Supplementary Submission No 14a

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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COMMENTS ON NSW GOVERNMENT'S SUBMISSION

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Introduction

In this paper I will comment on a number of features of the NSW Government's submission to this inquiry. First, the government deserves commendation in a number of respects. I will identify and comment upon them. Second, the submissions have not engaged with important issues. Those, too, will be identified and discussed. Lastly, I will evaluate the supposed advantages put forward by the government for maintaining the current structure of the Local Court's coronial jurisdiction.

(i) The government and State Coroner lay a foundation for a better system

The NSW Government's submission lists a number of ways in which it has responded to criticism and is attempting to make the coronial system more efficient and responsive to the needs of bereaved families.

First, the document provides insight into what appears to be an important turn in the government's conceptualisation of the coronial system: it is no longer considered as an appendage of the Local Court but as a *multi-disciplinary complex* involving a number of partner departments and agencies.

Secondly, it acknowledges that the prevention of future death and serious injury is "a central tenet" of the coronial system. The implications of that insight are vital.

Thirdly, delay in the system has multiple adverse effects, distress for bereaved families being the most important. The submission shows that complaints and evidence of serious delay within the system are being taken seriously.

Fourthly, the State Coroner's initiative of issuing a Practice Note in respect of s 23 inquests (dealing with deaths in custody and police operations) and a special Protocol for engaging better with Aboriginal families affected by such inquests is significant in both practical and symbolic ways.

Fifthly, the appointment of Aboriginal family liaison officers within the Coroners Court is a form of recognition of the unique place of Aboriginal people in Australian society and their special needs with the coronial system.

Reconceptualising the system

The most important aspect of the whole of this document is that it reveals that since 2019, when the Improving the Timeliness of Coronial Procedures Taskforce was set up, there has been a growing understanding within the NSW government that the coronial system is a multi-disciplinary complex – a death investigation *system* – involving a number of government departments and agencies which need to be combined and harmonised for it to work efficiently and effectively.

People working within the NSW system know how multifaceted the coronial system is. But for many years the Local Court, the largest criminal court in Australia, has run, and been allowed by government to run, the coronial system as if it were a 'lesser jurisdiction' or sideline activity of the court. Few have questioned this.

It is only recently, as the problems and inefficiencies that flow from treating a major death investigation system as a 'lesser jurisdiction of the Local Court' have been recognised, that this reconceptualization has begun to take place within government. The reaction to criticism of chronic delay has been to take a whole-of-government approach with the Taskforce and the Coronial Services Committee being established to co-ordinate and eliminate friction within the system.

Reconceptualising the coronial system in this way has a number of implications. One of the most obvious is that its complexity requires specialist coroners who understand its multidisciplinary character to make it work effectively and efficiently and to maximum effect. Country and regional magistrates are not trained, experienced or resourced for this task.

Secondly, management and co-ordination of such a multidisciplinary system for optimal service and performance is very difficult in the current structure which, in country and regional NSW, is akin to a cottage industry with magistrates exercising very wide discretion, sometimes quite idiosyncratically, without direct guidance in coronial matters.

A centralised specialist court would be likely to operate much more efficiently and effectively and harmoniously with its NSW Health and NSW Police partners than the current outmoded structure which the government submission has implicitly depreciated.

Thirdly, a multidisciplinary death investigation system, conceptualised as such, needs to structured and resourced accordingly.

Prevention of death as "a central tenet of the coronial jurisdiction"

It is interesting that the government argues that death prevention is a 'central tenet' of the coronial system because the Coroners Act, unlike similar Acts in Queensland, Victoria and New Zealand, does *not* emphasise the preventive role of coroners.

It is not until the fifth object of the Act that prevention makes a shy appearance - the Act is 'to enable coroners to make recommendations in relation to matters in connection with' inquests and fire inquiries concerning issues of public health and safety and investigations by other

bodies.[1] Read in the context of the Act's objects, and the Act overall, as well as legal authority,[2] death prevention would appear to be a secondary consideration of the NSW legislation.

One of the limitations of the NSW system is that its legislation empowers coroners to make recommendations only when holding inquests.[3] (In contrast, while holding few inquests, Ontario coroners and death review committees make many recommendations out of their investigations. In 2018, for example, they made approximately 600 recommendations.)[4] Compounding this problem is the fact that, although approximately 45% of reported deaths occur outside the metropolitan area, country and regional magistrates hold few inquests and make even fewer recommendations. They rarely address systemic issues causing preventable deaths.

Coronial systems can contribute to reducing risk of death in five main ways:

(i) By holding investigations which identify root causes of fatal incidents, especially systemic failures causing preventable deaths;
(ii) By prompting remedial action in respect of preventable deaths;
(iii) By making remedial recommendations;
(iv) By collecting and collating data which enable patterns and trends of preventable death to be identified; and
(v) By analysing those data and recommending preventive interventions.

In NSW, fatal incidents are investigated. In some, but not all, cases, root causes are identified. Fatal incidents frequently, but not always, prompt remedial action by agencies and organisations. For example, Root Cause Analysis investigations in the NSW Health system will often, but not always, result in useful preventive recommendations being made. The possibility of an inquest being held is an added incentive for agencies to take action to obviate potential criticism. Inquests conducted by specialist coroners frequently result in recommendations being made. All this has been recognised in NSW for many years.

Where NSW has fallen short, however, is in failing to optimise the public health and safety potential of the coronial system. In 2012, Associate Professor Lyndal Bugeja and a group of Victorian researchers with an interest in the preventive potential of coronial systems observed:

> Over the last 60 years, a scientific approach to injury causation and prevention has developed within public health. Application of this scientific approach has led to injury

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1 Coroners Act 2009 (NSW) s 3(e).

2 *X v Deputy State Coroner of NSW* [2001] NSWSC 46.

3 Coroners Act 2009 (NSW), s 82(1)

4 Ontario Auditor-General, *Annual Report 2019,* Ch. 3.08, 455. https://www.auditor.on.ca/en/content/annualreports/arreports/en19/v1_308en19.pdf

> being analysed in terms of population burden, risk factors, countermeasures and programme implementation.[5]

Bugeja's public health approach in coronial systems would see coronial data used to identify trends and patterns of preventable death. It would identify vulnerable or priority populations (e.g,, nursing home residents, patrons of music festivals, rock fishers); risks and contributing factors common to these populations; countermeasures; levels of intervention needed to address the risks (e.g. legislation; policy and standards; advocacy and education); strategies for implementation; organisations (who should implement the strategies); and suggest timeframes for implementing interventions.[6]

The public health value of coronial data has not been understood well within the Local Court nor has a high premium been placed on it in the coronial system more broadly. Until recently, when a suicide register was established, the only data collection and analysis carried out within the Coroners Court for public safety purposes was by the Domestic Violence Death Review Team. The work of that team is a very good example of how coronial data can be aggregated and analysed for public health and safety purposes.

In his Second Reading speech, Attorney-General the Hon. John Hatzistergos described the Domestic Violence Death Review Team's purposes as follows;

> The object of the bill is to create a statutory framework that will support the operation of the expert, multidisciplinary Domestic Violence Death Review Team. The team will through its functions work *to* ***identify systemic issues and causes of deaths occurring in a domestic violence contex*****t. *The focus is on reducing the incidence of these types of deaths through facilitating improvements in systems and services*****.** The review process is not a coronial investigation; it does not reinvestigate matters. The Domestic Violence Death Review Team will have a collaborative approach and will be informed by and learn from domestic violence deaths with the aim of identifying areas of service delivery or intervention that can be improved. Its ability to share information with similar review mechanisms and the involvement and active participation of key stakeholders ensures a holistic approach.
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> The Domestic Violence Death Review Team is to have the following functions: *review* closed cases of domestic violence deaths in New South Wales, or a death of a person who usually resides in New South Wales; ***analyse data to identify patterns and trends***

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5 Lyndal Bugeja et al., "Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention", (2012) 18 *Injury Prevention* 326-333.

6 Bugeja (2012); see also Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016), Ch 5 "The promise of saved lives: coroners' preventive function" especially at 182-193 on the public health approach and use of coronial data and statistics for preventive purposes.

> related to such deaths; ***make recommendations to prevent or reduce the likelihood of such deaths*; *establish and maintain a database about such deaths*; and *undertake research that aims to help prevent or reduce the likelihood of such deaths***. The bill also enables the team to review a death, notwithstanding the fact that it may be the subject of review by the Child Death Review Team, and contains provisions that enable information transfer between the two review mechanisms.[7] (Emphasis added.)

A public health approach to death prevention has as *its* central tenet data collection and analysis of key data, and systemic reform. Interestingly, the Hon. Robyn Parker, who spoke for the Opposition in the debate, which supported the bill generally, argued that the Ombudsman's Office would have been a better repository for the team because the Ombudsman's Office "promotes *systemic changes to combat issues* rather than apportioning blame".[8] (Emphasis added.) That could be a description a good coronial system.

The emphasised portions of the Second Reading speech demonstrated an intuitive understanding of the public health and safety potential of the coronial system. Yet, having established the DVDRT within the coronial system as a research unit a decade ago, the lessons were seemingly forgotten. No further action along these lines was taken until the suicide register was begun in 2020.

Professor Bugeja and Dr Jeremy Dwyer have described the Victorian Coroners Prevention Unit's methodology.[9] It collects and collates data. It conducts literature reviews to establish the epidemiology of mortality at state, national and even international levels; to identify known risks and protective factors; and to pinpoint promising or proven interventions. It consults with key agencies and organisations to obtain practical understanding of risk factors and possible prevention approaches. It conducts critical analysis of these data and other material to develop evidence-based preventive recommendations that can be applied by coroners or provided to relevant agencies.

On a much broader scale, the National Coronial Information System is a database which collects coronial data from all Australian jurisdictions as well as from NZ. For epidemiological purposes, however, the database is only as valuable as the data provided to it.

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7 Hansard, Legislative Council, 1 June 2010. https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-40658/link/2153

8 Hansard, Legislative Council, 1 June 2010. https://www.parliament.nsw.gov.au/Hansard/Pages/HansardResult.aspx#/docid/HANSARD-1820781676-40658/link/2153

9 Lyndal Bugeja and Jeremy Dwyer, "Enabling public health and safety through the coroners' death investigation system", (2016) 19:2 *Grief Matters* 47-51.

Unfortunately, provision of data by the NSW Local Court to the NCIS has been sub-optimal as the following table from the NCIS's operational statistics shows:[10]

Document attachment

Table 3: Document attachment rates by jurisdiction and document type

Jurisdiction	Police	Autopsy	Toxicology	Finding
NSW	58%	78%	66%	80%
VIC	94%	96%	98%	93%
QLD	95%	74%	51%	72%
SA	100%	1%	26%	88%
WA	100%	80%	92%	97%
TAS	99%	85%	93%	92%
NT	98%	94%	77%	98%
ACT	98%	93%	78%	98%
NZ	99%	99%	86%	99%

Note: only cases where a particular document type was produced have been included in the preparation of this data.

The NCIS reports that "Electronic copies of the police narrative of circumstances are routinely available for NSW cases investigated by the State Coroners Court (Lidcombe). However, these reports are less frequently available from local courts in regional areas of NSW".[11] (Emphasis added.) The NCIS also reports that " Statistics for NSW findings relate only to those cases where an inquest was conducted".[12]

Although NSW is one of the two largest jurisdictions in Australia, the NSW coronial system presents as one of the least efficient in Australia in providing full sets of coronial data to the national database. The reasons for this appear to be: (a) in a large number of cases, Local Court registries in NSW country and regional courthouses do not provide police reports of deaths (known as 'P79As'); (b) the Coroners Act does not require coroners or even empower coroners to making findings in relation to the 'manner' or circumstances of death if no inquest is held;[13] and (c) there may be a lack of co-ordination in the gathering together of NSW Health reports, NSW police reports and coroners' findings to be provided to the NCIS.

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10 NCIS Operational statistics – Document attachment rates – July 2021. https://www.ncis.org.au/about-the-data/operational-statistics/

11 Ibid.

12 Ibid.

13 For this reason, unlike coroners in some other states, such as Victoria and Queensland, in NSW coroners do not write "chamber findings" – that is, findings made without holding an inquest.

If an inquest is not held, coroners are required to provide 'particulars relating to death' to the Registrar of Births, Deaths and Marriages – the identity of the deceased person, the date, place and cause of death but *not* the 'manner' of death: s 34. In an inquest, on the other hand, a coroner must seek to determine each of those particulars *as well as* 'manner' of death: s 81. As approximately 6500 reports of death are made per annum, but only about 115 inquests are conducted, the NCIS does not receive coroners' findings in relation to 'manner' of death in about 98% of cases. It is then dependent the police reports for those details. But P79As are often inaccurate due to being made on very limited evidence shortly after the death occurs. And in about 40% of cases, even those reports are not provided by the NSW Local Court to the NCIS. If prevention is truly a 'central tenet' of the coronial system, this flaw in the Act which prevents coroners providing valuable data to the NCIS on 'manner' or circumstances of death needs to be fixed.

The problems the NCIS operational statistics reveal is further evidence of the need for better co-ordination of the NSW coronial system, and the need for better training of coroners, magistrates and registry staff in the public health value of coronial data. It is also another argument for relieving country magistrates (and registries) of coronial responsibilities and recognising the coronial jurisdiction as a domain requiring specialist training and skills.

In summary, if prevention of death is, indeed, a central tenet of the coronial system, the system needs to be structured and organised to enable it to carry out that function as well as reasonably possible. State Coroner O'Sullivan is well aware of the value of coronial data. She was a prime mover in establishing the suicide register which is referred to in the government submission. Victoria and Ontario are good exemplars of this methodology. Lessons can be learned from them. Placing practical emphasis on public health and safety is the way forward for a modern death investigation system.

What the submissions do not say

The government's submissions are interesting as much for what they do not say as for what they do. In the middle of a Covid pandemic, the crisis of the century so far, it is understandable that the government's attention is largely engaged elsewhere. This may explain some omissions.

The submissions refer to the Select Committee Inquiry into High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, the "Ice" inquiry, the incomplete statutory review of the Coroners Act, and the Timeliness Taskforce as raising matters which it is considering. It is impossible, from the submission, to discern any clear policy direction developing.

It seems that the government's thinking on these issues is in a state of flux. Despite demonstrating real advances have been made, the submissions:

(i) Provide no clear sense of the fundamental purposes or objectives of the coronial system;

(ii) Do not consider the Act itself;

(iii) Reveal no strategic plan for the coronial system;

(iv) Do not compare the NSW system with other coronial systems;

(v) Do not refer to, or even acknowledge, inquiries undertaken in other Australian and international jurisdictions into coronial systems or what flowed from them;

(vi) Offer no evaluation of the strengths and weaknesses of the current system;

(vii) Do not engage with the arguments made for a specialist coroners court;

(viii) Do not address the anomaly of the Local Court both sentencing people and investigating their deaths in custody.

In relation to (i), the submissions do, of course, highlight the death preventive purpose of the coronial system. Other purposes have been identified: respect for life; recognition of the dead and bereaved; holding the state to account where it involved in deaths; therapeutic and restorative justice. Although to some degree implicit, those matters were not paid express attention in the submissions.

To develop an optimally or even well-performing coronial system, it needs to address these issues. Significant lessons can be extracted from legislation, practice and inquiries in other jurisdictions and from close internal analysis of the NSW legislation and coronial system.

The structure of the Coroners Court – the government's argument

With respect, the weakest part of its whole submission is the government's list of advantages of maintaining the current system. In my own submission, I listed several more than the 4 outlined in the government's paper.

Three of these points should be dismissed immediately:

(i) "Increased flexibility in managing judicial resources across each jurisdiction"

This argument implicitly ignores the specialist nature of coronial work. It assumes that, because most magistrates are criminal law specialists, they equally adept at slipping in and out of the jurisdiction. That belief appears to derive from a notion that the coronial system and coronial work is an offshoot of the criminal justice system and the work is similar to criminal justice work.

That conception of a coronial system was declared 'outmoded' by the Brodrick Report in England in 1971.[14] Why it persists in NSW 50 years later, when only about 1% of reported deaths are suspected homicides, and most are resolved by police investigations, and when most coronial cases have much more to do with medicine, psychiatry and psychology, human error and systems failure, is difficult to understand.

That this idea is so persistent, however, probably has much to do with the history of coroners being embedded in the magistrates' courts. They have been unchallenged in their domination of the system for more than a century. Once the linkage with the criminal justice system was snapped, the structure of the system should have been reshaped. It was not. This inquiry should encourage the government to reconsider that history and its policy implications.

The government's argument also ignores experience and empirical evidence. Inexperienced magistrates coming into the jurisdiction take time to learn coronial work. In 2016, when several experienced coroners were rotated out of the jurisdiction or retired and were replaced by inexperienced magistrates, the number of inquests conducted collapsed from 150 in 2015 to 84 in 2017. Handovers, training, learning from experience all took time. The number of inquests began to rise again as the new coroners learned their craft but it took time.

The view that coronial work is relatively straightforward and can be done equally well by all magistrates is also belied by the performance of country magistrates as coroners.

If replacements are needed urgently, it would be much more efficient to recruit from Acting Magistrates *with coronial experience* or even members of the legal profession experienced in the jurisdiction. Experience is the key to efficiency in this specialist jurisdiction.

If the true sub-text of argument is actually the problem of dealing with under-performing or 'difficult' coroners (or magistrates), the submissions should have been direct on this point. It would make little sense to maintain an inefficient and under-performing structure, involving a large number of magistrates, at considerable cost, because, if a specialist court were to be established, it would eliminate the option of swiftly removing an under-performing coroner and 'hiding' him or her somewhere in the Local Court.[15]

In all courts, from time to time, there will be under-performing judicial officers. If a specialist court were to be set up, as in all other courts, leadership, recruitment, professional development,

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14 Ian Freckelton and David Ranson, *Death Investigation and the Coroner's Inquest,* (Melbourne: Oxford University Press, 2006), 23.

15 Under the current system, the Chief Magistrate has power to move magistrates, including specialist coroners, to any courthouse in his or her discretion: Local Court Act 2007, s 23(1). Metropolitan magistrates, including specialist coroners, are liable to be rotated every 3 years and country magistrates every 5 years. Whether they are rotated is a decision of the Chief Magistrate. Occasionally magistrates are moved for other reasons.

medical or psychological assistance, and general management would have to be the tools applied to protect the organisation and its work if under-performance were to become a significant issue. If a specialist court were set up it would also be possible, and may be desirable, to appoint coroners, as in Victoria, for a limited (but renewable) term.[16]

(ii) "Increased access for coroners to judicial resources and training"

This is a non sequitur. Does anyone suggest that if the structure of the system was changed, coroners would lose access to judicial resources and training? Coroners already have access, as magistrates, to judicial resources and training through the Judicial Commission. Establishing a specialist court would not alter that.

Maintaining the current structure of the court does not *increase* access to resources or training for coronial work. There is no reason why the Judicial Commission could not provide specialist coronial training and professional development for specialist coroners. The Judicial College of Victoria does so. Michael Barnes and I have presented coronial training through the National Judicial College of Australia. The structure of the current system has no bearing on any of this.

(iii) "Reduced risk of vicarious trauma"

No evidence is presented to suggest that coroners suffer vicarious trauma. To my knowledge, there is no basis for the claim that maintaining the current structure reduces the risk of vicarious trauma. In my 9 years as a coroner not a single coroner ever complained of vicarious trauma. I am unaware of any cases of vicarious trauma occurring among coroners since I left the court in 2016. In fact, all the coroners I worked with enjoyed the work because they regarded it as a positive jurisdiction in which you sought to help distressed families and to prevent future deaths. The same can be said for counsel, solicitors and police advocates assisting coroners. Similarly, forensic pathologists and staff of the Department of Forensic Medicine seemed immune from vicarious trauma.

I am, however, aware of distressed magistrates. Magistrates have committed suicide in other jurisdictions. In my own case, I found 12 years of constantly dealing with cases of violence, cruelty and even depravity in the Local Court's criminal jurisdiction far more psychologically taxing than working in the coronial jurisdiction.

For me, several protective factors operated in the jurisdiction against psychological harm: the positive ethos of the jurisdiction; working with fellow coroners, pathologists, family counsellors, police officers, counsel and solicitors whom I respected and admired as human beings; working as in teams; constantly learning; being able to provide answers for families;

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[16] Coroners Act 2008 (Vic) s 94(3)(b). Coroners are appointed for up to 5 years with the possibility of renewal. Within the terms of their appointments, they are only removable in the same way as a magistrate is.

being able to show recognition and respect to grieving people and being the recipient of their respect and gratitude; having a sense of doing good and performing a genuine public service.

(iv) "Reduced duplication of administrative functions and costs"

Superficially, this is the most cogent of the supposed advantages of maintaining the current structure. The submission seems, in essence, to be that it is cheaper to run 45% of the state's coronial workload out of country and regional courthouses than to establish a specialist court. This may be so but not because work would be duplicated if a specialist court were established.

It is not clear, from the submission, what duplication would be involved in centralising all coronial work in a specialist court. The registry work currently being done around the state would be done in the registry in Lidcombe. More registry staff would be required at Lidcombe and fewer in the country and regional courthouses. There is already a specialist coronial complex at Lidcombe – a new building would not be needed.

Recruiting additional specialist coroners would incur additional recurrent expenditure and some capital costs to provide accommodation for them. Some of those additional costs could potentially be mitigated by making adjustments within regional courts: fewer regional magistrates may be needed if all were relieved of coronial responsibilities.

The submission does not quantify what additional cost would be incurred by restructuring the coronial system to create a specialist court. NSW does not quantify the costs of providing coronial services in regional courts. But the submissions suggest that the differential between recurrent expenditure in NSW and in Victoria and Queensland is less (and probably much less) than the Productivity Commission's comparisons appear to show.[17] It useful, therefore, to consider the Productivity Commission's data.

The 2021 Report on Government Services shows that the 2019-20 costs *per case finalised* for all jurisdictions were as follows:

NSW $990; Victoria $3150; Queensland $2165; WA $2738: SA $1779: Tas $2199; ACT $5023; NT $3827 with an Australian national average of $2195 per case.[18]

These figures suggest that the costs of finalising cases in NSW are 55% lower than in the next least expensive state, SA. This is so unlikely that it is probable that the NSW Local Court is not properly costing cases, even when they are dealt with in the Lidcombe complex, because many costs are being submerged in general recurrent expenditure of the Local Court as a whole.

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17 See Productivity Commission, *Report on Government Services 2021* Table 7A.12. Real recurrent expenditure (excluding forensic costs) in 2019-20 on coroners courts was $6,908,000 for NSW; $21,549,000 for Victoria; and $12,437,000 for Queensland.

18 See Productivity Commission, *Report on Government Services 2021* Table 7A.35

And this problem is compounded by its failure to cost the 45% of cases dealt with in regional courts *at all*.

It seems more likely that the true costs of finalising a coronial case in NSW are close to the Australian average. Queensland is a better comparator than Victoria because it has a specialist court but it does not have a large in-house research unit (which is probably why Victoria's costs are above the national average). In population terms it is the third largest state in Australia. It is also a large state with a relatively decentralised population. Like NSW, it sits under the umbrella of the Queensland Magistrates Courts and shares facilities with it. Its costs are almost exactly the same as the national average.

Assuming that 6500 cases are finalised each year in NSW and that the cost per case is the national average of $2195, the true annual recurrent cost of the Local Court's coronial work would be about $14,250,000. That is around twice the sum reported by the Productivity Commission. It is approximately two-thirds of the recurrent expenditure of Victoria. If this estimate is reasonably close, the real difference in recurrent costs between NSW and Victoria is only about $7 million per annum, much of this being attributable to the cost of the Victorian Coroners Prevention Unit.

When the value of a statistical life in Australia in 2021 is estimated at $5.1 million[19], this puts the cost and value of the Coroners Prevention Unit in proper perspective. Savings lives is an economic benefit. If the CPU is even moderately effective in mitigating risk of deaths, investing in it seems a 'no-brainer'.

With or without a CPU, establishing a specialist Coroners Court of NSW can be justified on a cost-benefit basis for the following reasons:

- Measured against the background of the whole justice and public safety recurrent expenditure budgets, the additional costs would be very small;
- the system as a whole would certainly operate more efficiently in conducting death investigations;
- the quality of coronial services would significantly improve;
- it would work more restoratively and therapeutically for bereaved families;
- it would be more effective in conducting inquests into deaths in custody and police operations;
- the system would contribute much more to public health and safety;

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[19] Australian Government. Dept of Prime Minister & Cabinet. Office of Best Practice Regulation, "Best Practice Regulation Guidance Note: Value of statistical life", (August 2021). https://obpr.pmc.gov.au/sites/default/files/2021-09/value-of-statistical-life-guidance-note-2020-08.pdf

- last, but certainly not least, it would be fiscally transparent and accountable in ways the current system is not.

Conclusion

The government, working with the excellent State Coroner, has laid a promising foundation for reform of the coronial system.

As I have pointed out in my own submission, the system has significant strengths especially the quality of the people involved and the magnificent new facility at Lidcombe.

New directions are being developed – co-ordinating and harmonising the system, recognising the special place of Aboriginal people and emphasising prevention of death and injury as a 'central tenet' of a modern coronial system. The government and State Coroner deserve real credit for this.

Nevertheless, the government has yet to crystallise a clear policy direction concerning the coronial system. It needs to do so – the issues are clear but the nettle must be grasped.

Instead of lagging behind the rest of Australia in this domain with an outmoded structure and lack of clear purpose, the NSW Government should grasp the opportunity this inquiry presents, not simply to catch up but, as it did when it built the Lidcombe facility, to take the lead in this small but very important niche of the legal and public health systems.

7 September 2021