REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

INQUIRY INTO THE CORONIAL JURISDICTION IN NEW SOUTH WALES

UNCORRECTED

At Macquarie Room, Parliament House, Sydney, on Tuesday 30 November 2021

The Committee met at 10:15.

PRESENT

The Hon. Adam Searle (Chair)

The Hon. Trevor Khan
Mr David Shoebridge (Deputy Chair)
The Hon. Rod Roberts

PRESENT VIA VIDEOCONFERENCE

The Hon. Catherine Cusack
The Hon. Penny Sharpe

The CHAIR: Welcome to the second hearing of the Inquiry into the Coronial Jurisdiction in New South Wales. Before I commence, I acknowledge the Gadigal people of the Eora Nation, who are the traditional custodians of the land on which we meet today. I pay my respects to their Elders past, present and emerging and extend that respect to other Aboriginal persons present. Today we will be hearing from a number of stakeholders, including legal services, medical experts, public policy organisations and representatives from government agencies as well as, most importantly, families with lived experience of the coronial system. While we have many witnesses with us in person, some will be appearing via videoconference today. I thank everyone for making time to give evidence to this important inquiry.

Before we commence, I make some brief comments about the procedures for today's hearing. Today's hearing is being broadcast live via Parliament's website. A transcript of today's hearing, when available, will be placed on the Committee's website. In accordance with the broadcasting guidelines, media representatives are reminded that they must take responsibility for what they publish about the Committee's proceedings. While parliamentary privilege applies to witnesses giving evidence today, it does not apply to what witnesses say outside of their evidence at the hearing. I therefore urge witnesses to be careful about comments they may make to the media or others after they complete their evidence.

Committee hearings are not intended to provide a forum for people to make adverse reflections about others under the protection of parliamentary privilege. In that regard, it is important that witnesses focus on the issues raised by the inquiry terms of reference and avoid naming individuals unnecessarily. All witnesses have a right to procedural fairness according to the procedural fairness resolution adopted by the House in 2018. If witnesses are unable to answer a question today and want more time to respond, they can take a question on notice. Written answers to questions taken on notice are to be provided within 21 days. If witnesses wish to hand up documents they should do so through the Committee staff. By the same token, they can provide further documentation on notice if they wish to do so.

In terms of the audibility of today's hearing, I remind Committee members and witnesses to speak into the microphone. As we have a number of witnesses in person and via videoconference, it may be helpful to identify to whom questions are directed and who is speaking. For those with hearing difficulties who are present in the room today, please note that the room is fitted with induction loops compatible with hearing-aid systems that have telecoil receivers. Finally, I ask everyone to turn their mobile phones to silent for the duration of the hearing.

RON TOPIC, Father of Miss Courtney Jayde Topic, sworn and examined

LEESA TOPIC, Mother of Miss Courtney Jayde Topic, sworn and examined

The CHAIR: Would either of you like to give a brief opening statement?

Mrs TOPIC: I would like to, please. Good morning, ladies and gentlemen. My name is Leesa Topic. Alongside me is my husband, Ron. We are the family of Courtney Jayde Topic. Courtney was not just a beloved daughter, sister, granddaughter, cousin, work colleague and friend; she was an integral part of our closely knit family. She continues to be so, but sadly we are now forced to live without her. Courtney and her three brothers were our awesome foursome. That has forever been torn apart. We are that family. Tragically and senselessly, our precious daughter, Courtney, was shot dead by New South Wales police whilst in the midst of a mental health crisis on 10 February 2015 at 11.48 a.m. It was her first psychosis, to our knowledge. She was shot on the grass verge at the corner of Cowpasture Road and Hoxton Park Road within 41 seconds of New South Wales police arriving on scene. All calls to police were for concern for self-harm welfare check.

As this was a sudden, unexpected and unnatural death, our family was thrust into and endured the coronial inquest process, subsequent findings and all that those processes entail. It is a gross understatement to say that this was another harrowing and frightening experience within the horrific journey that we were already living, yet we believed it to be a vitally important component of the process. We wanted the truth, transparency, accuracy and a fully funded investigation. We are here today to put forward our lived experiences of these processes. Thank you.

The CHAIR: Committee members, who would like to start the questioning? Mr Khan?

The Hon. TREVOR KHAN: Yes. Firstly, can I express my—I am sure others will as well—appreciation for you coming, and also my acknowledgement of your loss and what you have been through.

Mrs TOPIC: Thank you.

The Hon. TREVOR KHAN: As I understand it, there are really two parts to this: one in terms of the internal police oversight of what happened to your daughter; and, the second, the court experience that you had.

Mrs TOPIC: Yes.

The Hon. TREVOR KHAN: In your submission you, in a sense, refer to both, but if we go to the court experience part of it, it seems to me that the first part of the exercise that is cause for legitimate concern is the lack of information that you got as to the process. Is that right?

Mrs TOPIC: Absolutely. We felt we were excluded from the process and we had no concept of what it involved. We had never had anything to do with the police, with courts, with anything, and it made it very difficult. Nobody was explicit with us in explaining what to expect or what to do. We had legal representation obviously, so we were up on some of the legal technology. But, as to the actual day-to-day proceedings, we were clueless, to be honest, and that added completely to our stress at a very tricky and difficult time in our lives.

The Hon. TREVOR KHAN: Sure. I think in your submission you say, in a sense, somebody indicated to you that you might be entitled to legal aid. How long after Courtney's death were you advised that you might be entitled to legal representation through Legal Aid; and, secondly, how long after Courtney's death was it that you actually were able to meet with a solicitor and start to get some sort of picture as to what might or might not occur?

Mrs TOPIC: We had no contact, just in context, with police from when the detectives from the local area command handed over to homicide, for five months after that point. So it was only five months later when Detective Inspector Gary Jubelin was brought on board and he suggested to us that we should go forward in terms of legal representation, so it was by a police officer that we were told that we could go forward five months after Courtney had been killed.

The Hon. TREVOR KHAN: So none of the local police that initially dealt with you provided—

Mrs TOPIC: No.

The Hon. TREVOR KHAN: I think you make a reference—and there have been a lot of submissions—to the fact that the police who originally attended to tell you that your daughter had been killed were pretty reasonable in terms of their approach.

Mrs TOPIC: They were.

The Hon. TREVOR KHAN: But they did not give you any advice beyond that initial advice that there had been a shooting?

Mrs TOPIC: The initial detectives—I was at work on the day and they were wonderful, given what they were having to tell us, and they were with us for the first week. After a week—and Courtney was not buried until nine days after she passed, so we had not even laid her to rest yet—it was handed over to homicide. The detectives from that week had given us a business card—"Here's a business card if you need anything"—and that was the end of the story. We had no idea whether we were criminals, whether Courtney was considered a criminal. We had no idea what was going on. We had not even laid our daughter to rest at this point. We were almost—well, we were in shock, absolutely.

The Hon. TREVOR KHAN: Sure.

Mrs TOPIC: Nobody was clear with us and we did not even understand that there could be a coronial investigation until we were told five months later when it was suggested to us, "You are entitled to legal aid", to apply and so forth.

The Hon. TREVOR KHAN: I am going to hand over questions. I have to whip out for what I think will be 15 minutes for a meeting. Please do not take that as in any way an indication of my lack of concern in terms of what has happened to you. Your submission is consistent with others that we have received in the past, particularly in the First Nations inquiry.

Mrs TOPIC: Okay.

The Hon. TREVOR KHAN: So I get the point you are making entirely.

Mrs TOPIC: Thank you.

Mr DAVID SHOEBRIDGE: Ron and Leesa, thanks so much for coming today and for your submission. Of course, we all share empathy with you in the loss of Courtney. The police turned up some time in the mid-afternoon. Is that right?

Mr TOPIC: Late afternoon.

Mrs TOPIC: I was at work when the police turned up. It was twenty to three. Records will say that she passed away at 11.48 a.m. They could not find us because we were cleanskins.

Mr DAVID SHOEBRIDGE: Can you tell me when you next had proactive contact from the system, if I can put it more broadly—police, coroners, counsellors' support—when you had lost your daughter? When was the next time you had proactive contact from the system?

Mr TOPIC: The Cabramatta detectives had a job to do, which was to locate us, inform us and then with our requests and their suggestion we all gathered back at Leesa's parents' place. So we did not go back to the family home. They had boxes that they had to tick. They had to do a walk-through of the home, so we agreed to that and I asked if I could be part of it, so I went back to the home with Cabramatta detectives and we did a walk-through. We looked for a smoking gun. We looked for something that indicated what would have caused this situation. They took diaries, they took hard drives, laptops, iPads—that sort of thing. They also took medication to do a countback on medication and that. An autopsy had to be done as part of the process. Once they sort of got that out of the road they indicated to us that, once the autopsy was complete, we would need to go into the morgue and identify Courtney, and they were quite happy to be part of that journey with us. By that time we did transition back to the family home.

There was media parked across the road and camped out there for days. We did not want to interact with them because we had no idea of what had just happened. We had no idea. We did not know if we were victims or criminals or whatever, so we just did not want to go anywhere near the media. Cabramatta detectives did pick us up from the family home and take us to Glebe morgue, where we identified Courtney and we signed off on that, and then they brought us home and spent some time with us and said that, unfortunately, they had to leave us, that was the end of their jurisdiction, and that is when they gave us the business card for homicide.

Mr DAVID SHOEBRIDGE: How long was that process that you have just described?

Mr TOPIC: Like Leesa said, Courtney was not laid to rest until nine days afterwards. We were not entitled to see Courtney until two days after the event because of the autopsy and, with that, there was a backlog of that sort of situation as well, where we had to wait for the autopsy to be carried out in a thorough and professional manner. So we did not actually go to Glebe morgue for two days afterwards to see Courtney, and between that period, which was sort of three days later, and the ninth day when Courtney was laid to rest, that is

when Cabramatta detectives signed off on us and gave us that business card, and from that moment forward there was a five-month period where police in any form had no contact with us.

Mr DAVID SHOEBRIDGE: So no counsellors came to your house?

Mr TOPIC: No, nothing.

Mrs TOPIC: Nothing was offered, absolutely nothing, and we did not know where we fit into the picture. From our perspective, we felt—in hindsight, probably not at the time—that the police had all the power, if you want, in terms of knowing what was going on and that, and it was like we were nothing. It was like we were criminals and they had just wiped their hands, clearly, of us.

Mr DAVID SHOEBRIDGE: Because Courtney had died as a result of a police shooting, did anyone explain to you clearly that there would be a coronial investigation?

Mr TOPIC: No.

Mrs TOPIC: Not at that time, no. Later, but not at that time.

Mr TOPIC: Five months later.

Mrs TOPIC: Yes, five months later.

Mr DAVID SHOEBRIDGE: I know it is tough asking you to do this. You got the business card.

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: And you were at home.

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: What was the family going through at that time?

Mrs TOPIC: Hell.

Mr TOPIC: We were making funeral arrangements. We were surrounded by family and friends and loved ones, and we were just surrounded in this cocoon of love by family and friends and the parish. There was still that media contingent that wanted this family to speak. They had an assistant commissioner stand on the corner on the day, saying that New South Wales police spent hours trying to negotiate and trying to talk the situation—they did everything they possibly could and used every facility at their disposal to try and get a peaceful ending, but unfortunately the girl charged at police with a knife and the consequence was that she was shot dead, which was totally false at the time. But that was the story that the police gave to the media on the day, on the spot, and that was carried through until three years later at the end of the coronial inquest.

Mr DAVID SHOEBRIDGE: You talk about the police PR machine being put in play. Is that what you are referring to?

Mr TOPIC: Yes.

Mrs TOPIC: Yes.

Mr TOPIC: They were very quick to stand on the corner and say, "We did nothing wrong, we did everything we could, we had all resources there, we had all the management there, we did everything that our training allowed us to do, but unfortunately this girl charged at us with a knife and she had to be shot dead."

Mr DAVID SHOEBRIDGE: And, of course, those police statements were entirely contradicted by the coronial findings.

Mrs TOPIC: Absolutely.

Mr TOPIC: That is right, three years later.

Mrs TOPIC: But, yes, we did not know any of that until three years later. So for three years we were very unsure of a lot of things.

Mr TOPIC: Those statements on the day went nationwide to every media outlet.

Mr DAVID SHOEBRIDGE: For three years there had been this uncontradicted story about Courtney—

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: Which was false.

Mr TOPIC: Yes.

Mrs TOPIC: Yes.

Mr DAVID SHOEBRIDGE: Looking back on it now, what should the police have done differently?

Mr TOPIC: They should have come to us and made us part of the process. The media was there waiting for something. Police gave them something. Then they came to the family, they wanted a response from the family, so obviously they wanted to fuel something, they wanted something to manifest from this and, being in the situation we were, we knew something was very wrong. We just felt it. Our gut instinct was something was very wrong, so we just decided to not go to the media at all, not go at all.

Mrs TOPIC: We know our daughter, or we knew our daughter. We knew that what was being portrayed in the media and so forth, and was not contradicted to us by any police officer or anything, was so far fetched from who Courtney was. Courtney was a gentle soul. Yes, on that day she did have a knife, absolutely, and through the inquest and everything it was put out there that she had had her first schizophrenic episode that day and she had taken it out of paranoia. We did not hear all of that until three years later, so family and friends, like I said, are still supporting us.

They all knew, we all know Courtney—that is her work colleagues, her friends, her preschool teachers, schoolteachers—but publicly, as in the media, social media, there was a lot that was very hurtful for us as her parents and for her siblings put out there in the media. Particularly our oldest son, it did not sit well with him. He did not feel that his sister should be treated like that, and she was not here to make a stand and say, "That's not me." And it was not corrected until three years later. Also, we made a point that we wanted to speak with the police commissioner, Mick Fuller.

Mr TOPIC: Then, back then. We wanted to be an inclusive part of the process. We wanted to get behind closed doors if needed with the police and sort this out.

Mr DAVID SHOEBRIDGE: Things changed a little five months after.

Mrs TOPIC: They did.

Mr DAVID SHOEBRIDGE: You talk about Gary Jubelin coming on.

Mrs TOPIC: Yes.

Mr DAVID SHOEBRIDGE: Can you tell us what happened then?

Mrs TOPIC: From the get-go that afternoon he turned up at our home. My parents had gone to church in the morning and ended up at Cabramatta Police Station. Dad had got quite upset that the police were doing nothing for our family. I do not mean just us, our extended family. Gary turned up and he apologised profusely and on many, many occasions. He said to us that he thought in situations like this that people who are involved with the police would not want the police calling them and inquiring. So he apologised and said, he has said to us since that he learnt many things from us in terms of dealing with the public. He said, obviously most of his core work was at the time related to those who were on the wrong side of the law, whereas we had had nothing to do with the law, so it was all very new to us.

He took our wrath. There were times when we rang him and really let him have it, and said to him we were not happy about the point where the police investigate police. That was another whole issue. He took it all on board and he offered us a transparent and a fully funded and a decent brief—

Mr TOPIC: Investigation.

Mrs TOPIC: —yes, investigation. We believe he delivered. We, yeah, could not fault him.

The CHAIR: On that, the Hon. Rod Roberts, do you have questions?

The Hon. ROD ROBERTS: No, I do not have any.

The CHAIR: The Hon. Penny Sharpe, do you have questions?

The Hon. PENNY SHARPE: Yes, sorry, I do. My apologies for not being in person. Thank you very much for coming today. I have two questions. One was whether you have had any reporting back as a result of the significant recommendations made by the Coroner in relation to mental health training for police. Is there still established communication around that?

Mr TOPIC: Yes.

Mrs TOPIC: Yes, there is. In fact we have been working with the chief officer with New South Wales Police, the Mental Health Intervention Team, the mental health training team. We actually were there yesterday over at—

Mr TOPIC: Collaroy.

Mrs TOPIC: —Collaroy, and we tell our story, or Courtney's story, to serving officers in regards to mental health and how they can see things from the other side of the situation. It is quite difficult. We get very positive feedback. We had an officer come up to us afterwards from Kings Cross and he said to us, "You guys are making a difference. We can't bring Courtney back; if I could, I would." There is a particular police program: stop, think, observe, plan, act and review—STOPAR—that is used and they have mental health nurses in certain stations. He has one at his station, this officer said, and he said it is saving lives. Mental health nurses are going out with officers de-escalating, rather than perhaps escalating, and making a difference. We had our last one for the year, obviously COVID impacted, but Matt Hanlon is asking us to go forward with him on that program in a different format next year as well.

The Hon. PENNY SHARPE: Thank you. That is very helpful. I am glad that there is some positive change happening because it is so desperately needed.

Mrs TOPIC: We do not want this to happen to anyone else.

The Hon. PENNY SHARPE: No. The other thing I wonder if you could expand on for the Committee, towards the end of your submission you talk about those really practical things that would help families when they are going through an inquest. Could you talk us through that specifically?

Mrs TOPIC: Originally I would say be explicit, break everything down. The people you are dealing with at the inquest are in a very traumatic state—even if it is years afterwards. We are nearly seven years, and we are still struggling, to put it mildly. I guess the original point starts with resourcing. Like any organisation—I mean I work for an organisation, I know everything is about funding. But the core to this is to get the right resources out there to ensure that the right advice, the inclusion of the families that are going through this trauma. Again, counselling access. We were not advised about counselling. Down the track we went down that path, but it was well after five months. It would have been a lot easier—I do not know about easier—but a lot more bearable if we had somebody there guiding us from an emotional perspective through those early days. We were on autopilot and that could have been very helpful to have somebody there offering the counselling from the get-go, and also advising us what was ahead in terms of the process.

We also found when we went to inquest we were at Glebe. We had our own room, which was helpful. That was a positive. To walk in there on that first day—and on that first day we had already met on site of the incident, so we had already met the Coroner out there, police, and then we had gone into Glebe. To walk into there for us—and it is still part of my post-traumatic stress at the moment, if I see a group of police officers it triggers my post-traumatic stress disorder, because that is all I can see surrounding my little girl that day. In saying that, we are working with the police now and they are not in uniform when we speak to them, fortunately. They all turned up on that first day, the big brass. It was almost, it was very intimidating. From our perspective we felt like we were being ambushed. They had all the bling on and all their important appointments and so forth, including guns and that as well. It had to be sorted out before we went in there, that they could be put away, they should not have been on them.

It did happen, but I found that very confronting because in my mind these were the people who had killed Courtney. So, irrespective—our children were brought up to respect the police, all of that. It was almost a conflict in our mind as well. For them to turn up—they were sitting right beside us in Glebe; I have not been to Lidcombe court but I assume it might be a little bit different—having the person who fired the fatal shot sitting right beside us was a big issue. It just felt like nobody cared about our mental health and our wellbeing and our loss, basically. I think simple, practical things; providing parking, that was a positive. You are in such a State. We had no idea what to expect. A counsellor had taken us through the court prior and that had made us somewhat comfortable with what we were to expect.

The Hon. PENNY SHARPE: Can I just stop you there?

Mrs TOPIC: Yes.

The Hon. PENNY SHARPE: Were the counsellors attached to the Coroners Court? Where did they come from?

Mrs TOPIC: They were. The day we went in to identify Courtney there was a counsellor who came in with us from the Coroners Court. We also had our parish priest at the time come with us as well. That beautiful lady, she was a godsend. She was an absolute godsend, and she initiated afterwards many phone calls with us and also counselling. We would come back into Glebe and go through counselling. It very quickly got to the point where the funding was well and truly used. She spoke to her boss and said, "Would it be possible if I can continue

to meet with these people semi-regularly?" It was approved and we are ever so grateful for that because it made the difference from the coronial inquest perspective.

She came with us, she was there every day, in and out for the inquest. It was before we were to go to coronial inquest we finally were going to be seeing the footage. Again, the police had seen all this. We had seen nothing. She organised with our legal team and she was there to watch Courtney die, which was horrific, as you can imagine. For us that meant the world, and she rang us after to debrief. This lady was an angel; she was an absolute godsend. We are aware that she no longer works in that role, but she kept us tethered to the ground in very, very traumatic circumstances. I could not fault her; she was beautiful.

Mr TOPIC: She was part of the forensic side of the Coroners Court. She was there to meet and greet us. We were there to identify Courtney and that is where her jurisdiction had stopped. She was to meet and greet us, she was to comfort us and she was to give us support during that process and then that was to be the end. But we sort of took an attachment to her in that horrific moment of our lives and she saw the stress and distress that we were in and she took it upon herself to be in our lives for the next three years through part of the whole process.

Mr DAVID SHOEBRIDGE: That was not a guaranteed resource?

Mr TOPIC: No.

Mrs TOPIC: No, it was not; absolutely not.

Mr TOPIC: That was just something that was—

Mrs TOPIC: She went above and beyond, very much.

Mr DAVID SHOEBRIDGE: Looking back on it, having heard there from that moment, from the start of the journey through the coronial, having that one resource there, the fact that she was with you throughout it, I assume, was really important and added value and made it much more useful to have her there.

Mrs TOPIC: Crucial.

Mr TOPIC: She was our connection. She was the girl that rang me on the phone when the autopsy was being carried out and said, "Mr Topic, I have your beautiful daughter here. Unfortunately, it is taking some time. This process is necessary and needs to be done now. It is part of a very important coronial investigation and I will keep you up to date of procedures and you will be the first person to know when you can come in." So her professionalism and the way she conducted herself and the way she connected immediately through the person that she was, her training and the position that she held, had us for the next three years.

The CHAIR: Ms Sharpe, did you have further questions?

The Hon. PENNY SHARPE: No, thank you.

The CHAIR: Ms Cusack, do you have any questions for these witnesses?

The Hon. CATHERINE CUSACK: No, I do not have any questions. Thank you.

The CHAIR: I have some questions which relate to the process. You were told you might qualify for legal aid. You did get legal aid?

Mrs TOPIC: That is correct.

The CHAIR: So you were represented during the coronial process itself?

Mrs TOPIC: We were. It did change, lawyers changed throughout the process and we met new people.

The CHAIR: Were they Legal Aid solicitors—

Mr TOPIC: They were.

The CHAIR: —or did you brief private solicitors?

Mrs TOPIC: No, they were Legal Aid solicitors. They were brilliant.

The CHAIR: Through them you were able to cross-examine witnesses, were you? Were you permitted to do that?

Mr TOPIC: No. No, we had to wait two years for the investigation brief to be complete and to be handed to the Coroner. Then Gary Jubelin suggested that the brief would be finished November-December and there would be a gap, break over Christmas and the good part of January and things would not get back in the New Year until early February and he suggested that we come into head office with him and sit down and just roughly go over the brief of evidence before he hands it over to the Coroner.

The CHAIR: So he was doing the investigation for the Coroner?

Mr TOPIC: That is right. At the time, he was head of New South Wales homicide.

The CHAIR: He was doing this for the Coroner?

Mr TOPIC: Yes.

Mrs TOPIC: No, no. He was doing the—the brief was for the police to be handed to the Coroner.

Mr TOPIC: That is right.

Mrs TOPIC: But before it got handed over he made the decision to contact us and say, "I will take these parents in". My parents came as well and he just briefly, again, reiterated Courtney did nothing wrong. And then it was handed over the Coroner for 12 months down the track.

The CHAIR: Did the Coroner have an inquest?

Mrs TOPIC: Yes.

The CHAIR: And you were present during the hearing of the inquest?

Mrs TOPIC: Every—

Mr TOPIC: Every day.

Mrs TOPIC: —minute of every day.

Mr TOPIC: Yes.

The CHAIR: Were you able to, through your lawyers, ask questions of the witnesses?

Mrs TOPIC: Through our lawyers, yes.

Mr TOPIC: In court?

The CHAIR: Yes, in court.

Mrs TOPIC: Yes.

Mr TOPIC: Yes, we had a representation in court.

The CHAIR: Was that a satisfactory process for you?

Mr TOPIC: It was.

Mrs TOPIC: It was. They were wonderful, could not fault them. The only thing that I would say is that the police had twice as many as we did. Again, it felt to us like intimidation. But, look, the people we had were brilliant, could not fault them.

The CHAIR: In terms of the outcome, the Coroner made certain findings and recommendations.

Mr TOPIC: That is right.

The CHAIR: I think Ms Sharpe asked you this. Do you have any visibility about what has happened as a result of those?

Mrs TOPIC: We do.

Mr TOPIC: We do, yes. Look, from day dot we wanted to sit down with Commissioner Mick Fuller and get a positive change and steps forward. Our whole purpose of being here is that this never happens again. We do not ever want to be sitting in our lounge room watching the television and seeing some family going through what we are living. We just did not let it go. We wanted to see the police commissioner or the head of New South Wales police, whoever that would be at the time. We finally got to sit with Commissioner Fuller and he turned around and said, "Listen, we have implemented nine of the 10 recommendations, and we are working on the tenth, and this is the first time that we have taken the time to work through every single recommendation that the Coroner has said."

The CHAIR: In terms of Detective Inspector Jubelin's criminal investigation, did anything emerge from that as far as you are aware?

Mrs TOPIC: In regards to?

The CHAIR: Were any charges laid against anybody?

Mrs TOPIC: No.

Mr TOPIC: No.

Mrs TOPIC: No, there were not, no.

Mr TOPIC: The Crown was represented too. They had their representation in court as well. They had a Crown solicitor and a team as well.

The CHAIR: And they were representing the police?

Mr TOPIC: They were representing the Crown. They were representing the deputy State Coroner, who was looking after the—

The CHAIR: Counsel assisting.

Mrs TOPIC: Counsel assisting.

Mr TOPIC: Yes.

The CHAIR: So there is a counsel assisting?

Mrs TOPIC: Yes.

The CHAIR: And the police obviously had their legal representation?

Mrs TOPIC: They did.

Mr TOPIC: Yes.

Mrs TOPIC: Then we had legal aid.

Mr TOPIC: And they did instruct us that no criminal charges could manifest from this process and if a situation arose that there looked like someone might be sort of presented with criminal charges or in the place where there might be criminal negligence or anything like that, then the process was to stop and then it goes to a different court.

The CHAIR: If you could change two or three things about the system, what would those two or three things be? I think you have touched on getting more information proactively earlier in the process.

Mr TOPIC: Yes.

Mrs TOPIC: Yes, definitely.

The CHAIR: For example, the counselling service you received, that support being provided earlier, more forthcoming.

Mrs TOPIC: Yes.

Mr TOPIC: Inclusiveness. It has got to be inclusiveness. It is not just the front line. There is a whole machine behind this. We are part of the investigation. We gave statements. It was our family that was involved. Courtney was us. She was involved, which made us involved. We need to be inclusive in the process. Inclusiveness does not mean talking to the frontline police, talking to the officers that were there on the day or anything like that. There is a whole background to New South Wales police. There is their legal system. They have great resources, they have great volumes. We need to be part of the process.

Mrs TOPIC: We felt like we were outsiders. We were not included. Early on—after Gary came on the scene things did change but it felt like they were treating us as suspects. We did not know where we fit into this story, if you like. We felt very out of place, very uncomfortable and felt like we were being treated as though we were criminals.

Mr DAVID SHOEBRIDGE: That is also in the context of the police having made those early false statements about Courtney.

Mr TOPIC: Yes.

Mrs TOPIC: I would say so, yes.

Mr DAVID SHOEBRIDGE: In some ways, the first thing the coronial had to do was disprove those statements about Courtney.

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: How long was it before the police, anyone in the police, said to you Courtney had done nothing wrong?

Mrs TOPIC: That was Gary Jubelin, and that was virtually around the five-month mark—

Mr TOPIC: Yes.

Mrs TOPIC: —when he came to our house and our first interactions with him, and he sat around our dining table.

Mr TOPIC: That was privately, that was not publicly. It was not until the investigation was as a brief of evidence and was handed to the New South Wales State Coroner.

Mr DAVID SHOEBRIDGE: That was the first time there was any kind of official acknowledgement?

Mrs TOPIC: Official, yes.

Mr TOPIC: Yes. Look, New South Wales police stood on the corner of Cowpasture Road, Hoxton Park Road on the day and gave their PR to the media and they turned around and said, "No more questions at this stage. This will be going to a coronial inquest because of the situation." And from that moment on there was a blackout. There was a blackout. They turned around and that is all they had to say. They just had to tell the media that this was under investigation and there was a blackout.

Mr DAVID SHOEBRIDGE: Basically they gave their version.

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: And then stepped away.

Mr TOPIC: Yes.

Mr DAVID SHOEBRIDGE: And there was no way for you to disprove that for years.

Mr TOPIC: No.

Mrs TOPIC: There was not.

Mr TOPIC: And they said to the media on the spot on the day, "Condolences to the family. Now I am going back to the station to check in with my officers because they are very distraught and very upset."

Mrs TOPIC: We felt like we were just a thorn in their side.

Mr TOPIC: That was it.

Mrs TOPIC: From their actions.

Mr TOPIC: And the whole situation, because they turned around and said it has to go to coronial inquest because of the nature of the operation, the nature of the situation, they were allowed to black it out and that was it.

Mr DAVID SHOEBRIDGE: You question the way in which police were investigating police?

Mrs TOPIC: Definitely.

Mr DAVID SHOEBRIDGE: It was police action that killed Courtney. What would a better system be for you?

Mrs TOPIC: A separate and transparent organisation or department that is completely separate from the police. I still believe that now. In saying that, Gary gave his all and did absolutely—was the utmost professional and did a fabulous job, and we thank him for that. I just think everybody is reporting to the same boss, it is police, and that is police. It just does not sit well with me, knowing that it appeared that they held all the cards. I know everyone is supposed to be following protocols and so forth, but at times why do you have the same organisation investigating the same organisation?

Mr DAVID SHOEBRIDGE: You do not come at this with a sort of anti-police view?

Mrs TOPIC: Not at all, not at all. We are working with the police now.

Mr DAVID SHOEBRIDGE: Having gone through this for six years, that is actually the best system result as well.

Mrs TOPIC: Yes. We said this yesterday at our police training, we said the officers involved that day did not go out to kill Courtney but there were failings and they have obviously come through the coronial inquest

and so forth. It is cruel. We get up every day and our daughter is still dead. It is Christmas coming up. She is not there. Any ordinary day, she is not there. We go to the cemetery to talk to her. If we can change that for one family then it is vital, and it is not just what happened, her death, as in being shot, but the process leading up through the coronial inquest, the investigation and all that process as well. It is traumatic. It is beyond traumatic from the get-go. And then when you are dealing with things that have never been part of your life, you do not understand what they are. You are sort of getting mixed messages from different departments, which confuses you further. That adds to your trauma; it absolutely adds to your trauma.

The CHAIR: We are at time. Mr and Mrs Topic, I thank you for coming to give evidence today, which cannot have been easy. On behalf of the Committee as a whole, I extend our condolences to you for your loss.

Mr TOPIC: Thank you.

Mrs TOPIC: Thank you.

The CHAIR: I do not think any questions have been posed on notice, but if Committee members have any subsequent information they want from you that will be forthcoming and you will have time to respond. Again, thank you for your evidence. You are excused.

Mrs TOPIC: Thank you for your time.

Mr TOPIC: Thank you.

(The witnesses withdrew.)

SARAH CRELLIN, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), affirmed and examined

The CHAIR: We note submission No. 36 by the Aboriginal Legal Service [ALS] but there is a capacity for a short opening statement for witnesses if they would like to avail themselves of that. Would you like to do so?

Ms CRELLIN: Yes. I have a brief opening statement, if I may.

The CHAIR: Please, proceed.

Ms CRELLIN: Thank you to the Select Committee on the Coronial Jurisdiction in New South Wales for inviting the Aboriginal Legal Service to provide evidence at today's hearing. I would like to begin by acknowledging the Gadigal people of the Eora nation, who are the traditional custodians of the land on which we are on today. I acknowledge and pay my respect to Elders past and present, and extend that respect to any Aboriginal people tuning in today. I also recognise the strength of the families that I have represented through the coronial process and acknowledge my privilege of being able to speak to you today. The ALS is a proud Aboriginal community controlled organisation and the peak legal service provider to Aboriginal and Torres Strait Islander adults and children in New South Wales and the Australian Capital Territory. The ALS also provides representation to Aboriginal and Torres Strait Islander families within the Coroners Court jurisdiction, predominantly families who have lost a loved one in custody or in a police operation.

There has been a substantial increase in the demand for these services in the past three years. Consequently, we have identified improvements that can be made to the practice and operation of the Coroners Court. The Coroners Court must be made accessible and appropriate for Aboriginal people as a matter of urgency, given the high incidence of Aboriginal people experiencing deaths in custody, as well as the far-reaching impacts of these deaths in Aboriginal communities. The Coroners Court should be a therapeutic model, and instead it has been seen to be a further traumatising experience. On top of the improvements to the process within the Coroners Court there needs to be a level of accountability for organisations like Corrective Services and Justice Health so that the outcomes are improved, otherwise going through these processes is for nought.

Losing a loved one in custody is traumatic enough, but then to further entrench that trauma by asking people to participate in a process that sees no real change is cruel. We are optimistic and hopeful that the recent changes to the system will improve the delays in communication, but further to that there needs to be accountability and action. Thank you.

The CHAIR: Thank you. We will proceed to questions from Committee members. I will ask the two members who are participating via Webex whether they have any questions. Ms Sharpe?

The Hon. PENNY SHARPE: [Inaudible]

The CHAIR: Ms Cusack?

The Hon. CATHERINE CUSACK: Thank you.

The CHAIR: Ms Cusack, if you have any questions please proceed.

The Hon. CATHERINE CUSACK: Sorry. No, I do not have any questions. Thank you, Chair.

The CHAIR: Mr Khan, do you have any questions?

The Hon. TREVOR KHAN: No, I do not at this stage, taking into account that we did the First Nations so I think we add that on top.

The CHAIR: Indeed, yes.

The Hon. CATHERINE CUSACK: Chair, sorry, can I change my mind and ask a quick question?

The CHAIR: You can, but I have given the call to Mr Shoebridge.

Mr DAVID SHOEBRIDGE: No.

The CHAIR: Mr Shoebridge gives way. Ms Cusack, please proceed.

The Hon. CATHERINE CUSACK: I just wanted to ask if there has been consultation between your service and the police regarding the protocol for what happens when there is a death? Secondly, at what point do families get informed that perhaps they should be contacting you when they unfortunately find themselves in this awful process?

Ms CRELLIN: The New South Wales police and the Aboriginal Legal Service have a protocol that we are called when there is a death in a police operation. When there is a death in Corrective Services custody we are notified by the Corrective Services, by their Aboriginal Services Unit. It is often that we are notified of the details of the next of kin and we reach out to that person. Rather than the family being told to call us, we will call them.

The CHAIR: Ms Cusack, do you have follow-up questions?

The Hon. CATHERINE CUSACK: Thank you very much for that.

Mr DAVID SHOEBRIDGE: Thank you, Ms Crellin, for the submission and your attendance today. One of the constant frustrations that is fed back to my office is how narrow the focus of a coronial investigation is, the minutes or seconds leading up to a death, maybe a day. Whereas what you are pointing out in your submission is often it is the systemic causes and those deeper factors that would be more fruitfully considered at a coronial. Do you want to expand on that in your submission, and then do you want to tell us where you think the bounds properly should be in a coronial inquest?

Ms CRELLIN: In my experience it is very often difficult for families to go through this process because the Coroner's considerations are limited to the manner, cause, time, place, name of the death of the deceased. In my submission, the Coroners Court is uniquely placed to deal with systemic factors that lead to over-incarceration of Aboriginal people. The Coroner is in a position to address why that person was in custody or why that person was, indeed, wanted by the police on a warrant perhaps. In doing that, we could look at those causative factors as to why Aboriginal people are so over-represented in the criminal justice system, whether that is Corrective Services custody or whether that has come to the attention of police. Often families feel really upset about the issues that upset them: Why was my loved one in custody for just four months, they were about to get out? Why was my loved one in custody at all when they could have been out on bail with me? Those are not factors that the Coroner is able to consider with the current Act.

That is very traumatic because we tell the family that they will receive answers through this process, but often the answers they receive are very limited—they are indeed, "Your loved one had a heart attack running away from police and there was a warrant out for their arrest." We do not go into is there another way with warrants? Is there another way that people in fact could feel safe with the police, feel that they could hand themselves in to the police perhaps? For example, there is a system in the Australian Capital Territory, a front-up program. The Coroners Court really has a unique position in my submission that they really could look at all of these factors that lead to systemic over-incarceration of Aboriginal people.

The CHAIR: Mr Khan has a follow-up question.

The Hon. TREVOR KHAN: Is there any legislative model that would allow that wider inquisition that you are aware of?

Ms CRELLIN: I am not aware of any current legislative model. I guess it would have to be looked at by yourselves, by Parliament. But my submission would be that you could expand perhaps that definition of cause of death, or perhaps manner of death. You could expand that definition to include more broader circumstances, perhaps, of the death.

The CHAIR: Just on that point, I think it was the Public Interest Advocacy Centre [PIAC] submission that makes the point that in Tasmania, for example, their Coroner's legislation provides that a coroner must, wherever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter the Coroner considers appropriate, and in particular must report on the care, supervision or treatment of the person. In that sense, the coroners can do that now, but some of the submissions suggest that coroners may be reluctant to do the sort of systems analysis and confine their findings to—

The Hon. TREVOR KHAN: And I think we have heard that the—what do we call them—standing coroners in country courts, particularly, are reluctant to.

The CHAIR: Yes. So we have a situation where, as you say, the findings and the scope of an inquiry are fairly narrowly focused to manner and cause of death, immediate preceding, rather than the wider systems issues. They can do that, but they are not required to do that. The Tasmanian provision seems to suggest they are required to do that. I do not know whether that applies to other jurisdictions. Would you feel that a strong mandate to coroners to have to report on those sort of system issues, if they are appropriate, if they are at play, would also assist families in this situation?

Ms CRELLIN: Indeed, it would. I imagine it would be a matter of resourcing. We know that the Coroner placed in Lidcombe perhaps had more time than—Mr Khan references country magistrates, who are fairly limited in the scope.

The CHAIR: Just on that, we have got 5.2 coroners, maybe we are about to get a sixth, and the evidence we have received so far is that 80 per cent of the coronial work that arises in the country is in fact referred back to Lidcombe simply because the country magistrates, who are coroners also, do not have the capacity and the time.

Mr DAVID SHOEBRIDGE: It is not necessarily a drafting error in the legislation, because the phrase "manner and cause" does not necessarily have a legislative ambit, it is the interpretation that has been taken by coroners and when it has been tested by the Supreme Court on a very narrow view about cause. Is that right?

Ms CRELLIN: It is, and we are seeing coroners lately in the last couple of years certainly expand that definition. You would have seen the findings in the last couple of years go deeper into what Mr Searle refers to as the health causes. We are seeing a lot of focus on the health system in Corrective Services' Justice Health system. But broader still, I think the coroners have capacity, and certainly they should have capacity, to go further than that.

Mr DAVID SHOEBRIDGE: Could you take on notice whether or not the Victorian formulation would be adequate? I fundamentally support the direction of your submission, but is there a boundary on it? Should there be a legislative boundary on it, or should there just be a broader definition of cause and allow the coroners on a case-by-case basis to work out where the inquiry should cease, for example, chronic overcrowding, systemic poverty, intergenerational trauma? Many of these are factors that are relevant to the manner and cause of death of a First Nations person at the hands of police, for example. Is there a legislative boundary or is it just a broader definition and you allow the coroners to police the boundary?

Ms CRELLIN: I will take that on notice. But I will say also I think you could link it into the Royal Commission into Aboriginal Deaths in Custody and the recommendations that came out of that.

The CHAIR: Just on that, I have two or three questions. One of the Royal Commission into Aboriginal Deaths in Custody recommendations was that within three calendar months of publication of the findings of recommendations of the Coroner as to any death in custody, agencies were supposed to respond in that period of time. That has not been implemented in New South Wales, but I think it has been implemented by a number of other jurisdictions. Whether it is three months or six months, do you think there should be a legislative requirement on relevant agencies—and, for that matter, any private sector person or body that might be involved—to have to respond to a coronial finding within a specified period of time and for those responses, for example, to be reported back to Parliament?

Ms CRELLIN: Absolutely. It is so traumatising that a family could go through it. The Coroner who is invested—and the coroners really work hard and make really important recommendations that they imagine will be followed through. It is so important that these government departments are held accountable and have to report back to the Parliament and say, "Yes I did do this" or "No, I did not do this", just so families can have some peace of mind to know that if they are going through this process that actual change will be made.

The CHAIR: Further, recommendation 16 of the Royal Commission into Aboriginal Deaths in Custody report suggested that coroners should be empowered to call for further explanations or information considered necessary as a way, if you like, of following up on any responses or lack of responses to coronial findings. Is that something that your organisation would also support in New South Wales?

Ms CRELLIN: I would support it, but I would question how that would work in the court proceedings, given that the matters would be finalised once the findings are handed down. So I wonder how that would work.

Mr DAVID SHOEBRIDGE: Your submission talks about the Coroner needing to be empowered to call for such further explanations or information as they consider necessary, including reports as to further action taken in relation to the recommendations. Is that the kind of jurisdiction there?

Ms CRELLIN: It is. I think you would have to ask the Coroner to do that before the findings were handed down. So perhaps it is a matter of the Coroner indicating to the parties what the recommendations will be and allowing the parties to have an opportunity to respond.

The CHAIR: A bit like an Ombudsman's report?

Mr DAVID SHOEBRIDGE: You might want to take this question on notice. I read recommendation 6 (c) in your submission as that happening very much after the findings had been handed down, waiting for the response and, if there had been an inadequate response, enlivening the Coroner's jurisdiction afterwards.

Ms CRELLIN: I will take that on notice.

The Hon. TREVOR KHAN: I have got to say it strikes me—picking up on your point—as problematic if you take into account that the Coroner is busy now, essentially inviting them some months, many months, later—

The CHAIR: Could be years.

The Hon. TREVOR KHAN: Yes, indeed—to reopen an inquest to re-ventilate matters. I would have thought, as a matter of practicality, that is not going to fly, is it?

Ms CRELLIN: I very much doubt it with the current resources.

The Hon. TREVOR KHAN: Even with more resources they are likely to increase the number of hearings, as opposed to reinvestigating or re-initiating matters that have already been completed?

Ms CRELLIN: I think perhaps what is more important is that when a similar inquest comes before a Coroner that they are able to look back at previous recommendations and call on those parties to say, "You've been asked to do this previously. Has it been done?" Because there is no database that shows—they are all everywhere—it is very difficult for a Coroner to know whether these issues have been considered before, unless it is brought to the attention of them by the parties that appear in front of them.

The CHAIR: Just on that point, in Victoria—our knowledge is limited to paper information at the moment—the Coroner's unit appears to have that role, that is, it takes the data and information from coronial hearings and puts it into some kind of accessible database so that coroners in the future can draw on that. I cannot remember whether this is the case, or it was a suggestion in one of the submissions, that there is a national coronial database that is supposed to do the same that coroners apparently presently can draw on if they have got similar issues in an inquiry. They can ask that database for a bespoke report about those matters. Whether those things, in fact, exist, they would be very useful to coroners in New South Wales, would they not?

Ms CRELLIN: Absolutely useful. My understanding is the national database is fairly limited in who can access.

The CHAIR: Yes.

Ms CRELLIN: You need specific access and it is difficult if not all parties can access, I think. It would help if, for example, in New South Wales Justice Health could access to know whether a similar coronial inquiry had occurred in Queensland to know what kind of programs they have in their service that could be implemented in New South Wales.

The CHAIR: Yes.

Mr DAVID SHOEBRIDGE: I mean these are most often publicly available decisions, publicly available findings. Why should there not just be a publicly available, well-resourced database that draws together findings by subject matter and by agency? Why shouldn't it be publicly available?

Ms CRELLIN: It should be publicly available.

Mr DAVID SHOEBRIDGE: And then there may well need to be an addendum to it because there are some coronial findings that have a non-publication order. There may need to be an addendum for the coroners and for those other agencies. Surely just a publicly available, comprehensive, linked database seems to be a minimum.

Ms CRELLIN: I would have thought so.

The CHAIR: Two things: case studies one and two in your submission speak of five- and six-year delays between a death and coronial findings. That is just grotesque, isn't? Isn't that a terrible experience for families to have to suffer those sorts of time delays?

Ms CRELLIN: It is absolutely horrible. In one of those inquiries there was a reason for that, in that there were criminal charges that were ongoing. In the second one there has been absolutely no explanation as to the delay. The Coroner has apologised for the delay but still the family, and the ALS that represented the family, are still none the wiser as to why it took six years for the findings to be handed down.

The CHAIR: You do not know whether it is the pressures on the Coroners Court in terms of finding hearing dates or whether it is a forensic medicine hold-up?

Ms CRELLIN: Not sure.

Mr DAVID SHOEBRIDGE: Has there been an apology, because surely any family is owed an apology after a six-year delay?

Ms CRELLIN: The Coroner apologised in her findings.

Mr DAVID SHOEBRIDGE: But without any explanation?

Ms CRELLIN: Yes.

The CHAIR: Recommendation 13 of your submission talks about recognition mentioned as an alternative to holding a full inquest. Can you step us through as to what that entails, what it might look like?

Ms CRELLIN: Often a loved one might die in a police operation that does not, perhaps, strictly fall, in that they were not in custody or there might be some debate about the technicality around whether the deceased was in custody or not. To go through that sort of legal debate, technicality debate, in a Coroners Court is extremely traumatic. Often what the family would like is some sort of recognition within a courtroom with a Coroner explaining to them why the matter does not fall within the ambit of a full inquest but that it is a matter that the Coroner has looked at, that the brief has been read to acknowledge that the death happened in a police operation but not strictly falling within the legal definition in the Coroner's Act of a section 23 death to allow the family to have that day in court, I guess. The idea of the Coroners Court is that it should be a therapeutic model; it should allow families to be able to grieve, to understand and that is why we would submit a recognition mention would be beneficial for some parties.

The Hon. TREVOR KHAN: On the basis of the First Nations inquiry, and some of what you could describe as case studies that we saw there, I am concerned that even when people have been through the full process, they leave entirely disheartened and dissatisfied by the process—I am not being critical of them in any way. Taking that into account, if a full hearing does not bring resolution how does a short, sharp mention or explanation provide a degree of satisfaction?

Ms CRELLIN: I think there is a difference between a lawyer telling you over the phone, explaining that legal technicality to you, saying the Coroner has read the brief and actually having a day in court where there is a bit of ceremony to it; you can come in, you can sit down, the Coroner looks at you and apologises for your loss, and there is an acknowledgement of your loved one and that they died in a way that is unusual, could be really beneficial. I am not saying in all cases.

The CHAIR: Is that done elsewhere?

Ms CRELLIN: I am not sure of that. I will take that on notice.

The CHAIR: Okay, that would be very interesting. Do Committee members have further questions?

Mr DAVID SHOEBRIDGE: I have a question about funding. I will ask an open question. Tell us about funding for the ALS for this kind of support work and representation work.

Ms CRELLIN: Very recently the Commonwealth has allocated funding in relation to coronial inquiries and extensive cases funding. At this stage we are unsure exactly how much that is. We are still waiting to be told. That is only very recently. Obviously we still have not received that funding but prior to that, no, we were not funded in relation to these representations.

Mr DAVID SHOEBRIDGE: In most coronial proceedings the State funding goes to Legal Aid, is that right?

Ms CRELLIN: Yes, Legal Aid has a Coronial Inquest Unit.

Mr DAVID SHOEBRIDGE: Does that include representing First Nations families?

Ms CRELLIN: Yes, as I understand it. In saying that, despite not having allocated funding for this work, we have done it for many years, and done it to the best of our ability.

Mr DAVID SHOEBRIDGE: That is what I want to ask you about. What sort of resourcing strain has it been on the ALS to be doing this work without any funding? Do you have an idea of what proportion of your budget it is?

Ms CRELLIN: I do not have an idea of proportion of budget. It is an extremely high workload, especially recently. There have been five deaths in custody in the last three weeks, and we represent four of those families. It is an extremely high-capacity workload in that families need a lot of time and we want to give them that time. We also want to give them the time to explore all the issues that they have, and do it early because that is when the real change can actually be made by expending lots of time with them as soon as the person passes away. Yes, it is very resource intensive and we do need more funding to do it properly.

The CHAIR: I know that primarily your funding comes from Federal sources. Have you had any discussions with the State Government about providing some of that additional funding because the coronial process is really a State process? Have you had any discussions with the State Government?

Ms CRELLIN: I will take that on notice. Not to my knowledge.

The Hon. TREVOR KHAN: I think you might run into a barrier with Legal Aid if you are talking about divvying up the pie.

The CHAIR: Anyway this is subject for a another—

Mr DAVID SHOEBRIDGE: What I would suggest is we are talking here about additional funding. Clearly, Legal Aid is already stretched for its resources. But it is not just legal assistance; it is that wraparound support and advocacy you want. Is that right?

Ms CRELLIN: Yes, we rely very heavily on organisations like Jumbunna as well, who provide the wraparound support that we are sometimes not able to. So we do rely very heavily on other community organisations to assist us in that process.

Mr DAVID SHOEBRIDGE: On notice, will you give us some details about what those additional wraparound services would, in a perfect world, look like?

Ms CRELLIN: Certainly.

The CHAIR: Ms Crellin, thank you for your evidence. If there is anything further Committee members wish to pose to you—and I know you have taken some questions from Mr Shoebridge on notice—we will write to you about that.

(The witness withdrew.)

JONATHON HUNYOR, Chief Executive Officer, Public Interest Advocacy Centre, affirmed and examined

The CHAIR: I now welcome our next witness from the Public Interest Advocacy Centre. The Committee has submission No. 23 of the PIAC dated 9 July 2021. Witnesses have the capacity, if they wish, to give a brief opening statement. Would you like to do so?

Mr HUNYOR: Yes, I will. I will not read through our whole submission but the Committee will see that the thrust of it is that PIAC's view is that there is a need for comprehensive reform to deliver a modern coronial system that meets the needs of our community. This is not intended as a criticism of the people involved in the system, it is about ensuring that those people have the tools they need and that their work is supported by the structures and systems in which they work. The Committee will see our submission highlights five main areas for reform. The first is making good the potential to promote community health and safety. The second is enhancing the potential for the Coroners Court to play a therapeutic and restorative role. The third is ensuing robust, independent investigations into deaths in custody. The fourth is delivering greater accountability for the implementation of recommendations; and, fifth, responding to the needs of First Nations people.

We think there is a compelling case for a specialist standalone Coroners Court but, as important as that, is ensuring that any such court has the right functions, powers, structure and resources to do the job of a modern Coroners Court. This means, firstly, having a clear legislative mandate for coroners to make appropriate recommendations to address systemic issues connected with a death. So, for example, we highlight the Tasmanian provision, section 28, which requires a Coroner to make recommendations in relation to matters concerning deaths in custody, particularly the conditions of care. It also means increased and dedicated resources for the court's preventive functions, including a Coroners Prevention Unit. It means a legislative obligation on government to respond to Coroner's recommendations and, as importantly, a capacity for monitoring of the implementation by something like a Coroners Prevention Unit.

We think there is significantly merit in an independent body to investigate all deaths in custody, including systemic issues rather than having investigations done by police. Finally, we think there is a need for a fundamental reset of how the justice needs of Aboriginal and Torres Strait Islander people can be better met. This of course needs to be led by First Nations people themselves and should go beyond, in our view, deaths in custody to include all deaths in which the State is involved, particularly including deaths in care settings. That was all I wanted to say by way of opening comments, Chair. Thank you for the opportunity to give evidence today.

The CHAIR: Thank you, Mr Hunyor. I will ask some opening questions before I pass to Committee members. You make a submission that we should have a provision in New South Wales similar to section 28 of the Tasmanian legislation, that is, a strong, positive mandate on coroners to address systemic issues.

Mr HUNYOR: That is right.

The CHAIR: The First Nations deaths in custody inquiry in which Committee members here were involved made a recommendation to that effect, although I do not think we had in mind that provision. What are the benefits of such a provision?

Mr HUNYOR: It is partly to ensure that that is seen as a central function of the Coroner. I think a number of the other submissions to this inquiry have highlighted the baggage of history where the primary functions of the Coroner are seen as the who, what, when, where and why questions, with a real focus on the medical questions about the cause of death, and the functions around death prevention and systemic recommendations have been seen as ancillary functions and that is reflected in the way the Act is structured.

The CHAIR: So they should become core functions?

Mr HUNYOR: That is right. It is not impossible. As the Committee will be aware, there is capacity for coroners to make those sorts of recommendations, and they do. But it is considered to be an ancillary set of functions and it also means that coroners will tend to shy away from more wideranging inquiries into some of those systemic issues because they will often say those are really secondary functions. There are often comments made about it not being a royal commission and those sorts of things, which make sense within the priorities and the resourcing of inquests and coroners courts. But we think that is a missed opportunity to look into those things which can better protect the community and prevent deaths.

The CHAIR: Another royal commission recommendation was for a legislative requirement that government agencies should not have to respond to coronial recommendations within a set period of time. I think the recommendation was three months. In your submission you say the South Australian, Australian Capital Territory, Victorian and Northern Territory legislation have provisions to that effect. Again, what would be the benefit in New South Wales of having such a provision?

Mr HUNYOR: Again, it is a matter of giving a clear statement from Parliament as to the importance of responding to recommendations and providing for an accountability mechanism. It is not just a matter of a response being provided in three months but a process whereby they are tabled in Parliament and they can be subject to greater scrutiny. But the follow-up from that from PIAC's perspective is not just an obligation to provide a response—because responses can, for good reasons and bad, be "We agree in principle. We will look into this." Sometimes that is a stalling tactic, other times it is because it is a complicated issue. What we really need to see is some mechanism whereby that is actually monitored and there is a capacity to follow that through because there are countless recommendations made.

I have appeared previously in coronial inquests so I feel embarrassed that I do not know whether a lot of those recommendations are ever followed through because, unfortunately, the next case comes through the door and that is where I have had to go. There needs to be some formal mechanism so that the recommendations can actually be tracked and we can get a sense of "Well, okay, you said you would review it. You said you agreed in principle. What happened next and why?" Otherwise the recommendations are only as good as the follow-through.

The CHAIR: You also make a recommendation that we should have something like the Victorian Coronial Prevention Unit in place here. What would be the benefit to New South Wales of having such an underpinning for the court?

Mr HUNYOR: It means that we have got something that is properly resourced so that coroners can pursue systemic issues because they are resourced to do it. They have got research capacity. They have actually got that standing capacity. Currently coroners get a lot of that assistance from the parties, sometimes there can be interveners or an amicus curiae role of friends where you have got, once you can demonstrate a sufficient interest, sometimes parties will appear to make systemic recommendations. But having that capacity within the court just means, again, that we are elevating it from something that is an ancillary function to something that is really considered to be core business.

The CHAIR: That would be of benefit in terms of the public tracking the recommendations and what has happened to them and also for future coronial inquiries being able to draw on that research and that experience to see what learnings there have been from similar situations?

Mr HUNYOR: Absolutely. I would have thought that a Coroners Prevention Unit would be able to assist the court in the immediate inquest to investigate what systemic issues there may be and also to assist making solid evidence-based recommendations. I think this is something that Hugh Dillon picks up on in his submission, the need to have that culture that supports that work to be done because it is not necessarily within the skill set of coroners to be thinking in those systemic terms and making those sort of recommendations to make sure they are useful. There is no point making recommendations that are unrealistic or are not going to be usefully implemented.

Mr DAVID SHOEBRIDGE: It would be a skills base to test those recommendations before they are made as well internally within the Coroners Court?

Mr HUNYOR: That is right, to help develop them and then to have a sense of also a bit of corporate knowledge—so what sort of things have been done previously; what has been done elsewhere. A national database of recommendations—

The CHAIR: Which apparently exists but it is very limited.

Mr HUNYOR: Yes, but to have a sense so that we can say, "Actually in 2007 the South Australian Coroner made a similar recommendation and actually here is what happened with that" or "It was not a good idea for this reason" or "It was a great idea for that reason". It is that capacity that does not exist and it is a missed opportunity.

The CHAIR: I have one final question before I hand over to other Committee members. It is a sort of system design question. We have 5.2 full-time equivalent coroners, soon to be a sixth. Outside of Sydney metro, country magistrates fulfil the work of coroners but the evidence the Committee has received is the bulk of the coronial work is referred back to Sydney. In a design system, although the Coroners Court is part of the Local Court, effectively the State Coroner is subordinate to the Chief Magistrate. The Chief Magistrate really has control and direction, as far as we can work out on paper at least. Given the importance of this jurisdiction, is there an argument for a separate Coroner's jurisdiction, separate to any court?

Mr HUNYOR: I think there is. I think it needs to be recognised that it is specialist jurisdiction. It is not a criminal jurisdiction and it has got really unique features. If we are going to make the most of its therapeutic capacity and restorative capacity then I think we need to be looking for ways to recognise and support that institutionally. Again, not to criticise the current people in those roles but to recognise that everyone is doing a job within a framework, and a different framework with better support.

The Hon. TREVOR KHAN: I cannot remember where we have ventilated this, whether it is by discussion, is it a separate jurisdiction or is it a separate division rather like the Children's Court?

Mr HUNYOR: PIAC does not have a strong view on which of those would work but it is a matter of figuring out where we want to be and what is the best structure to get us there.

Mr DAVID SHOEBRIDGE: Functionally distinct.

Mr HUNYOR: Functionally distinct, that is right.

The Hon. TREVOR KHAN: I think this might have been a matter of discussion with Hugh Dillon.

The Hon. ROD ROBERTS: It is a question I actually raised. There was a conflict between Michael Barnes and Hugh Dillon as to what model.

The CHAIR: And in this context, I am reminded, we have a Workers Compensation Commission, which looks after injured workers, headed up by a District Court judge. We have the NSW Civil and Administrative Tribunal that deals with a whole variety of important civil matters headed up by a Supreme Court judge. Surely, given the important work of this jurisdiction, it is no less important than freedom of information applications or whether some professional person should maintain their registration.

Mr HUNYOR: Sure, I agree. I do not think we have a strong view on whether it should be a magistrate, a Supreme Court judge or a District Court judge.

The CHAIR: It should be autonomous.

Mr HUNYOR: That is right.

The Hon. TREVOR KHAN: I think in the Hugh Dillon conversation part of the issue was if you completely separate it out then the issue is "Yes, you will create a professional body of coroners but the danger is that those coroners will burn out."

The Hon. ROD ROBERTS: With nowhere to go.

The Hon. TREVOR KHAN: What do you do with them then, in a sense? Whereas there is a benefit in being able to move people in and move people out of the magistrate's jurisdiction from the point of view that, if they are burnt out by the very particular experiences of the Coroners Court, it is not the end for those people. I think we have seen that certainly in my time—

Mr DAVID SHOEBRIDGE: In Parliament?

The Hon. TREVOR KHAN: Yes, it has been a long journey. You see some coroners actually not be able to cope with the nature of the—

Mr HUNYOR: I simply do not know whether you could achieve that by having people acting in the roles and coming across and being relieved from duties and having sort of administrative arrangements whereby that can happen as opposed to actually being part of the one institution.

The CHAIR: But, equally, we have the other side of the coin, as it were—which I think was ventilated by Professor Dillon—which is, because of the rotational nature of the Coroner's jurisdiction, people are really just beginning to develop a facility and expertise and affinity with the jurisdiction—

The Hon. TREVOR KHAN: And then they get moved out.

The CHAIR: —before they are rotated back into the Local Court and you lose that skill set.

Mr HUNYOR: I think it will depend. Some people may be able to do this sort of work for 10 or 15 years in a healthy and comfortable way and bring great expertise, and others after five years will need to move—

The CHAIR: But it is the same with any court, surely. Any court has a limited jurisdiction and some people may be good, bad or indifferent at different parts of the task or may not be suitable.

Mr HUNYOR: That is right. I think the subject matter here can be particularly distressing in the same way that some aspects of the criminal law—child sex trials, for example, can be particularly distressing. I think there is a need to be mindful of the precarious—

The Hon. TREVOR KHAN: The traumatising effect.

Mr HUNYOR: —trauma issues but that is a matter of having that flexibility so that you can accommodate that while recognising that there is some great expertise that you need to build and that it is not the role of a regular criminal court.

Mr DAVID SHOEBRIDGE: I think many people would be surprised to realise that it is not currently a function of the New South Wales Coroner system to try to prevent future deaths. I actually find that quite astounding that it is not part of the statutory requirement to try to prevent future deaths. You suggest picking up the wording from the Tasmanian Coroner's jurisdiction. I will read section 28 (2) onto the record, where it says a coroner:

> … *must*, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.

Are you aware of any examples where that has been particularly useful?

Mr HUNYOR: I might have to take that on notice. I cannot, off the top of my head.

The CHAIR: The benefit of that sort of provision is that it directs the Coroner's attention to whether there are systemic issues. It is still a matter for the Coroner to make the judgement about whether it is useful or appropriate.

Mr HUNYOR: But it is front of mind.

The CHAIR: It is front of mind, but maintains the independence of the officer whilst still directing their attention.

Mr HUNYOR: Yes.

Mr DAVID SHOEBRIDGE: And that works together with the other recommendations that you put forward about having the preventative unit within the Coroner. These things work together; it is a package. Is that right?

Mr HUNYOR: That is right.

Mr DAVID SHOEBRIDGE: But, of course, none of that is useful without additional resourcing.

Mr HUNYOR: That is absolutely right, yes.

Mr DAVID SHOEBRIDGE: I suppose you have got six separate recommendations but really you cannot do any one of them by themselves?

Mr HUNYOR: No.

Mr DAVID SHOEBRIDGE: There needs to be that package of reforms.

The CHAIR: Do other Committee members have questions? If not, we will go back to Mr Shoebridge.

Mr DAVID SHOEBRIDGE: I go back to the First Nations recommendations.

Mr HUNYOR: Yes.

Mr DAVID SHOEBRIDGE: Do you want to talk us through your recommendation about reforming the system so that it is culturally safe for First Nations people?

Mr HUNYOR: The first thing I note is that PIAC is not a First Nations organisation so we very much defer to the evidence of First Nations people and organisations. The submissions that were made to the First Nations inquiry were detailed, particularly the submissions of groups like Jumbunna and the Aboriginal Legal Service. Those highlight a range of areas where things could be done better and differently. Some of the specific reforms that we have set out in our submission are things like: establishing a Koori engagement unit within the Coroners Court; having a specialist stream within the coronial system to respond to First Nations deaths; opportunities for restorative and therapeutic options, such as family conferences with those involved in a death; developing protocols and practice guidelines to guide the conduct of inquests—I know that the State Coroner has already taken action there—resourcing wraparound support for families through the coronial process; and allowing the idea of recognition proceedings that you heard earlier from Ms Crellin to following investigations and increasing funding for the ALS. Those are the sorts of things that we think can make sure that the system is done better but in our view it really needs a reset.

Mr DAVID SHOEBRIDGE: One other element of that is your recommendation 5 involving deaths in custody and police not investigating police. Can you talk us through how that would work within the coronial system?

Mr HUNYOR: Sure, there are a number of different options. Again PIAC does not have a strong view about precisely where the body should be located except it is strongly of the view that it should be independent from police. A specialist unit within the Coroners Court has been suggested as one example so that the investigation can be overseen and undertaken by an investigatory team with special skills within the Coroners

Court so that the police are not the ones who are preparing the brief or interviewing witnesses and so on. That is just essential for independence.

The Hon. TREVOR KHAN: Can I raise a matter? What concerns me in this whole area is that we talk about police not investigating police—and I accept the problem—but the majority of deaths in custody are not occurring in police custody; the overwhelming majority are in Corrective Services. Are we saying that in the context of a Corrective Services death it is inappropriate for the police to be involved in the investigation?

Mr HUNYOR: It does not raise exactly the same issues but it raises similar issues because it is all part of the criminal justice system. It is still people in uniform and that is still how it is presented. Those systems work closely together. So I think from the perspective of improving the confidence of First Nations people in the system and maintaining that sense of independence and integrity then I think police should also not be involved in investigations into deaths in prisons. Also because the issues may flow over, so it may be that there are issues that cross over between what happened during the course of the police interactions and what then happens in the cells.

The Hon. TREVOR KHAN: I think the statistics that we gained on the First Nations inquiry is that the rate of death of First Nations people in custody is—

The CHAIR: Consistent with their level of over-representation—

The Hon. TREVOR KHAN: —consistent with their level of over-representation.

Mr HUNYOR: Yes.

The Hon. TREVOR KHAN: What I am then left with is this question: Does that mean that all deaths in custody—deaths of any sort, particularly in Corrective Services—should not involve police, even though there is no evidence of, in a sense, statistical over-representation when viewed as part of the prison cohort?

Mr HUNYOR: That is our view, that they should be done separately. Obviously, in one sense it is still the State investigating but the idea of an independent Coroners Court and a specialist unit within that that investigates with an improved mandate around accountability and death prevention, and those sorts of things, I think that can be seen much more clearly to provide a more rigorous and independent investigation that the public and, particularly, First Nations people can have greater confidence in.

Mr DAVID SHOEBRIDGE: But I do not think it is no involvement of the police; it is just not the police being the primary investigation unit. I do not think anyone has ever said there should be no role for police.

Mr HUNYOR: No.

Mr DAVID SHOEBRIDGE: And I do not think that is your position?

Mr HUNYOR: No, it is not.

The Hon. TREVOR KHAN: I am not certain that that is what was being said before, David.

Mr HUNYOR: I am sorry if I was not clear. Police are going to have to be involved because there may have to be criminal charges and so on.

Mr DAVID SHOEBRIDGE: But the primary responsibility lies with an independent unit.

Mr HUNYOR: That is right.

The Hon. TREVOR KHAN: Where would the people be draw from?

Mr HUNYOR: There is a range of places that people could be drawn from. Some people may have experience themselves in law enforcement but there is a range of other investigatory bodies where people may have that experience—corporate regulators and the Ombudsman. There are human rights commissions that do investigations into things, so there is a range of different things. It will be a matter of identifying what skills you need for that position.

The Hon. ROD ROBERTS: Homicide investigation, I would suggest. It is fairly difficult to recruit them from anywhere outside a law enforcement body though.

The CHAIR: But whatever their background it is a question of what hat they are wearing at the time.

The Hon. ROD ROBERTS: I agree. Corporate regulators do investigations; there is no disputing that. But we are talking about a fairly unique skillset when referring to the investigation of a homicide.

Mr HUNYOR: Yes, I accept that.

The CHAIR: Are there any further or additional questions from Committee members? Mr Hunyor, thank you very much for your submission from PIAC and for your evidence here today. If there is anything further from Committee members it will be forthcoming in questions on notice.

(The witness withdrew.)

(Luncheon adjournment)

IAN DOUGLAS BROWN, Secretary, Independent Bushfire Group, affirmed and examined

DAVID GEORGE DARLINGTON, Committee member, Independent Bushfire Group, before the Committee via videoconference, affirmed and examined

GEOFFREY BRUCE LUSCOMBE, Convenor, Independent Bushfire Group, before the Committee via teleconference, affirmed and examined

The CHAIR: We have submission No. 37 of the Independent Bushfire Group. Would one of you like to give a short opening statement?

Mr BROWN: Yes, we would, thank you. Chair, Deputy Chair, and Committee members, thank you for inviting us to appear today. Our submission is the only one that focuses on bushfires yet they can be a large part of the coronial workload as shown by the still ongoing inquiry into the Black Summer fires. This workload is likely to increase with the worsening fires under climate change. We formed the Independent Bushfire Group after the Black Summer bushfires to advocate for better fire management. Our group is a voluntary collaboration of experienced bushfire practitioners with diverse backgrounds. There is no other group like us really, with a depth of on-ground experience, independent of any funding, government agency or political stripe, and with a focus on practical firefighting, science and evidence.

We have worked hard on our advocacy and we have been influential. We started with a 180-page report to the New South Wales independent bushfire inquiry, including analysis of some Black Summer fires. These are still the only such studies that have been published. We have made other submissions and liaised with fire agencies, media, firefighters, researchers, politicians and community groups. Better review processes are critical to better outcomes, so one reform we have argued for is an inspector general of emergency management. We are now into the second fire season, after our worst bushfires in 200 years, yet there is still no comprehensive review of bushfire operations.

The New South Wales bushfire inquiry requested in-house reviews of just four high-profile fires which have been kept secret in deference to the subsequent coronial. That coronial looks like producing nothing definitive until at least three fire seasons have gone. Current mechanisms for bushfire review are helpful but flawed. They do not deliver timely and robust lessons for improving things on the ground. For the sake of firefighters and communities, we need a more effective system. It would embody a number of features. It would be blame-free, non-adversarial and fact based. It would be independent. It would be resourced. It would look at successful as well as adverse events. It would develop expertise in bushfire operations, as well as fire science and investigations. It would have powers to compel information. It would face fewer legal impediments. It would focus on lessons learned to improve bushfire operations. It would develop accountable action plans to deliver on those lessons and it would produce outcomes before the following fire season.

Bushfire coronials can produce good outcomes, but fall short of what is needed. They can also get in the way of best practice and they are slow to deliver. Coronial and other processes are poorly integrated. I should say that our group has personal experience of many bushfire investigations and coronials. My two colleagues on the screen have appeared as witnesses at coronial hearings, having been in charge of emergency level fires. We strongly agree with the many submissions that argue for a greater focus on timeliness, prevention and accountability. We also urge this inquiry to recommend that non-fatal bushfire investigations be given to a new purpose-built body—an inspector general of emergency management—as in other States and with the features already mentioned. Separating bushfire would also reduce coronial workload and assist timeliness. Bushfires have enormous impacts on lives, trauma, community, property, environment and Treasury. The Black Summer operations probably cost more than $1 billion. More rigorous, inbuilt, timely and transparent processes to improve bushfire outcomes are possible. We suggest they are essential. Thank you.

The Hon. ROD ROBERTS: I will open the batting on this one. I direct my question to you, Mr Brown, simply because you are here in the room but if Mr Darlington or Mr Luscombe feel it is more appropriate for them to answer, feel free to participate. Having read your submission there are a number of salient points but the key thing that I take away is the delay in the coronial process, the protracted nature of it and, therefore, the opportunity to learn from lessons is lost. Let us hope that this season is not a fire season because of all the wet weather. But because the coronial process might take two, three and sometimes up to five years to complete we are losing the opportunity to learn. Is that a good summation?

Mr BROWN: It is a very key point. We do not lose the opportunity completely but obviously it is delayed. Mr Darlington might mention—we were talking about this only yesterday—some outcomes from the Sir Ivan Dougherty Drive coronial, the last major coronial on a bushfire. The other issue is that coronials tend to be pretty intimidating. They are very legalistic and there are barristers and cross-examination, and sworn statements

and all that sort of thing. There are a whole lot of issues around liability and blame, and that sort thing, which people who are trying to review fires face if the coronial is the ultimate arbiter. There are some other issues as well but timeliness is certainly critical, yes. Mr Darlington might want to add something about the Sir Ivan fire, as we call it.

Mr DARLINGTON: Yes. Thank you for that question. It certainly is very relevant. I direct the Committee to the first point in our submission which makes reference to that Sir Ivan fire. It is not country I am personally familiar with. But having read the coronial inquiry report and findings it was fairly clear that that fire was one of the first to experience fire behaviour under catastrophic weather conditions. That is the top of the fire range. It was one of those absolutely dreadful days. We experienced many of those during the 2019-20 bushfire period.

I would imagine the findings from that in a more timely way could have helped feed into better preparedness, I guess, and a better understanding of fire control for the 2019-20 fire events—another key finding for improved communication between the farming community and firefighters and, indeed, how to integrate the private firefighting resources that farmers often have into the fleet of fire agency suppression equipment. Those are just two examples. No doubt there were others but had that come out before the commencement of the 2019-20 bushfire season perhaps there may have been opportunities for greater adoption of those findings.

Mr BROWN: Some of those things are being addressed now but it is after the 2019-20 fires, not before them unfortunately.

Mr LUSCOMBE: Can I chime in? There are a couple of other important differences as well. A fire event in itself, particularly a bushfire, can take days, weeks or months to unfold. Understanding what occurred requires a forensic investigatory process undertaken by people who understand fire, obviously, and have a relevant understanding of fire. Those are investigatory skills that quite often the police are not able to bring to bear to assist the Coroner. I think the nature of the investigation is quite different in a bushfire setting compared to the majority of the work that is undertaken by the Coroner.

The CHAIR: Thank you, Mr Luscombe.

The Hon. PENNY SHARPE: Thank you for coming along. I think that your submission really adds a different flavour to what we are looking at with the inquiry so I thank you for that. I noticed your advocacy for an independent inspector general of emergency management, and I see quite a lot of merit in that idea. I suppose my question to you is: How do you see that operating with the Coroner, or is this really a separate process that is more directly to deal with what went well, what went badly and what do we immediately need to change as we prepare for the next fire season? I am just trying to understand how you see that fitting with the coronial process.

Mr BROWN: Ideally, I think it would feed into the coronial process as an input rather than the Coroner having to send out police and agree to do it, which is sort of a very analytical, forensic-type legalistic approach. What we are looking for is a much faster capacity, I suppose, to review fires soon after the event rather than waiting a couple of years. We are not experts in coronial process; we are not lawyers. But what we can do is point out what we would like to see as an outcome or the shape of what we would like to see, and I think that is the way we see it. The process of inspector general go straight in there after a fire and talk to people and that sort of thing—perhaps in a different, more informal style.

Anyone who has been involved in a major fire and knows what happened—and there is not that many people for most fires, actually—can probably tell you what the key issues were without going through months and months of interviewing witnesses and so on like a police process would do. So it would follow more informal processes and get to some sort of outcomes first. The other issue is, obviously, if there are deaths the Coroner has to be involved. It is not entirely clear to me why the Coroner investigates other fires because, as Mr Luscombe said, they are quite different in process to single events like murders and deaths and that sort of thing.

The Hon. PENNY SHARPE: If I can just follow up on that, I suppose there are two things that arise out of that. Forgive me, I have not been involved in fighting fires and I really would like to understand the process after the fire happens and the actual debriefing that goes on. My understanding is that the RFS or whoever else—that there is some kind of debriefing process and there is a review of what has gone on. I am trying to understand how that is separate, leaving aside deaths, which is a different issue. I suppose the question I am coming to is: Is the coronial jurisdiction the right place for this?

Mr BROWN: No, we do not think it is necessarily. The coronial is at least independent—and strongly independent—which is a very strong plus and so ought an inspector general of emergency management be. However, internal reviews by agencies and so on are inherently challenging. Let us be honest, fires are very traumatic, challenging events. People often just want to move on; they do not want to rehash it and all. So if it is left to the agencies and so on it is a real challenge to do that thoroughly and well. Things are improving on that

front—and Mr Darlington might like to comment on this because he has been involved in some recently—and after-action reviews and so on are happening.

The key agency has just recently adopted a lessons management framework, which people have been lobbying for for many years. However, it still seems to be being applied somewhat inconsistently and as yet there is no statewide statement on the lessons that came out of the Black Summer fires, apart from the independent New South Wales inquiry, which only went so far. That is probably because they are deferring to the coronial process. That is a key issue. Internal reviews are beset with issues of liability and blame and that sort of thing, which really need to be got away from if we are going to get good outcomes promptly.

Mr LUSCOMBE: It is important to note too that something like the New South Wales inquiry was not an operational review. In fact, I think the words of inquiry were something like "this should only be the beginning". So they were not able to look at the operational aspects to review those things to understand what worked well and what did not. So significant gaps is I guess where we are coming from.

The Hon. PENNY SHARPE: So where does the operational review occur or does it not occur? What is the role of Resilience NSW in this?

Mr DARLINGTON: If I could jump in there, that is a really good question. I have been trying to get my head around the role of Resilience NSW, so possibly this Committee could find some value in seeking some clarification around their role. Obviously they are a new agency but I suspect there is some real value in sitting down with the Resilience commissioner, given his enormous background and respect in fire management, and having that discussion. I think that is a really good point you raise. The other answer to your question "Who is in charge of operational reviews?", is they always occur. The lead agency for fires, if it has been a section 44 fire it will obviously be the Rural Fire Service. If it is a fire of lesser scale, it will be a land management agency—Forestry Corporation, National Parks and Wildlife Service or Fire and Rescue—that would be managing that debriefing process.

Debriefs can be challenging and, in my experience, you have to have really good skills to get the best out of a debrief because it is a real balance between people feeling that they are under the spotlight because perhaps the decision they made would have in hindsight been better not to have been made. Firefighting is like that. It is not a precise science. Sometimes you have to make a decision and you say, "I wish we had not done that." But, equally, sometimes a really challenging decision can be implemented with the right people and a lot of lessons can be learnt from those as to why that worked this time and why some operation two years ago did not work. It is important to have those discussions and those learnings.

The Hon. TREVOR KHAN: I will direct this to Mr Brown on the basis that, again, you are here. Some of the matters you have put are very persuasive, I think. Indeed, the overall question about why coroners investigate fires is equally on point. I suppose I will ask in that regard: Would you foresee the inspector general of emergency management having a power to investigate all fires?

Mr BROWN: I think fatal fires would have to be remain with the Coroner.

The Hon. TREVOR KHAN: Well, fatalities would remain with the Coroner. I think we will take that as given.

Mr BROWN: Yes. My working assumption of why other fires are in the Coroner's thing is because they may involve people in terms of arson and other human causes because the key role of the Coroner is to investigate the cause and origin of fires. However, when it comes to fires that are fairly obviously not arson—in that bad season most of the major fires were not arson, they were lightning strikes—

The Hon. TREVOR KHAN: But there are certainly occasions where it is unclear as to whether it is arson, a lightning strike or powerlines. Indeed, it may be a combination of all three.

Mr BROWN: Yes, there are. Within government agencies, particularly the Rural Fire Service, there is a process of investigating bushfires and the cause of them. Then when the coronial occurs the police come in and do it again, basically. They often rely on the RFS investigation as well, from what I have observed of the recent coronial process. I agree there is a demarcation issue there. I do not know if I can suggest a precise answer. It depends on what—

Mr LUSCOMBE: It is important to note that it is not just the origin of the fire; it is the events during the fire suppression operation, which can be days, weeks or months to unfold.

Mr BROWN: Yes, that is right.

Mr LUSCOMBE: It is not limited to the actual point of ignition. The investigation needs to look at all the intervening points.

Mr BROWN: Yes. If an impact happens, all the events leading up to that may be relevant in terms of controlling what the fire did or did not do. In the case of—I lost my train of thought there.

The Hon. TREVOR KHAN: It happens to me all the time.

The CHAIR: Can I ask this question then: What function would an independent inspector general of emergency management do, as it is understood in Queensland and Victoria, that is not currently being fulfilled by Resilience NSW or any other agency, leaving aside, of course, the notion that it would be independent? I think we can all agree independence is a great virtue with inquiries, whereas Resilience NSW is a budget sector super agency. How does it work in Queensland and Victoria?

The Hon. TREVOR KHAN: It is actually a coordination agency.

The CHAIR: I take that point.

The Hon. TREVOR KHAN: It is not actually, in a sense, a cost centre in itself.

The CHAIR: No, but it coordinates the activities of others, including the RFS and the SES.

Mr BROWN: As far as I am aware, the role of an independent investigation is not part of Resilience NSW role. I might be mistaken on that, but I am pretty sure that is the case. Yes, you took the words out of my mouth: Independence is key. I think when you look across the other jurisdictions and governance, the police have independent oversight, the military has independent oversight, even our spies have independent oversight, but our fire agencies do not in New South Wales. I would not say that necessarily the Queensland and Victorian models are ideal. There have been some independent reviews done recently of fires in those States and in South Australia, and we felt they were okay but they were not fantastic. They did not really delve into the operational detail very much; they stuck with higher-level stuff.

The CHAIR: What are you proposing? How would it look like if we were to recommend it here in New South Wales?

Mr BROWN: I think I mentioned the points that I mentioned in my introductory talk that it would be critical to develop expertise in the investigation of fires. Something I should say is that one of the problems at the moment with the standard sort of debriefs and after-action reviews and other things is they do not start from a point of common understanding of what even happened. We were very strong on the idea that there should be analysis of fires and then you do the debrief—analysis of exactly what happened in terms of a time and event process—and the inspector general would perform that as well, either by commissioning expertise or developing in-house expertise.

The Hon. TREVOR KHAN: If the inspector were to have an investigatory function, would you see that being assisted by powers of compulsion with regards to the production of documents or answering questions, which are in many ways similar powers to what a coroner has?

Mr BROWN: That would be ideal, yes. However, I think it is important that it maintain an informal sort of focus with a key objective of getting to the truth rather than sort of trying to look for someone to blame and making it a very adversarial sort of situation where they have to demand documents and that sort of thing. Ideally, it would be a less legalistic process.

The Hon. TREVOR KHAN: Indeed, but the question is obtaining the cooperation of the parties, and I think we see in government that you do not necessarily get cooperation from different government departments at various times in terms of undertaking reviews and the like.

Mr BROWN: No. Government departments—part of their role is to protect themselves and the Government, which would not be the role of an independent arbiter.

The Hon. TREVOR KHAN: Indeed. That is why you want that independent status.

Mr BROWN: Yes.

The CHAIR: I thank Mr Brown, Mr Darlington and Mr Luscombe for giving evidence today. You have given us a lot to think about.

Mr BROWN: Thank you very much for your time. If you would like to come back to us on anything, please do.

The CHAIR: Will do.

(The witnesses withdrew.)

TIMOTHY BOWEN, Manager, Advocacy and Legal, Medical Insurance Group Australia, sworn and examined

DANIELLE McMULLEN, President, Australian Medical Association NSW, affirmed and examined

ANDREW ELLIS, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, affirmed and examined

CHRISTINA MATTHEWS, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, sworn and examined

The CHAIR: Would each organisation present like to give a brief opening statement? We have got your submissions, but there is a capacity to give an opening statement should you wish. Mr Bowen?

Mr BOWEN: Thank you, Chair. On behalf of Medical Insurance Group Australia [MIGA], I thank the Committee for the invitation to give evidence today. Our focus is on coronial matters involving health care, where we support and educate doctors and organisations. I head up MIGA's advocacy and policy work and in a past life represented doctors and organisations in coronial matters. Our interest is in seeing how the handling of healthcare matters can be improved and made more efficient, particularly through resuming past productive engagement between the Coroners Court and healthcare stakeholders, and making a number of important modifications to the current legislative framework.

We think the proposals and recommendations in our submission are appropriately directed to improving evidence gathering and processes for other preparatory work, clarifying when inquests should be held and how they should run, and modernising coronial processes. In our view, these steps could go a long way to reducing the delays and avoiding some of the challenges we see in coronial matters. A standalone Coroners Court also deserves careful consideration. We are conscious of the funding and other practical challenges that this could involve, but there may be other ways to try and achieve at least some of the benefits that could offer. Finally, thank you again for the opportunity to appear today.

The CHAIR: Thank you. Dr McMullen?

Dr McMULLEN: Thanks. Australian Medical Association [AMA] (NSW) thanks you for the opportunity to appear before this inquiry into the coronial jurisdiction in New South Wales. As the peak representative body for medical practitioners in New South Wales, the AMA (NSW) submission focuses upon the coronial jurisdiction from the perspective of the medical profession and addresses those areas of the coronial jurisdiction where the processes and procedures may be improved from that viewpoint. We have also given due consideration to those members of the public who find themselves involved in the coronial system.

AMA (NSW), firstly, wishes to express its appreciation for the work of the Coroners Court of New South Wales. AMA (NSW) is cognisant of the fact that the Coroner works tirelessly to improve systems and processes in New South Wales, with the ultimate aim of protecting the community. In our submission, we have focused on key aspects of the reporting process following adverse events, predominantly in the public hospital system, and have relied upon anecdotal evidence and feedback from our hospital practice committee members, AMA (NSW) members and members of the New South Wales public hospital medical staff councils.

A number of key recommendations are made. Firstly, addressing delays. AMA (NSW) believes that delays in the coronial jurisdiction are a core issue which must be addressed to better the delivery of health care to the public and decrease emotional distress to families involved. One area where that delay exists is due to the duplication of investigation and recommendations by the Coroner and the health service, also causing potential unnecessary use of the Coroner's resources. To address this, serious adverse events or root cause analysis [RCA] reports or recommendations could be routinely released to coroners.

Secondly, efforts should be made to allow increased involvement and inclusion of relevant clinicians into coronial recommendations. A new model of practice could be developed which allows for practitioners to be directly involved in implementing the recommendations that a coroner recommends. This will ensure best practice and provide a system of improvement rather than disruption. Lastly, AMA (NSW) believes that coronial recommendations should not be made without reference to the costs and resources associated with implementing those changes. At the same time, of course, we do not want to detract from the importance of change and improvement in this jurisdiction, which is required for the protection and prevention of harm to the public at large. Thanks again.

The CHAIR: Thank you. The Royal Australian and New Zealand College of Psychiatrists?

Dr MATTHEWS: Thank you. I might just read out a brief statement. Thank you, Mr Chair and other honourable members. Dr Ellis and I wish to thank the Select Committee for the opportunity to speak today on

behalf of the college, on this land that belongs to the Gadigal people. The college is concerned with promoting and advocating for an optimal level of mental wellbeing for all members of the community. Given this, we have a professional interest in various aspects of the coronial jurisdiction. It is the unfortunate reality that the Coroners Court regularly hears cases that involve the death of a person with a mental illness, who may have been suffering psychological stress or perhaps died unexpectedly in a place of lawful detainment. These are the people we, as psychiatrists, assess, manage and support on a daily basis.

The college is also aware of the mental health needs of the bereaved and community witnesses who encounter the coronial process. The tragic events which may result in an inquest being held, or indeed the inquest itself, unsurprisingly, have a significant adverse effect on the mental health of those personally connected to the deceased. In consideration of this, we hope to highlight the need for adequate resourcing for social and mental health services for the bereaved. It is particularly imperative that culturally appropriate support be available to First Nations people and others from culturally diverse backgrounds. Funding should also be allocated to appointed expert psychiatry witnesses in cases that involve the death of a person with a mental illness. Evidence from such conditions can prove useful to the inquest and there have been clear examples in the past where such assistance has not been sought.

With awareness of the complexity of the coronial process, we still wish to highlight the need for timeliness in the Coroner's handing down of decisions and recommendations. A prolonged time period between this and the inquest, or indeed the tragic event itself, can lead to increased psychological stress for those connected to the case, as well as potentially missed opportunities for relevant agencies to move forward towards systems change and improvement. Our written submission also considers other mechanisms to enhance the efficiency and effectiveness of the coronial process and we would be happy to speak further to this if the Select Committee desires. Thanks for your time.

The CHAIR: Thank you for your opening statements. Committee members, who would like to open the batting for questions?

The Hon. TREVOR KHAN: I might start with Mr Bowen. I am referring to page 2 of your submission and particularly the proposed changes to the Coroners Act. Can you flesh out the issue where you say there is not presently procedural fairness shown to participants who may be adversely impacted?

Mr BOWEN: In a healthcare inquest perspective, my own personal experience and the experience of my colleagues and our members has, generally, been quite a good one. Our issue around that is more that we see it as a deficiency in the Act that there is not a reinforcement of the need for that. Now, certainly, we are comfortable with how it is being dealt with at the moment, but it is important to have that, we would say, in the Act to guide future practice and put it within the DNA of the coronial jurisdiction, which at the moment is dependent on how individual coroners do that.

The Hon. TREVOR KHAN: Can you point to particular areas where you have a concern, even if you say it is not a demonstrated problem at the present time?

Mr BOWEN: I would not say that doctors, particularly, are being denied important aspects of procedural fairness. But there are opportunities to respond to certain things in certain ways that, if perhaps we put procedural fairness front and centre, may assist with those things. For instance, if something is in the mind of a coroner to make a certain recommendation or perhaps refer a matter for consideration by the Health Care Complaints Commission, perhaps an emphasis on procedural fairness would say that should be put forward at the very beginning, not necessarily raised further down the track.

Mr DAVID SHOEBRIDGE: At the very beginning? But how would a coroner know at the very beginning, before they have started contemplating the evidence and heard some cross-examination? How could the Coroner possibly know at the very beginning

The Hon. TREVOR KHAN: Indeed, it might be suggested, if that is being flagged up-front, the allegation would be made that the Coroner has come to a preconceived position?

Mr BOWEN: I accept that—

The Hon. TREVOR KHAN: Well—

Mr DAVID SHOEBRIDGE: But how can the Coroner know at the very beginning, Mr Bowen?

The CHAIR: Just one person speaking at a time please. Mr Shoebridge, I think you were actually speaking at the time, and then back to Mr Khan.

Mr BOWEN: I would not say, Mr Shoebridge, it would be at the beginning in every case. I would suggest that it could be on the cards in certain cases that there may be—probably more in the sense of making

recommendations to certain organisations, that it would be an opportunity to give those organisations a chance to think, "Well, what have we already done and what else could we do?", and explain that to the Coroner in the early stages.

Mr DAVID SHOEBRIDGE: But that seems—

The CHAIR: Sorry, Mr Shoebridge. Just to follow up. Are you talking about a particular incident that, let us say, leads to a death and the Coroner is hearing from the people directly involved that there may be bodies or stakeholders whose expertise or experience may bear on those events but they may not have been directly involved—is that what you are talking about?

Mr BOWEN: That is exact, Mr Chair. My personal experience has been that sometimes those organisations may be involved later. It may be particular bodies within NSW Health or colleges like the Royal Australian and New Zealand College of Psychiatrists or, particularly, the Royal Australian College of General Practitioners as well. An earlier opportunity to comment on things which—look, it may not be a legal definition of procedural fairness, but where people's interests are affected in that area or organisations' interests are affected, getting the opportunity to respond earlier to that. My submission would be, I guess, that improves the quality of the recommendations that the Coroner is making.

The CHAIR: So what you are really talking about is people's professional interests, more broadly, being impacted by perhaps a coroner's recommendations, but their representative bodies not having the opportunity to comment on that particular matter?

Mr BOWEN: Yes, that would be fair to put it that way.

The CHAIR: Back to you, Mr Shoebridge. Sorry for interrupting.

Mr DAVID SHOEBRIDGE: But it is an inquisitorial process. It does not commence by pleadings or statements of parties' positions. It starts with an open slate, largely. Obviously, there are discussions between the counsel assisting and the Coroner. But what you are suggesting seems, to me, entirely contrary to the very idea of an inquisitorial process, where you basically start with a statement of issues and work your way back. That is not how I understand it works and I would need to be persuaded that that would be a good path to go down.

Mr BOWEN: In a range of healthcare inquests already—and I understand it is more the general practice—a list of issues will be produced. It may be just before an inquest or it may be at an earlier stage of an inquest. That can be quite a helpful mechanism. That is not necessarily consistent and that might be because of the issues you have raised around it is not able to identify issues necessarily early—the nature of the inquisitive process. But the issues can, in some situations, be identified earlier and, in my respectful submission, without detracting necessarily from the quality of that inquisitorial process.

Mr DAVID SHOEBRIDGE: If you have a disciplinary process where you have an authority challenging the registration of a professional, then you can see how at the beginning the allegations and the exchange would happen. But coronial inquests are not disciplinary processes. They are trying to get to the truth of a matter and, hopefully, starting without a preconception about where it will end. Do you say that the processes involved in disciplinary processes can just be translated into coronial inquests? Because I have trouble, for the reasons I have said, accepting that.

Mr BOWEN: Not directly, because there is a clear recognition of that different aim, as you have identified already. But there can be a very fine line at times between not getting into issues of civil liability or disciplinary criticism and expressing views on what should not have happened and what can be done better. It is a difficult line for coroners to walk, and I do think coroners can do it quite well at times. But that fine line means that it would only be fair and proper in certain circumstances to give the opportunity to respond. I am not saying that is not given at times, but I think it would be helpful that that is recognised in the Act.

The Hon. TREVOR KHAN: Can I just move on to another part?

The CHAIR: Yes, of course, Mr Khan.

Mr DAVID SHOEBRIDGE: I have one further question.

The Hon. TREVOR KHAN: I was starting by going through some of the sections on page 2 of his report dealing with changes to the Coroners Act.

The CHAIR: I will give the call to Mr Khan.

The Hon. TREVOR KHAN: I do not want to use all the time we have. I go to section 61, which is the use of certificates. Will you flesh out for us where you say the deficiency is? Are you saying that it is too difficult to get those certificates at the present time?

Mr BOWEN: Not difficult to get the certificates once we reach the inquest stage, but an enormous number of matters are being looked at and dealt with on the papers, so to speak. That protection, unless certain processes can be invoked—there is a debate about whether they could be—does not apply at that early investigatory stage. What we are proposing is that the Coroner's ability to grant that certificate or protection be extended to that earlier stage.

The Hon. TREVOR KHAN: It does not seem unreasonable in terms of moving the matter along in some way. There are other matters, but I will cede the floor at this stage.

The CHAIR: Before I go back to Mr Shoebridge, does any other Committee member have questions?

The Hon. CATHERINE CUSACK: Yes.

The CHAIR: I will give the call to Penny Sharpe first, then to Ms Cusack and then back to Mr Shoebridge.

The Hon. PENNY SHARPE: I want to ask Dr McMullen a question about the root cause analysis. I am familiar with the root cause analysis issue. My understanding is that it is supposed to go through an issue in detail, not as a blame exercise but to get to the bottom of what an issue is and to deal with the systemic issues that are there. I want to understand how that could be of use in terms of a coronial inquiry. I am surprised that is not an automatic part of the process. Will you take me through that? I am interested in the interaction. It goes to the point that Mr Shoebridge was making before, which is the inquisitorial part of this and looking at it with fresh eyes. How does that all come together, in your view?

Dr McMULLEN: Yes, certainly, and thanks for the question. Our main point around this is around duplication of resources, outcomes and the delays to the system. It is standard, common practice in the public hospital system and increasingly in private hospitals and across the private sector—particularly in larger, corporate general practices—that if there is a serious adverse event then a process of investigation is undertaken locally to investigate that event and to implement systemic change to prevent a similar event from occurring in future. NSW Health has recently, it is my understanding, undertaken a bit of a review of exactly how that is done in the public hospital system, between the time when our submission went in and now. But further information, if that was required, could be obtained from NSW Health.

Often we find that the outcomes and the recommendations made by the Coroner either mirror or very closely align with those that have already been made at the local level and have, in fact, often already been implemented. Where we see improvements could be made is in the information sharing between stakeholders such as the public hospital system and the Coroner's jurisdiction—recognising that we would suggest that, yes, the coronial system should remain a fresh set of eyes, open and without a preconceived idea of the outcome. But at a certain point in their investigation there could be improvements made in terms of the information-sharing ability, so that the Coroner could gather information from other investigations that have already been made and would be allowed to either have access to the outcomes or to the full inquiry—both to streamline their resource use and also to minimise duplication of outcomes and delays to families when improvements have already been made and implemented through local investigations.

The Hon. PENNY SHARPE: Is there a danger that because they are system focused and do not apportion blame to individuals, if the root cause analysis was too swept up in the coronial outcome then that could influence the way in which people participate in the root cause analysis? Is that an issue that needs to be thought about?

Dr McMULLEN: It is my understanding that if there has been a serious adverse event that obviously has an individual issue then that is dealt with separately. It is not to say that is never dealt with, but there are different pathways with which you undertake that disciplinary action if there is an individual where it is needed. But the purpose of the root cause analysis should be to improve the system and prevent similar occurrences in future. The same should be then said for the Coroners Court: If an obvious error has been made or an obvious apportionment of blame is to be put to an individual or to a service, we are not saying that should not happen.

It is just that in a significant chunk of cases there is overlap in the recommendations made and there is duplication there. Of course, you would have to work out the details of making sure that there was still independent oversight of the Coroner and that they were not routinely just trusting a local resource if other investigation needed to happen. But in a significant number of cases it would be appropriate to share information.

The Hon. CATHERINE CUSACK: My questions are similar to Penny Sharpe's. When there is an adverse event in a hospital, it triggers multiple inquiries to address different aspects. For example, the hospital itself needs to know quickly if the wrong bottle has been attached to the oxygen cord. You do not want to wait for a coronial inquiry before you address that, so I think everybody is very understanding of why the hospital moves

quickly to do that. But there is also the Health Care Complaints Commission, the health department itself overseeing what the hospital is doing, the Coroner and the police. Can I get a sense of where all of this fits together and whether the multiple inquiries that are triggered are inhibiting each other in some way?

The other question that I want to ask is: Once the Coroner makes recommendations, how are they communicated and implemented? I ask that question because I remember that Coroner's recommendations were made about how the meningococcal virus was dealt with in children at accident and emergency, and they did not seem to be taken up by all of the hospitals. We had a repetition of the same mishap occurring in different hospitals, so I am interested in understanding what is the course and the effectiveness of communicating those recommendations. They are the two parts to my question.

Dr McMULLEN: I do not know if you want me to answer first, and then others may have other things to say. The first part of your question about the multiple layers of investigation speaks to the point we were talking about before that there are often multiple lines of inquiry after an adverse event. That may be appropriate in the circumstances, but we would think that it should be easier to share information where appropriate. Often there are very separate lines of inquiry, but it would often be appropriate to be able to share resources. In terms of implementation, it speaks to the other points in our submission around the Coroner's jurisdiction and having an eye to the implementation and resourcing of that.

It is my understanding that implementation of Coroner's recommendations is not mandated. We have not formed a view on whether it should be. But the resourcing required at times to implement recommendations can be significant, either in terms of equipment required, IT changes or changes to workflow in terms of communication between other clinical jurisdictions or, for example, between the hospital service, ambulance and primary care. Getting those three to talk to each other would be ideal but is actually quite difficult to implement. So our suggestions for that were to allow greater input by practising clinicians at the time of forming recommendations, at least to inform how implementable recommendations will be and how real world they are, and then perhaps thought could be given to some resourcing of implementation oversight, if that was thought to be appropriate.

Mr BOWEN: Absolutely there are different processes that can be sometimes challenging, but recognising as well that they do need to happen sometimes at the same time. The root cause analysis needs to happen quickly. Medical councils and professional councils need to act appropriately and quickly where possible. Yes, there will be some times where they all can say, "Let's wait and see what happens from the coronial investigation." On the point of the recommendations, it would be really good if we can see a broader view coming out of some of the inquests around what can be done, not just necessarily focused on a particular hospital or context but what else is working in other hospitals and what can be learnt from that as well. Often the recommendations can be quite narrow to a particular hospital or local health district.

The Hon. CATHERINE CUSACK: I am sure that you would agree that there are often multiple things that have gone wrong in a hospital mishap. I am not really aware of—I am aware of one. Normally when there has been a mishap it has been a series of things that have combined. In terms of the quality of care and the professionalism of medical staff, what role does the AMA play in that? Do you wait for a complaint from the Health Care Complaints Commission or do you take an active interest along the way?

Dr McMULLEN: The AMA has no regulatory or disciplinary function. We are a professional association and our role is advocacy on behalf of doctors, but we are not involved in a regulatory capacity. We will sometimes support members if they are undergoing an investigation by a regulatory body, but generally even then they would be supported instead by their medical defence organisation.

Mr BOWEN: If the question is directed at that issue, Ms Cusack, or the issue of representation or the issue of whether we have a—

The Hon. CATHERINE CUSACK: Yes. I am actually—it is their professional licence to operate and their accreditation.

Mr BOWEN: Certainly, professional councils and the Australian Competition and Consumer Commission could step in at a very early stage. Our role in that would be to assist doctors and organisations through that process, representing them and supporting them. The mechanism to step in at an early stage does exist.

The CHAIR: I have a couple of questions. In terms of some of the submissions that we have received, a number of them have been around the issue of responses to coronial recommendations. For example, the Royal Commission into Aboriginal Deaths in Custody 30-plus years ago recommended that there should be a mandatory legislated time frame of three months for government agencies to respond to coronial inquiries. A number of jurisdictions other than New South Wales appear to have implemented that. Is it something that we should consider

that when a coroner makes recommendations, affected agencies and possibly private sector bodies should be required by law to at least respond? Do you want to take that on notice?

Dr ELLIS: Our submission was that there should be an oversight of those recommendations. The recommendations may not necessarily be accepted, but they ought to be responded to in a public fashion so that there is a feedback loop, essentially, that coronial recommendations can be either acted upon or challenged.

The CHAIR: Another set of submissions that we have received talks about the Victorian Coroners Prevention Unit, which actually seems to provide, if you like, an evidence base supporting coroners in the discharge of their duties and analysing information and evidence given to coronial inquiries to create an evidence database so that you can see what has happened historically and also so that future coroners have got an evidence base to draw on. Dr McMullen, I take your point about the need to make sure that recommendations are—if their costing has not been done, at least that they are viable or real world. Do we need to look at some kind of supporting infrastructure for the Coroners Court that they can draw on in developing their recommendations?

Dr McMULLEN: I think if thought was being given to making implementation mandatory, then certainly the recommendations themselves would have to be well supported and then support given to the Coroner to be able to make evidence-based, informed recommendations and then, as others have said, that process of implementation and having some structure around it, particularly given that we represent both public and private sector members. As we have referenced in our submission, the impacts particularly in the private sector on cost would need to be taken into account. But also the communication of recommendations. It is quite easy for hospitals or public sector to be given the recommendations of the Coroner. For that to be widely disseminated in the private sector is challenging. Obviously if something was mandated, we need to make sure people know about it.

Mr DAVID SHOEBRIDGE: I do not think the call is to mandate the implementation; the call is to have a mandatory substantive response to the recommendations within three months.

The Hon. TREVOR KHAN: No, a mandatory response would be a step in the right direction.

Mr DAVID SHOEBRIDGE: A response would be good, but a mandatory response would be better. A mandatory substantive response would be what you would hope for, but that is different to mandatory implementation. What is your position on a mandatory substantive response?

Dr McMULLEN: In terms of public sector organisations, that is likely to be more feasible than it is for independent, small individuals. If it was every doctor, if you were going to say that every doctor needs to be able to respond to a coronial recommendation, then that is difficult.

Mr DAVID SHOEBRIDGE: A coronial response is normally directed either to a substantial institution, maybe a private hospital or the Government or some other regulatory body. I cannot conceive of them requiring a response from every GP. On the assumption that they are directed to those kinds of other substantial institutions of regulatory bodies or the Government, do you have a position on getting a substantive response to a coroner's recommendation within three months?

Dr McMULLEN: On that limit, I think we can take that on notice and provide an answer. It is not in our submission, but we can take that on notice.

The CHAIR: One of the other issues that has emerged is the fact that the Coroners Court is at the moment not really autonomous; it is certainly not a separate court. We have had different submissions either advocating for it to be a separate court altogether or at least an autonomous part of the local court, similar to the Children's Court. Do any of your bodies have a view about that?

The Hon. TREVOR KHAN: Mr Bowen does.

Mr BOWEN: I would not want to bind just to a standalone court. I accept that particularly former Coroner Barnes raised some important points about whether it would be better along a Children's Court model.

The Hon. TREVOR KHAN: Yes, we had that discussion again this morning. It seems to me that it is not an either/or; there are a number of different models.

The CHAIR: Gradation.

Mr BOWEN: We would very much jump on board with one of those models. But, again, we recognise that there is only finite funding. If we can incrementally move towards that, we welcome whatever steps can be done.

The Hon. TREVOR KHAN: I think, as we discussed this morning, one of the problems with going to a wholly standalone model—and I think Mr Barnes referred to this—is that there is a problem that some coroners will burn out in a longer or shorter period of time. If they are burnt out from doing coroner's work, what do we

then do with them? If it is entirely standalone, they are sort of alone without a leader. If they are part of an integrated system, it may be possible to move them and they can do prescribed concentration of alcohol pleas until they are blue in the face. That is probably less stressful than most or many inquests.

Mr BOWEN: If we can hold on to that expertise somehow, we are not wedded to how it is done. There have been coroners over time—and you have already heard from some of them before this Committee—who have built up a wealth of expertise. How that is passed on and preserved would be a great thing to look at.

Mr DAVID SHOEBRIDGE: Could we just go back to the root cause analysis? I think your submission says that either 60 or 90 days after a reportable death there is a requirement to have a root cause analysis, at least in the public system. Is that right? Secondly, does it also apply in the private system? Who can answer that? Mr Bowen or Dr McMullen?

Mr BOWEN: There are very similar systems by both public and private. I could not speak to the exact time frame, Mr Shoebridge, but 60 or 90 sounds quite familiar. My memory is that it might be 90, but it is of that order.

Dr McMULLEN: We have 60 in our submission. There are clear policies and frameworks in the public sector. My understanding is that, as Mr Bowen said, it applies in the private sector increasingly as well.

Mr DAVID SHOEBRIDGE: You will normally get a report, together with a series of recommendations. Would that be the standard format of a root cause analysis?

Mr BOWEN: Correct, yes.

Mr DAVID SHOEBRIDGE: And then, as I understand it from the AMA's evidence, that is not routinely provided to the Coroner. Is that right?

Dr McMULLEN: My understanding is that it has to be requested by the Coroner. I am told that there are sometimes—and we can get back to you if more information is needed—challenges within the coronial jurisdiction. They need to ask for it or they need to know that it has happened to get it, and that information sharing is not as easy as it otherwise could be.

The Hon. TREVOR KHAN: Are there any barriers to the provision of those root cause analyses from, say, the health department or the hospital's level? Does there have to be a sign-off in terms of approval to release?

Dr McMULLEN: From my understanding, the health sector would be willing to share such information and there have not been barriers put up by the health sector. It is more that it needs to be requested. It sounds like Mr Bowen may know more details, but it is the order of events that is the challenge.

Mr BOWEN: Yes. Look, we have seen them in coronial inquests. They have been used by the Coroner as a building block, so to speak.

Mr DAVID SHOEBRIDGE: When I read your submission I had a little, primitive Google search about the issue of root cause analysis and coronial investigations. I was referenced a number of Queensland coronial decisions where the Coroner actually leaned on the root cause analysis that came out of the Queensland health system, referenced the recommendations of the findings and reports, and said, "I do not really need to revisit this because I am quite satisfied with the outcome from the root cause analysis." You would not want to just have the Coroner tick the box; you would want some sort of satisfaction that it was a correct response, but not duplicating resources, understanding the learnings that happen much more quickly in the health system—there seem to be a lot of benefits in having a system that has at least an element of that in it.

Dr McMULLEN: Exactly, so that is why we have called for increased sharing of that information. We think that there is a delay in processes for families and for the health sector, and potentially unnecessary use of coronial resources.

Mr DAVID SHOEBRIDGE: That seems very low-hanging fruit, and you could implement that even without statutory response. You could just have a memorandum of understanding between NSW Health and the Coroners Court that wherever there is a reportable death from the health system it is provided, I would have thought.

Dr McMULLEN: We do not have a view as to what mechanism makes it happen but, as you said, the principles of it being that the Coroner should still take a fresh pair of eyes, not just tick the box—but that that information is routinely, readily available. But it is our understanding that it is not always accessed in New South Wales and could be accessed more.

The Hon. TREVOR KHAN: I am tempted to ask the question that Penny Sharpe asked. If we have a reportable death and, as a matter of course, the root cause analyses were provided to the Coroner, will all the participants in the undertaking of the root cause analysis remain as relaxed about participation in the process?

Mr BOWEN: There are protections in there around the identity, although some things can be worked out by inference, and of course there are protections around whether it can be used as evidence. But, as Mr Shoebridge has pointed out, we do have that similar process in New South Wales where the Coroner can take notice of the recommendations and work them into their own recommendations. I acknowledge there is that question there. I do think the access there is already ready, and I believe there may be some existing thing along the lines of a memorandum of understanding or a direction to make those root cause analyses available where there is knowledge of the coronial inquest. Again, it might come back to people's knowledge of the ability to do that or realising that one has been done, because the threshold for actually doing a root cause analysis could be higher than ordering a coronial inquest into certain matters.

Mr DAVID SHOEBRIDGE: Does this come back to some of what you put in your submission, Mr Bowen, about ensuring there are adequate protections on the exchange of information prior to the hearing itself commencing?

Mr BOWEN: To a degree, I think. I do think, around the root cause analysis question, it may be just realising what can be requested and provided at certain times, and realising when it may be available or not be available—or, in terms of not being available, it just has not been done.

Mr DAVID SHOEBRIDGE: So it is a bit of a knowledge gap, in some ways, between the Coroners Court and the health system?

Mr BOWEN: Yes.

The Hon. TREVOR KHAN: Going back to you, Mr Bowen, seeing as you talked in terms of sections, you refer to sections 81 and 82 and this issue of civil liability down the bottom of page 2. Are you finding that coroners are regularly opining on the question of liability? Really, section 81 or 82 does not make any reference to it at all.

Mr BOWEN: They are not regularly opining on it, no. Part of the problem is that we see experts in coronial matters regularly opining on it, and there is not necessarily the clear understanding amongst some of those involved in the preparation of a matter for inquest that questions that go to things of civil liability should not be explored. Doctors who are asked to comment in reports might assume they are being asked, when they talk about how it could have been prevented, they would go into issues like, "Well, that person should have done that. They made a mistake there, so you need to educate them around that." I think being clear around that in the Act would assist not necessarily so much the coroners but those assisting the coroners.

The Hon. TREVOR KHAN: It would be terrible of me to say this, but years ago when I was being trotted off to do inquests but never did civil matters, those who were doing civil matters may have encouraged me to take lines of inquiry relating to liability simply because it was perceived as a way of shortening the potential areas of dispute, or closing off potential areas of dispute, if civil proceedings were undertaken. Even to this day, I do not think that was a necessarily bad outcome, from my perspective, because it may have shortened the whole process in terms of resolving the litigation between the parties. You do not see that as a legitimate, if unspoken, use of the Coroner's jurisdiction?

Mr BOWEN: It becomes a fine balance, then, because we are talking about inquisitorial jurisdiction. It has been pointed out that it has a different focus and different opportunities for people to respond, not the same focus on whether someone should have done something or not. The concern we have there is that a person who is criticised—in a way that, down the case, there could be a civil case against them—is not necessarily able to marshal a proper response. We say that puts them at a disadvantage. The problem then would be that, if you provide the necessary protections, we turn the Coroners Court into something it is not.

Mr DAVID SHOEBRIDGE: But cause for the purpose of the Coroner is going to have a significant overlay for cause for the purpose of civil liability. You are never going to avoid that. There is going to be a substantial overlap between the two.

The CHAIR: Even just on the finding of facts, leaving aside the law.

Mr BOWEN: I accept that can occur in some cases. I think the Coroner walks that fine line of it being, looking at the system, "What actually led all of that together to this outcome?" as opposed to looking at this civil liability standard or professional disciplinary standard and whether someone should or should not have done a certain act.

The Hon. TREVOR KHAN: I suppose where I get to is that certainly the Coroner should not be making findings of liability—that is clearly outside—but the evidence that is adduced, maybe quite appropriately, may fit two footprints.

Mr BOWEN: We accept that.

Mr DAVID SHOEBRIDGE: I recall appearing in at least two coronials where that was an element of the point. You were there for the family. The family had a civil matter. You had a watching brief on the coronial inquest because it was relevant to other matters.

The Hon. TREVOR KHAN: Yes, absolutely.

Mr DAVID SHOEBRIDGE: I understand that is awkward with your insurer's hat on, Mr Bowen—

Mr BOWEN: I accept that, yes. I bring a certain perspective.

Mr DAVID SHOEBRIDGE: —but there is always going to be an element of that, isn't there? It is not always bad.

Mr BOWEN: I think the Coroner should be allowed to discharge their functions. The cause of death, the manner of death and opportunities to improve the system cannot be fettered. But once we are looking at those individual tests, that becomes the problem.

Mr DAVID SHOEBRIDGE: I accept that.

Mr BOWEN: Coroners are quite good at being clear at the beginning of inquests and saying, "We are not looking at civil liability. This is what our focus is." The question that we have around that is the beforehand—

The Hon. TREVOR KHAN: That is an observation that is not only made to the family of the deceased; from my perception, it was also an observation made to the bevy of counsel that was appearing for the medical practitioner.

Mr DAVID SHOEBRIDGE: Yes. It is not a defence case, either.

The Hon. TREVOR KHAN: Yes.

Mr DAVID SHOEBRIDGE: It is on both sides, isn't it, Mr Bowen?

Mr BOWEN: Yes, inquisitorial jurisdiction.

Mr DAVID SHOEBRIDGE: It is not your job to beat up other witnesses and pass blame amongst different professions.

Mr BOWEN: No. Hence there is a very limited opportunity at the discretion of the Coroner to contribute.

The CHAIR: Just on that issue of system improvement, some of the submissions we have received suggested—I think the previous inquiry, the First Nations deaths in custody inquiry, recommended that—although coroners do have the capacity now to make system recommendations, the lived experience has been that a number of them do not; they take quite a narrow view of the role of the coronial. Should there be a legislative mandate to require coroners to make system improvement recommendations where that is appropriate? Obviously, the Coroner would have to form the view that that is appropriate. Our attention has been drawn to the Tasmanian Coroners Act that apparently has such an injunction.

Mr DAVID SHOEBRIDGE: Section 28 (2).

The CHAIR: Section 28 (2) of the Coroners Act in Tasmania.

Mr BOWEN: I only speak in respect of healthcare inquests. I would not want to cast speculation on other inquests. But I do think the coroners already have a clear realisation of where they can and should exercise that function, make recommendations for significant improvements. I am not sure that a requirement to consider that would not take it any further than is already being done in that context.

The Hon. TREVOR KHAN: If I look at what you say and your submission says and what Dr Matthews said with regard to the failure to investigate certain lines of inquiry regarding forensic psychiatry, it seems to me you might be working on different ends of that scale.

Mr BOWEN: I would actually query whether it represents a resourcing issue as well. Certainly, we talk of 1 per cent or 2 per cent of matters going to inquest around that, appreciating there is a variety of things that can be looked to—many avenues of inquiry in an inquest alone, let alone the other hundreds of matters, thousands of

matters a coroner deals with every year. I am not so convinced that it is not the coroners doing what they have the time and ability to do but rather just a challenge of how much they have got on their plates.

The CHAIR: Does the AMA or the college have a position on this issue of whether coroners should at least have their attention drawn to the possibility of system improvement recommendations? They do have the jurisdiction. But should their attention be specifically drawn to it in the legislation?

Dr ELLIS: I do not think we would have a position on whether the Coroner did that.

Dr McMULLEN: We recognise that they have the jurisdiction but can take it on notice if you want us to form a view on whether that should be in the legislation.

The CHAIR: Yes. If you could take it on notice, whether we should have a provision like 28 (2) of the Tasmanian legislation. Mr Shoebridge.

Mr DAVID SHOEBRIDGE: I was hoping I could go to Dr Matthews or Dr Ellis. One of your really interesting contributions in your submission is the idea of a panel to help select the cases that go to hearing. We have had a number of submissions from aggrieved families and others who were very aggrieved that their family member's death was not the subject of a hearing and who felt like the decision was a little arbitrary. You suggest sometimes it can be quite arbitrary. You talk about the suggestion of a panel. Do you want to take us to that?

Dr MATTHEWS: Certainly. Yes. I suppose that is what the feeling of our members has been as well, that these decisions can be quite arbitrary and that perhaps the process would be assisted by several people with knowledge in the particular cases that are being brought to the Coroner. This advisory panel could be, for example, led by the Coroner and could include legal professionals, various medical professionals, psychiatrists, depending on the types of cases that they were going to be looking at on that particular occasion, and representatives from First Nations peoples as well. Through that, the opinions and the views and, I suppose, the understanding of the various questions that may come up in these cases would really come to the fore and, also I suppose, an identification during that process of various pertinent questions that may come about, particularly if there are, for example, two quite similar cases and it has been decided that one probably is not going to progress but one is. Is there something that we should be considering if issues that are appearing frequently are coming up?

Mr DAVID SHOEBRIDGE: I think you suggest there might be merits in the following:

> The advisory panel could function by considering all deaths related to psychiatric illness in, say, a three-month period, based on documentation presented to the panel.

Dr MATTHEWS: Yes.

Mr DAVID SHOEBRIDGE: You would have a series of cases. You could be looking at potential commonalities. Rather than have these atomised, individual decisions, you would have a kind of better perspective on the scope of cases that the Coroner might investigate.

Dr MATTHEWS: That is exactly right. Those are our thoughts on the matter. Then hopefully, because we would be thinking that other major stakeholders like First Nations people would be involved in this process, we would be able to get an understanding from their perspective regarding the importance of particular points as well.

Mr DAVID SHOEBRIDGE: Do either of the other witnesses have a view about that concept of how the Coroner selects a matter for hearing, having something like a panel? It would not be the same panel for every class of case. Do you have a view about that?

Dr McMULLEN: I can take that on notice.

Mr BOWEN: The coroners certainly do, in healthcare matters, draw on expertise from independent experts. My feeling would be that that is sufficient, where they have the ability to do that. I would not exclude the use in appropriate cases. I recognise that in forensic psychiatry cases there could be particular warrant for that. Certainly, as you suggested, being able to draw on different expertise at different times would be an important component of that.

Mr DAVID SHOEBRIDGE: Other suggestions for recommendations that overlap this are having a larger preventions unit, a more skilled group of professionals within the Coroners Court themselves, who the Coroner could reference, building up that body of expertise within the coroners courts. I suppose I will go to you, Dr Ellison and Dr Matthews. Would that be an alternative?

Dr ELLIS: Yes. I think that would also add to an empirical basis and would, potentially, lend to the perception of arbitrariness being reduced if all cases are reviewed at some level. Then select cases might be moved

forward. But also having an expert panel might guide the line of questioning, and also to detect trends and patterns that might be important that cannot be picked up in individual cases.

Mr DAVID SHOEBRIDGE: There is not a huge amount of transparency at the moment about on what basis matters are selected. I think I am being polite by saying there is not a huge amount of transparency; there is minimum transparency about why cases are being selected, why this case gets a one-week hearing, why this case is dealt with on the papers, and why this case is entirely dispensed with. Do any members of the panel have an understanding about how that decision-making happens at the moment?

Mr BOWEN: No.

Mr DAVID SHOEBRIDGE: It is pretty fundamental though, is it not?

Mr BOWEN: I would not call it predictable in a scientific level. We might have a sense of where a matter would go to an inquest or not, and it may not. Again, matters that we felt might not go inquest do go to inquest. Why and why not are not entirely clear.

Mr DAVID SHOEBRIDGE: Dr McMullen?

Dr McMULLEN: I do not have particular expertise or knowledge in the area. But in general we would advocate that it was a transparent process and evidence-based where possible. As you mentioned before, the idea of having trends on a—I can see there would be some use for looking at cases at a larger level to identify trends that might not be obvious on an individual level, but do not have any specific comments around the choice of cases at the individual level at the moment, other than being supportive of the calls for increased transparency if you are getting lots of feedback that it is not transparent.

The Hon. TREVOR KHAN: I would have thought that currently, one area where there is the potential for quite a number of inquests related to COVID deaths—particularly COVID deaths in the health system, whether it be in aged-care facilities or Liverpool Hospital, for instance, or wherever—those are the sorts of inquiries where you would have thought they would have benefited from picking representative cases and running them in some sort of—and this is terrible to say—cost-effective way so that the common features of some or all of the cases can be explored in some detail and the outlier issues can either be put to one side or alternatively not examined at all.

Mr BOWEN: It has been done in the past.

The Hon. TREVOR KHAN: Yes. I have been thinking of that too. I just cannot remember where.

Mr BOWEN: Opioid medications and their use was one example of that where the Coroner was able to draw a few different matters together—quite a few—identify some themes, look at certain deaths, but also had a benefit of looking more broadly at a number of cases.

Mr DAVID SHOEBRIDGE: Music festivals—deaths at music festivals is the most recent example. But that goes back to whether or not the current Act adequately directs coroners to be looking at those kind of system-wide issues. I know, Mr Bowen, your evidence is that in your experience within the area of the healthcare work that you do, the coroners' courts do, but pretty much the unanimous evidence from the balance of the coroners' work is that they do not. Maybe there is some learning from the health care part that can be applied to the balance of the Coroner's jurisdiction.

The Hon. TREVOR KHAN: There certainly does not seem to be a legislative basis for it, does there?

Mr DAVID SHOEBRIDGE: The prohibition on it?

The Hon. TREVOR KHAN: Yes.

Mr DAVID SHOEBRIDGE: One way or another?

The Hon. TREVOR KHAN: Well, no, either way.

Mr DAVID SHOEBRIDGE: Yes. The decision one way or another, no.

The Hon. TREVOR KHAN: It is essentially silent.

The CHAIR: Any further questions for the witnesses?

The Hon. TREVOR KHAN: No, I am happy.

Mr DAVID SHOEBRIDGE: I do not want to delve into an individual case but it comes from the individual case of the death of David Dungay. In that case, I know that the family was very keen to have the Coroner investigate the circumstances in which people are held in forensic facilities, either in a dedicated forensic hospital or in a forensic wing of the prison hospital. That was very much an issue the families wanted

recommendations on, but the Coroner refused to go down that path and investigate those kinds of system recommendations. If you have any observations on that, feel free, but what is your view about system recommendations in relation to mental health? Are they a part of coronials normally? Or are the recommendations normally narrower?

Dr ELLIS: I have experiences, being a witness for the Coroner and for interested parties, and also having been a clinician before the Coroner. I think that it varies considerably. Sometimes it is limited to a very narrow issue of a case and sometimes systems issues are looked at. Again, I think that mental health care occurs in a system. I think for the best result from a coronial investigation of a mental health-related death, some investigation of the systems ought to occur.

Mr DAVID SHOEBRIDGE: Dr Matthews?

Dr MATTHEWS: My opinion is very similar to Dr Ellis, that particularly when adverse events occur in mental health, it is not to do just with one single person; there is a whole system around them. Even if they are a person living in the community—an outpatient—generally there has been some sort of mechanism as to whether they have attracted mental health assistance. I think that it is reasonable to suggest that if a case is being brought to an inquest then that whole system should be looked at as well.

Mr DAVID SHOEBRIDGE: The Tasmanian Coroners Act provides that a coroner must, whenever appropriate, make recommendations with respect to preventing further deaths and any other matter et cetera. That probably goes some way towards—if the focus is on preventing further deaths then that directs the Coroner's mind to a systemic outcome. If I understand your evidence, you would probably support an express requirement to look at any systemic issues that may have caused the death.

Dr ELLIS: I think that we would support a requirement to direct that it be considered. I am not sure that it would necessarily apply in every case.

The CHAIR: No, it would not.

Mr DAVID SHOEBRIDGE: But only to turn the Coroner's mind to it. The Coroner's mind must be turned to whether or not there are any systemic issues. There does not have to be one; it may be just a terrible tragedy.

Dr MATTHEWS: And in mental health cases there are more often going to be systemic issues.

Mr DAVID SHOEBRIDGE: Does the AMA or Mr Bowen have a view about an express requirement for the Coroner to turn their mind to systemic issues?

Dr McMULLEN: It seems to me there was a similar question posed earlier about—

The Hon. TREVOR KHAN: Yes, by me.

The CHAIR: And by me.

Mr DAVID SHOEBRIDGE: But I think it goes beyond the Tasmanian provision.

The CHAIR: But you are asking about the specific mental health context, are you not?

Mr DAVID SHOEBRIDGE: It was in the mental health context, and I think that is very clear, but in the broader context—

Dr McMULLEN: Previously on the broader context we had said that—I have already got it on my list of things taken on notice, as to whether there should be a legislative clause that requires the Coroner to put their mind to systemic recommendations. That was not addressed in our submission.

Mr BOWEN: I think it would be a good idea putting that emphasis on the system, rather than looking at one particular hospital, group of individuals, but what can be done more broadly.

The CHAIR: Any other questions? If not, thank you to the witnesses for attending the hearing. The Committee has resolved that answers to questions taken on notice be returned within 21 days. The secretariat will contact you in relation to the questions you have taken on notice. You are excused.

(The witnesses withdrew.)

(Short adjournment)

ISABEL BROUWER, Chief Forensic Pathologist and Clinical Director Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service, sworn and examined

REBECCA GIGLI, Chief Operating Officer Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service, sworn and examined

DANNY DOHERTY, Detective Superintendent, NSW Police Force, sworn and examined

DON McLENNAN, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, sworn and examined

MARK FOLLETT, Executive Director, Policy, Reform and Legislation Branch, Department of Communities and Justice, affirmed and examined

CARLO SCASSERRA, Assistant Commissioner Governance and Continuous Improvement, Corrective Services NSW, before the Committee via videoconference, sworn and examined

The CHAIR: We have some submissions for this session, including submission number 18, which is the combined New South Wales Government submission dated 9 July 2021. Yesterday afternoon we received a further submission from the Minister for Health and Medical Research, the Hon. Brad Hazzard, and the Attorney General, Mr Mark Speakman, SC, attaching the *Improving Timeliness of Coronial Procedures Taskforce* October report. Whether it is about that or anything else, do any of you have a brief opening statement you wish to give?

Dr BROUWER: Honourable Mr Chair and other honourable members, thank you for the opportunity to appear before the inquiry as a witness on behalf of NSW Health pathology forensic medicine service. Forensic medicine is a statewide service with three dedicated facilities in Sydney, Newcastle and Wollongong. As a health entity independent from the Coroner, NSW Health pathology forensic medicine is well positioned in its clinical and operational independence to utilise the health-specific capabilities of the broader system.

Forensic pathologists are specialised medical practitioners who provide expert medical opinions regarding the cause of death to support the Coroner in making legal rulings and other recommendations. This is a complex and specialised medical-legal partnership that relies on a high level of understanding of the medical practice of forensic pathology and the coronial system. Coronial post-mortem examinations can only be performed by qualified forensic pathologists, who require the support of forensic mortuary technicians, forensic radiologists and radiographers, clinical nurse consultants and Forensic Medicine social workers. There is a national and international shortage of forensic pathologists. Forensic Medicine has responded to this challenge through expanding its forensic pathology training program and continued efforts to recruit additional forensic pathologists, both locally and overseas.

Before a post-mortem examination begins, direction must be obtained from the Coroner. The Forensic Medicine model in New South Wales ensures examinations are carried out in the least invasive and most timely manner. For regional and rural cases, this can impact examination time frames if the local magistrate is involved with other cases and unable to issue the direction promptly. Since the March 2020 declaration of the COVID-19 pandemic, the initial coronial direction for rural and regional deaths has now been centralised and allocated to the senior coroner at the New South Wales Coroners Court in Lidcombe. Forensic Medicine welcomes continuation of the centralised coronial decision-making for regional deaths in New South Wales. It is important to note that the decision-making regarding these deaths following completion of the post-mortem examination remains in the domain of the regional courts.

A transformation of Forensic Medicine information system is currently under development. This digital accelerated platform will enable better agency connection through a portal, enabling more accurate dashboard reporting to better inform performance monitoring to support continuous quality improvement, improved timeliness and effective statewide case management. A unique feature of the New South Wales coronial system is the role of the Forensic Medicine social worker. There are 14 social workers employed by Forensic Medicine, which reflects a recent increase in staffing of 25 per cent. The Forensic Medicine social workers liaise closely with families whose loved ones are referred to the Coroner and provide compassionate support for viewing of deceased and identifications.

In 2019 Forensic Medicine published a social work model of care, which informs all aspects of support provided to bereaved families. At Forensic Medicine, we are committed to delivering a world-leading service in support of bereaved families across New South Wales to provide the answers and support they need. We are continuing to explore opportunities to improve the coronial process with our interagency partners through a number of initiatives as outlined in, but not limited to, the New South Wales Government report submitted previously to the Committee.

The CHAIR: Thank you, Dr Brouwer.

Mr DOHERTY: Good afternoon, everyone. Thank you to the Committee for the opportunity to provide a submission on behalf of the NSW Police Force. The NSW Police Force are an integral part of the coronial process, as they report all the deaths to the Coroner and conduct these investigations on behalf of the Coroner. I know this will be touched on by some of the people here in the hearings, but in 2019 there were around 6,500 deaths in New South Wales reported to the Coroner. A large percentage—around 60 per cent—of these deaths were found to be of natural causes or medical certificates were issued. However, police utilise P79A reports to the Coroner to document and to initiate the initial coronial process.

In the metro area of Sydney alone, including Newcastle and Wollongong, there are about 3,500 P79A reports of deaths to the Coroner processed each year, and NSW Police Force work closely with NSW Health, Forensic Medicine New South Wales, Department of Communities and Justice [DCJ] and other partners as part of the multiagency coroners case management unit to assist the New South Wales State Coroner. In 2020 there were 112 inquests held in New South Wales. In 2019 there were 25 inquests held which resulted in coronial findings, with recommendations for New South Wales to respond to within six months of the Attorney General's in accordance with the Premier's Memorandum M2009-12. In total, all 25 responses were delivered within that time frame.

In 2020 there were 21 inquests with coronial findings, with recommendations to the New South Wales police to respond within a six-month time frame to the Attorney General's, and 20 responses were delivered in the required time frame. NSW Police Force work closely with other agencies to enhance the coronial process, to improve timeliness and assist families through a very difficult time. Some of the task force and working groups that we are involved with, which may get touched on by some of the other witnesses, are: Improving Timeliness of Coronial Procedures Taskforce, which the Chair has just mentioned as being tabled; the coronial services committee; suicide monitoring working group; the sudden unexpected death in infancy cross-agency working group; Child Death Review Team; unidentified human remains working group—and there are other agencies and other subcommittees. This work is ongoing, and NSW Police Force remain committed to improving coronial processes.

The CHAIR: Thank you. Committee members, who has questions for these witnesses? Mr Roberts.

The Hon. ROD ROBERTS: I will direct my question to Dr Brouwer. Your submission notes that there is a national and worldwide shortage of forensic pathologists, and I know that you note in here that you are making recruitment efforts et cetera. Is there an authorised strength for pathologists in New South Wales, first of all? Is there a set number that you are authorised to have?

Dr BROUWER: No, we have never managed to get to a number where we can say we now have sufficient forensic pathologists. We also have a number of pathologists who are sort of reaching retirement age, so it will be an ongoing process of recruiting pathologists and NSW Health Pathology has been very supportive. Every time we have got an interested pathologist, they have managed to create additional positions. There has also been quite a bit of movement of pathologists interstate from New South Wales, so we are constantly trying to catch up and fill positions.

The Hon. ROD ROBERTS: I will be a bit more blunt with my question then. How many are we under strength? How many more do we need in New South Wales to operate efficiently at this point in time?

Dr BROUWER: Currently we have 15 forensic pathologists in New South Wales. It is difficult to put a number to it, but I think we are probably looking to at least recruit, I would say, anything between one to five pathologists.

The Hon. TREVOR KHAN: Well, there is a big difference between one and five.

Mr DAVID SHOEBRIDGE: At any given time.

Dr BROUWER: It is really a constant process. I have been a forensic pathologist now for 25 years. The first day I walked into the office, I started looking for recruiting more pathologists.

The Hon. TREVOR KHAN: I am not doubting that. You must have an aim as to where you want to end up.

Dr BROUWER: Yes. I think at the moment if we can at least recruit two more forensic pathologists that would be good. At the moment we have got a model in Wollongong where we have a single pathologist, which is not ideal because it is always difficult to find leave cover for that pathologist. So the longer-term plan is also to expand our service in Wollongong to have an additional pathologist there.

The Hon. TREVOR KHAN: It is a lovely city.

The Hon. CATHERINE CUSACK: Can I just jump in? The Wollongong pathologist, are they doing all of southern New South Wales?

Ms GIGLI: No. In terms of the catchment area for our Wollongong—I can take it on notice for the exact police area command coverage and court coverage—it is a large proportion of the southern part of the State.

Mr McLENNAN: South Coast area.

Ms GIGLI: South Coast area, including Riverina.

Mr McLENNAN: Albury.

Ms GIGLI: Yes.

Mr McLENNAN: The Wollongong pathologist's catchment is the coastal area of South Coast down to Eden and the Albury police command.

The Hon. CATHERINE CUSACK: That is massive for one person.

Mr McLENNAN: In terms of post-mortems, I understand it is consistent with the number that a pathologist undertakes.

Ms GIGLI: That is correct. We also have a hybrid model where our pathologist is able to still attend their training and education component of their employment, and we perform activity at our Sydney facility with the support of our agency partners and the local courts in the southern area as well.

The Hon. TREVOR KHAN: How many are at Newcastle?

Ms GIGLI: Sorry, how many pathologists?

The Hon. TREVOR KHAN: Yes, sorry.

Ms GIGLI: Currently we have five forensic pathologists in our Newcastle facility and we also have trainees.

Mr DAVID SHOEBRIDGE: I would have thought that your unit, Forensic Medicine in NSW Health, would have had a training program in place and be offering attractive incentives for people to train so that you have sufficient trainees to produce sufficient graduate pathologists.

Dr BROUWER: We have recently, now about a year ago, created a new position, a clinical training coordinator position, that is a part-time position for one of our pathologists who looks after the training program. We have an established program and we have just recently had a Royal College of Pathologists of Australasia [RCPA] psych visit in Sydney and we have received accreditation to do training in Sydney. Our Newcastle site and Wollongong site have already been accredited. The Sydney accreditation has just extended or renewed the training accreditation for Sydney. Currently we have four registrars, four trainees—two at each of the Sydney and Newcastle sites. At the moment, as I said, Wollongong has got accreditation for training, but because of the current single pathologist model it is very difficult to train trainees there because of the limited exposure to a single pathologist, whereas at the other facilities there is a bigger exposure to a wider range of cases and also different approaches from different pathologists.

Mr DAVID SHOEBRIDGE: That may be a structural failing within NSW Health, having only a single pathologist at a unit like Wollongong. Is there any review about reviewing having only a single pathologist?

Ms GIGLI: There is support around consideration to infrastructure development to support additional workforce capability and capacity at that site and, as the Committee could recognise, there are appropriate processes being undertaken in NSW Health pathology to consider what those infrastructure requirements may be and proceed with advocacy for capital infrastructure to do so.

The CHAIR: Dr Brouwer, you said in your opening submission that your organisation is independent of the Coroner's office. What is the nature of the relationship and how is it regulated? Is there a memorandum of understanding [MOU]?

Dr BROUWER: At the moment there is no memorandum of understanding between us and the Coroner.

The CHAIR: Because you are part of the department of Health, is that correct?

Dr BROUWER: Yes. As I said, the independence is because we are part of Health we can function independently. We have close interaction with the coroners though, especially through our front-end process, the triage process, and that initial decision-making around coronial direction and type of examination. So our pathologists provide advice to the Coroner on what would be the most appropriate examination to determine the

cause of death in the least invasive manner. The coronial direction is then issued based on that recommendation usually.

The CHAIR: Taking up a point raised by, I think, Mr Shoebridge earlier, is there a proactive training program in place through NSW Health to attract and retain sufficient pathologist services? When you are addressing that, and noting I think you said you have been losing staff interstate, is it to work in the coronial jurisdictions in those States?

Dr BROUWER: Yes.

The CHAIR: Is that because they get paid more in those jurisdictions, or are you are able to discern some sort of trend for the reasons for their departure—workload, for example?

Dr BROUWER: I do not think there is a consistent reason for it. For example, one of our most recent pathologists who left went to New Zealand—a young pathologist who just wanted to broaden her experience. As I said, with regard to the training program, we have a clinical training coordinator who manages the training program for the registrars and she is also introducing a number of other initiatives to try to engage with, for example, medical students and organise elective rotations of medical students at our facilities to sort of trigger that interest in forensic pathology early on. Our pathologist in Wollongong is also doing fantastic work around a Resident Medical Officer program that he has instigated with the Wollongong Hospital, where we now have junior medical officers rotating through Forensic Medicine in Wollongong, and it has been so successful that two of our current trainees are rotating through that program. It has really triggered an interest for them.

Mr DAVID SHOEBRIDGE: There might have been more success though if they had been able to just go in and do their traineeship in Wollongong.

Dr BROUWER: Yes.

The CHAIR: Mr Doherty, is there an MOU between the NSW Police Force and the Coroner as to how the Coroner can access the services of the police for investigative—

Mr DOHERTY: There is an MOU with DCJ, in my understanding.

The CHAIR: Okay. Can any other DCJ representatives address that MOU? How does it work?

Mr McLENNAN: I am not aware of the MOU with DCJ, but the Coroners Act provides that the Coroner can direct police to investigate deaths on behalf of the Coroner, but—

The CHAIR: I understand that. How does that work in practice?

Mr DAVID SHOEBRIDGE: Sorry, before we go on, are you saying there is not an MOU?

Mr McLENNAN: I am not aware of the MOU with police, no.

Mr DOHERTY: I will take that question on notice and I can confirm it then.

Mr DAVID SHOEBRIDGE: It is a pretty fundamental question. If there is a document that regulates the relationship between the police and coroners, I would have thought someone from DCJ or someone from the police would know that when they turn up to an inquiry of the coroners.

The Hon. TREVOR KHAN: Well, just keep yourself—

Mr DAVID SHOEBRIDGE: I would have thought it was a fundamental question. The answer is you do not know if there is some kind of formal arrangement?

Mr McLENNAN: No, the answer is I am not aware of it.

The Hon. TREVOR KHAN: David, it is early on.

Mr DAVID SHOEBRIDGE: It is not early on; it is 3.32 and it is a pretty fundamental point.

The CHAIR: Anyway, the point is that the witnesses have given their answer. Given that the Coroners Act does provide that the Coroner can access the police for the purposes of discharging their statutory duties, how does that work in practice? I am assuming a coroner does not just ring the local police station or ring any police they know; there must be an established procedure by which this is activated. Are any of the witnesses here able to step us through how that works in practice?

Mr DOHERTY: It is a case-by-case scenario in relation to it, but generally there is a report of a death to the Coroner—that is the first process—so the Coroner is aware. That sounds like a simple process but it goes through the Coronial Case Management Unit. There is a lot of investigation that goes into just that initial document and forming that obviously with the initial post-mortem and other evidence from the police. Depending on the

circumstances, if it is a death where there is direct medical evidence that it is a natural death or there is going to be a certificate issued, that circumvents most of our process there and then and it makes it easier for an initial finding. However, if it is a drawn-out procedure where the cause of death is unknown for whatever reason and we need further toxicology and other testing and forensics, we may not know for some time. And under the Act, there is obviously mandatory reporting for certain deaths and mandatory inquests for certain deaths as well. New South Wales police are compliant under the Coroners Act.

The CHAIR: Mr Doherty, in a number of submissions we have received—and this is not a reflection on the professionalism of the police—particularly with First Nations families but also other families, there is a perception that because of the role of the police in the criminal justice system that there may be a tension, a conflict of interest in the police doing the investigative work for the Coroner and that maybe there should be a separate set of investigators working directly with the Coroner. Does the NSW Police Force have a particular view on that proposal?

Mr DOHERTY: Again, as we have said, there are thousands of deaths that we have to investigate and the police are well-trained and well-versed in cultural sensitivity for all people. It is a difficult time when someone has just died, obviously, but we are very aware of the cultural sensitivities, especially with Indigenous communities. So we use whatever resources are required in relation to that as well. We use our Aboriginal community liaison officers, or ACLOs. And also, thankfully, through DCJ and through the coroners, we now have two Aboriginal assistance officers that are there to support the families and to provide information and engage with them. That breaks down a lot of the barriers and the language. If they do not wish to particularly talk to the police they have got these staff that are willing to assist.

That has only been implemented recently. Especially with a couple of sensitive matters that we have been investigating recently on behalf of the Coroner—one being a death in custody and the other one being a critical incident shooting just recently in western Sydney—that was well received from us. Also, they are not only explaining the police role, they are explaining the coronial process. That is what they are there for and helping with something they have probably never had to deal with before, especially with their loved one going through a post-mortem—what that examination means, when the body can be released and all those sorts of issues.

Mr DAVID SHOEBRIDGE: Mr Doherty, are you saying that after the recent shooting in Seven Hills it is the police's position that there has been a positive interaction between the family and police?

Mr DOHERTY: No, with the Aboriginal assistance officers who were employed by DCJ—that they were engaged with them, with the family. That is my understanding, and that is the information I got. That was only a recent example, that they were there to assist and explain the coronial process.

Mr DAVID SHOEBRIDGE: But they are not with police; they are with forensics.

Mr McLENNAN: The Coroners Court.

Mr DOHERTY: The Coroners Court.

Mr McLENNAN: Aboriginal Coronial Information and Support Program [CISP] Officers.

Mr DAVID SHOEBRIDGE: That may be the case, but they are not police resources.

Mr DOHERTY: No, they are not. That is what I am saying, but they assist police—having that resource to explain the coronial process.

Mr DAVID SHOEBRIDGE: But they are not police resources.

Mr DOHERTY: Because we also had the ACLO there at the time as well, the Aboriginal Community Liaison Officer.

The CHAIR: Mr Doherty, you do not see any potential tension in the role of the police acting as investigators for the Coroner and also perhaps, on the same set of facts, having a role in the criminal investigation that may arise from the same events?

Mr DOHERTY: Not at all because that is their role. It is the role of the police to be able to separate those. They are different Acts. If you look at them, one is going through the Crimes Act 1900 and one is going through the Coroners Act 2009.

The CHAIR: It is the same police force.

Mr DOHERTY: It is the same police force but we are trained in those areas. It is the same question, which we probably alluded to, in relation to critical incidents, where, depending on the type of critical incident, we are able to investigate that critical incident.

Mr DAVID SHOEBRIDGE: But you cannot train away a conflict of interest. The conflict is still there.

The CHAIR: Or at least even a perceived conflict.

Mr DAVID SHOEBRIDGE: You cannot train a conflict away, can you, Mr Doherty.

Mr DOHERTY: You train in conflict resolution and you also can train in cultural sensitivity. You can also be professional and do what you have to do. That is what we do. We do our work on behalf of the Coroner in those situations for a critical incident.

The CHAIR: I might move on to Mr McLennan and Mr Follett. Are you able to give us an update as to where the statutory review of the Coroners Act is up to and when we might see the results of it?

Mr FOLLETT: Yes, sure, Chair. I understand the Attorney General has written to the Committee in response to your request to see the draft report.

The CHAIR: Yes, declining to give us a copy because it is a—

Mr FOLLETT: Because it is a Cabinet document.

The CHAIR: Yes.

Mr FOLLETT: The position for responding to the statutory review was that it was put on hold while the task force completed its work because there is an obvious crossover in the areas that the coronial task force would be looking at. The continuing of that statutory review is now continuing because the task force has concluded its work, and the task force report was, as you mentioned at the start, Chair, provided to the Committee. It wrapped up in October this year, and there are some matters that it has referred for the continuing oversight to the coronial services committee. But the task force has wrapped up, so the statutory review will be re-engaged and continue. I would anticipate that there will be a response to that in 2022.

The CHAIR: Okay. In relation to the task force, we received the October report from the task force yesterday afternoon. It indicates a number of improvements through initiatives to shorten the time frames around the processing of bodies, the release to their loved ones for burial and the like, but it specifically excluded processes involving inquests and the dispensing of coronial matters by the Coroner. That seems to be the missing piece in the jigsaw, if you like. I think the Government has announced one additional full-time equivalent coroner to be appointed.

Mr McLENNAN: That is correct.

The CHAIR: Looking at the number of full-time equivalent coroners that exist, for example, in Victoria and Queensland, we seem to be well short at 5.2, now to be 6.2. Is there any plan to up that number?

Mr McLENNAN: That is a matter for government. In terms of how the Victorian coronial system works compared to New South Wales, it is quite different. We do about 120 inquests a year. They do far less, but all their matters that they dispense with—our coroners in New South Wales provide reasons for dispensing with matters. The Victorian coroners provide more formalised findings, so they are quite more involved. So how the work is completed is different. We have, since the introduction of the statewide directions, which commenced when COVID started last year, we saw that there was a number of benefits having one senior coroner making all coronial directions for New South Wales. There is a continuity of decisions. We were having far greater oversight of what was happening in New South Wales. As a result of that, the Government has now appointed a coroner so that could be established full-time into the future. As far as multiple appointments, I am not aware of any proposals that would increase it.

Mr DAVID SHOEBRIDGE: Rather than asking you a subjective question about whether 6.2 coroners are enough, what will the impact be, in reducing the delay, of going from 5.2 coroners to 6.2 coroners? What will that mean in reduced delay?

Mr McLENNAN: I expect that you will see a reduction in delays. Are you talking about the delays in finalisation of matters?

Mr DAVID SHOEBRIDGE: Correct, the delay in finalisations.

Mr McLENNAN: I cannot put an exact figure on it now, but I would expect there would be a delay.

The CHAIR: Presumably there is modelling. Can you provide us on notice with any modelling?

Mr McLENNAN: I can take that on notice.

Mr FOLLETT: We can take that on notice.

Mr DAVID SHOEBRIDGE: I assume you have been involved in this process, Mr McLennan.

Mr McLENNAN: Not directly, no.

Mr DAVID SHOEBRIDGE: Mr Follett?

Mr FOLLETT: Are you talking about the budget process, Mr Shoebridge?

Mr DAVID SHOEBRIDGE: About the process of adding an additional coroner—the rationale. You must be aware of the rationale behind it.

Mr FOLLETT: I am aware of the rationale behind it.

Mr DAVID SHOEBRIDGE: Was that supported by modelling?

Mr FOLLETT: Yes. It went through a budget process, so it was supported by modelling.

The CHAIR: There is always modelling if there are budget processes. I do not know to whom to direct this question. A number of the witnesses who we heard from this morning spoke of their experiences as a family of going through the coronial process and the bewildering nature of the process. The themes that have emerged include that there is no one person or body who tells them what they are going to be experiencing or provides them with the information that they are going to need to go forward. That is the nature of their experience. Has any thought been given to some kind of liaison role that provides families early on in the process with all of the information they might need to navigate, whether it is, "You can apply for legal assistance here", or "There is this counselling available for you through this mechanism"—those sorts of milestones?

Mr McLENNAN: Every family that comes in contact with the jurisdiction from the beginning—from when the death is reported—to the end, there is some sort of communication back and forth, either from counsellors from the CISP team or from the registry, or, if the matter goes to inquest, the counsel assisting. There is other information on the internet. There are brochures available. New South Wales is the only State, or the only jurisdiction, in Australia that has a coronial information and support team, which is employed by Justice. Its sole role is to provide information and support to families—inquest support. They are advised if families require assistance at inquests, and they will provide those families with education on what is going to happen at the inquest. That happens regularly. There is also the coronial forensic counsellors, who also provide ongoing support—not counselling, but they then refer them off to counsellors. So there is that support that goes through the process.

The CHAIR: When you say "refers them off to counselling", often those families do not have huge amounts of financial resources. What support services are provided by the State to assist them through this process?

Ms GIGLI: Our forensic social workers in Forensic Medicine engage with families within the first 24 hours of the reportable death. As soon as we have received that a death referred by New South Wales police to the Coroner has occurred, our social worker will engage with the family. I think I would also like to recognise the complexities of that engagement in a time of significant distress and how much information is provided and, at times, loss of information, if we will. We are always looking for opportunities and feedback from families about how best to provide that information. Sometimes verbally on the phone works, sometimes via email, sometimes via the letters in which families ask for it. It is a multi-strategy approach in terms of engagement with families. What we do recognise then is we also support families through each step. As soon as a coroner has made a direction, we re-engage with the family to let them know what that direction is in terms of examination type, clarification of whether or not there is an objection or not an objection at that point in time, and then we will also help to liaise—

The Hon. TREVOR KHAN: That is an objection to an autopsy.

Ms GIGLI: Yes, correct, an objection for an autopsy. We also then re-engage with the family once the examination is complete, and then we also re-engage with the family upon release of their loved one back to their appointed funeral director. Post that, our forensic social workers will re-engage with the family for a follow-up conversation and check-in post three months of the release from our care. What we do recognise is—you are correct, Chair—that New South Wales is a very broad area in terms of access to any ongoing counselling support, whether that be through non-government agencies or through private systems or through the GP Medicare plans that are available for families, but our social workers do help access certain external agencies or points in time for families as required.

Mr DAVID SHOEBRIDGE: I just want to reflect back. There was some very grateful evidence given about one of your counsellors coming from the forensic part of the system and then following through, although not budgeted for, into the coronial hearings. It was very positive feedback. But the recommendation that came

from the family was that that sort of counselling and the follow-through from that moment where they have the discussion—and then often it is in very emotionally distressing circumstances talking about the post-mortem and identifying the body of a loved one—having that counsellor follow all the way through to the end of the coronial hearing seems to me a very positive potential reform. It does not happen now. What happens now? You have some counsellors and then they have some counsellors. How does it happen now?

Ms GIGLI: All of those points in time that I spoke about and in between, we clinically hand over formally to each other as required, and what we do our best in is continuity of care. What we do is we will speak with the CISP team social workers. We will not just hand a family straight over and cut off from agency to agency. We work with the family and what is in their interest for that continuity of care. That example that the family provided was wonderful feedback to that continuity of care and why we provide it that way. I think the limitations of the question in which you are asking are absolutely correct, and that is a budgetary one in terms of capability of follow-through from the end-to-end process of the family experience in the coronial system and the resource capability of being able to provide that.

Mr DAVID SHOEBRIDGE: Let us be simple about it; the best outcome would be a counsellor who hears from the family once, hears about their trauma, gets to know them, follows them all the way through from the initial forensic engagement—perhaps seeing the body—to the conclusion of the coronial hearing. That is not how it operates at the moment. As you say, it is a hand-off, is it not?

Ms GIGLI: It can be. Yes, you are correct.

Mr DAVID SHOEBRIDGE: It can be. Other than in the very odd case where there is discretionary funding provided, it is.

Ms GIGLI: It also sometimes has to be legislatively because our forensic social worker cannot actually negotiate or manage sometimes on behalf of a family some of the unique circumstances that arise, like objections, tissue retention requests or dispute matters that may arise that need to escalate even outside the jurisdictional responsibility or powers of our coroners.

Mr DAVID SHOEBRIDGE: But they are a counsellor; they are not an advocate.

Ms GIGLI: No, they are forensic social worker. They are not directly employed as a counselling service as such. I guess that is what I was addressing in terms of capability and capacity and the difference between the two in terms of the employment of a forensic social worker.

The CHAIR: We might go to Mr Khan and then we can come back to that point.

The Hon. TREVOR KHAN: Sorry, it is sort of on the same field. I wanted to get back to the objection issue. New South Wales and Australia have a pretty culturally diverse community. We have large non-English speaking or poor English-speaking communities and they are culturally very diverse. How do you deal with that diversity in these discussions that you were talking about?

Ms GIGLI: We have community engagement strategies that we use and we have in place. They have been disrupted by COVID—

The Hon. TREVOR KHAN: Everything has been disrupted by COVID.

Ms GIGLI: Depending on the community group themselves, it could be elders of a particular community that we meet with or it could be a particular faith group that we meet with, and we talk through how we can best engage with the communities. From a more formal perspective, we also use interpreter services and we use advocate services that we can bring in to help have those family conferences and discussions with so we can better understand what is happening. I would defer to my colleagues in the room today in relation to the work we have also done around the timeliness process too in terms of meeting cultural and spiritual beliefs, especially in terms of our timeliness, of coronial directions, examination requirements and then timely releases in relation to faith and burials for that.

Mr McLENNAN: In terms of objections to post-mortems, the Coronial Information and Support team, on behalf of the Coroner, negotiates with the family. What the families are objecting to is not the post-mortem; it is the post-mortem direction of the Coroner under the Act. If the Coroner is of the view that some type of post-mortem is applicable and the family is objecting, that is when the CISP team comes in and negotiates between the Coroner and the family. We have moved right away from what used to happen many years ago where you will report it to the Coroner and have a three cavity examination, no ifs or buts. We have moved right away from that now, and thankfully that is the case.

The Coroners Act says we must do the least invasive examination. We have a lot of other avenues at our disposal, CT examinations, external toxicology, medical records review and we have also introduced a coroner's

certificate under the Act, which is when no invasive examination is required upon the body, the Coroner is satisfied that the person has died of natural causes and the family does not wish to have an examination of the body. We issue about 900 of those a year. That is 900 less examinations of what would have happened years ago.

In terms of our Coronial Information and Support team, they work very well with the families. The Coroner is very flexible as to what sort of examination they do. As long as there is that flexibility, 99 per cent of the time we can come to an agreement with the family that will satisfy their requirements spiritually and satisfy the requirements of the Coroner. It does not adversely affect any examination result down the track that will cause difficulties for the Coroner. The three within the team and now the two Aboriginal assistance officers work together as one unit, and it works very well. As we have it, no other State or Territory has it, and we are very lucky to have that team with us.

The Hon. TREVOR KHAN: I accept all that you say and I congratulate you all on that. Referring to the evidence that we received in the First Nations inquiry, I observe that in the case study witnesses that we had, I struggle to think of any of them who referred to the work that you are talking about. Is that because it is just a different time frame and that what you are now doing has been relatively recently rolled out, or is something else going on? I am not suggesting anyone is doing anything—

Ms GIGLI: Is it okay, Chair, if I make a response to that?

The CHAIR: Please.

The Hon. TREVOR KHAN: Yes, go for it.

Ms GIGLI: I think it is probably a combination. I think one is about community engagement and communication and access. As agencies, some of the work we have been doing is things like updating websites so that information is accessible about what our strategies and plans are. But I also think that there is recency about it. NSW Health pathology, for example, now has a wrap plan that is in place. We have very key initiatives that are in place within our forensic facilities particularly. We have communities now where we have, for example, donations from Elders of Aboriginal quilts that we put on deceased persons. We identify persons by country now, even when we put them to bed and we are caring for them. We do smoking ceremonies.

There is a whole range of strategies we have in place, but I would probably make an assumption that is about newness of the model and the changes we are making, such as the ones referred to earlier in terms of employment of the Aboriginal health liaison officers, which is probably now about eight weeks since their employment. I would be indicating that the feedback that members have provided to the Committee is based on history and their ride. What we have been doing as agencies is working together on how we can improve that.

The CHAIR: Mr Roberts?

The Hon. ROD ROBERTS: Mr McLennan, when did the CISP team actually start?

Mr McLENNAN: It followed an inquiry into forensic medicine in relation to organ retention.

The Hon. ROD ROBERTS: Just a year will do.

Mr McLENNAN: I think it was around 2000. If that is incorrect—

The Hon. ROD ROBERTS: No, that is fine. Can you flesh out for us a bit about the CISP team? How many members do you have? Do they actually go out in the field and visit and sit with the families or is it all done over the phone? How does it actually work?

Mr McLENNAN: We have three full-time members of the CISP team and then we have two in the Aboriginal CISP team. The Aboriginal CISP team, the two newly created positions, their role is to—from the point in time when an Aboriginal person is reported to the Coroner, they will make contact with the family and continue the support and provide coronial information and support to that family from the beginning until the completion of the coronial jurisdiction. The CISP team, their main role is to provide information to families on the processes, on inquest support. They also deal with objections to post mortems, next of kin disputes and they also sit down with families and—for instance, we get lots of requests for families to look at coronial scene photos, which we do not normally give out.

They will sit down with families and go through the coronial brief with the family and show them the photos. So they have this ongoing support and it is really an information exchange between the Coroner and the family—that conduit passing on information and then passing information back to the Coroner.

Mr DAVID SHOEBRIDGE: But two of those positions have just started?

The Hon. ROD ROBERTS: Just one last question.

The CHAIR: Sorry, Mr Roberts and then Ms Sharpe.

The Hon. ROD ROBERTS: Do they visit the families in their homes or do the families have to come to the Coroners Court complex?

Mr McLENNAN: We have had them go out to regional areas and visit families, they come in to work, whatever—the last year or so we know that things have been difficult, but there is nothing to prevent them going out and they have done that in the past.

The CHAIR: Ms Sharpe?

The Hon. PENNY SHARPE: Thank you. Sorry, I cannot see you very well, so I will just direct my question generally and we will see who can answer. I have a couple of questions. I want to know, and other members have touched on this, how many people are there specifically to provide that sort of support? Obviously, Forensics have got some social workers. How many?

Ms GIGLI: Forensic Medicine currently has 14 forensic social workers.

The Hon. PENNY SHARPE: Thank you. Do I understand correctly that within the Coroners Court there are two general, and there has just recently been two First Nations people appointed? Is that right?

Mr McLENNAN: No, there are three. Three general CISP officers and two Aboriginal CISP officers.

The Hon. PENNY SHARPE: That is in total?

Mr McLENNAN: That is in total. They provide a statewide service.

The Hon. PENNY SHARPE: From your submission, the police also have some role in terms of family liaison, is that correct?

Mr DOHERTY: With the officer in charge [OIC] of an investigation of a death, depending on the nature of it, it may be that it is just the OIC having constant contact with the family members or it would be a family liaison person appointed to do that, depending on the scope of the inquiry. It also depends on the type of death it is. Obviously, there are different responses when it is a young baby—for a sudden unexpected death in infancy, for example—than maybe to another type of death like a suicide of an adult. Again, there are different vagaries and challenges around all those issues and there are different support groups for those types of death as well that they get referred to, on top of the ones that have been mentioned already.

For example, there are a lot of support groups in relation to the death of a child or a baby, through the Red Nose foundation—those types of organisations. There are several suicide support groups, and Victims Services is another great support service. Depending on the type of death, again, whether it was a car accident—there is a newly formed support service that has been implemented along the same lines as the Homicide Victims' Support Group, which is a great organisation, and there are other NGOs.

The Hon. PENNY SHARPE: But, essentially, the police officers or the officer in charge would just refer them to those groups, give them information?

Mr DOHERTY: Yes, but they would keep on continuing—they would have a continuing liaison for the police with the family.

The Hon. PENNY SHARPE: Can I just say that has not been the evidence that we have had from—I accept that we have only had a small sample of people, but they often say that they hear very little for a long period of time before they get that. I am interested though, given the number of cases that you are dealing with, which is significant, whether you think there is—the recruitment of two new First Nations people is obviously welcome, but it sounds to me if you have only got five and Forensics have got 14 that there is a disparity there?

Mr McLENNAN: The forensic social workers have a very different role. They make contact with every family as soon as the death is reported. That is not the case with Coronial Information and Support. They deal with only certain situations, like objections and brain—organ retention or assistance as required.

The CHAIR: Mr Shoebridge?

The Hon. PENNY SHARPE: Sorry, I have just got one more—

Mr DAVID SHOEBRIDGE: You go, Penny.

The Hon. PENNY SHARPE: Police are responsible for the 30-day letters, is that correct?

Mr DOHERTY: I missed that, sorry?

The Hon. PENNY SHARPE: The 30-day letters, they are referenced in your submission, which is basically where a family has requested an inquest and then there is a liaison with the family where the Coroner has decided that there is not going to be an inquest but there is a 30-day period—if I am reading this incorrectly, please tell me—

Mr McLENNAN: No, I am sorry—the 30-day letter is issued by coroners. So if a coroner has made a determination that they do not feel that an inquest is required but the family has indicated that they wish for an inquest and the Coroner has considered those reasons for the inquest but still is of the view that an inquest is not necessary, the family is provided what is referred to as a "30-day letter" indicating that the Coroner has made that determination and offering them a period of time to make further submissions as to why the Coroner should hold an inquest. Based on those further submissions, the Coroner then makes a determination. It is not a—

The Hon. PENNY SHARPE: I am just trying to be clear. Is it police that deal with those? That is what it says in your submission.

Mr McLENNAN: No. They are a letter that is sent out by some coroners. Not all coroners do that. It has revolved down to a practice where the Coroner will simply write to the family indicating they are of the view that the matter should be dispensed with and giving those reasons and then offering the family a time to respond. Certainly, the 30-day letter is something that is common within the Coroners Court.

Mr DAVID SHOEBRIDGE: Your submission says, on page 22—

The Hon. PENNY SHARPE: Yes, I am just trying to get—

Mr DAVID SHOEBRIDGE: —that police coronial advocates perform—

The Hon. PENNY SHARPE: Yes, your submission says police advocates do that. So my understanding is that 30-day letters are kind of automatic. The letter goes to the family and invites them to provide another reason about why they would like to have an investigation. But I am just trying to clarify who actually—when you say that the police liaise with family members, "including preparation of 30 day letters", can you just tell me what that process involves?

Mr McLENNAN: The police coronial advocates are advocates who are situated within the Coroners Court who assist the Coroner in some inquests. Sometimes they are directed by the Coroner to issue the 30-day letter. It does not happen often, but they can do that on behalf of the Coroner. In most cases, the court registry issues those letters. But it certainly can be the case that the police advocates, on the instruction of a coroner, can issue those letters.

The Hon. PENNY SHARPE: Why would police be doing that?

Mr McLENNAN: They work within the—they are assigned matters by the Coroner. They are asked to review the matters and provide a review to the Coroner. If the Coroner makes that determination, the Coroner then continues—it is like the Coroner working with Crown solicitors, they sometimes prepare letters on behalf of the Coroner and send them out to families or stakeholders. That is the same situation where the coronial advocates, if the Coroner asks them too, will provide those letters to the family.

The CHAIR: Are they legally trained?

The Hon. PENNY SHARPE: But what is the reasoning—

Mr McLENNAN: Some are legally trained.

Mr DOHERTY: Yes. They are from the Police Prosecutions Command.

The Hon. PENNY SHARPE: Yes, okay. Sorry, I do not want to take a lot of the time of the Committee. I am very interested in this issue though, because it seems to me pretty fundamental given the distress of families, particularly if they have asked for an inquest and that is not being undertaken. I am not suggesting that there are bad reasons for that. Are you able to take on notice for us, maybe for the last three years—given we have had two years of COVID—what was the number of requests from families, and the number of 30-day letters, and who actually provided those letters to the families?

Mr McLENNAN: I can take that on notice.

The Hon. PENNY SHARPE: Thank you.

Mr DAVID SHOEBRIDGE: This question is probably to you, Mr McLennan. We had the AMA and one of the medical insurers in earlier. Their understanding was that the root cause analysis investigations done by NSW Health following a death are often not requested by the Coroner and not obtained by the Coroner. Can you shed any light upon why that is happening?

Mr McLENNAN: The root cause analysis is often requested by the Coroner, but there is a law that indicates that the root cause analysis cannot be used at an inquest. I cannot think of what the section is now, but the root cause analysis is still routinely requested by the Coroner under section 53. When we request medical records we also request the root cause analysis. But that root cause analysis under the legislation, if I can take on notice what the legislation is, it is a health Act—

The Hon. TREVOR KHAN: Is it under the Public Health Act?

Mr McLENNAN: I am not sure, but it specifically says it cannot be used at inquests or other proceedings.

Mr DAVID SHOEBRIDGE: Can you explain if there is a rationale behind that?

Mr McLENNAN: I am not the author of the legislation; I have no idea.

The Hon. TREVOR KHAN: Yes, if it is legislation then we should know.

Mr DAVID SHOEBRIDGE: I do not recall doing it myself.

Mr McLENNAN: It was a valuable tool for coroners for inquests. It was a very valuable tool because the root cause analysis had recommendations. In my recollection, it cannot even be referred to at the inquest.

Mr DAVID SHOEBRIDGE: Will you take on notice if there is any institutional knowledge about what the rationale for that is?

Mr McLENNAN: I do not know whether—

Ms GIGLI: Yes, there is a NSW Health policy directive around root cause analysis. I would probably dare to say there is meaning within that which on notice we could provide back in relation to that privilege.

Mr DAVID SHOEBRIDGE: That would be useful.

The Hon. CATHERINE CUSACK: I think it has to do with no-fault, just getting the truth of what has occurred there. It is trying to cope with culture but—

Mr DAVID SHOEBRIDGE: I can conceive of rationales. Other jurisdictions have regularly used them in coronial investigations; it is just that New South Wales is an outlier in that regard. But we might get some answers on notice.

Mr McLENNAN: The Health Administration Act 1982.

Mr DAVID SHOEBRIDGE: But notwithstanding that, it is regularly requested by coroners.

Mr McLENNAN: We still request it because—

Mr DAVID SHOEBRIDGE: It is relevant.

Mr McLENNAN: —it is very relevant, and it has recommendations in there. The Coroner can still form recommendations around that root cause analysis without referring to it.

Mr DAVID SHOEBRIDGE: Sometimes it is obtained by the Coroner but not used in the coronial proceedings. Is that what happens?

Mr McLENNAN: Exactly.

Mr DAVID SHOEBRIDGE: Then no party to the coronial proceedings can make submissions on it.

Mr McLENNAN: No.

Mr DAVID SHOEBRIDGE: It kind of has a half-existence in coronial investigations.

Mr McLENNAN: Yes.

Mr DAVID SHOEBRIDGE: That seems awkward.

Mr McLENNAN: It is, and I think it was only a matter of some years ago that occurred. Prior to that, the root cause analysis was regularly called for and referred to in proceedings.

Mr DAVID SHOEBRIDGE: There clearly would be forensic benefits for the coronial process to being able to openly refer to it.

Mr McLENNAN: Yes, particularly around the recommendations. I know we talked about no-fault, but the Coroner does not need to look at who is at fault. The Coroner is there to try to prevent deaths and make

recommendations to do that, so it was a very useful document. In a backdoor method, say, we still use it, but it is simply not referred to within the proceedings.

Mr DAVID SHOEBRIDGE: I understand. Can I ask you about the triaging process? Only 2 per cent of reportable deaths end up having a coronial hearing. What criteria are used to determine when a matter gets an investigation and when a matter does not?

Mr McLENNAN: In New South Wales we have around 6,500 deaths a year. Each matter is triaged through the duty pathologist, through the regional triage unit in Newcastle or the Coronial Case Management Unit in Sydney. We have a duty pathologist, duty coroner, social workers, police—there is a whole number of people there. The matter is presented to the Coroner in Sydney—if I could use Sydney as an example. We have a duty coroner every week. The matter is presented to the Coroner and a recommendation is given by the duty pathologist, and there is discussion. The Coroner makes a determination at that point about what type of forensic examination is required, if any at all, and also makes a determination as to what type of coronial brief is required if a coronial brief is required. When that material comes in, the Coroner has five things to determine: identity, date, place of death, manner and cause of death. That is the basic things that coroners find. Section 23 matters, which are deaths in custody and deaths in police operations, all require an inquest—no matter if a person dies of natural causes—

Mr DAVID SHOEBRIDGE: I know there is no triage there; they all have hearings.

Mr McLENNAN: They all have hearings.

Mr DAVID SHOEBRIDGE: That part is clear; it is the other 99.5 per cent of matters that I am asking about.

Mr McLENNAN: It is those matters where the Coroner feels that a recommendation can be made that might prevent deaths of a similar nature in the future. You can only make a recommendation after holding an inquest. You cannot dispense with a matter and hold an inquest. There has to be procedural fairness applied to those persons that the recommendation affects. Those matters where the Coroner is of the view that recommendations should be made would require an inquest. Where the Coroner is not satisfied as to the cause of death, the manner of death or the identity, or there are issues that need further forensic examination, the Coroner on those occasions can require an inquest. Working in the system for so long, coroners often talk about it. They say, "How do we get to a point where we say this is the sort of matter where you have an inquest?" But there is no sort of magic formula. For each matter, you look on the facts. If they cannot be satisfied as to one of the statutory requirements—for instance, the cause of death or the identity—the Coroner might hold an inquest to see whether they—

The Hon. ROD ROBERTS: "Might".

Mr McLENNAN: —may hold an inquest. That inquest might just hear the same evidence that the Coroner is already aware of, and it is not going to create anything further.

Mr DAVID SHOEBRIDGE: Given that 98 per cent of matters do not go to a hearing and do not have an inquest, that is kind of the critical decision, is it not?

Mr McLENNAN: Yes.

Mr DAVID SHOEBRIDGE: For the overwhelming majority of reportable deaths, that decision is the single most important decision. Would you agree?

Mr McLENNAN: That is correct.

The CHAIR: There is no visibility about how that discretion is exercised.

Mr DAVID SHOEBRIDGE: There are no guidelines.

Mr McLENNAN: There is no magical formula, no.

Mr DAVID SHOEBRIDGE: Let us be clear: There are no guidelines.

Mr McLENNAN: Yes, the guidelines are the Coroners Act.

Mr DAVID SHOEBRIDGE: Can you point me to anywhere in the Coroners Act that structures that decision-making?

Mr McLENNAN: There is a section within the Coroners Act that talks about when an inquest is required to be conducted, and then it talks about where one of those criteria—the manner and cause—has not been sufficiently disclosed.

Mr DAVID SHOEBRIDGE: That is when one is required, but that is a tiny minority of inquests.

Mr McLENNAN: Yes.

Mr DAVID SHOEBRIDGE: So we have a tiny minority of inquests where there is a statutory requirement because one of those matters cannot be satisfied, although I thought your evidence before was "may".

Mr McLENNAN: May, because you simply do not have an inquest if the evidence is not going to be available that is going to assist the Coroner any further.

Mr DAVID SHOEBRIDGE: So even that is discretionary.

Mr McLENNAN: Yes.

Mr DAVID SHOEBRIDGE: We have a handful of cases where it involves police operations or a death in custody, and they must be done. But for the other overwhelming majority of decisions there is no statute, no policy and no guideline.

Mr McLENNAN: It is a decision of the coroners themselves.

Mr DAVID SHOEBRIDGE: How do we know those decisions are being properly made?

Mr McLENNAN: These are senior coroners who are trained within the jurisdiction who look at each case carefully as to whether there is a requirement for an inquest, taking into account the family's views, taking into account what they need to establish and whether there is anything that is going to come out of the inquest.

Mr DAVID SHOEBRIDGE: Does anybody review a year's decisions? Is there any qualitative analysis of those decisions?

Mr McLENNAN: If a decision is made to dispense with an inquest by a coroner, there is a process where that decision can be appealed—where the State Coroner can review the decision of that coroner that dispensed with the inquest and then that State Coroner, after reviewing, can either support the decision of that coroner or make a decision that an inquest should be held. That does happen regularly.

Mr DAVID SHOEBRIDGE: If you are an aggrieved family and you are concerned about the decision not to hold an inquest then how do you start drafting a submission seeking for that to be reviewed, if you do not know the basis upon which the original decision was made or the basis upon which the review determination will be made? How do you go about that?

Mr McLENNAN: When a coroner dispenses with a matter, they provide reasons for dispensing. That is one of the documents the family can apply for, and have, and they can see the reasons why the Coroner has made that decision to dispense with the inquest. Most of the representations we receive from families if they are not satisfied with the Coroner's finding is simply an email to the court. It is very informal. We do not require any great deal of formality.

Mr DAVID SHOEBRIDGE: You do not recognise that there is a difficulty with the single most important decision in the whole system being an utterly unstructured discretion? You do not see a problem with that, Mr McLennan?

Mr McLENNAN: In each case where the Coroner makes a determination, the families provide advice to the Coroner. The Coroner will not dispense with the inquest unless there is an advising of the family yes or no if they require an inquest. If it is yes, and they have provided their reason, the Coroner will address those reasons to the family generally by a letter to the family where they say, "Even though you have asked for an inquest, this is why—"

The CHAIR: Just to the point, sections 25 and 26 of the Act seem to govern that. It is pretty clear that unless the Coroner is required by law to hold an inquest, they may dispense. There is a process to go through—they have to ask the families and medical practitioners and the like. But it is very process driven and then there is nothing in the body of the provision that indicates any yardsticks by which a coroner would discharge their discretion. Often in legislation where there is a discretion, there will at least be some guiding principles. Here, there are really no guiding principles. Unless you tell me differently, I do not think there is a coroner's practice note that colours in some of the gaps. It really is a discretion at large. Frankly, some of the evidence we have received from former coroners and a Deputy State Coroner was that largely the decision is driven by overwork and a lack of resources and time by coroner magistrates, who simply do not have time to do inquests. They are dispensing with the need to have inquests, even though maybe they should not. That is of real concern to this inquiry because of the lack of judicial officers.

Mr McLENNAN: Look, I cannot answer that because that is not a role I play if the Coroner dispenses with those inquests.

The CHAIR: No, but you must be aware of those issues in the system.

Mr McLENNAN: I am aware that—look, each coroner does have a large workload but from my experience that is not something that plays on their mind when they are dispensing inquests.

Mr DAVID SHOEBRIDGE: Mr McLennan, that cannot be your evidence, can it?

Mr McLENNAN: Yes, it is.

Mr DAVID SHOEBRIDGE: Are you saying that coroners do not take into account their workload or their capacity to hold an inquiry? You are saying they do not take that into account when they are making decisions about whether or not to dispense with an inquiry. You are saying that is not part of their decision-making.

Mr McLENNAN: I do not know what is in their head at the time when they make that decision. How could I answer that?

Mr DAVID SHOEBRIDGE: You told me the kinds of things that were on the minds of coroners. You told me earlier a bunch of factors that were on their mind.

Mr McLENNAN: Yes, generally.

Mr DAVID SHOEBRIDGE: Now you are telling me that this one factor that is a little awkward you cannot give any evidence about whether or not that is on their mind.

Mr McLENNAN: That is not what you asked me before. You are saying to me that the time constraint is something that plays on their mind. I cannot answer that.

Mr DAVID SHOEBRIDGE: No, I want to be clear, resource constraints are what I asked about. Are resource constraints one of the considerations taken into account by coroners when determining whether or not to have an inquest?

Mr McLENNAN: I do not think it plays a predominant role.

Mr DAVID SHOEBRIDGE: I will give you the opportunity to reflect upon the evidence that we have had—

The Hon. TREVOR KHAN: David, we are not scoring points here. He has answered the question.

Mr DAVID SHOEBRIDGE: We had quite contrary evidence from former coroners who made it very clear it was a very substantial part of their thinking and a very substantial matter for them. Your evidence seems to be contrary to their evidence. I am just wondering how to square the circle about two very contradictory pieces of evidence.

Mr McLENNAN: It is not contrary to them. I am just saying—

The Hon. CATHERINE CUSACK: Point of order: Mr Shoebridge is asking the witness to read other peoples minds. He has answered the question to the best of his ability. Maybe it is a valid thing to pursue, but maybe we need to pursue it in other avenues.

The CHAIR: Thank you. I do not uphold the point of order. Mr Shoebridge asked the question and the witness was answering, but we do seem to be going around in circles a bit here so this will be the last question on this specific point.

Mr DAVID SHOEBRIDGE: I was trying to square the circle.

The CHAIR: To be fair, the witness cannot answer for anybody else.

Mr DAVID SHOEBRIDGE: Mr McLennan?

Mr McLENNAN: Each coroner does have a very high workload, but to my knowledge I am not aware that they do not hold inquests because of that workload capacity. Where an inquest is necessary, my view is that they will hold an inquest if it is required.

Mr DAVID SHOEBRIDGE: We have the difficulty though, don't we, that we cannot tell what criteria coroners are using because there is no policy, legislation or guidelines that identify the criteria?

Mr FOLLETT: There is some.

Mr McLENNAN: In the magistrates' bench book I understand there might be guidelines. I am not a magistrate, so I am not aware of it.

Mr DAVID SHOEBRIDGE: If you have got any information from the magistrates' bench book that you could provide on notice, that would be of assistance.

Mr McLENNAN: I do not have access to the bench book. I am not a magistrate.

The Hon. TREVOR KHAN: He does not have to do that. It is publicly available. I can assure you of that.

The CHAIR: We will also be speaking to the State Coroner. If there is any information around that, you can provide that on notice.

Mr McLENNAN: I understand there is a bench book that provides some sort of guidance to the Coroner. I am not a magistrate; I do not have access to it.

Mr FOLLETT: There are provisions in the Act. They are fairly general.

The CHAIR: I think we have well established that outside the provisions of the Act, there is no other guidance for magistrates as far as we are aware in the exercise of the coronial jurisdictions. We will move on to any other topics that members have to pose these witnesses.

The Hon. TREVOR KHAN: I do. I think my question is to Mr Gigli and Dr Brouwer, if I pronounced those names correctly. Something that interests me is that we talk about the release of the body. What I am interested in is the time frame for obtaining toxicology reports. I am going back a long way since it was relevant to me, but it seemed to me that a significant delay in matters progressing, whether it be criminally or in the Coroners Court, was often the toxicology reports. Is that something of the past or does that remain an issue in terms of the final issuing of the death certificate or the autopsy report or the like?

Dr BROUWER: Currently, we generally get the toxicology results back within 15 working days—three weeks. We also have a process of an express toxicology. In certain instances we use it if there is an objection by the family and the outcome of the Coroner's decision about a type of examination depends on that result. We will arrange an express toxicology, and that takes about 72 hours. There is some work we need to do in that space around the express toxicology. At the moment it is available for our Sydney facility, for example, but as soon as you go to regional areas there is an extended time frame around getting the express toxicology. Generally, it does not—

The Hon. TREVOR KHAN: Why is that? We are doing COVID tests and getting the reports back hopefully within 24 or 48 hours. I understand that toxicology reports are of a different nature, but certainly the transport of the material is pretty well overnight in a little bag. Is it different in terms of these samples?

Ms GIGLI: No, you are correct. The transportation is overnight, so you are looking at 24 to 48 hours pre- getting on the analysis equipment, and then the 72-hour time frame for the results. The results are all electronic now. The results themselves we get every morning. We receive the results that come through and then they are dispersed out to the doctors accordingly. That has created an improvement in timeliness in terms of receiving those results. But you are correct; transportation is the key factor for our rural and regional areas.

The Hon. TREVOR KHAN: My next question goes to, in a sense, forensic pathologists. I was looking at newspaper articles, which are often not helpful in any matters, but on this occasion they appeared to be helpful. Has there been a change in the last few years in the qualification level that has been required for forensic pathologists, and how has that impacted—there was a matter reported in 2020. I do not want to go into those specific issues, but has that impacted on the availability of forensic pathologists and the training thereof?

Dr BROUWER: I am not sure exactly what the time frame is, but I would say about 12 years ago the Royal College of Pathologists of Australasia [RCPA] changed the—there are different pathways that you can follow to become a forensic pathologist. It used to be a subspecialty of anatomical pathology, so you had to become an anatomical pathologist first and then specialise in forensic pathology. That changed a couple of years back when forensic pathology became a specialty on its own, so you can purely decide you want to be a forensic pathologist. You do 18 months of anatomical pathology and spend the rest of your time working in forensic pathology as a forensic pathology trainee. It has made it, in a way, easier to attract pathologists who specifically want to specialise in forensic pathology. It has not affected the quality of the training at all.

At the moment we have a hybrid of people who are purely qualified as anatomical pathologists or have some experience in anatomical pathology and then specialise in forensic pathology and those ones who have purely done the forensic pathology training.

The Hon. TREVOR KHAN: Where is the training performed? Obviously some of it is in house, so to speak, but in terms of the academic component, is that—

Dr BROUWER: Yes, all the training is work-based training. Eighteen months of the training occurs in an anatomical pathology accredited training facility, and the remainder of the training occurs within a forensic pathology facility. As I have previously said, all three of our facilities are accredited through the Royal College of Pathologists of Australasia as training facilities, though we currently only have trainees in Sydney and Newcastle.

The Hon. CATHERINE CUSACK: In relation to pathology, do you have information on the backlog of cases or the time it is going to take to deal with cases? Is there some sort of performance indicator that you use internally when working out how to allocate cases and prioritise them?

Dr BROUWER: Yes. In the last two years or so we have managed to reduce the backlog of cases by about 48 per cent. We are aiming to have a turnaround time of about six months for an autopsy report. There is ongoing work that we are doing in introducing some efficiencies for the pathologists—for example, our forensic medicine information system will have standardised autopsy reporting templates that will make it easier for pathologists to do the reporting. We also have a priority request system whereby, either through the Department of Communities and Justice or our Forensic Medicine social workers, families can—for legal purposes, we do receive requests for prioritisation of reports. It is often families who are in need of a medical cause of death certificate because otherwise they cannot claim insurances et cetera, so we do have a way of accommodating that.

The Hon. CATHERINE CUSACK: For the purposes of our inquiry, would you be able to provide us with a snapshot of your activities and what the backlogs are for each of them? Is that something that you could provide to us? Do you do DNA testing, as well, for the police?

Dr BROUWER: No. That is done within—we are part of the Forensic and Analytical Science Service, but that is a different division within New South Wales.

The Hon. CATHERINE CUSACK: Okay, put that to one side. Just for the list of activities that you undertake, could you provide us with a snapshot of those activities and what the time frames are? Factual information would help us. In relation to the police, I would find it very valuable to have a mud map or a flowchart of, when a matter is likely to be subject to a coronial inquiry, how that case is handled by the police according to the type of death. For example, in relation to a motor vehicle accident, you would not have homicide involved in that; that would be, I assume, managed by a different branch of the police. If you could, talk about the initial investigation and then where that case goes.

The reason I ask for that flowchart is harking back to an earlier question by Penny Sharpe where there had been negative feedback from the family. I think the initial liaison was regarded highly by the family; it was when the case transitioned to homicide. The reason it went to homicide was because the police were involved in the death of the person, so this is a very special subset of matters that police are dealing with, with the Coroner. I hope you comprehend my question. You could find remains in a national park. You could have a drug overdose. I assume there is some sort of different flowchart as to where those deaths go in relation to management by the police and which police end up liaising with the Coroner.

Mr DOHERTY: That is a pretty big scope for a question in relation to providing a flowchart for each matter.

The Hon. CATHERINE CUSACK: You must have some sort of a protocol.

Mr DOHERTY: Yes.

The Hon. CATHERINE CUSACK: When the body of somebody is found and it is believed that they had a drug overdose, the police on the scene must know where that case is headed to.

The CHAIR: I guess this must be getting to the standard operating procedures to different death types.

The Hon. CATHERINE CUSACK: Yes.

Mr DOHERTY: That's right, and there is a police handbook.

The Hon. CATHERINE CUSACK: Thank you, Mr Chair.

Mr DOHERTY: There is a police handbook, and there is obviously different training, depending on the type of death.

The CHAIR: To the extent that you can, provide us with that.

The Hon. CATHERINE CUSACK: Can you give us a flowchart of it? That would really help us to know. How the counselling services are travelling as the case is handed off inside the police service—the counsellors who were initially there with the family when they got the terrible news seem to vanish midstream

because a different branch of the police takes it over. Do you see what I am saying? I am trying to crack the protocol. Anyway, I am just asking as a question of fact. I am not trying to argue it. I am trying to work out how the counselling services, which seem to be good—it just seems that the way the police investigative process operates does not seem to be a good match for the way the counsellors are allocated.

The CHAIR: All right. To the extent that the police can do that, they will provide us their standard operating procedures relating to different death types, as you have asked for.

The Hon. CATHERINE CUSACK: Thank you.

Mr DAVID SHOEBRIDGE: The progress report on the task force to improve the timeliness of coronial procedures, which is dated October 2021 but which I received about 23 hours ago, does not have any actual data in it. It does not put in the number of cases that are backlogged or the current average delay for any part of the process. Mr Follett, I note that is largely your report. Do you have any of that data? Does the task force have that data?

Mr FOLLETT: We are collating the data, and the task force notes—I think it is in the next step. It has transitioned its work to the coronial services committee, which the State Coroner chairs. We have set out some key performance indicators in the task force report. The plan is for the coronial services committee to have oversight of progress against those key performance indicators and collate the data. It will ultimately be a matter for the coronial services committee.

Mr DAVID SHOEBRIDGE: But this task force was established in July 2019.

Mr FOLLETT: That's correct.

Mr DAVID SHOEBRIDGE: We are now in November 2021. You are telling me that it has been going for 2½ years and you have not collated the data?

Mr FOLLETT: Sorry, just to clarify, collated the data against the key performance indicators that the task force has agreed upon. There is a number of actions that that report sets out that the task force undertook. The data that I am talking about relates to the key performance indicator [KPI].

Mr DAVID SHOEBRIDGE: You say in your report the lengthiest phase of the coronial process is the port-mortem investigation. What is the data on that? What is the median time frame for a post-mortem investigation? How many are waiting?

Mr FOLLETT: I do not have that to hand, Mr Shoebridge. If that data is available—which I suspect it is—we can provide that. I can take that one on notice.

Mr DAVID SHOEBRIDGE: I could go through and identify each of the points in your report and ask you to take them on notice. But a much more useful response would be, if you could, to provide us with all of the data you have on the actual time frames for each of the critical steps.

The Hon. TREVOR KHAN: No, I do not think that is the way. If you have specific things—I am not suggesting it be done now—questions can be put to Mr Follett.

Mr DAVID SHOEBRIDGE: I might just ask my question.

The CHAIR: You can ask your question.

Mr DAVID SHOEBRIDGE: You must have a dataset for this task force. You must have a dataset.

Mr FOLLETT: Yes. We do, Mr Shoebridge. We do.

Mr DAVID SHOEBRIDGE: Can you provide that dataset to the Committee?

Mr FOLLETT: Obviously, I would not provide the committee's workings, because a lot of that is different agencies' documents. But if there are particular datasets that you are after in terms of timeliness, we could provide those.

Mr DAVID SHOEBRIDGE: You must have data on timeliness.

The CHAIR: Mr Shoebridge, is a better way to proceed to put questions on notice?

The Hon. TREVOR KHAN: That is precisely what I was suggesting, rather than spending the next 10 minutes doing this.

The CHAIR: Eight minutes.

Mr DAVID SHOEBRIDGE: I really do not appreciate constantly being spoken over by you this afternoon, Trevor. It is not fruitful. I will ask my questions and you ask your questions.

The CHAIR: Committee members will speak through the Chair.

The Hon. TREVOR KHAN: Don't be rude. That is a good start.

Mr DAVID SHOEBRIDGE: I agree with you. That is a good start. Don't be rude.

The CHAIR: Committee members should address the Chair and not each other. Please frame a question.

Mr DAVID SHOEBRIDGE: What is the average length of delay between death and the provision of a post-mortem report?

Mr FOLLETT: I do not know that offhand, Mr Shoebridge. But we can provide on notice data on timeliness that backs up some of the report's findings if that is going to be helpful to the Committee.

Mr DAVID SHOEBRIDGE: Have delays reduced since July 2019 when the task force was established?

Mr FOLLETT: Yes.

Mr DAVID SHOEBRIDGE: By what magnitude?

Mr FOLLETT: I cannot recall off the top of my head. But—

Mr DAVID SHOEBRIDGE: What has caused the reduction?

Mr FOLLETT: What has caused the reduction? Sorry. Delays in terms of post-mortem releases?

Mr DAVID SHOEBRIDGE: Has anything been effective? What has been effective? What has been the most effective measure so far that you have implemented in reducing delay?

Mr FOLLETT: There has been some reduction in reporting natural causes of death. That has been effective—

Mr DAVID SHOEBRIDGE: That is the statutory reform.

Mr FOLLETT: The statutory reform, correct.

The CHAIR: Mr Follett, can I put this to you quite directly. The reports you have given us are about reducing the delays in everything other than the actual coronial inquest process itself. Correct? It expressly excludes that. It says, "We're not dealing with coronial inquests. We're not dealing with the work of the coroners in dispensing with inquiries." It is about other parts of the process.

Mr FOLLETT: That is right. It had four key drivers.

The CHAIR: We have received a fair bit of evidence that says it can take a number of years from death to final coronial decision or recommendations. It can take five or six years. We all agree that is far too long. I guess what we really want to know is: How much will the reforms that you have implemented reduce that backlog of time? What is being done to tackle the rest of the delay? A significant amount of delay seems to be, frankly, the lack of judicial officers to process the work. What have you done so far and how much will that reduce the time delay?

Mr FOLLETT: That is a fair question, Chair. The task force really focused on four discrete areas—

The CHAIR: I understand that. We are not being critical of the task force. We are now just trying to look at the other parts of the process that we have received evidence on.

Mr FOLLETT: I understand. Yes. On notice, we can provide data behind timeliness.

The CHAIR: Any data you have on timeliness and measures to improve it, and projections about what has been achieved and what is, hopefully, to be achieved from those measures would be very useful in our deliberations.

Mr FOLLETT: Yes. Absolutely.

Mr DAVID SHOEBRIDGE: Is timeliness, the ability to deliver an outcome in a timely fashion, part of the decision-making when coroners are deciding whether or not to hold an inquest? Is timeliness one of those things? That is the first question, perhaps to you, Mr McLennan.

Mr McLENNAN: It plays a role, yes.

Mr DAVID SHOEBRIDGE: Are there reports that the Coroners Court gets about delays and length of time? Are they generating that data themselves and comparing it over time?

Mr McLENNAN: With the Coronial Services Committee, which is chaired by the State Coroner, it is taking that from the task force. The whole idea of the Coronial Services Committee taking over that role is that we will have that data and we will be able to monitor those against what we expect is a timely procedure. There are delays. We are trying to reduce delays not just in the completion of the matter but in having the examination and the body released. So there is a number of steps through the whole process.

Mr DAVID SHOEBRIDGE: This brings me back again to the concerns I have about those kinds of data-driven KPIs. One of the best ways of reducing delays is to rapidly dispense with the need for an inquiry and finalise a matter, which works against the wishes of the family and the benefits of systemic reports. How are those things balanced?

Mr FOLLETT: In the statute, obviously, there are the steps that will need to be taken in making that decision that were set out in the Act and in the—

The CHAIR: Given the time, does anyone have any questions for Mr Scasserra? I have just noticed he has been waiting patiently online all afternoon. No-one has posed a question to him. I am not suggesting that anyone needs to but if anyone has questions for him now is probably the time in the last three minutes.

Mr DAVID SHOEBRIDGE: My questions are about supporting families, that is all. I regularly have family members, where there has been a death in custody, desperately trying to get some assistance either from Corrective Services or from attorneys general for something as basic as being able to afford the cost of travelling to Sydney and staying in Sydney for a week while the coronial inquest is held. They cannot afford travel. They cannot afford accommodation. Is there any policy in place for Corrective Services to assist families in those circumstances?

Mr SCASSERRA: Thank you. There are limited circumstances that we can provide some financial assistance, but they are limited. We will assist where we can. The commissioner has the capability of assisting if somebody has a specific need, but they are very limited.

Mr DAVID SHOEBRIDGE: Is there any other agency that has the ability to help families in that most practical need that they have to be able to afford to come to Sydney, to be there for the inquest in relation to the death of their loved one? Can anyone else help?

Mr McLENNAN: It is an issue that comes up from time to time. What you raise is where a person might live in regional New South Wales but die in a facility in Sydney. It is a difficult area. Our court, the Coroners Court, is not set up to provide that sort of funding—

The CHAIR: Just on that, Mr McLennan, it may also be the case that they might have died regionally but the coronial was actually conducted in Sydney. Is that not the case?

Mr McLENNAN: Generally, if the person has died regionally, the inquest will be conducted regionally. The Coroner will go out to that area because the witnesses come from there and, again, it is easier for the families.

The CHAIR: That is not the evidence we have received.

Mr DAVID SHOEBRIDGE: I can cite matters if you want. I can give you a list.

Mr McLENNAN: I think the issue you raised is when someone might perhaps die in a correctional facility in Sydney but the family is from country New South Wales. The difficulty for families—

The CHAIR: Do you provide transport and accommodation support services?

Mr McLENNAN: If they are a witness to the inquest, they can get witness expenses. But there is no other provision.

The CHAIR: What about family members—

Mr DAVID SHOEBRIDGE: I am talking about mum, dad, brothers, sisters and aunts. Mum can come but she needs the support of the other family members. It seems to me that there is nowhere in the New South Wales Government that has a policy to help families in the most practical and obvious place that they need help. Is that right?

Mr McLENNAN: I agree with that. From our point of view we do not have the funding to do it. But it is a problem.

The CHAIR: I note the time.

Mr SCASSERRA: Sorry. I was going to say quickly, Mr Shoebridge, we do where we can. We will provide assistance, particularly to the Coroners Court as well, to assist with cost and accommodation to attend, as well as for funerals and accommodation as well. There is limited financial assistance that we do provide.

Mr DAVID SHOEBRIDGE: Mr Scasserra, for the record, on ad hoc requests there is some ad hoc funding occasionally available for Corrective Services, but that requires, first of all, a discretion, it requires someone to know you are going to ask for it, and then of course sometimes it is refused. I note that on occasion it has happened, but surely we can all agree that that would be a good thing as a basic—well, I cannot ask you about a policy point.

The CHAIR: No.

Mr DAVID SHOEBRIDGE: I think it would be a good basic provision for families, would release a lot of the stress for families and perhaps make their engagement with all of your services much easier at that point.

The CHAIR: I think Mr McLennan basically agreed with you. I note the time. I thank the witnesses for giving evidence. The Committee has resolved that answers to questions taken on notice be returned within 21 days. The Committee secretariat will be in touch with those of you who have taken questions on notice about the terms of those questions and to make sure you have clarity about what you are expected to return to us in the 21-day time frame.

Ms GIGLI: Excuse me, Mr Chair, I know it is finished but can I just say one thing if that is okay?

The CHAIR: Yes, you may.

Ms GIGLI: Respectfully, sir. I am sorry, I have forgotten your name.

The CHAIR: Mr Shoebridge?

Ms GIGLI: Sorry, Mr Shoebridge. In terms of that idea, I think on notice about the data is really important, but just for the purposes of the Committee I would like it noted that where you had referred to being data driven, I think it is important to clarify that point to being data informed. Because the idea of the—I am sorry, I am nervous now.

The CHAIR: Do not be nervous.

Ms GIGLI: The idea of the timeliness standards is about being data informed. So data driven would imply an input and an output and a process which you have identified in your questioning, where data informed is about actually through the coronial services committee each agency is committed to timeliness standards across each point in time across the entire coronial pathway so we can be informed through that data to make decision points on where we can create opportunities for improvement, timeliness and effective systemic change, and that a right, if you will, governance model that can actually inform that change.

Mr DAVID SHOEBRIDGE: I understand that may be your position, and I accept that is the position that you come from.

The CHAIR: Mr Shoebridge, it is not a matter of dialogue. She has given the further information. The Committee will make whatever use it can of the information it has got. Thank you all for your time. You are all excused.

(The witnesses withdrew.)

The Committee adjourned at 16:46.