture and beliefs as an Aboriginal person. Caitlyn believes that when a person goes to Dreamtime their body needs to be whole. Caitlyn remains deeply distressed about Abigail being cut open and the impact on Abigail in the afterlife.

Caitlyn remains distressed, too, by the knowledge that Abigail's body, in particular her genital area, was examined by male practitioners. Such an examination by a person of opposite gender is also highly culturally inappropriate, and is particularly upsetting given that, in the circumstances, there was no need to examine Abigail's genital area at all.

Caitlyn has suffered significant trauma as a result of the autopsy and her interaction with the Coroners Court administration.

Caitlyn had no legal recourse from the conduct of the Coroners Court administration and sought an ex gratia payment from the Attorney General in recognition of the wrongdoing by the Coroners Court administration and the harm she suffered as a result. However, her application for ex gratia payment was rejected.

Case study 2

Rachel appointed her grandson Alex (our client) as executor of her Will. When Rachel passed away, her son William applied to the coroner to be appointed senior next of kin. Alex indicated that he had no objection to William's appointment, but as Rachel's executor, he applied for Rachel's body to be released to him.

Alex was advised by Coroners Court staff that he had to provide evidence of his role as executor to his Local Court and Rachel's body would be released to him. Alex attended the Local Court and was advised that they had no jurisdiction to determine the matter. The person who provided this advice then failed to return Alex's calls to advise him what to do next to have the body released to him.

Following legal advice Alex wrote to the Coroner providing a copy of Rachel's Will and outlining the relevant legal principles that apply to the release of a body. However, in the interim William had asked that the body be released to him.

The Coroner advised Alex that as there were competing claims, the Coroners Court did not have the power to release the body and asked that the parties make all possible efforts to come to an agreement.

Alex attempted to contact the Community Justice Centre to arrange mediation, but received no response. No assistance was provided by the Coroners Court to resolve the matter.

Alex and William were unable to resolve the matter and ultimately Alex was required to commence proceedings in the Supreme Court in order to reach a resolution.

The protracted dispute and necessity of commencing court proceedings was extremely stressful for and damaging to Rachel's family.

Case study 3

Our client Juliet is the senior next of kin of her mother Faye, who passed away in 2017. It appears Faye committed suicide.

Faye, who had a long history of mental illness, sought help on the morning she died from both NSW Police and Ambulance. Juliet also sought urgent assistance for Faye on the evening of Faye's death from various services without success. During preliminary investigations into Faye's death, Juliet raised concerns about the conduct and lack of action of those services.

In 2019, approximately 17 months after Faye's death and prior to Juliet providing a statement to the Coroner about her interactions with the various agencies on the evening of Faye's death, Juliet was advised by letter that the coroner had not identified any systemic failings or issues which would require the holding of an inquest, and accordingly, the Coroner was proposing to dispense with the holding of an inquest.

Following receipt of this letter, Juliet advised the Coroner that she intended to request that the Coroner reconsider this decision, and later in 2019 Juliet provided additional material in support of her request for an inquest.

Following the provision of this additional material, Gilbert + Tobin followed up with the Coronial Law Unit on a number of occasions to determine the status of the matter. Initially, in January 2020, Gilbert + Tobin was advised the Coroner was considering the material. In June 2020, we were informed that the matter had been referred to the Crown Solicitors' Office (**CSO**) due to the concerns Juliet had raised about the police. We were advised it was unclear how long it would be until a response was received from the CSO. In November 2020, Gilbert + Tobin followed up with the Coronial Law Unit and was advised that a response from the CSO had not yet been received. In December 2020, Gilbert + Tobin was advised that carriage of the matter had been transferred to the Department of Communities and Justice (**DCJ**). Following further inquiries from Gilbert + Tobin, in April 2021, DCJ advised that the Coroner was no longer waiting on a response from the CSO, however, DCJ could not clarify the reason for the extensive delay prior to their involvement and indicated that they hoped to receive further instructions from the Coroner in the next week or so. In June 2021, DCJ advised that they had now received instructions to assist the Coroner with certain further investigations to determine whether an inquest is required. To date, no further update has been received.

Juliet is greatly distressed about the time it has taken for her mother's matter to progress and the lack of transparency from the Coroner's office about the delays. Almost four years after her mother's death, she has been unable to achieve closure and feels that the coronial process has been insensitive and retraumatising. The delay is particularly concerning given the Coroner is still only at the stage of making a decision whether or not to hold an inquest as if an inquest was to proceed, it is likely that it will be years before the matter is concluded.

Case study 4

Michael's son Nicholas passed away in 2017. Michael was appointed as senior next of kin. Nicholas had a significant disability and died during restraint by police and while living in out of home care. Gilbert + Tobin acted for Michael in the inquest on a pro bono basis. Despite the public interest in aspects of the inquest, Michael was ineligible for Legal Aid due to his income. His employment was uncertain, and while he was over Legal Aid's means test while he was working, he did not have the capacity to pay for a lawyer.

The first instalment of the brief of evidence was served eighteen months after Nicholas' death. There followed a series of updates to the brief of evidence, which continued right up until the inquest. As a

result of these initial delays and later challenges finding a hearing date, the inquest did not take place until three years after Nicholas's death.

Many people were involved in Nicholas' restraint and aspects of the restraint were relevant to findings on the cause of death and to recommendations that may be made about restraint. Unfortunately, some three years after the incident the memories of witnesses had faded such that it was not possible to establish critical facts about the restraint.

Michael's ability to raise issues for consideration in the inquest, to request additional evidence and generally to engage with the coroner on matters of concern prior to the commencement of the inquest would not have been possible if he had not been represented. Michael needed assistance to review and make sense of the voluminous material in the brief of evidence and to communicate his views. Although the solicitors assisting the coroner were receptive, engaged and sensitive in their dealings with Michael, they would not have been able to take Michael through the evidence with the same thoroughness as his own solicitors nor to provide him with options and advice.

Michael also required assistance to raise with the solicitors assisting the coroner those issues which required expert opinion. As Michael could not afford to engage his own experts to consider the issues before the Coroner, Michael's ability to engage with the solicitors assisting the coroner early in the process was essential to ensuring that, where his concerns required expert opinion, that opinion could be sought from the Coroner's experts. Michael's lack of access to experts resulted in significant additional work to properly understand and test the evidence of the Coroner's experts, much of which was technical medical evidence and meant that Michael could not put alternative expert opinion.

While it was important to Michael that all of the necessary steps be taken to ensure the factors resulting in Nicholas' death were properly considered in the inquest, the three years between Nicholas' passing and the hearing into his death took a significant toll on Michael's mental health and cast a heavy shadow over that time. s

Case study 5

Jonathan's wife Margaret passed away in early 2018. In June 2018, Jonathan was advised that the Deputy State Coroner assumed jurisdiction and ordered a police brief of evidence.

Prior to her death Margaret had engaged a non-medical practitioner promoting health and dietary services. A significant consideration in the investigation of Margaret's death is whether those services in any way contributed to her passing. The NSW Department of Public Prosecutions (**ODPP**) is considering whether or not to prosecute the practitioner. The Coroner has postponed the decision about whether or not to conduct a coronial inquiry until after the ODDP has made a decision about the prosecution of the practitioner.

A police brief was provided to the ODPP in late 2019/early 2020. Since June 2018, so far as we or our client has been advised, the only progress is the completion of the police brief. Our team has written to the ODPP and the Coroner requesting updates and none have been forthcoming. There is no indication of how much longer Jonathan will have to wait for a decision on whether or not there will be a prosecution or an inquest.