Statutory Review

Report on the Statutory Review of the *Coroners Act 2009*

December 2023

Published by

Policy, Reform and Legislation
NSW Department of Communities and Justice
Email: policy@justice.nsw.gov.au
Phone: 02 8688 7777
Locked Bag 5000 PARRAMATTA NSW 2124
www.justice.nsw.gov.au

Table of Contents

Executive summary 1
Summary of Recommendations 3
1. Introduction 15
1.1 History of the Review 15
1.2 Related Reviews 16
2. Overview of the coronial jurisdiction in NSW 17
2.1 Coronial process 17
2.2 Workload 18
2.3 Operational arrangements 19
2.4 Institutional arrangements 19
3. The policy objectives of the Act 22
3.1 Objects of the Act 22
3.2 Structure and framework of the Act 27
4. The preventative role of the coronial jurisdiction 29
4.1 Definition of domestic violence death 30
5. The coronial jurisdiction 32
5.1 Legislative provisions establishing jurisdiction 32
5.2 Consolidating the jurisdiction over deaths 36
5.3 Defining ‘deaths’ to include ‘suspected deaths’ 36
5.4 Clarifying the categories of deaths 37
6. The coronial framework 40
6.1 Change to the coronial process: inquests 40
6.2 Families of the deceased person in the coronial process 49
6.3 Dealings with the deceased person’s body 53
6.4 Review mechanisms 59
6.5 Right to request directions 63
6.6 Change to the coronial process: inquiries 65
6.7 Supplementary changes to the coronial process: inquests and inquiries 68
7. Supporting framework 72
7.1 Counsel Assisting the coroner 72
7.2 Prohibition in attributing findings of guilt and liability 73
7.3 Publication of, and access to, coronial matters 76

7.4 Responding to coroners' recommendations 79
7.5 Administrative and procedural efficiencies 82
8. Practice notes, guidelines, and approved forms 84
8.1 Extension beyond coronial proceedings 84
8.2 Power to issue guidelines beyond coroners 84
8.3 Suggestions for practice notes and guidelines 85
Appendix A: Written submissions received to the Review between 2014 to 2017 87
Appendix B: Stakeholder consultations on the Review from 2016 to 2017 90
Appendix C: Written submissions received on the Review in 2023 93
Appendix D: Diagram of coronial process 95

Executive summary

Coroners perform an important role in our community. They are responsible for ensuring deaths and suspected deaths occurring in circumstances of public interest are properly investigated. In this process, coroners may uncover and expose systemic issues concerning public health and safety, and refer matters for criminal investigation, as well as play a significant role in contributing to the reduction in the number of preventable deaths through recommendations for change. Coroners are also responsible for ensuring fires and explosions occurring in circumstances of public interest are properly investigated and determined. In their independent, objective and fair search for the truth in these matters, coroners assist bereaved members of our community with gaining an understanding of the circumstances surrounding a death.

The *Coroners Act 2009* (**the Act**) presents the legislative framework of the coronial jurisdiction, and outlines its nature, scope, process and procedure. This Report is the result of a review of the Act (**the Review**), as required by s. 109. The terms of the Review are to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

The Department of Communities and Justice (**the Department**) undertook the Review on behalf of the Attorney General. In conducting the Review, the Department engaged closely with the Chief Magistrate of the Local Court of NSW, State Coroner, NSW Police Force, Ministry of Health and the then Department of Premier and Cabinet and more recently established Cabinet Office. The Department also consulted with key government and external stakeholders and invited written submissions on a Draft Review and Supplementary Discussion Paper in June 2023. A list of the 37 written submissions received is at **Appendix C**.

The Department also considered submissions and feedback it received in 2017 and 2018 when it consulted stakeholders on an earlier version of the Statutory Review. These submissions and consultations are referenced at **Appendix A** and **Appendix B**.

The primary outcome of the Statutory Review is that the broad policy objectives of the Act remain valid. However, the Act does not adequately provide a complete and accurate picture of modern coronial process and procedure.

In response to the targeted consultation and following consideration of coronial legislative frameworks throughout Australia and New Zealand, we recommend the Act be amended to:

- establish the coronial jurisdiction as a standalone court within the Local Court framework
- modernise the policy objectives of the coronial jurisdiction
- strengthen the preventative role of the coronial jurisdiction
- assist in reducing inefficiencies in the current framework, by recognising the prominence of coronial investigations and providing mechanisms to formally finalise the coronial process where matters don't go on to inquest
- better support the deceased person's family by recognising the impact that coronial investigations and proceedings have on them, enabling their views to be considered and recognising the need to consider different cultures and religions when making decisions under the Act
- promote consistency in decision-making under the Act

- enhance the transparency, effectiveness and accessibility of the coronial jurisdiction
- make the Act clearer and easier to understand where there is currently some ambiguity in its interpretation.

Summary of Recommendations

Institutional arrangements

Recommendation 1

That, in principle and subject to resourcing being available (including, depending on the approach, to meet necessary operating, capital and technology costs), the Act be amended to reform the institutional arrangements of the coronial jurisdiction and establish the jurisdiction as a standalone court within the Local Court framework.

Policy objectives of the Act

Recommendation 2

That the objects clause of the Act be amended to recognise the importance of the following:

a) the coronial jurisdiction investigates certain kinds of deaths and certain kinds of fires and explosions

b) the processes adopted by the coronial jurisdiction should be sensitive to and supportive of trauma and distress

c) the processes adopted by the coronial jurisdiction should be cultural safety and responsive, and respectful of different beliefs and practices

d) the unique status and needs of Aboriginal and Torres Strait Islander peoples

e) the coronial jurisdiction should contribute to the reduction in the number of preventable deaths, fires and explosions by considering systemic factors and issues and making recommendations

f) the coronial jurisdiction should be inquisitorial in nature

g) the coronial system should operate in a fair and efficient manner

h) the coronial jurisdiction should avoid unnecessary duplication of investigations, inquests and inquiries, and seek to expedite those processes.

Recommendation 3

That the Act be amended to prescribe factors a person should consider, as far as possible in the circumstances, when exercising a function under the Act as follows:

a) that the death of a family member, friend or community member is distressing, and distressed persons may require referral for professional support or other support

b) that different cultures and religions have different beliefs and practices surrounding death that should, where appropriate, be respected

c) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation

d) the desirability of promoting public health and safety and the administration of justice

e) that procedural fairness should be afforded to persons involved in all stages of the coronial process

f) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death

g) the need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the use of that information

h) minimising costs that may be incurred by persons involved in coronial investigations or proceedings.

Recommendation 4

That the Act be amended to provide that coronial proceedings should be conducted with as little formality and technicality as the interests of justice (including procedural fairness) permit and, as far as possible in the circumstances, in a non-adversarial manner.

Recommendation 5

That the Act be amended so that:

a) its structure represents the sequential order of the coronial process and expressly recognises the functions of investigations pre-inquest and pre-inquiry

b) the functions of investigations pre-inquest and pre-inquiry are clarified so that coroners may exercise investigatory powers to the extent necessary to determine whether a death is ‘reportable’.

The preventative role of the coronial jurisdiction

Recommendation 6

That the definition of domestic violence death in s. 101B of the Act be amended to:

a) include any death occurring in the context of domestic violence, including as determined by the Domestic Death Review Team

b) require the Domestic Death Review Team to develop and publish guidelines for what constitutes a domestic violence death.

Jurisdiction

Recommendation 7

That the relevant Acts be amended to:

a) give medical practitioners discretion to issue a medical certificate of cause of death for certain unascertained natural cause deaths provided the medical practitioner is satisfied:

   i. that the person died of natural causes (whether or not the precise cause of death is known)

   ii. that there are no issues of care or treatment that contributed to the death

   iii. there are no apparent suspicious circumstances

iv. at the time of making a decision, there is no known objection by a family member; and

v. the person was aged 72 years or older.

b) give forensic pathologists discretion to issue a medical certificate of cause of death for certain unascertained natural cause deaths provided the forensic pathologist is satisfied:

i. that the person died of natural causes (whether or not the precise cause of death is known)

ii. that there are no issues of care or treatment that contributed to the death

iii. there are no apparent suspicious circumstances; and

iv. at the time of making a decision, there is no known objection by a family member.

Recommendation 8

That the Act be amended to:

a) list the categories of all deaths within the coronial jurisdiction as 'reportable deaths' under s. 6
b) consolidate the provisions outlining the deaths within the coronial jurisdiction in a single place in the Act, including the requisite connection with NSW.

Recommendation 9

That the Act be amended to define 'death' to include 'suspected death'.

Recommendation 10

That the Act be amended to require inquests for deaths that occur following involuntary admission and detention:

a) in mental health facilities under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW), *Mental Health Act 2007* (NSW), or *Crimes Act 1914* (Cth); or

b) under the *Public Health Act 2010* (NSW)

unless the coroner is satisfied that:

a) the person died of natural causes (whether or not the precise cause of death is known); and

b) there are no issues of care or treatment that contributed to the death.

Recommendation 11

That the Act be amended to clarify that jurisdiction under s. 23 includes deaths as a result of police operations or in lawful custody associated with Commonwealth agencies.

Changes to the coronial process: inquests

Recommendation 12

That the Act be amended to provide:

a) coroners with a general discretion to hold, rather than dispense with, an inquest if there is a public interest in holding an inquest

b) the factors coroners must consider in exercising that discretion, to include:

   i. whether the identity, date, place, cause or manner of death is sufficiently disclosed

   ii. whether the person died of natural causes (whether or not the precise cause of death is known)

   iii. whether the circumstances raise any issues about the deceased person's care or treatment that contributed to the death

   iv. whether there are any issues of public health or safety to address

   v. whether there are any suspicious circumstances

   vi. whether holding an inquest is likely to provide additional information

   vii. the views of the deceased person's family, if known

   viii. any request made by persons with sufficient interest in the circumstances of the death for an inquest to be held

c) that a coroner who decides that an inquest will not be held must, if requested by the State Coroner, the Minister, the senior next of kin or any person who, in the opinion of the coroner, has a sufficient interest in the circumstances of the death, give written reasons for deciding that an inquest will not be held

d) for the Act to provide for a regulation making power, whereby regulations may stipulate a process for persons with sufficient interest in the circumstances of the death to submit a request for an inquest to be held, for the coroner to consider when exercising their discretion. Regulations may include the period of time within which a request for an inquest to be held may be made.

Recommendation 13

That the Act be amended to require inquests to be held only in the following circumstances:

a) if it appears to the coroner concerned that the person died or might have died as a result of homicide (not including suicide)

b) if it appears to the coroner concerned that it has not been sufficiently disclosed whether the person has died (except where a Senior Coroner considers that an inquest will not assist with determining whether that person has died)

c) if the jurisdiction to hold the inquest arises under s. 23 (i.e. deaths in custody or in police operations)

d) in the circumstances set out in recommendation 10 (involuntary detention)

e) nothing in paragraphs (a)-(d) requires a coroner to continue an inquest if that inquest has been suspended or discontinued under s. 78, and the coroner considers that:

   i. the cause and manner of death have been sufficiently disclosed in a criminal proceeding, or

ii. after considering any relevant public interest issues, it would be futile to continue the inquest.

Recommendation 14

That the Act be amended to provide:

a) that coroners have discretion to issue a 'Coronial Certificate' where:

   i. the coroner is satisfied that the person died of natural causes (whether or not the precise cause of death is known) and considers that there is no need for further coronial investigation, clinical examination, a post-mortem or inquest

   ii. in the case of a person who died in relevant care settings, the coroner has also considered whether there are circumstances that raise any issues about the deceased person's care or treatment that contributed to the death

   iii. a forensic pathologist advises the coroner that they consider that the person died of natural causes and there is no need for a post-mortem or further clinical examination to determine the cause of death

   iv. a police officer advises the coroner that the death is not suspicious (where the death is reported by NSW Police); and

   v. there is no objection from the senior next of kin in relation to issuing a Coronial Certificate and not proceeding with any further clinical examination or coronial investigation

b) that a Coronial Certificate should include:

   i. relevant particulars including the name of the deceased, and the date, time, and place of death

   ii. a statement that the death was due to natural causes

c) that coroners have discretion to issue findings without inquest where the coroner:

   i. has not issued a coronial certificate

   ii. having regard to advice from a forensic pathologist and police officer, considers a post-mortem, further clinical examination, or coronial investigation is needed to determine the cause of death (this may include where the person died of unnatural causes, or where the person died of natural causes but a coronial certificate is not appropriate in the circumstances)

   iii. having regard to the outcome of the post-mortem, further clinical examination, or coronial investigation, considers that an inquest is not required; and

   iv. having regard to the views expressed by a person's senior next of kin in relation to issuing findings and not proceeding with an inquest

d) that findings without inquest should include relevant particulars, including the person's identity, date and place of death, and manner and cause of death

e) that a coroner who issues findings without inquest must, if requested by the State Coroner, the Minister, the senior next of kin or any person who, in the opinion of the coroner, has a sufficient interest in the circumstances of the death, give written reasons for deciding that an inquest is not required.

Families of the deceased person in the coronial process

Recommendation 15

That s 6A of the Act be amended to:

a) provide that, in addition to where the statutory senior next of kin is unavailable, the coroner can appoint an alternate senior next of kin from the statutory hierarchy where the statutory senior next of kin is not appropriate to be senior next of kin; and

b) add to the meaning of 'senior next of kin' an adult who, immediately before the deceased person's death, had a relationship with the deceased person such that the coroner considers them to be the most appropriate senior next of kin, where the statutory senior next of kin is not available or the coroner considers that they are not appropriate to be senior next of kin in the circumstances.

Recommendation 16

That the Act be amended to:

a) allow any person with sufficient connection to the deceased person to notify the coroner of their eligibility to be considered as a senior next of kin within a reasonable timeframe

b) require coroners to:

i. consider competing claims and communicate with the default appointee in regard to such competing claims

ii. make a decision as to who is most suitable to be senior next of kin and communicate that outcome to competing parties.

Recommendation 17

That the definitions of 'relative' and 'senior next of kin' be amended to recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures).

Recommendation 18

That the definition of 'relative' be amended to include the appointed 'senior next of kin'.

Dealings with the deceased person's body

Recommendation 19

That the Act be amended to require that:

a) coroners:

i. consult with medical investigators in making post-mortem investigation directions

ii. order the least invasive post-mortem investigation direction appropriate in the circumstances

iii. specify the type of examination required

b) medical investigators use the least invasive procedures appropriate in the circumstances (within the scope of any applicable coroner's direction and in the context of the information available at the time) for all tests and examinations.

Recommendation 20

That the Act be amended to remove all references to Coronial Medical Officers.

Recommendation 21

That the Act be amended to allow for the senior next of kin to exercise their functions orally, including:

a) to allow for the senior next of kin to object to an exercise of a relevant post-mortem investigative function under s. 96 orally; and

b) to authorise another person to exercise their functions under s. 98 in appropriate cases orally.

Recommendation 22

That the Act be amended so that the provision for coroners to issue written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths in appropriate cases under s. 34(2) (i.e. once coroners are able to determine particulars of the death) be:

a) a requirement

b) effected as soon as possible throughout the coronial process.

Recommendation 23

That the Act be amended to prescribe the function of issuing written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths, as one that may be delegated to assistant coroners under s. 15.

Recommendation 24

That the Act be amended to:

a) require orders for the release of the body or remains to specify the person to whom the body or remains may be released

b) provide the orders for the release of the body or remains may contain any terms or conditions that the coroner considers necessary

c) provide a presumption for the body or remains to be released to the senior next of kin (or someone authorised by the senior next of kin)

d) allow coroners to order the release of the body or remains and that the body or remains be released to a person other than the senior next of kin (or the person authorised by the senior next of kin), if:

i. after a reasonable time, the senior next of kin (or the person authorised by the senior next of kin) has not accepted release of the body or remains, or

ii. the body or remains cannot be identified and a senior next of kin cannot be determined

e) replace language such as 'the disposal of human remains' with language that is more sensitive and respectful of the families of people who have died.

Review mechanisms

Recommendation 25

That the Act be amended to:

a) allow persons with sufficient connection to the deceased person to apply within a reasonable time to the Supreme Court for review of decisions by coroners as to who is the senior next of kin, and

b) provide for a regulation making power to prescribe what constitutes such a reasonable time.

Recommendation 26

That the Act be amended to enable persons with sufficient connection to the deceased person to apply, within a reasonable time, for a review of the following decisions to the Supreme Court:

a) authorising the release of the body or remains at the conclusion of coronial proceedings under s. 101

b) issuing a warrant for the exhumation of the deceased person's body or remains under s. 91.

Recommendation 27

That the Act be amended to provide:

a) that the State Coroner may direct that a death is a reportable death if the State Coroner is of the opinion that a death is a reportable death

b) that the State Coroner may direct that an inquest be held following the issuing of a Coronial Certificate or finding without inquest if the State Coroner is of the opinion that an inquest should be held

c) that the State Coroner may direct that an inquiry should be held (in relation to a fire or explosion)

d) that persons with a sufficient interest in the matter have the right to request that the State Coroner direct a coroner:

i. that a death is a reportable death

ii. that an inquest should be held following the issuing of a Coronial Certificate or finding without inquest

iii. that an inquiry should be held (in relation to a fire or explosion)

e) that the State Coroner may hold the inquest or inquiry instead of directing another coroner to hold the inquest or inquiry

f) that the State Coroner may delegate these functions (the power to direct a coroner that a death is a reportable death or that an inquest or inquiry be held) to a Deputy State Coroner

g) that s. 29(3) of the Act, requiring the State Coroner to seek the Chief Magistrate's consent before giving a direction to a coroner who is a Magistrate, be removed.

Change to the coronial process: inquiries

Recommendation 28

That the Act be amended to provide:

a) coroners with a general discretion to hold, rather than dispense with, an inquiry if there is a public interest in holding an inquiry into a fire or explosion

b) coroners must consider the following factors when exercising that discretion:

   i. whether the cause and origin of the fire or explosion is not sufficiently disclosed

   ii. whether the inquiry into the cause and origin of the fire or explosion is necessary

   iii. whether there are any issues of public health or safety to address

   iv. whether there are any suspicious circumstances

   v. whether holding an inquiry is likely to provide additional information

   vi. any request made by persons with sufficient interest in the circumstances of the fire for an inquiry to be held.

Recommendation 29

That the Act be amended to:

a) allow the Commissioner of the NSW Rural Fire Service to request an inquiry into any fire within the Commissioner's jurisdiction under the *Rural Fires Act 1997*

b) amend the reference to the 'Commissioner of New South Wales Fire Brigades' to the 'Commissioner of Fire and Rescue New South Wales'.

Supplementary changes to the coronial process: inquests and inquiries

Recommendation 30

That the Act be amended to authorise:

a) a coroner who held an inquest/inquiry, or the State Coroner, to conduct a fresh inquest/inquiry on their own motion on the basis of the criteria in s. 83 of the Act

b) any person with sufficient interest in the subject matter of the previous inquest/inquiry to make an application for a fresh inquest/inquiry under s. 83, for the coroner to consider.

Recommendation 31

That the Act be amended to clarify that, when a coroner issues an 'open finding', coroners have discharged their duty, such that any reconsideration of the matter would require a 'fresh inquest or inquiry' to be ordered under s. 83.

Recommendation 32

That the Act be amended to authorise the holding of concurrent inquests and inquiries where numerous incidents occur as a result of a single incident, in similar circumstances or where it is otherwise in the interests of justice to do so.

Improving the supporting coronial framework

Recommendation 33

That the Act be amended to explicitly provide:

a) for the appointment of Counsel Assisting the coroner

b) that Counsel Assisting and the legal representatives of interested parties (where granted leave to appear) should have the power to cross examine a witness at an inquest or inquiry.

Recommendation 34

That in relation to the record of Coronial Certificates or findings (including findings without inquest) by the coroner or verdicts by juries, and recommendations by a coroner or jury:

a) there be a prohibition on the making of any statements that a person is or may be guilty of an offence, unless that statement concerns an offence already found proven
b) any record of written reasons accompanying Coronial Certificates, findings (including findings without inquest) or recommendations must not contain any statements that a person is or may be guilty of an offence, unless that statement concerns an offence already found proven.

Recommendation 35

That the Act be amended to prohibit coroners from issuing Coronial Certificates, findings (including findings without inquest) or recommendations attributing civil liability in similar terms to the proposed prohibition on attributing findings of guilt in the previous Recommendation.

Recommendation 36

That the Act be amended to enable coroners to refer matters connected to an inquest or inquiry (including relevant information and material) to relevant investigative, prosecutorial or disciplinary agencies (including Commonwealth agencies), where appropriate.

Recommendation 37

That the Act be amended to require coroners to publish details of pending inquests and inquiries on the coronial jurisdiction's website.

Recommendation 38

That access to documents under s. 65 of the Act be amended to:

a) clarify that it applies to documents or other evidentiary material which are part of coronial proceedings (inquests and inquiries)

b) require coroners or assistant coroners to also have regard to:

   i. whether granting access may compromise a coronial investigation, coronial proceeding or criminal investigation or proceeding

   ii. whether granting access may reveal sensitive police methodology or disclose or enable a person to ascertain the existence or identity of a confidential source of information relating to the enforcement of the law; and

   iii. the clinical implications of releasing certain sensitive or potentially traumatising information and whether the views of a forensic pathologist should be sought on the matter

c) allow a coroner or assistant coroner to impose conditions upon access and provide for non-compliance to such conditions to be punishable by fine, and enable regulations to be made to specify the process for issuing and enforcing a fine.

Recommendation 39

That s. 36(2) of the Act be amended to require relevant material be provided to the Ombudsman or the Commissioner of the NDIS Quality and Safeguards Commissioner:

a) as soon as practicable after its receipt by the State Coroner, but no later than a decision not to hold an inquest or the conclusion or suspension of an inquest; and

b) after considering any objections to the provision of the information on the grounds it may expose or prejudice an ongoing investigation.

Recommendation 40

That the Act be amended to require that:

a) within six months of receiving a coronial recommendation, a Minister, government agency or non-government entity write to the Attorney General outlining any action being taken to implement the recommendation, or the reasons why no action has been taken

b) a non-government entity need not respond if a government agency responds to a recommendation directed to the non-government entity

c) the Minister, government agency, or non-government entity's response be published online on the Coroners Court website as soon as practicable.

Recommendation 41

That the Act be amended to:

a) remove the provision that provides that reports of inquest proceedings with a suicide finding must not be published unless the coroner makes an order permitting the publication; and

b) retain the provisions that allow a coroner to make non-publication orders in relation to suicides.

Recommendation 42

That the Act be amended to:

a) provide for the electronic service of documents, if the recipient (or their legal representative) has provided an electronic address for service for that purpose

b) provide that a regulation may define the term ‘electronic service’.

Recommendation 43

That the Act be amended to:

a) enable coroners or assistant coroners issuing subpoenas to direct any person to effect service of a subpoena

b) allow for the electronic service of subpoenas only in circumstances where the recipient (or their legal representative) has provided an electronic address for service for that purpose.

Enabling for practice notes, guidelines and approved forms to be issued

Recommendation 44

That the Act be amended to allow the State Coroner to issue practice notes and approve forms for use in the coronial process.

Recommendation 45

That the Act be amended to allow the State Coroner to issue guidelines to persons exercising a function under the Act (i.e. not limited to coroners).

1. Introduction

The *Coroners Act 2009* received assent on 19 June 2009 and commenced upon proclamation on 1 January 2010.

The Act is the result of a Departmental review of the *Coroners Act 1980*, conducted in 2009. Based on the findings of that review, the Department sought legislative amendments to modernise and provide a more cohesive legislative framework to support coroners, ensuring matters could be investigated effectively, sensitively and in a timely manner. Those legislative amendments largely dealt with reforming the governance structure of the coronial jurisdiction, the categories of death within the coronial jurisdiction, the conduct of post-mortem examinations and the case management of coronial proceedings.

Section 109 of the Act requires the Attorney General to commence a review of the Act as soon as possible after the period of five years from the date of assent to the Act. The terms of the Review are to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives.

1.1 History of the Review

Work on the Review commenced in 2014. The Department invited submissions from members of the public and other key stakeholders, including NSW Government agencies, professional organisations, and the heads of jurisdiction of all NSW Courts. A list of all written submissions received from that time is at **Appendix A**.

From 2016 to 2018, the Department undertook targeted consultation with key stakeholders to consider and advise on issues raised in the Review, including former State Coroners and the former Chief Magistrate of the Local Court of NSW, NSW Government agencies, victim support groups, cultural and religious groups, agencies that represent the interests of Aboriginal and Torres Strait Islander people, and various agencies in the health and legal sectors. The Department also undertook roundtable consultations among key stakeholders. A list of all stakeholders consulted at this stage of the Review is at **Appendix B**.

The Review was then placed on hold during the operation of the *Taskforce on Improving the Timeliness of Coronial Procedures* (**the Taskforce**). Work on the Taskforce commenced in June 2019 and the Taskforce held its final meeting in October 2021.

In 2022, the Department recommenced consultation with key government stakeholders, including the State Coroner, the Chief Magistrate of the Local Court of NSW, NSW Police Force and NSW Health. In 2023, the Department undertook targeted consultation with key stakeholders, including the State Coroner, as well as key government and external stakeholders. The Department invited written submissions on a Draft Review and Supplementary Discussion Paper in June 2023. The Department received 37 written submissions. A list of all written submissions received at this stage of the Review is at **Appendix C**.

1.2 Related Reviews

Review of Chapter 9A of the Act

In 2015, the Department completed a separate review of the Domestic Violence Death Review Team provisions under Chapter 9A of the Act.[1] The recommendations of that Review were effected upon the commencement of the *Crimes (Domestic and Personal Violence) Amendment (Review) Act 2016* on 1 December 2016. This Report therefore does not consider the provisions of Chapter 9A of the Act, except for section 101B(1) that defines 'domestic violence death.' Recommendation 6 proposes amendments to this definition (see section 4.1).

Improving the Timeliness of Coronial Procedures Taskforce

The Taskforce examined the coronial pathway, excluding processes involving inquests and the dispensing of coronial matters by a Coroner, and identified a range of initiatives to improve the coronial system. These are outlined in the Taskforce's final Progress Report.[2] The Taskforce concluded in October 2021. The Coronial Services Committee, an interagency committee chaired by the State Coroner, will have oversight of ongoing Taskforce initiatives beyond 2021. The Review was completed with the benefit of the Taskforce's work and findings.

The Taskforce oversaw the implementation of two legislative amendments to the Act to:

- remove the requirement to report a death on the basis the deceased person had not seen a medical practitioner in the 6 months prior to death
- allow a forensic pathologist to undertake preliminary examinations of deceased people without a direction from a Coroner.

These changes sought to reduce the over reporting of natural deaths and reduce delays in the release of deceased persons. The amendments were implemented under the *Justice Legislation Amendment Act 2019* and commenced in January 2020.

Select Committee on the Coronial Jurisdiction in NSW

The Legislative Council Select Committee on the coronial jurisdiction in NSW (**the Select Committee**) was established on 6 May 2021 and handed down its report with 35 recommendations on 29 April 2022. The then NSW Government responded to the Select Committee's report on 31 October 2022.

The Review overlaps with some recommendations made by the Select Committee that require legislative amendments to the Act. Where this is the case, the relevant Select Committee recommendations are referred to.

The Department continues to consider other possible reforms arising from the Select Committee's report and their operational and funding implications.

[1] The Department's report on that Review is available on the Department's website at: http://www.justice.nsw.gov.au/justicepolicy/Pages/lpclrd/lpclrd_publications/lpclrd_complete_reviews.aspx.
[2] The Taskforce's final report is available at: https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=273#tab-otherdocuments

2. Overview of the coronial jurisdiction in NSW

Coroners investigate certain kinds of deaths, including suspected deaths, as well as fires and explosions. Coronial investigations benefit family and friends of a deceased person, as they may provide a sense of closure and certainty where they provide an understanding of the circumstances surrounding a death. Coronial proceedings can result in recommendations to improve issues of public health and safety. Coronial investigations also often assist in identifying criminal conduct.

2.1 Coronial process

Types of matters

The coronial jurisdiction is inquisitorial in nature. Its overarching goal is to search for the truth independently, objectively, and fairly. This process is conducted actively by the coroner as judicial officer in charge of the matter. The vast majority of matters before coroners are deaths. Other matters are suspected deaths (e.g. missing persons), and fires and explosions that have destroyed or damaged property.

The types of deaths a coroner investigates include those that are sudden, unexpected, unexplained, violent, or suspicious (such as a murder). When investigating a death, the coroner's primary function is to establish whether a death has occurred, the identity of the deceased person, the time and place of death, and the cause and manner of death. When investigating fires or explosions, the coroner's primary function is to establish its cause and origin and, in some cases, its circumstances.

The coronial process

In order to carry out their functions, coroners are granted broad legislative powers to conduct investigations, direct and control inquests and inquiries, and make formal findings and recommendations.

When a death is reported, coroners can order medical examinations of the remains of the deceased person, request police to conduct investigations and search premises for evidence, require the production of documents, request expert reports, subpoena witnesses, and hold public hearings. The views of family members of the deceased person are considered in key coronial decisions, particularly decisions about the handling, examination and release of the deceased person's remains.

Some investigations result in public hearings, which result in the making of findings and, where appropriate, recommendations. Public hearings in relation to deaths are referred to as inquests, and public hearings in relation to fires and explosions are referred to as inquiries. While findings record the particulars of the death, fire or explosion, recommendations are made to address and improve issues of public health and safety.

An overview of the coronial process for inquests is provided at **Appendix D**.

People involved in the coronial process

Many people play important roles throughout the coronial process. In particular, the Act specifically recognises the role of:

- police in the investigation phase
- medical practitioners in reporting deaths

- medical investigators (including coronial medical officers and forensic pathologists) in following post-mortem investigation directions from coroners, including directions to conduct post-mortem examinations and tests and to review medical files
- coronial officers, that is, the State Coroner, Deputy State Coroners, coroners, and assistant coroners in conducting investigations, directing and controlling inquests and inquiries, and making formal findings and recommendations
- Counsel Assisting, barristers, and solicitors in the Department's Legal group and the Crown Solicitor's Office in supporting coroners to prepare for and conduct inquests and hearings
- the family of the deceased person; that is, relatives who have general standing under the Act, and the senior next of kin in representing the views of the deceased person's family.

The impact of the coronial process can be wide reaching and the list of people who have an interest in that process can be lengthy. This includes relatives of the deceased person as they have a legitimate interest in how coronial proceedings are conducted and concluded, and how and what decisions are made about the treatment of the deceased person's body. Those involved in the circumstances of the death of the deceased person in a professional or personal capacity have an interest in the outcomes of coronial processes and if adverse findings will be made, ensuring they are afforded procedural fairness. Where matters raise broader public interest questions, the public and media have a right to know about any systemic issues concerning public health and safety.

While numerous individuals may take an interest in each coronial proceeding, the Act limits those who have specific rights based on their connection to the death of the deceased person, or the coronial proceedings or inquest. This is recognised in the Act through the use of the following two categories of people:

- persons with sufficient interest in the circumstances of the death, who can currently request written reasons when an inquest has been dispensed with
- persons with sufficient interest in the subject matter of the proceedings or inquest, who the coroner may notify about the time and place of the inquest or inquiry, or who may be granted leave to appear in person in coronial proceedings.

2.2 Workload

In NSW, 62,980 deaths were registered in 2022.[3] However, there is no requirement to report all deaths to a coroner. In the same year ending December 2022:

- 7,651 deaths were reported to NSW coroners, which is an increase of 932 deaths from the previous year,
- 7,066 coronial cases for deaths and fires were closed, and
- 126 inquests were conducted.[4]

Matters that do not proceed to inquest are mostly finalised within a year and matters that do proceed to inquest are mostly finalised within two years.

[3] Australian Bureau of Statistics, https://www.abs.gov.au/statistics/people/population/deaths-australia/latest-release (accessed 28 September 2023).
[4] Local Court Annual Review 2022, https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html.

In 2022, 93 fires (including explosions) were reported to NSW coroners.[5]

2.3 Operational arrangements

The Forensic Medicine and Coroners Court Complex (**FMCCC**) in Lidcombe, Sydney, is the NSW headquarters for a system of coroners that spans the state.

In the metropolitan area, coronial matters are exclusively handled in FMCCC by the State Coroner or a full time Deputy State Coroner. At the time of writing, there are six FTE Deputy State Coroners, in addition to the State Coroner, who are based at the FMCCC. The State Coroner and Deputies are each supported by an administrative team leader and an administrative team (of about three to four full-time positions), as well as a Registrar who oversees the structure and day-to-day operations of the registry and the Deputy Registrar. The State Coroner is also supported by an Executive Officer.

The work of coroners at the FMCCC is supported by the Coronial Case Management Unit (**CCMU**), which was established in 2017 to triage all deaths reported to coroners in the metropolitan area. The CCMU comprises cross-agency staff, including a duty coroner, forensic pathologist, clinical nurse consultant, social worker, registry staff and police, who are co-located at the FMCCC. It meets twice daily to present relevant information so that coroners can make a direction for the next steps of the investigation, including whether an autopsy or other forensic examinations need to be performed.

The CCMU model supports coroners to make timely, consistent, and appropriate coronial decisions at the early stage of the coronial process that are consistent with the legislative intent of establishing the cause of death by the least invasive means.

In March 2020, in the context of the COVID-19 pandemic, the CCMU took on a state-wide role in co-ordinating a centralised model of initial coronial directions. All reported deaths in NSW are now reported to the duty coroner at the FMCCC for an initial coronial direction.

In regional NSW, Local Court magistrates exercise the coronial jurisdiction part-time, following an initial coronial direction made at the FMCCC. This function is performed in addition to their routine conduct of exercising the jurisdiction of the Local Court and the Children's Court. Due to a high number of coronial matters arising in the Newcastle circuit, the regional coordinating magistrate for that circuit has been appointed as a Deputy State Coroner (on a part time basis). All regional coroners are supported by the administrative team, which includes assistant coroners, of each respective Local Court registry.

2.4 Institutional arrangements

The coronial jurisdiction sits within the NSW Local Court. It is headed by the State Coroner who is subject to the control and direction of the Chief Magistrate of the Local Court and has the same status as a Deputy Chief Magistrate: ss. 7 and 10 of the Act. The coronial jurisdiction is mostly composed of Local Court magistrates who are coroners by virtue of their office and subject to the Chief Magistrate's triennial rotation program. Although the Act does not expressly recognise the coronial jurisdiction as a court of record, it is recognised as a court of record under case law (see *Decker v State Coroner* (1999) 46 NSWLR 415 at [6]).

Currently, all NSW magistrates are coroners by virtue of their office as a magistrate under s. 16 of the Act. The State Coroner is responsible for overseeing and coordinating all coronial

[5] Local Court Annual Review 2022, https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html.

services in NSW, and together with Deputy State Coroners (Deputies), has exclusive jurisdiction to handle sensitive deaths (such as deaths in custody, police operations, or in disability settings, or deaths of children in care). The State Coroner and Deputies are all magistrates and are collectively known as senior coroners. The State Coroner and Deputies are also supported by a network of coroners (all of whom are magistrates) and assistant coroners (court registry staff that provide administrative assistance to coroners) across NSW.

Coinciding with this Review, the Select Committee recommended, among other things, that the coronial jurisdiction be restructured to be an autonomous and specialist court within the Local Court framework, similarly to the institutional arrangements of the Children's Court of NSW (recommendation 4). The Select Committee's recommendation was that an autonomous and specialist Coroners Court have the following key features:

- the appointment of additional dedicated coroners to undertake all coronial work, including at least one full time coroner to each region, such that regional magistrates should no longer be required to perform any coronial duties
- all specialist coroners still to be appointed also as Local Court magistrates, following consultation with both the State Coroner and the Chief Magistrate, but appointed solely to the coronial jurisdiction without limited term
- the requirement for the office of the State Coroner to be a Judge of the District Court, with the authority to select and appoint coroners who are drawn from the Local Court, in consultation with the Chief Magistrate
- any transfers from the Coroners Court of New South Wales to the magistracy to occur only with the agreement of both the State Coroner and the Chief Magistrate
- the State Coroner to be a member of the Judicial Commission of NSW.

Subject to the comments below, key government agencies and stakeholders consulted generally supported the Select Committee's recommendation for reform to the institutional arrangements of the coronial jurisdiction. They noted that, with appropriate resourcing, a standalone Coroners Court could result in stronger coronial practices, enhanced and more consistent support for families – including First Nations families – involved in the coronial process, case efficiency and improved timeliness. And it was further considered that enhancing the specialisation of the jurisdiction could support the identification of systemic issues and a reduction in preventable deaths. It was said that these enhancements could be achieved through:

- coroners operating as specialist judicial officers, rather than the current hybrid arrangement where coronial duties are split between senior coroners at FMCCC and regionally based magistrates, who often perform coronial duties in an 'out of hours' capacity on top of their magistracy duties
- senior coroners generally being based at the FMCCC, enabling enhanced opportunities for collaboration, knowledge sharing, and consistency of practice.

We acknowledge the advantages of the current structure and arrangements of the jurisdiction, including:

- transferability of judicial officers and resources across jurisdictions, enabling prompt coronial appointments to occur on an as needs basis

- facilitating the rotation of coroners to the Local Court to avoid excessive exposure to traumatic coronial material
- reduced duplication of administrative functions and costs.

However, these advantages need to be considered in the context of the potential additional benefits of a standalone Coroners Court, such as:

- the development of expertise in managing inquisitorial (rather than adversarial) proceedings, multidisciplinary team management and investigation, and understanding of complex expert forensic medicine and science evidence
- the opportunities senior coroners would have to develop expertise through higher coronial caseloads and working with other senior coroners and the multidisciplinary team at the FMCCC
- improved consistency, quality and timeliness of decision making
- avoiding issues associated with balancing coronial work with demanding Local Court caseloads, which is very often performed in an 'out of hours' capacity
- a more appropriate model to support the modern objectives of a coronial jurisdiction, which includes contributing to the reduction in the number of preventable deaths and fires, focusing on identifying systemic factors and issues, emphasising therapeutic processes and practices, and stronger support for and responsiveness to First Nations families and communities and different beliefs and practices.

If a standalone Coroners Court were to be established, some key government agencies and stakeholders noted a preference for retaining and building on the existing centralised operating model at FMCCC, rather than moving to a decentralised model of having senior coroners situated across the state. However, there are considerations associated with moving to a fully centralised model, including the physical ability to accommodate additional senior coroners and support staff at the FMCCC (both currently and with some building modifications).

It was noted that any operating model (either a fully centralised operating model involving senior coroners based entirely at the FMCCC, or a blended model with most senior coroners based at FMCCC and some located in regional areas) needs to be established in a way that it is responsive to regionally based families and communities at key points in the coronial process, in particular for inquests and inquiries. If a fully centralised model were adopted, this could involve centrally located senior coroners conducting inquests and inquiries in regional cities and towns where the deceased passes in the region, and subject to consultation with families. Assistant Coroners would also continue to perform existing administrative functions from regional courts to support centrally located coroners. This could ensure that the benefits of centralisation are achieved and flow back to regional families and communities and are balanced with the important need for a regional coronial presence at key points in the coronial process.

Further analysis of these issues and their operational and funding implications will be undertaken by the Department in conjunction with stakeholders. Subject to further consideration of these issues, and securing necessary funding to meet operating, capital and technology needs as necessary, in principle statutory amendments to the institutional arrangements of the coronial jurisdiction are recommended.

Recommendation 1

That, in principle and subject to resourcing being available (including, depending on the approach, to meet necessary operating, capital and technology costs), the Act be amended to reform the institutional arrangements of the coronial jurisdiction and establish the jurisdiction as a standalone court within the Local Court framework.

3. The policy objectives of the Act

An important part of the Review is determining whether the policy objectives of the Act remain valid. When introduced in Parliament in 2009, the second reading speech emphasised that the object of the Act is to provide a cohesive legislative framework to support coroners and to ensure matters can be investigated effectively, sensitively and in a timely manner. This was supported by prescribing seven objects in s. 3 of the Act.

While we conclude that the broader policy objectives of the Act remain valid, the prescribed objects under the Act do not fully reflect the modern coronial process. This section of the Report recommends amending the objects in s. 3 to reinforce what the Act is aiming to achieve, prescribing factors to be considered by persons exercising functions under the Act to ensure that anyone operating under the Act does so in accordance with its policy objectives, and prescribing supporting principles for coronial proceedings.

This section of the Report also recognises that the structure and framework of the Act does not properly represent the sequential order of the coronial process and the prominence of coronial investigations, recommending its revision.

3.1 Objects of the Act

Section 3 sets out the objects of the Act as follows:

a) to provide for the appointment of coronial officers
b) to provide that magistrates are coroners by virtue of their office
c) to enable coroners to investigate certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths
d) to enable coroners to investigate fires and explosions that destroy or damage property within the state in order to determine the causes and origins of (and in some cases, the general circumstances concerning) such fires and explosions
e) to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)
f) to provide for certain kinds of deaths or suspected deaths to be reported and to prevent death certificates being issued in relation to certain reportable deaths
g) to prohibit the disposal of human remains without appropriate authority.

We received a number of suggestions for amendment to the list of objects prescribed in the Act. These included to:

- simplify and distil the objects of coronial jurisdiction to those that are critical to the coronial process, including death investigation, respect and care for families, and the jurisdiction's systemic focus and preventative role
- ensure that coroners consult and engage families during the coronial process having regard to the distressing nature of a death to family and friends
- ensure that coroners respect differing cultural and religious beliefs and practices surrounding a person's death
- recognise the therapeutic nature of the jurisdiction and the need for processes to be sensitive to and supportive of the trauma and distress experienced by family members and others
- recognise the unique status and needs of First Nations families
- contribute to the reduction in the number of preventable deaths and fires through considering systemic factors and issues and making recommendations
- explicitly state that an object of the coronial jurisdiction is to be inquisitorial in nature
- ensure the coronial system operates in a fair and efficient manner and avoids unnecessary duplication of investigations, inquests and inquiries
- ensure that coroners balance the public interest in protecting a living or deceased person's personal or health information against the public interest in the legitimate use of that information
- ensure the dignity of the deceased person is respected
- ensure costs are minimised for all involved in the process.

Under the *Coroners Act 2008* (Vic), most of the additional objects suggested by stakeholders are similarly provided for in either the purposes and objectives clause or a set of factors to be considered when exercising functions under that Act.[6]

The Select Committee also recommended that the NSW Government review and propose amendments to the objects of the Act to ensure that they reflect the key functions of modern coronial practice, including the therapeutic and restorative aspects of the jurisdiction and an express reference to the object of preventing future deaths (recommendation 10).

Amendments to the objects clause

We agree that the objects of the Act should reflect modern coronial practice and that the objects clause should reflect the objects that are most central and critical to the coronial process. These are principally the investigation of certain deaths, fires and explosions, and processes that recognise and respect the needs of families and others (including the needs of Aboriginal and Torres Strait Islander peoples).

With this in mind, we recommend s. 3 be amended to recognise the importance of the following:

- the coronial jurisdiction investigates certain kinds of deaths and certain kinds of fires and explosions

[6] See example, sections 1(c), 1(d), 7 and 9; and 8 (a), 8(c) and 8 (e) of the *Coroners Act 2008* (Vic).

- the processes adopted by the coronial jurisdiction should be sensitive to and supportive of the trauma and distress experienced by family members and other persons involved in the coronial process
- the processes adopted by the coronial jurisdiction should be culturally safe and responsive, and respectful of different beliefs and practices
- recognise the unique status and needs of Aboriginal and Torres Strait Islander peoples
- the coronial jurisdiction should contribute to the reduction in the number of preventable deaths, fires and explosions by considering systemic factors and issues and making recommendations
- the coronial jurisdiction should be inquisitorial in nature
- the coronial system should operate in a fair and efficient manner
- the coronial jurisdiction should avoid unnecessary duplication of investigations, inquests and inquiries, and seek to expedite those processes.

These amendments to the objects will better reflect the purpose of the Act and its principal objectives, clarify its systemic focus, therapeutic processes and practices, and provide important guidance as to its proper administration and interpretation.

Recommendation 2

That the objects clause of the Act be amended to recognise the importance of the following objects:

a) the coronial jurisdiction investigates certain kinds of deaths and certain kinds of fires and explosions

b) the processes adopted by the coronial jurisdiction should be sensitive to and supportive of trauma and distress

c) the processes adopted by the coronial jurisdiction should be culturally safe and responsive, and respectful of different beliefs and practices

d) the unique status and needs of Aboriginal and Torres Strait Islander peoples

e) the coronial jurisdiction should contribute to the reduction in the number of preventable deaths, fires and explosions by considering systemic factors and issues and making recommendations

f) the coronial jurisdiction should be inquisitorial in nature

g) the coronial system should operate in a fair and efficient manner

h) the coronial jurisdiction should avoid unnecessary duplication of investigations, inquests and inquiries, and seek to expedite those processes.

Factors to be considered

While there is merit to all the objects suggested by stakeholders, not all are appropriate for an objects clause. They do not go to the heart of what the Act is aiming to achieve but establish a number of important factors that should guide the exercise of functions under the Act. On this basis, we recommend the creation of a separate set of factors to be considered when exercising functions under the Act, similar to that provided in the *Coroners Act 2008* (Vic).

Section 8 of the *Coroners Act 2008* (Vic) provides:

> **'8 Factors to consider for the purposes of this Act**
> When exercising a function under this Act, a person should have regard, as far as possible in the circumstances, to the following—
> (a) that the death of a family member, friend or community member is distressing, and distressed persons may require referral for professional support or other support;
> (b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;
> (c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
> (d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;
> (e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;
> (f) the desirability of promoting public health and safety and the administration of justice.'

The primary obligation of coroners and other people exercising functions under the Act is to fulfil their functions in relation to the investigation of deaths, fires and explosions. However, there are a variety of discretionary decisions made by coroners and other persons under the Act for which a flexible set of factors could be a useful mechanism for ensuring the Act's other policy objectives are adhered to. In targeted consultation, all stakeholders supported adopting the Victorian model in the Act. Similar to Victoria, persons operating under the Act should be required to consider the prescribed factors when exercising functions under the Act, as far as possible in the circumstances.

An additional factor suggested by stakeholders is aimed at ensuring the costs incurred by persons involved in coronial investigations or proceedings are considered. This factor would not be considered in isolation: it is one of eight proposed factors. Any consideration of the factors would also be in the context of the objects in s. 3, including the new object to avoid the unnecessary duplication of investigations, inquiries and inquests. Therefore, we recommend including a prescribed factor that requires persons operating under the Act to consider the costs incurred by persons involved in coronial investigations or proceedings.

Although procedural fairness applies to the coronial jurisdiction under common law, some stakeholders submitted that the Act should be amended to specifically provide for it, in particular to put in place mechanisms to ensure procedural fairness is provided to persons in all stages of the coronial process. We agree with this and consider it appropriate to require all persons operating under the Act to consider procedural fairness.

Recommendation 3

That the Act be amended to prescribe factors a person should consider, as far as possible in the circumstances, when exercising a function under the Act as follows:

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

Supporting principles for coronial proceedings

Certain stakeholders raised concerns about an increase in the 'civil litigiousness' and complexity in the conduct of coronial proceedings. Examples given included an increase in coroners coordinating multi-disciplinary inquiries involving numerous witnesses, coronial proceedings being treated as a 'pre-litigation test run' to establish issues of liability that do not relate to the manner and cause of the subject death, and the strict reliance on rules of evidence.

However, the coronial jurisdiction is inquisitorial in nature and the rules of evidence do not apply. Section 58 of the Act expressly provides that a coroner is not bound to observe the rules of procedure and evidence applicable to proceedings before a court of law.

Recommendation 2 includes an amendment to s. 3 to expressly state that an objective of the coronial process is to be inquisitorial in nature. In addition to this, we recommend a further amendment to the Act to provide for coronial proceedings to be conducted with as little formality and technicality as the interests of justice permit, and with as little emphasis on an adversarial approach as possible. Such an amendment should be located with provisions relating to coronial proceedings, which are contained in Chapter 6.

Similar provisions exist in s. 65 of the *Coroners Act 2008* (Vic) and s. 17 of the *Independent Commission Against Corruption Act 1988* (NSW). This would be supported by Recommendation 3 above, which provides for procedural fairness to be afforded to persons involved in all stages of the coronial process.

Recommendation 4

That the Act be amended to provide that coronial proceedings should be conducted with as little formality and technicality as the interests of justice (including procedural fairness) permit and, as far as possible in the circumstances, in a non-adversarial manner.

3.2 Structure and framework of the Act

Many experienced coroners and practitioners experience difficulties navigating the Act and finding key provisions. This may be attributable to the fact that the Act:

- does not represent the sequential order of the coronial process
- is framed by reference to the holding of inquests and does not recognise the prominence of the investigation phase in the coronial process.

We recommend the structure of the Act be amended to better represent the sequential order of the coronial process:

- preliminary matters: commencement date, the objects of the Act, reference to the dictionary
- reportable deaths: defining 'reportable deaths', including the location of those deaths
- obligation to report
- coroners' jurisdiction to investigate
- post-mortem examinations, orders and objections
- powers of investigation
- findings
- inquests and inquiries
- fresh inquests and inquiries, and reviews
- access to coronial documents and physical evidence
- appointment of the State Coroner, Deputies, Coroners, and administration
- miscellaneous.

The Act should also recognise the pre-inquest investigation phase of the coronial process and be framed accordingly. An overwhelming majority of matters are finalised without going to inquest. In the period from 2019 to 2022, about 1.6% of deaths and fires reported to the coroner were closed by findings at inquest or inquiry.[7]

In many situations, investigations provide coroners with the information they need to decide whether to finalise a matter without inquest. For example, to determine that a death falls outside of jurisdiction (i.e. that it is not a 'reportable death') or that an inquest should be dispensed with.[8]

[7] This is an average figure calculated from the total inquests and inquiries into deaths and fires closed by findings over the calendar years 2019 to 2022 (inclusive), as per the Local Court of New South Wales Annual Review 2022 https://www.localcourt.nsw.gov.au/publications/annual-reviews.html.

[8] Section 27 of the Act lists the circumstances under which an inquest must be held.

The important role that investigations play outside of the inquest process is not recognised in the Act. In particular, provisions establishing the coronial jurisdiction set out in Chapter 3 of the Act are framed by reference to the holding of inquests and do not recognise the need to investigate in order to establish jurisdiction or to decide whether or not to dispense with an inquest. This is misleading and should be clarified to recognise that coroners may hold investigations and exercise investigatory powers pre-inquest for the purpose of determining whether a death is 'reportable'.

As the Act presents the legislative framework of the coronial jurisdiction, these amendments would create a clearer and more cohesive legislative framework to assist coroners, legal practitioners, and members of the public.

Recommendation 5

That the Act be amended so that:

a) its structure represents the sequential order of the coronial process and expressly recognises the functions of investigations pre-inquest and pre-inquiry

b) the functions of investigations pre-inquest and pre-inquiry are clarified so that coroners may exercise investigatory powers to the extent necessary to determine whether a death is 'reportable'.

4. The preventative role of the coronial jurisdiction

The coronial jurisdiction carries out an important function to ensure that sudden, unexpected, or unexplained deaths are properly investigated. Coronial investigations can also contribute to improved public safety, and a reduction in preventable deaths. Coroners have broad powers to make recommendations to address systemic issues connected with a death, including public health and safety, and any other issues considered necessary or desirable.[9] This Review makes several recommendations to strengthen the preventative role of the coronial jurisdiction by:

- highlighting the reduction of preventable deaths and enhancement of public safety as an object that is central to the coronial process (recommendation 2)
- requiring those exercising functions under the Act to consider the promotion of public health and safety and the administration of justice (recommendation 3)
- requiring coroners to consider whether there are any issues of public health or safety to address and whether there are any care or treatment issues that contributed to the death, among other factors, when exercising their discretion to hold an inquest (recommendation 12)
- requiring that government and non-government entities to respond to coronial recommendations within six months of receipt, and that responses should outline any actions taken to implement recommendations or if no action is being taken the reasons why (recommendation 40).

The Domestic Violence Death Review Team (**DVDRT**) established under Chapter 9A also carries out a preventative function with a focus on deaths occurring in the context of family violence. The DVDRT undertakes reviews of closed cases of domestic violence deaths to identify patterns and trends and make recommendations to prevent or reduce the likelihood of such deaths.[10] The DVDRT is required to report every two years on domestic violence deaths reviewed and set out systemic and procedural failures identified, recommendations to reduce the likelihood of such deaths and the extent to which previous recommendations have been accepted.[11] These reports are tabled in the NSW Parliament and made publicly available.[12] This Report makes a further recommendation to improve the capacity of the DVDRT to undertake its functions that is detailed below.

The Select Committee recommended that the preventative capacity of the coronial jurisdiction be strengthened by introducing a specialist preventative death review unit (recommendation 16). It recommended that this unit be modelled on the Coroners Prevention Unit in the Coroners Court of Victoria, and that it expands on the processes of the DVDRT to a broader range of reported deaths. The Select Committee also

[9] Section 82, Coroners Act 2009 (NSW).
[10] Section 101F, *Coroners Act 2009* (NSW).
[11] Section 101J, Coroners Act 2009 (NSW).
[12] Section 101K, *Coroners Act 2009* (NSW).

recommended that the membership of the DVDRT be expanded to include more non-government service providers (recommendation 17).

The Department is undertaking work to consider the operational and funding implications of establishing a Coroners Prevention Unit within the coronial jurisdiction. Alongside this ongoing work, the Department will also continue to consider opportunities to strengthen the role, functions, and structure of the DVDRT.

4.1 Definition of domestic violence death

In its 2017-2019 report, the DVDRT recommended that the NSW Government amend the definition of a 'domestic violence death' in s 101B of the Act to 'a death which occurs in the context of domestic violence' and that the reference to domestic relationship should be omitted (recommendation 33).[13]

Section 101B(1) of the Act defines 'domestic violence death' as the death of a person caused directly or indirectly by a person (the perpetrator) where, at the time of the death:

- the deceased person was in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- the deceased person was in a domestic relationship with a person who was or had been in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- the perpetrator mistakenly believed that the deceased person was in a domestic relationship with a person who was or had been in a domestic relationship with the perpetrator and the death occurred in the context of domestic violence, or
- the deceased person was a witness to or present at, or attempted to intervene in, domestic violence between the perpetrator and a person who was or had been in a domestic relationship with the perpetrator.

A domestic relationship in the Act has the same meaning as in s. 5 of the *Crimes (Domestic and Personal Violence) Act 2007.*[14]

The DVDRT provided examples of the types of cases they have reviewed that may, on a strict interpretation, not fit within this definition but which have occurred in the context of domestic violence:

- the death of a perpetrator killed by police while intervening in a domestic violence episode
- the death of a victim where there is a history of domestic violence and evidence of physical assault but no official finding of homicide, for example due to issues of causation related to the victim's intoxication, health issues, or multiple persons being involved
- deaths of perpetrators by suicide, in circumstances where there is no other associated domestic violence related death.

[13] NSW Domestic Violence Death Review Team Report 2017-2019 https://www.coroners.nsw.gov.au/resources/domestic-violence-death-review.html pp 149-150
[14] *Coroners Act 2009 (NSW)* s 101B(1).

Most stakeholders consulted supported broadening the definition of 'domestic violence death' in s. 101B to enable to the DVDRT to examine certain deaths which occur in the context of domestic violence but may fall outside the current definition.

We agree that the definition in s. 101B requires broadening and consider that the DVDRT requires more flexibility to determine what constitutes a 'domestic violence death'. The DVDRT has significant expertise on domestic violence to inform such an assessment and ensure only appropriate and relevant cases are reviewed. Most stakeholders also supported giving the DVDRT greater flexibility to determine whether a death constitutes a 'domestic violence death.'

We recommend that the definition of 'domestic violence death' in s. 101B of the Act be amended to include any death occurring in the context of domestic violence, including as determined by the DVDRT. It is also recommended that the DVDRT be required to develop and publish guidelines for when a death is considered to have occurred in the context of domestic violence to promote transparency and consistency.

Recommendation 6

That the definition of domestic violence death in s. 101B of the Act be amended to:

a) include any death occurring in the context of domestic violence, including as determined by the Domestic Death Review Team

b) require the Domestic Death Review Team to develop and publish guidelines for what constitutes a domestic violence death.

5. The coronial jurisdiction

Coroners are not required to investigate all deaths. Their jurisdiction is limited to deaths referred to in a range of provisions spread throughout the Act. This section of the Report recommends amending the Act to improve clarity over the issue of jurisdiction by:

- ensuring all provisions establishing the coronial jurisdiction are located in one place
- simplifying common terminology by defining 'death' to include 'suspected death' (i.e. missing persons or where a body has not been found)
- removing ambiguity for deaths that were 'not the reasonably expected outcome of a health-related procedure'
- removing uncertainty around the requirement for mandatory inquests for:
    - deaths following involuntary admission and detention in mental health facilities
    - deaths in the custody of and as a result of operations associated with Commonwealth agencies.

5.1 Legislative provisions establishing jurisdiction

Coroners have jurisdiction to investigate types of deaths that are prescribed in various Chapters and Parts under the Act. These are:

- reportable deaths defined under s. 6
- deaths that occurred in circumstances under Division 2 of Part 3.2
- deaths that are subject to mandatory inquests under s. 27.

These categories of deaths are not mutually exclusive, and one type of death may fall within one or more of these categories of deaths. These categories of deaths are outlined below.

Reportable deaths

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

Reportable deaths are:

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

The definition of reportable death under s. 6 was amended in January 2020 to repeal the requirement to report a death of a person who had not been treated by a medical practitioner within six months of their death. This amendment followed a recommendation of the Taskforce. It sought to reduce the number of natural cause death referrals to the coroner, thereby enabling the coronial system to focus on deaths that warrant investigation.

Inquests that must be conducted by senior coroners

Only a senior coroner can hold an inquest into the following deaths under Division 2 of Part 3.2:

- deaths in custody or police operations as prescribed under s. 23
- deaths of children and disabled persons in circumstances prescribed under s. 24.[15]

Mandatory inquests

A coroner (or, where required, a senior coroner) is required to hold inquests (i.e. mandatory inquests) in the following circumstances under s. 27 of the Act:

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

Deaths in custody under s. 23 include deaths where it appears, or where there is reasonable cause to suspect, the person has died while:

- in custody of the police
- in 'other lawful custody' (e.g. in a correctional facility, a youth justice centre, or an immigration detention centre)[16]
- on 'weekend leave' from detention at their family home (if it involves the death of a young person).

The scope of deaths in custody includes deaths that occur while the person was being transported to or from, temporarily absent from, and attempting to escape from such custody.[17]

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

- all deaths in custody be required to be the subject of a coronial inquiry that culminates in a formal inquest and such inquests should be conducted in public hearings 'unless there are compelling reasons to justify a different approach'; and
- a coroner inquiring into a death in custody must investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased person prior to death.[18]

Since the Royal Commission, the definition of a death in custody has been expanded to cover situations in which a person dies during an attempt to escape custody or during a police operation. This expansion was to provide for a mandatory inquest into all cases in

[15] The State Coroner and Deputy State Coroners are senior coroners: s. 22(2) of the Act.
[16] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [23.3 to 23.7].
[17] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [23.3].
[18] Recommendations of the Royal Commission into Aboriginal Deaths in Custody (1991), p 2.

which police or correctional staff are involved, codifying coronial practice and to satisfy concerns raised by the Royal Commission.[19]

Reporting deaths where a person died of unascertained natural causes

Currently, medical practitioners may issue a Medical Certificate of Cause of Death (**MCCD**) if they are 'comfortably satisfied' as to the likely underlying cause of a natural death. In these cases, the death is not required to be reported to the coroner. In some circumstances a practitioner should not issue a MCCD, and instead, the death should be reported to a coroner.

Medical practitioners are not permitted to issue a MCCD where they are satisfied that a person died of natural causes but are unable to determine a precise cause of death due to the presence of multiple potentially fatal conditions.

The Taskforce found that this contributes to the overreporting of natural cause deaths. The Taskforce reported that natural cause deaths account for approximately 60% of deaths reported each year.[20] It is estimated that approximately 5% of deaths reported each year are natural cause deaths where medical practitioners were unable to determine a precise cause of death.[21] The Taskforce proposed amending the Act to give medical practitioners discretion to issue MCCDs for unascertained natural cause deaths, subject to the views of any relative of the deceased. Under the proposal, a medical practitioner would still have discretion to report a death to a coroner, for example if they considered that some issue warranted further investigation.

During consultation, stakeholders raised concerns in relation to this recommendation, including that it may hinder the detection of cases where a death resulted from deliberate medical actions or negligence or may reduce investigations into natural cause deaths that are preventable (e.g. where quality of care and treatment issues may have contributed to a death). Accordingly, the recommendation includes additional criteria that need to be met to ensure medical practitioners have considered such factors and are satisfied that no such issues exist in relation to the death when issuing the MCCD.

Stakeholders raised further concerns that medical practitioners, such as GPs, would still be reluctant to issue MCCDs for unascertained natural cause deaths. The Taskforce had undertaken data analysis to better understand the reasons why GPs may be reluctant to issue a MCCD. Commonly reported reasons included that the GP:

- believed the patient's pre-existing conditions would not have resulted in death
- was unfamiliar with the patient due to infrequent attendance
- had not seen the patient recently or they were uncertain about the precise cause of death.[22]

[19] Second Reading Speech to the Coroners (Amendment) Bill 1993, Legislative Assembly, Mr Merton (Minister for Justice, and Minister for Emergency Services), 21 April 1993.
[20] Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce, October 2021, p 11.
[21] There were data limitations in estimating this number, but it is the best estimate available.
[22] Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce, October 2021, p 11.

Stakeholders advised that medical practitioners may be more inclined to issue a MCCD for unascertained natural cause deaths if there was an age restriction (in the same way that s. 38 allows a MCCD to be issued if a person aged 72 years old or older dies from an injury from an accident attributable to the age of that person (e.g. a fall)). However, it was considered that there would still be benefits for retaining the same provision for forensic pathologists without an age restriction to further support the diversion of appropriate natural cause deaths from the coronial system.

The Review supports the Taskforce's proposal with additional criteria that must be satisfied. Amending the Act in the way suggested would reduce the overreporting of natural cause deaths. This may assist grieving families who would not have to await the outcome of coronial processes where it is apparent the deceased died as a result of natural causes. Diverting natural cause deaths from entering the coronial pathway will also enable resources to focus on deaths which warrant coronial scrutiny, for example unnatural, violent or suspicious deaths.

Recommendation 7

That the relevant Acts be amended to:

a) give medical practitioners discretion to issue a medical certificate of cause of death for certain unascertained natural cause deaths provided the medical practitioner is satisfied:
    i. that the person died of natural causes (whether or not the precise cause of death is known)
    ii. that there are no issues of care or treatment that contributed to the death
    iii. there are no apparent suspicious circumstances
    iv. at the time of making a decision, there is no known objection by a family member; and
    v. the person was aged 72 years or older.

b) give forensic pathologists discretion to issue a medical certificate of cause of death for certain unascertained natural cause deaths provided the forensic pathologist is satisfied:
    i. that the person died of natural causes (whether or not the precise cause of death is known)
    ii. that there are no issues of care or treatment that contributed to the death
    iii. there are no apparent suspicious circumstances; and
    iv. at the time of making a decision, there is no known objection by a family member.

5.2 Consolidating the jurisdiction over deaths

Provisions outlining the scope of the coronial jurisdiction over certain deaths are scattered in various Chapters and Parts under the Act. For example, the categories of deaths within the coronial jurisdiction are defined in separate provisions under ss. 6, 23, 24 and 27 of the Act (outlined above). In addition, s. 18 requires that these deaths must also have a connection with the State in order to be within jurisdiction.

The definition of 'reportable death' in s. 6 only lists some of the deaths that fall within the coronial jurisdiction. To improve clarity, we recommend that the definition of 'reportable death' should encompass all categories of death within the coronial jurisdiction. This would not expand jurisdiction under the Act or place a greater burden on those who are required to report deaths. It would merely improve readability of the legislation by centralising all categories of deaths within the coronial jurisdiction in one provision in the Act.

Consolidating the provisions outlining the coronial jurisdiction over deaths would further support the policy objective of providing a more cohesive legislative framework and provide greater clarity around the interpretation of the Act. We recommend that all provisions establishing the framework for coronial jurisdiction should be located together.

Recommendation 8

That the Act be amended to:

a) list the categories of all deaths within the coronial jurisdiction as 'reportable deaths' under s. 6

b) consolidate the provisions outlining the deaths within the coronial jurisdiction in a single place in the Act, including the requisite connection with NSW.

5.3 Defining 'deaths' to include 'suspected deaths'

Coroners have jurisdiction to investigate 'suspected deaths': that is, cases of missing persons or where a body has not been found. References to 'suspected deaths' are scattered throughout the Act, usually following references to 'deaths'. However, this is done in an ad hoc and inconsistent way.

There is no reason to distinguish between the jurisdiction that applies to deaths and suspected deaths. In some cases, investigations into suspected deaths may become an investigation into a death once a body has been found. In addition, the coronial factors and objectives applicable to deaths apply equally to suspected deaths. We recommend that the definition of 'death' include 'suspected death' to ensure a consistent approach is taken in relation to suspected deaths throughout the Act. Simplifying common terminology would enhance the Act's clarity and accessibility and prevent any unintended drafting errors and inconsistencies.

Recommendation 9

That the Act be amended to define 'death' to include 'suspected death'.

5.4 Clarifying the categories of deaths

Deaths following involuntary admission and detention in mental health facilities

It is unclear if deaths that occur following involuntary admission and detention in mental health facilities are deaths arising in 'other lawful custody' under s. 23 and therefore subject to a mandatory inquest under s. 27.

In NSW a person can be subject to involuntary admission and detention in mental health facilities under the following Acts:

- *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW)
- *Mental Health Act 2007* (NSW)
- *Crimes Act 1914* (Cth).[23]

A public health order under the *Public Health Act 2010* (NSW) may also provide that a person be detained in a specified place.[24]

Consulted stakeholders supported clarifying whether deaths following involuntary admission and detention in mental health facilities fall under s. 23, and most supported that such deaths should be subject to inquest in some or all circumstances. We agree this requires clarification and also consider that deaths that occur following involuntary admission and detention under the relevant Acts listed above should be subject to appropriate oversight by the coronial jurisdiction.

To that end, we recommend that the Act be amended to require inquests for such deaths, unless the coroner is satisfied the person died of natural causes and there are no issues of care or treatment that contributed to the death. This is similar to the approach taken in Victoria and Queensland. In Victoria, an inquest into a death must be held where the deceased was, immediately before death, a person placed in custody or care, unless the coroner considers the death was due to natural causes.[25] In Queensland, an inquest must be held into a death in care in circumstances that raise issues about the deceased person's care.[26]

[23] See sections 20BC(2), 20BJ and 20BS, *Crimes Act 1914* (Cth).
[24] Section 62(4) *Public Health Act 2010* (NSW).
[25] Section 52(2)(b) *Coroners Act 2008* (Vic).
[26] Section 27(1)(a) *Coroners Act 2003* (Qld).

Recommendation 10

That the Act be amended to require inquests for deaths that occur following involuntary admission and detention:

a) in mental health facilities under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* (NSW), *Mental Health Act 2007* (NSW), or *Crimes Act 1914* (Cth); or

b) under the *Public Health Act 2010* (NSW)

unless the coroner is satisfied that:

a) the person died of natural causes (whether or not the precise cause of death is known); and

b) there are no issues of care or treatment that contributed to the death.

Deaths in custody and police operations associated with Commonwealth agencies

Section 23 provides that a senior coroner has jurisdiction to hold an inquest into deaths in custody or as a result of police operations but does not expressly prescribe for deaths in these circumstances associated with Commonwealth agencies (for example, deaths in the custody of federal police).

Section 12 of the *Interpretation Act 1987* (NSW) provides a reference to an officer, office or statutory body in any NSW Act is a reference to such an officer, office, or statutory body in and for NSW. However, s. 18 provides that coroners have jurisdiction in regard to deaths with the requisite connection with NSW in the following ways:

- the remains of the person are in NSW, or
- the death or suspected death or cause of the death or of the suspected death occurred in NSW, or
- the death or suspected death occurred outside NSW, but the person had a sufficient connection with NSW, that is:
    - at the time of the death or suspected death, the person ordinarily resided in NSW or was in the course of a journey to or from some place in NSW, or
    - the person was last at some place in NSW before the circumstances of his or her death or suspected death arose.

The requisite connection to NSW is particularly broad. It is therefore unclear whether deaths in custody or as a result of police operations also include deaths occurring in such circumstances when associated with Commonwealth agencies.

The rationale for mandatory inquests for deaths in lawful custody or as a result of police operations associated with NSW agencies applies equally to deaths associated with Commonwealth agencies, especially given there is no Commonwealth coroner. Although this is how the Act has been interpreted in practice, there is benefit in removing any doubt by clarifying the scope of the provision. Relevant Commonwealth agencies were consulted and supported this recommendation.

Recommendation 11

That the Act be amended to clarify that jurisdiction under s. 23 includes deaths as a result of police operations or in lawful custody associated with Commonwealth agencies.

6. The coronial framework

This section of the Report is concerned with those parts of the Act that are central to the coronial framework. It focuses on:

- the processes of the coronial investigation phase and when to hold inquests
- the role of families of the deceased person in the coronial process and identifying the senior next of kin
- the processes for dealing with the deceased person's body.

The recommendations contained within this section of the Report are focused on ensuring the coronial framework is consistent with the Act's policy objectives and reflects and improves upon current practice. In summary, they recommend:

- replacing the discretion to dispense with an inquest with a discretion to hold an inquest where it is in the public interest
- increasing transparency, and formalising and improving upon the investigation phase of the coronial process by:
    - requiring coroners to consider prescribed factors when deciding whether or not to hold an inquest (including the views of the deceased person's family and any requests made for an inquest to be held)
    - providing coroners with the discretion to issue a 'Coronial Certificate' for natural cause deaths to finalise a matter where there is no need for further investigation and the family does not object to the issuing of the certificate
    - providing coroners with the discretion to issue findings without inquest for deaths that require some investigation to determine the cause and manner of death, but do not require an inquest
- revising the criteria for mandatory inquests to ensure resources are devoted to those matters of greatest public importance
- revising the process for determining who is the senior next of kin by recognising cultural differences in familial structures and enabling competing claims to be made
- improving and clarifying processes for dealing with the deceased person's body
- enhancing access to justice by providing families with the right to request that the State Coroner direct that a death is a reportable death or that an inquest or inquiry should be held
- clarifying the process for fresh inquests and inquiries, and concurrent inquests.

6.1 Change to the coronial process: inquests

The first stage of the coronial process after a death is reported to a coroner is an investigation. The Act gives greater emphasis to the inquest process than to the role that investigations play in determining the date, place, cause, and manner of death. This is

despite the fact that, in the period from 2019 to 2022, about 1.6% of deaths and fires reported to the coroner were closed by findings at inquest or inquiry.[27]

There is currently no process in the Act to guide finalising the investigation process and there is no legislative requirement to give families information arising out of the coronial process about the death of their loved one at the completion of an investigation. Where a decision is made to dispense with an inquest, reasons for dispensing with the inquest are only given to families of the deceased person upon request.

The recommendations that follow are aimed at promoting greater transparency and consistent decision-making in relation to the outcome of investigations and whether or not matters proceed to inquest.

The current process

Coroners must investigate all deaths within their jurisdiction. Section 35 sets out the obligation on persons to report these deaths to the coronial jurisdiction. Despite the large number of deaths that are reported to NSW coroners each year, only a very small proportion of those deaths proceed to an inquest. This is not unique to NSW but occurs in all Australian jurisdictions.

The framework for holding inquests is set out in Chapter 3, Part 3.2 of the Act. Except for mandatory inquests, a coroner has a general discretion to dispense with an inquest under s. 25 of the Act. In practice, coroners will generally dispense with an inquest if following their initial investigation: the identity, date, place, cause, and manner of death are clear; there are no issues of public health or safety to address; there are no suspicious circumstances; and no compelling request for an inquest has been made by the deceased.

Section 25(2) provides a specific scenario where inquests may be dispensed with where the coroner is satisfied the death was a result of natural causes and the senior next of kin does not require an examination of the deceased person's body. In this situation, inquests may be dispensed with irrespective of whether the precise cause of death is known and provided the required consultation has occurred.

The Act sets out specific deaths for which an inquest is mandatory at s. 27. They are:

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

Discretion to hold an inquest, rather than dispense with an inquest

Providing a discretion to dispense with an inquest implies that conducting inquests is the norm, creating a common misunderstanding around the coronial process and an expectation that an inquest will be held. This is inconsistent with what happens in practice. The framework is also unhelpful as it means that principal case management decisions are framed in the negative.

[27] This is an average figure calculated from the total inquests and inquiries into deaths and fires closed by findings over the calendar years 2019 to 2022 (inclusive), as per the Local Court of New South Wales Annual Review 2022 https://www.localcourt.nsw.gov.au/publications/annual-reviews.html.

NSW and the Australian Capital Territory are the only Australian jurisdictions to provide for a general discretion to dispense with an inquest.[28] In all other jurisdictions, the relevant coronial legislation provides for a general discretion to hold an inquest (other than for mandatory inquests).[29]

Consistent with the approach taken elsewhere in Australia and as a means of overcoming the issues identified above, we recommend that there should be a general discretion to hold an inquest where there is a legitimate forensic or policy purpose to do so. These purposes include where an inquest is necessary to:

- resolve factual uncertainties about the cause and manner of death
- resolve differences among the opinions of relevant experts
- explore possible changes to improve public health and safety and formulate the appropriate recommendations.

We agree that the framework should be modernised and more appropriately reflect what occurs in practice, as outlined below.

New framework

We recommend amending the coronial framework, so that following an investigation, coroners would decide whether to hold an inquest rather than whether to dispense with an inquest. In making that decision, coroners would determine whether there is a public interest in holding an inquest by considering, but without being limited to, the following prescribed factors:

- whether the identity, date, place, cause, and manner of death is sufficiently disclosed
- whether the person died of natural causes (whether or not the precise cause of death is known)
- whether the circumstances raise any issues about the deceased person's care or treatment that contributed to the death
- whether there are any issues of public health or safety to address
- whether there are any suspicious circumstances
- whether holding an inquest is likely to provide additional information
- the views of the deceased person's family, if known
- any request made by persons with sufficient interest in the circumstances of the death for an inquest to be held.

Those factors are substantively the same factors coroners currently consider when dispensing with an inquest under s. 25, but for providing for persons with sufficient interest in the circumstances of the death to make requests for an inquest to be held and requiring coroners to consider those requests in exercising their discretion, which is a new factor. This would ensure that any such persons are afforded the opportunity to outline to the coroner why they consider an inquest should be held. Regulations would stipulate the process for

[28] See section 34A, *Coroners Act 1997* (ACT)
[29] Section 28 of the *Coroners Act 2003* (Qld), s. 15 of the *Coroners Act 1993* (NT), s. 52 of the *Coroners Act 2008* (Vic), s. 21 of the *Coroners Act 2003* (SA), s. 24 of the *Coroners Act 1996* (WA), and s. 24 of the *Coroners Act 1995* (TAS).

making those requests as a means of providing further rigour to the process, particularly in relation to timeframes.

Under this new framework, the coroner must give written reasons for deciding that an inquest will not be held if requested by the State Coroner, the Minister, the senior next of kin or any person who, in the opinion of the coroner, has a sufficient interest in the circumstances of the death. This is consistent with the requirements under s. 26 in relation to the coroner's written reasons for dispensing with an inquest.

The new framework reformulates the decision about whether to hold an inquest in the positive, and does not dilute any existing safeguards to ensure deaths are properly investigated. It also brings NSW into line with other Australian jurisdictions.

This framework better reflects current practice and will provide greater transparency and accessibility. It provides better guidance for determining those matters where inquests should be held, and places greater emphasis on this process.

Under this framework, families would not be required to request inquests. However, the option of making such a request would be open to them if they wished to do so. Their views on whether an inquest should be held, if known, would be considered by the coroner.

This new framework is supported by Recommendation 13 and Recommendation 26, which aim to further increase transparency and promote the involvement of families in the coronial process (see below).

Recommendation 12

That the Act be amended to provide:

a) coroners with a general discretion to hold, rather than dispense with, an inquest if there is a public interest in holding an inquest

b) the factors coroners must consider in exercising that discretion, to include:

i. whether the identity, date, place, cause or manner of death is sufficiently disclosed

ii. whether the person died of natural causes (whether or not the precise cause of death is known)

iii. whether the circumstances raise any issues about the deceased person's care or treatment that contributed to the death

iv. whether there are any issues of public health or safety to address

v. whether there are any suspicious circumstances

vi. whether holding an inquest is likely to provide additional information

vii. the views of the deceased person's family, if known

viii. any request made by persons with sufficient interest in the circumstances of the death for an inquest to be held

c) that a coroner who decides that any inquest will not be held must, if requested by the State Coroner, the Minister, the senior next of kin or any person, who in the opinion of the coroner, has a sufficient interest in the circumstances of the death, give written reasons for deciding that an inquest will not be held

d) for the Act to provide for a regulation making power, whereby regulations may stipulate a process for persons with sufficient interest in the circumstances of the death to submit a request for an inquest to be held, for the coroner to consider when exercising their discretion. Regulations may include the period of time within which a request for an inquest to be held may be made.

Mandatory inquests

Specific deaths for which inquests are mandatory under s. 27 are:

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

Inquests are a valuable tool for resolving factual issues in dispute by the testing of evidence, including through cross-examination of witnesses and experts. However, there are cases where inquests may be of minimal assistance in resolving those matters because of limited evidence. This may include matters where holding an inquest is currently mandatory. For example, it is mandatory to conduct an inquest into cases involving missing persons but, in some circumstances, it might be impossible to determine the cause and manner of the suspected death.

In some cases, a body will not be able to be located, because the person is missing, the body is lost at sea, or the body has decomposed. In such cases, the coroner's file will often disclose evidence of efforts made to locate the person but in some cases there may be limited utility in conducting an inquest, which would most likely result in inconclusive findings as to manner and cause of death.

Advocates for missing persons groups, however, have raised concerns about past proposals to not have mandatory inquests for missing persons, on the basis that inquests greatly assist the families of missing persons and often help to bring public attention to missing persons cases.

To address these issues, it is proposed to generally retain mandatory inquests for missing persons, but that s. 27 be amended to provide a senior coroner with the discretion to decide not to hold an inquest in the case of a missing person in limited circumstances – that is, when it is clear an inquest will not assist with determining whether that person has died. For the same reasons it is also recommended that s.27 be amended to remove the current requirement for mandatory inquests in cases where the evidence presented to the coroner does not sufficiently disclose the identity of the deceased person and the date and place of death, or the manner and cause of death.

To ensure resources are properly utilised, and to minimise any negative impact on families by unnecessarily extending legal proceedings, it is also recommended that the Act be further amended to provide coroners a new discretion to dispense with an inquest involving a homicide that has previously been suspended or discontinued under s. 78. If a coroner considers that the cause and manner of a death has already been sufficiently disclosed in criminal proceedings and determines that proceeding with an inquest would be futile and not in the public interest, they can decide to not continue with the inquest.

Recommendation 13

That the Act be amended to require inquests to be held only in the following circumstances:

a) if it appears to the coroner concerned that the person died or might have died as a result of homicide (not including suicide)

b) if it appears to the coroner concerned that it has not been sufficiently disclosed whether the person has died (except where a Senior Coroner considers that an inquest will not assist with determining whether that person has died)

c) if the jurisdiction to hold the inquest arises under s. 23 (i.e. deaths in custody or in police operations)

d) in the circumstances set out in recommendation 10 (involuntary detention)

e) nothing in paragraphs (a)-(d) requires a coroner to continue an inquest if that inquest has been suspended or discontinued under s. 78, and the coroner considers that:

   i. the cause and manner of death have been sufficiently disclosed in a criminal proceeding, or

   ii. after considering any relevant public interest issues, it would be futile to continue the inquest.

Finalising matters without inquest: Coronial Certificates and findings without inquest

There is no legislative power or requirement to make coronial findings in matters finalised without proceeding to an inquest. Coronial findings are only required at the conclusion (or suspension) of an inquest: s. 81(1). This means coronial findings are delivered in a very small proportion of deaths investigated by coroners.

However, in the remaining 98% of reported deaths, coroners record written reasons for dispensing with an inquest (as per the State Coroner's Circular) and written reasons are made available to persons with sufficient interest in the circumstances of the death, upon their request: s. 26.

It is proposed that that Act be amended to create a legislative basis for coroners to issue Coronial Certificates and findings without inquest in appropriate cases. These measures are intended to improve clarity, transparency and consistency in the coronial process for this 98% of reported deaths, while also balancing the need for efficiency and timeliness in the delivery of those written statements.

Coronial Certificates

In relation to Coronial Certificates, it is proposed that coroners be given the discretion to issue such written certificates where the coroner is satisfied that the person died of natural causes and finds, after considering the advice of a forensic pathologist and NSW Police Force, that there is no need for further coronial or post-mortem investigations. In the case of deaths in relevant care settings, such as in aged care or other health settings, the coroner must also consider whether any act or omission in the deceased's care or treatment contributed to the death.

The coroner is only able to issue the certificate if there is no objection from the senior next of kin.

The Certificate, which will be made available to the family, will include the relevant particulars of the death, including the person's name, date, time and place of death. It will also contain a statement that the death was due to natural causes.

Specifically providing for the issuing of Coronial Certificates for natural cause deaths will promote efficiency and reflects current practice where coroners dispense with matters under s.89(6) and s.25(3).

Findings without inquests

In relation to issuing findings without inquest, it is proposed that coroners be given the discretion to do so where:

- a Coronial Certificate has not been issued (i.e. because it is not considered appropriate to conclude the matter with a certificate)
- having regard to the advice of a forensic pathologist and the police, the coroner considers that a post-mortem, further clinical examination, or coronial investigation is required to determine the cause of death
- having regard to the outcome of those processes, the coroner considers an inquest is not required; and
- the views of the deceased person's senior next of kin have also been considered.

Findings without inquest, which will be made available to the family, will contain the relevant particulars of the death, including the person's identity, date and place of death and the manner and cause of death.

Specifically providing for the issuing of findings without inquest will promote the efficient and timely conclusion of matters. Requiring coroners to consider the views of the senior next of kin will also promote transparency and support the family's involvement in the process.

If families require further information as to why their family member's matter was finalised by issuing findings without inquest, they will also have the right to request written reasons for deciding that an inquest is not required. This will further promote transparency in the coronial process.

Recommendation 14

That the Act be amended to provide:

a) that coroners have discretion to issue a 'Coronial Certificate' where:
   i. the coroner is satisfied that the person died of natural causes (whether or not the precise cause of death is known) and considers that there is no need for further coronial investigation, clinical examination, a post-mortem or inquest
   ii. in the case of a person who died in relevant care settings, the coroner has also considered whether there are circumstances that raise any issues about the deceased person's care or treatment that contributed to the death
   iii. a forensic pathologist advises the coroner that they consider that the person died of natural causes and there is no need for a post-mortem or further clinical examination to determine the cause of death
   iv. a police officer advises the coroner that the death is not suspicious (where the death is reported by NSW Police); and
   v. there is no objection from the senior next of kin in relation to issuing a Coronial Certificate and not proceeding with any further clinical examination or coronial investigation

Recommendation 14 (continued)

b) that a Coronial Certificate should include:
   i. relevant particulars including the name of the deceased, and the date, time, and place of death
   ii. a statement that the death was due to natural causes

c) that coroners have discretion to issue findings without inquest where the coroner:
   i. has not issued a coronial certificate
   ii. having regard to advice from a forensic pathologist and police officer, considers a post-mortem, further clinical examination, or coronial investigation is needed to determine the cause of death (this may include where the person died of unnatural causes, or where the person died of natural causes but a coronial certificate is not appropriate in the circumstances)
   iii. having regard to the outcome of the post-mortem, further clinical examination, or coronial investigation, considers that an inquest is not required; and
   iv. having regard to the views expressed by a person's senior next of kin in relation to issuing findings and not proceeding with an inquest

d) that findings without inquest should include relevant particulars, including the person's identity, date and place of death, and manner and cause of death

e) that a coroner who issues findings without inquest must, if requested by the State Coroner, the Minister, the senior next of kin or any person who, in the opinion of the coroner, has a sufficient interest in the circumstances of the death, give written reasons for deciding that an inquest is not required.

6.2 Families of the deceased person in the coronial process

The Act recognises the rights and interests of family members of the deceased person in the coronial process. The term 'relative' is used to recognise the general standing of families, and the term 'senior next of kin' is used to recognise the specific standing of a spokesperson for the deceased person's family in the coronial process.

The process for determining the senior next of kin is done according to an established hierarchy under the Act. This rigid process does not consider who the most appropriate appointee is in the circumstances, nor does it reflect the varying familial and kin structures in our society based on different cultures. The recommendations that follow propose amending the process for appointing the senior next of kin to provide greater flexibility in appointing the most appropriate person.

Overview of legislative provisions

The senior next of kin is determined by their legal relationship to the deceased person and acts as a point of contact between the coroner and the deceased person's family in key coronial decisions. For example:

- for deaths that occur by natural causes, coroners are required to consult with the senior next of kin before dispensing with an inquest under s. 25(2) and dispensing with a post-mortem examination under s. 89(6)
- the senior next of kin may object to the exercise of a relevant post-mortem investigative function (i.e. the function of issuing a direction for the conduct of a post-mortem examination or authorising the retention of whole organs) under s. 96. While other persons may also object (s. 99), only the senior next of kin must be notified of any contrary decision and may apply to the Supreme Court for review of that decision under s. 97. Furthermore, only the senior next of kin is required to be notified of any order authorising the retention of whole organs under s. 90(6)
- in practice, bodies are often released to the senior next of kin at the conclusion of coronial proceedings, a practice that we recommend should become a legislative presumption.

The senior next of kin is determined in the following order of priority: the spouse (including de facto partners), adult child, parent, sibling, and named executor or legal representative of the deceased person: s. 6A. In practice, if there is more than one candidate available to be the senior next of kin (e.g. several children), the coroner will decide who the senior next of kin is.

Relatives have more general rights under the Act. For example:

- relatives can request the coroner provide reasons for dispensing with an inquest under s. 26(1)(c) and are deemed to have standing to appear in an inquest: s. 57(3)
- medical certificates that may be issued for accidental deaths of the elderly, which would otherwise be within the coronial jurisdiction and subject to a coronial investigation, may not be given if a relative objects: s. 38(3)
- regard must be had to the impact on relatives in determining whether to grant access to a coroner's file: s. 65(3)(b)
- relatives may be de-identified in any non-publication orders for suicides: s. 75(2).[30]

A 'relative' is defined as a spouse, parent, guardian, or child of the deceased person where they are adults. If there is no relative, a sibling will be considered a relative: s. 5. 'Relative' is defined differently for the making of non-publication orders in suicides and for the purpose of Chapter 9A concerning the Domestic Violence Death Review Team.[31]

Competing claims

The senior next of kin is determined by default according to a pre-determined hierarchy set out in s. 6A of the Act. The hierarchy is comprised of family members of the deceased person (in order, their spouse, adult child, parent, brother or sister), the executor of their will or their legal personal representative immediately before their death.

Unless there is more than one person of equal status in this hierarchy with competing claims to be senior next of kin (e.g. two parents or several siblings), the coroner currently has no discretion to determine that a person in the hierarchy is not appropriate to be the senior next

[30] In this context, relative is defined differently under s. 75(3).
[31] For the making of non-publication orders in suicides, a 'relative' is defined as a spouse, parent, guardian, child, or sibling of the deceased; or a person living with the deceased as their husband or wife at the time of their death: s. 75(3). A more extensive definition of 'relative' is provided under s. 101C(2) for the purpose of Ch 9A, 'Domestic Violence Death Review Team'.

of kin. This means that the coroner is required to appoint the person designated in the hierarchy, regardless of the availability or appropriateness of other persons in the hierarchy to be senior next of kin.

Stakeholders agree that this rigid hierarchy has resulted in anomalous situations. Under the hierarchy, for example, a spouse that is a person of interest in the murder of the deceased person or was long estranged from them prior to their death will be deemed to be the senior next of kin rather than the deceased person's adult child or parent, for example.

The Act also does not provide a mechanism to allow a person who evidences a sufficient connection to the deceased person but is not in the statutory hierarchy to notify the coroner of their eligibility to be considered as senior next of kin (for example, the best friend or a long-term carer of the deceased person). This means that there is no discretion for coroners to appoint such a person as senior next of kin where there is no other person in the statutory hierarchy available or appropriate.

We recommend that the definition of 'senior next of kin' retain its current hierarchy but be amended to:

- provide that, in addition to where the statutory senior next of kin is unavailable, the coroner may appoint another person in the statutory hierarchy to be senior next of kin where the statutory senior next of kin is not appropriate
- extend the statutory hierarchy to include an adult that had a relationship with the deceased person immediately before their death, such that the coroner considers them to be the most appropriate senior next of kin. This person can only be appointed when another person who sits above in the statutory hierarchy is not available or appropriate.

This proposed approach was recommended by the State Coroner and is also informed by the approach taken in Queensland.

We also recommend that the Act be amended to reflect the current practical position that coroners are required to consider competing claims to be senior next of kin between persons on the same level of the statutory hierarchy (e.g., the competing claims of parents) and to notify competing complainants of their decision. Under these arrangements, any person with a sufficient connection to the deceased person could also notify the coroner of their eligibility to be considered as senior next of kin. However, any competing claim would need to be supported by sufficient evidence to justify a deviation from the statutory hierarchy.

Under recommendation 25, families will now also be able to seek a review of a decision to appoint a senior next of kin at the Supreme Court. While some stakeholders were concerned such a dispute mechanism may delay matters, particularly given the senior next of kin's role in any order for a post-mortem examination, the need for a dispute mechanism process was supported on the basis it be undertaken in a timely manner.

A further amendment was also considered to allow more than one senior next of kin to be appointed in limited circumstances where more than one person of equal standing request to be jointly appointed. However, stakeholders raised concerns that the requirement for jointly appointed senior next of kins to make decisions unanimously might lead to difficulties and place a significant burden on families. We agree that this may be an unrealistic expectation and could lead to additional distress for families. From an operational perspective, the requirement that decisions must be made jointly and unanimously was essential to accommodate the joint appointment of senior next of kin. Following this

feedback, we do not propose to proceed with this amendment. All other jurisdictions in Australia only permit the appointment of a single senior next of kin, however, provide for competing claims to be made.

Recommendation 15

That s. 6A of the Act be amended to:

a) provide that, in addition to where the statutory senior next of kin is unavailable, the coroner can appoint an alternate senior next of kin from the statutory hierarchy where the statutory senior next of kin is not appropriate to be the senior next of kin; and
b) add to the meaning of 'senior next of kin' an adult who, immediately before the deceased person's death, had a relationship with the deceased person such that the coroner considers them to be the most appropriate senior next of kin, where the statutory senior next of kin is not available or the coroner considers that they are not appropriate to be senior next of kin in the circumstances.

Recommendation 16

That the Act be amended to:

a) allow any person with sufficient connection to the deceased person to notify the coroner of their eligibility to be considered as a senior next of kin within a reasonable timeframe
b) require coroners to:
    i. consider competing claims and communication with the default appointee in regard to such competing claims
    ii. make a decision as to who is most suitable to be senior next of kin and communicate that outcome to competing parties.

Cultural differences in familial structures

The current definitions of 'relative' and 'senior next of kin' do not recognise the varying family arrangements customary among different cultural groups.

Section 98 of the Act provides that a senior next of kin can authorise another person to exercise their functions. This power of delegation was intended to address important cultural differences by recognising the kinship and other familial relationships that exist in different cultural groups.[32] However, the power of delegation relies on willingness of the senior next of kin to delegate their authority appropriately. Therefore, we recommend amending the definitions of 'senior next of kin' and 'relative' to expressly recognise cultural differences in familial structures (including Aboriginal cultures).

Stakeholders submitted the current definition should include a reference to the concepts of extended family or traditional kinship ties that are of particular importance to Aboriginal and Torres Strait Islander cultures. Differing family arrangements customary to Aboriginal cultures are recognised in the context of Chapter 9A of the Act relating to the Domestic

[32] Second Reading Speech to the Human Tissue and Anatomy Legislation Amendment Bill (NSW), Legislative Assembly, Mr Knowles (Minister for Health), 23 October 2002, at p 5746.

Violence Death Review Team. .[33] Section 101B defines 'domestic relationship' as having the same meaning as in the *Crimes (Domestic and Personal Violence) Act* 2007. Under s. 5(1)(h) of that legislation, 'domestic relationship' is defined to include, for Aboriginal and Torres Strait Islander persons, a person who 'is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture.' However, the same is not provided for in the definition of 'relative' and 'senior next of kin' outside of Chapter 9A. For consistency throughout the Act, we agree that the definition of 'relative' and 'senior next of kin' should adopt a similar approach to that in Chapter 9A.

If the definition of 'senior next of kin' is amended to enable coroners to appoint a person other than the default appointee, cultural differences may be recognised as a consideration in the assessment of whether appointing someone other than the default appointee is appropriate in the circumstances.

Recommendation 17

That the definitions of 'relative' and 'senior next of kin' be amended to recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures).

Relatives to include the appointed senior next of kin

While the term 'relative' recognises the general standing, rights and interests of the deceased person's family, the term 'senior next of kin' recognises the specific standing of a spokesperson for the deceased persons' family in the coronial process. These different rights and interests are outlined above.

If Recommendation 14 and Recommendation 15 are adopted, the definition of 'senior next of kin' will be broadened to enable persons with sufficient connection to the deceased person to be appointed as the senior next of kin (e.g. persons who are not relatives but who may be the long-term carer or best friend of the deceased person).

This broadening of the definition of 'senior next of kin' could create an anomalous situation if the definition of 'relative' is not amended to include the senior next of kin. For example, a close friend of the deceased person may have been appointed to be the senior next of kin because the relative was determined not appropriate. The close friend may object to the exercise of a relevant post-mortem investigative function on the deceased person's body as the senior next of kin. However, the close friend would not have deemed standing to appear in the inquest (not being a relative), while the relative would have deemed standing to appear (although determined not appropriate to be the senior next of kin). We recommend that the definition of 'relative' be amended to include the appointed 'senior next of kin'.

Recommendation 18

That the definition of 'relative' be amended to include the appointed 'senior next of kin'.

6.3 Dealings with the deceased person's body

[33] Chapter 9A of the Act, 'Domestic Violence Death Review Team' was inserted in 2010 by the *Coroners Amendment (Domestic Violence Death Review Team) Act 2010.*

Post-mortem investigations are important for gathering necessary information to enable coroners to determine the date, cause and manner of death. However, this needs to be balanced against the significant impact such processes may have on the deceased person's family. Legislative provisions relating to the conduct of post-mortem investigations should:

- maintain public confidence in post-mortem examinations
- balance the community's expectations concerning the dignified and respectful treatment of deceased persons, the interests of justice and the need for ongoing medical and scientific research, teaching, and inquiry
- provide a greater role for and increase the rights of the deceased person's family in the coronial decision-making process on post-mortem examinations.

This Report makes seven recommendations that are aimed at supporting these goals.

Overview of legislative provisions

Chapter 8 of the Act outlines post-mortem investigative procedures in the coronial process, Chapter 9 outlines the authorisation required for the disposal of human remains (i.e. the release of the deceased person's body) and s. 34 requires a coroner to provide notice of particulars of a death to the Registrar of Births, Deaths and Marriages.

Under s. 88 of the Act:

- regard is to be had to the dignity of the deceased person in the conduct of a post-mortem examination or other examination or test
- persons conducting post-mortem examinations must endeavour to use the least invasive procedure appropriate in the circumstances for establishing cause and manner of death.

Section 89 of the Act then provides that a coroner may give medical investigators, such as forensic pathologists, post-mortem investigation directions if the coroner considers it is necessary or desirable for assisting in the investigation of a death. Post-mortem investigation directions include directions to conduct any one or more of the following:

- a post-mortem examination
- a special examination or test as specified in the direction
- a review of medical records (including consultations with medical practitioners involved in treating the deceased person).

In practice, a coroner consults with medical investigators in deciding what order for a post-mortem investigation direction is appropriate in a particular case. Coroners have a general power to place limitations on these directions, meaning that they may be more specific and restrictive as necessary or desirable in a particular case: s. 89(4). In a particular case, coroners may decide to dispense with a post-mortem examination under s. 89(6).

Section 88A allows a pathologist to carry out a preliminary examination in relation to the remains of a deceased person even if a post-mortem investigation direction has not been given. A 'preliminary examination' includes:

- a visual examination of the remains (including a dental examination)
- the collection and review of information
- the taking of samples of bodily fluid and the testing of those samples

- the imaging of the remains
- the taking of samples from the surface of the remains and the testing of those samples
- taking the fingerprinting of the remains
- any other procedure that is not a dissection, the removal of tissue or invasive in any other way.

This section was inserted by the *Justice Legislation Amendment Act 2019* on the recommendation of the Taskforce on Improving the Timeliness of Coronial Procedures. This section allows the coronial process to start earlier and may negate the need for an invasive procedure, enabling the deceased person to be returned to their family sooner.

Using the 'least invasive procedure' appropriate in the circumstances

It is imperative that when handling the deceased person's body, the dignity of the deceased person is respected and that the least invasive procedure appropriate in the circumstances is used. This is reflected in s. 88 of the Act.

In relation to s. 88(2), which deals with using the least invasive procedure, several anomalies and ambiguities have been identified in its operation:

- it is not clear who determines what 'the least invasive procedure available in the circumstances' should be. While s. 88(2) specifies that 'the person conducting the examination' is to determine what procedures are 'appropriate in the circumstances', the leading commentary on the Act indicates that the better view is that coroners make this determination.[34] In our view, the obligation to use the least invasive procedure should rest both on coroners making the order for post-mortem examination and the person conducting the examination
- it is not clear how much discretion medical investigators have to conduct examinations that are less invasive than the coroner's post-mortem investigation direction
- the obligation to use the 'least invasive procedure appropriate in the circumstances' only applies to 'post-mortem examinations'. However, there appears to be no reason why this restriction should not also apply to 'other tests or examinations' on a body that are less invasive than a post-mortem examination
- the obligation to use the 'least invasive procedure appropriate in the circumstances' only applies to examinations to determine the 'cause and manner of death'. However, examinations may be ordered under s. 89 for a range of reasons in connection with the 'investigation of the death' (for example, a post-mortem examination could be necessary to determine the identity of the deceased person).

We recommend amending the Act to address the above issues.

We also recommend amending the Act to require coroners to consult with medical investigators to help them decide what order for a post-mortem investigation direction is most appropriate to make in each case. While this occurs in practice, it should be expressly provided for in the Act. In exercising such functions, persons should consider and respect the differing beliefs and practices surrounding death held by different cultures and religions, as far as possible in the circumstances.

[34] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [88.3].

Recommendation 19

That the Act be amended to require that:

a) coroners:
   i. consult with medical investigators in making post-mortem investigation directions
   ii. order the least invasive post-mortem investigation direction appropriate in the circumstances
   iii. specify the type of examination required
b) medical investigators use the least invasive procedures appropriate in the circumstances (within the scope of any applicable coroner's direction and in the context of the information available at the time) for all tests and examinations.

Coronial Medical Officers

Under s. 92 of the Act, the Secretary of NSW Health may appoint medical practitioners to be Coronial Medical Officers (**CMOs**). Historically, CMOs were based in regional locations and would undertake non-suspicious post-mortem examinations at the direction of a coroner for paid remuneration.

CMOs have now ceased to exist and all post-mortem functions are carried out by Forensic and Scientific Services. It is therefore proposed that all references to CMOs be removed from the Act.

Recommendation 20

That the Act be amended to remove all references to Coronial Medical Officers.

Written notices by the senior next of kin

There is no legislative requirement for a person to provide written notice or documentation in order to establish they are the senior next of kin. However, the senior next of kin is required to provide written notice to exercise the following functions:

- to object to an exercise of a relevant post-mortem investigative function (i.e. the function of issuing a direction for the conduct of a post-mortem examination or authorising the retention of whole organs): s. 96
- to authorise another person to exercise some of their functions: s. 98.

Requirements for senior next of kin to provide written notice and documentation in the coronial process can be difficult for some groups of people. We therefore recommend that the Act be amended to allow the senior next of kin to be able to object to a relevant post-mortem investigative function under s. 96 orally or authorise another person to exercise their functions under s. 98 orally, in appropriate cases.

The presiding coroner or assistant coroner would then consider each matter on a case-by-case basis and determine whether it was appropriate for the senior next of kin to have exercised their function orally. If the coroner or assistant coroner determines it to have not been appropriate, the requirement to exercise the function in writing would apply.

Recommendation 21

That the Act be amended to allow for the senior next of kin to exercise their functions orally, including:

a) to allow for the senior next of kin to object to an exercise of a relevant post-mortem investigative function under s. 96 orally; and

b) to authorise another person to exercise their functions under s. 98 in appropriate cases orally.

Registering the death

Where an inquest is held, dispensed with or suspended, coroners are required to provide the Registrar of Births, Deaths and Marriages (**BDM**) with written notice of known particulars of the subject death to enable the registration of the death under s. 34 of the Act. Those written notices contain particulars of the death including identity, date, place, and cause of death. In practice, coroner's certificates are also issued following an order for the disposal of the body under s. 101.

Delays in proceeding to inquest or dispensing with an inquest may cause significant hardship concerning the administration of an estate. To address this, provisions are available for the early registration of deaths and for interim death certificates to be issued where there may be delay in concluding an inquest, and where the coroner is able, on the basis of such evidence as the coroner considers sufficient, to determine the particulars relating to the death of the person: s. 34(2).

Where an inquest is pending and a finding has not been made about the cause of death, such deaths may be registered by the Registrar of BDM under s. 40(2) of the *Births, Deaths and Marriages Registration Act* 1995 (NSW) (**BDM Act**), including on the basis of incomplete particulars under s. 42.

Provision for the early registration of deaths is limited. Once a coroner is satisfied of the grounds currently provided for (i.e. determines particulars of the death on sufficient evidence) coroners may only register the death if satisfied there will be a delay in concluding the inquest, and may still choose not to register the death. However, the vast majority of coronial matters conclude at the investigation stage without proceeding to inquest, and there is no reason for coroners to choose not to register deaths early in appropriate cases (once they are able to determine particulars of the death).

We therefore recommend broadening the provision so that coroners may register deaths throughout the coronial process in appropriate cases as soon as possible, rather than only where there will be delay in concluding the inquest. We also recommend making the early registration of deaths mandatory rather than discretionary. To support these changes, we also recommend making consequential amendments to ss. 38 and 40 of the BDM Act, which references these provisions.

These changes would also be supported by allowing the function of issuing interim written notices (i.e. for the early registration of deaths only) to be delegable to assistant coroners. Assistant coroners provide invaluable administrative assistance to coroners and exercise a number of functions upon delegation under s. 15. These functions include issuing orders for the disposal of the deceased person's remains, issuing post-mortem investigation directions, and dispensing with inquests for natural cause deaths. Section 49 of the *Interpretation Act*

1987 outlines the nature and scope of these delegations, which may be made to a named person or title of office and may be general or limited.

We consider the function of issuing interim written notices is similar to existing functions exercised by assistant coroners and should also be included. The BDM Act contains the following safeguards to protect the integrity of the BDM Register for any errors made in the early registration of deaths:

- provision for the Register to be corrected following a coronial finding under s. 45 of the BDM Act
- a requirement for death certificates issued before the completion of an inquest to be endorsed to reflect that fact under s. 40(3) of the BDM Act.

Recommendation 22

That the Act be amended so that the provision for coroners to issue written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths in appropriate cases under s. 34(2) (i.e. once coroners are able to determine particulars of the death) be:

a) a requirement

b) effected as soon as possible throughout the coronial process.

Recommendation 23

That the Act be amended to prescribe the function of issuing written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths, as one that may be delegated to assistant coroners under s. 15.

Release of the body or remains

Section 101 of the Act provides a coroner with authority to make orders disposing of human remains (i.e. releasing the deceased person's body). However, the provision does not provide guidance on the mechanics for releasing a body and, in particular, does not prescribe to whom bodies are to be released. In practice, bodies are routinely released to the senior next of kin. According to Forensic Medicine's procedure manuals, bodies are released in 'good faith' on the assumption that funeral directors are authorised to make any funeral arrangements.

We recognise the need for greater certainty and transparency in coronial decisions about the release of the body. In practice, this phase of the coronial process has been particularly sensitive and highly contested. To better assist grieving families of the deceased person and facilitate funeral arrangements, we recommend the Act prescribe that:

- coronial orders for the release of the body or remains specify to whom the body or remains should be released and contain any terms or conditions the coroner considers necessary for the appropriate release of the body or remains
- there is a presumption for the body or remains to be released to the senior next of kin or someone authorised by the senior next of kin.

It is also recommended that the Act be amended to provide that a coroner can make an order to release the body or remains and order that the body or remains be released to a person other than the senior next of kin or the person authorised by the senior next of kin. These new powers will only be used in limited circumstances, if the senior next of kin has not accepted the release of the body or remains within a reasonable period or the body or remains cannot be identified and a senior next of kin cannot be determined. The intention of the amendment is to ensure deceased persons, whose body or remains are not accepted by their family or who are unable to be identified, are still buried or cremated respectfully. This would include the respectful repatriation of Aboriginal or Torres Strait Islander remains back to country.

Stakeholders also raised concerns that language such as the 'disposal of human remains' could be construed as insensitive and disrespected by families. It is also recommended that the Act be amended to replace language such as 'the disposal of human remains' with language that is more sensitive and respectful of the families of people who have died.

Recommendation 24

That the Act be amended to:

a) require orders for the release of the body or remains to specify the person to whom the body or remains may be released

b) provide the orders for the release of the body or remains may contain any terms or conditions that the coroner considers necessary

c) provide a presumption for the body or remains to be released to the senior next of kin (or someone authorised by the senior next of kin)

d) allow coroners to order the release of the body or remains and that the body or remains be released to a person other than the senior next of kin (or the person authorised by the senior next of kin), if:

   i. after a reasonable time, the senior next of kin (or the person authorised by the senior next of kin) has not accepted release of the body or remains, or

   ii. the body or remains cannot be identified and a senior next of kin cannot be determined

e) replace language such as 'the disposal of human remains' with language that is more sensitive and respectful of the families of people who have died.

6.4 Review mechanisms

There are limited opportunities to seek a review of key coronial decisions. This section of the Report recommends new review mechanisms that would allow persons with a sufficient connection to the deceased person to apply within a reasonable time to the Supreme Court to review the following decisions:

- determination of who is the senior next of kin
- authorising the release of the body or remains at the conclusion of coronial proceedings
- issuing a warrant for the exhumation of the deceased person's body or remains.

Allowing for a review mechanism straight to the Supreme Court for such matters was recommended by the State Coroner and Chief Magistrate noting that these early-stage decisions are now made by specialist Deputy State Coroners at the FMCCC, rather than being made by regional magistrates as had occurred previously.

The recommendations in this section will provide a statutory mechanism for affected persons to seek review by senior judicial officers. It will promote access to justice and consistency by ensuring people with a sufficient connection to the deceased person have clear pathways of review, and avoid delays associated with the litigation of appeals within the coronial jurisdiction.

Current review rights

The Act provides particular persons with access to the following review mechanisms:

a) In relation to dealings with the deceased person's body:

- A senior next of kin can apply to the Supreme Court to review a decision not to uphold the senior next of kin's objection to an exercise of relevant post-mortem investigative functions: s 97. Relevant post-mortem investigative functions mean issuing a direction for the conduct of a post-mortem examination or authorising the retention of whole organs: s. 95.

b) In relation to an inquest, generally:

- The Minister or any other person can apply to the Supreme Court for an inquest to be held if in the interests of justice (regardless of whether an inquest has been partly held and terminated or suspended): s. 84.[35]

c) In relation to fresh inquests (i.e. where previous inquest finalised):

- A person granted leave to appear or be represented, or a police officer, may apply to the State Coroner for a fresh inquest to be held by the State Coroner (or another coroner), the findings of which may be in addition to or in substitution for previous findings. A fresh inquest:
    - must be held if in the interests of justice following new evidence or facts: s. 83(4)
    - may be held if an inquest was terminated before its conclusion because it appeared the person had not died: s. 83(2)
    - may be held if a previous inquest was concluded on the basis the person did not die or it was uncertain whether the person had died: s. 83(2)
    - may be held even though a previous inquest was held concerning the suspected death of a person if the remains of a person are found in the State: s. 83(3).

[35] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [84.13], '…s 84 does not require the Supreme Court to "review" a coroner's decision to dispense with an inquest. Accordingly, it is not strictly speaking necessary for a coroner to have made a decision to dispense with an inquest prior to approaching the Supreme Court.'

- The Minister or any other person can apply to the Supreme Court for an inquest to be quashed and for a new (i.e. fresh) inquest to be held, if in the interests of justice because of fraud, rejection of evidence, irregularity of proceedings, insufficiency of inquiry, the discovery of new evidence or facts, or any other reason: s. 85.

In addition, judicial review by the Supreme Court is available for legal errors made in the exercise of statutory powers, generally. This includes legal errors made by decision makers in determining the above review applications, exercising any of the above administrative powers, and in exercising other statutory powers (including the making of interlocutory decisions). Interlocutory decisions include the issuing of subpoenas, granting persons leave to appear, upholding objections to cross-examination, granting certificates against self-incrimination, and granting or refusing privilege and public interest immunity claims.

Case for change

Various provisions throughout the Act currently provide for a right of review. However, there are limited or no opportunities to seek review of the following key coronial decisions:

- who is the senior next of kin (there is currently no right of review)
- select dealings with the deceased person's body (there is currently no right of review, except by the Supreme Court, for decisions not to uphold an objection to a relevant post-mortem investigative function (i.e. issuing a direction for the conduct of a post-mortem examination or authorising the retention of whole organs).

Where review mechanisms are available, these are limited to:

- a right of review to the Supreme Court (see ss. 84 and 97); or
- the State Coroner's exercise of administrative powers (see ss. 28, 29 and 50).

These existing review mechanisms do not provide the most effective access to justice.

New rights of review to the Supreme Court

Throughout our stakeholder consultations, we identified that many coronial decisions are sensitive and highly contentious. However, affected persons have limited or no rights to seek a review of those decisions. We therefore recommend introducing new rights of external review for the following decisions:

- who is the senior next of kin
- authorising the release of the body or remains
- issuing a warrant for the exhumation of the deceased person's body or remains.

Who is the senior next of kin

A default hierarchy applies to decisions about who is the senior next of kin under s. 6A. However, these decisions have proven to be contentious, perhaps because of the unique rights and interests held by the senior next of kin in the coronial process. We have recommended amendments to the decision-making process for who is the senior next of kin to enable coroners to depart from the default hierarchy where:

- there are cultural differences in that particular familial structure
- the default appointee is not appropriate in the circumstances

- a person with sufficient connection to the deceased person has successfully made a competing claim within a reasonable time.

To support this new decision-making process, we recommend providing a right of review to the Supreme Court for decisions about who is the senior next of kin. This right of review should only be available to persons with sufficient connection to the deceased person (i.e. those persons who are eligible to make a competing claim to be senior next of kin), if made within a reasonable time. This would provide appropriate persons with an additional statutory mechanism to seek review of the relevant decision by the Supreme Court.

As senior next of kin decisions are made in the early stages of the coronial process by specialist Deputy State Coroners at the FMCCC or, in some cases, made personally by the State Coroner, the legislative right to seek review by the Supreme Court will ensure an independent review process.

It has previously been submitted that senior next of kin decisions should be reviewed internally by the State Coroner, however under the centralised operating model now in place at FMCCC, the Deputy State Coroners who make these decisions are specialists in the jurisdiction and closely directed by the State Coroner. Before the centralised model was introduced, an internal review mechanism was perhaps more justified because regionally located magistrates were making senior next of kin decisions. However, the State Coroner considers that an external review mechanism is now more appropriate.

All stakeholders supported amending the Act to provide this right of external review. To provide greater clarity around this process, we also recommend the Act provide that Regulations prescribe what constitutes a reasonable time to seek review.

Recommendation 25

That the Act be amended to:

a) allow persons with sufficient connection to the deceased person to apply within a reasonable time to the Supreme Court for review of decisions by coroners as to who is the senior next of kin, and

b) provide for a regulation making power to prescribe what constitutes such a reasonable time.

Dealings with the deceased person's body

The Act currently allows the senior next of kin to apply to the Supreme Court for a review of a decision not to uphold an objection to an exercise of a relevant post-mortem investigative function: s. 97. An objection to the exercise of a relevant post-mortem investigative function may be made under s. 96, which provides a basis for the senior next of kin to indicate their wishes at the outset of the coronial process. A relevant post-mortem investigative function is defined under s. 95 as the function of:

- issuing a direction for the conduct of a post-mortem examination
- authorising the retention of whole organs.

We recognise the need to enhance review rights for key coronial decisions about dealings with the deceased person's body. To further promote access to justice as it relates to dealings with a deceased person's body, it is proposed to amend the Act to include new

review pathways to the Supreme Court for the following decisions (for which there are currently no rights of review):

- authorising the release of the body or remains under s. 101
- issuing a warrant for the exhumation of the deceased person's body or remains under s. 91.

As referred to above, the State Coroner has advised that these decisions have been centralised at the FMCCC and are now made by specialist Deputy State Coroners. Having external review rights is important to ensure independence, transparency and fairness in the process. This recommendation will reflect what currently happens with reviews of decisions not to uphold an objection to an exercise of a relevant post-mortem investigative function (s.97). Creating review pathways to the Supreme Court for s.101 and s.91 decisions will ensure consistency.

The Department appreciates that seeking a review via the Supreme Court may take more time. However, the State Coroner has indicated that creating internal review mechanisms would have large resource implications for the jurisdiction and would lead to an increased number of applications that need to be heard. It is submitted that these coronial resources could be better directed towards other priorities.

Release of, and exhumation of, the deceased person's body or remains

The release of the deceased person's body or remains enables funeral arrangements to commence, and the exhumation of the body or remains allows for the conduct of necessary examinations and tests in some circumstances. These dealings are also highly sensitive and contested among the deceased person's family. We therefore recommend expanding access to review rights to the Supreme Court for decisions about the release of, and exhumation of, the deceased person's body or remains.

Compared to decisions about post-mortem examinations and the retention of whole organs, decisions about the release of, and exhumation of, the deceased person's body or remains are made under lesser time constraints. There is, therefore, no reason to limit the review of such matters to the spokesperson of the deceased person's family or to impose a similar objection process and strict time limitation as is currently required for s. 97 review requests.

Recommendation 26

That the Act be amended to enable persons with sufficient connection to the deceased person to apply, within a reasonable time, for a review of the following decisions to the Supreme Court:

a) authorising the release of the body or remains under s. 101

b) issuing a warrant for the exhumation of the deceased person's body or remains under s. 91.

6.5 Right to request directions

The Act currently provides the State Coroner, coroners, and the Minister with a number of discretionary administrative powers. These powers, which are available at different stages of the coronial process, include:

a) Before a decision to dispense with an inquest has been made:

- the State Coroner may (s. 50):[36]
  - direct coroners to conduct coronial proceedings that have not yet commenced
  - direct coroners to assume jurisdiction from another coroner to conduct coronial proceedings (before an inquest has commenced or a decision to dispense with an inquest has been made)
  - personally assume jurisdiction to conduct coronial proceedings.

b) Where an inquest has been dispensed with:

- the presiding coroner may hold an inquest if in the interests of justice following new evidence or facts: s. 25(3).
- the State Coroner may personally hold, or direct a coroner to hold, an inquest: s. 29.

c) For other matters:

- the Minister or State Coroner may direct and require an inquest to be held: s. 28.

Although these powers currently exist, there is no formal process for relevant persons to request that the State Coroner exercise these powers. In practice, persons affected by a finding that a death is not a reportable death or a decision not to hold an inquest or inquiry can write to the State Coroner outlining their dissatisfaction with the decision. This does not provide the most effective and transparent process for families seeking further coronial investigations. There is currently no enforceable right to request the State Coroner to exercise their discretion.

We propose that the Act be amended to provide people with sufficient interest the explicit right to request that the State Coroner give the following directions:

- that a death is a reportable death
- that an inquest should be held following the issuing of a Coronial Certificate or finding without inquest
- that an inquiry should be held (in relation to a fire or explosion).

After receiving a request for directions, the State Coroner will be required to re-examine the matter and consider the reasons why the person believes further coronial investigations are required. If satisfied, the State Coroner may then direct another coroner to conduct the requested further investigations. The State Coroner may also personally perform the further investigations, rather than directing another coroner to do so.

We also propose that the State Coroner be able to delegate these functions (the power to direct a coroner that a death is a reportable death or that an inquest or inquiry be held) to a Deputy State Coroner. This approach was recommended by the State Coroner as it avoids tiers of decision and review processes becoming part of the coronial process. This approach will also allow coronial resources to be better directed to other priorities and will ensure efficiency and transparency.

[36] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [50.1].

Recommendation 27

That the Act be amended to provide:

a) that the State Coroner may direct that a death is a reportable death if the State Coroner is of the opinion that a death is a reportable death

b) that the State Coroner may direct that an inquest be held following the issuing of a Coronial Certificate or finding without inquest if the State Coroner is of the opinion that an inquest should be held

c) that the State Coroner may direct that an inquiry should be held (in relation to a fire or explosion)

d) that persons with a sufficient interest in the matter have the right to request that the State Coroner direct a coroner:

   i. that a death is a reportable death

   ii. that an inquest should be held following the issuing of a Coronial Certificate or finding without inquest

   iii. that an inquiry should be held (in relation to a fire or explosion)

e) that the State Coroner may hold the inquest or inquiry instead of directing another coroner to hold the inquest or inquiry

f) that the State Coroner may delegate these functions (the power to direct a coroner that a death is a reportable death or that an inquest or inquiry be held) to a Deputy State Coroner

g) that s. 29(3) of the Act, requiring the State Coroner to seek the Chief Magistrate's consent before giving a direction to a coroner who is a Magistrate, be removed.

6.6 Change to the coronial process: inquiries

Over the calendar years 2019 to 2022, an average of 130 fires were reported to coroners each year.[37] Generally, fires account for less than 10% of matters reported to a coroner and very few result in an inquiry.[38]

The fires and explosions that are considered to be within the coronial jurisdiction are those which the coroner is satisfied has destroyed or damaged property within NSW: s. 30.

As of 1 November 2022, the State Coroner has further directed that a fire or explosion need only be reported to the coroner when:

- a person dies or is seriously injured as a result of the fire or explosion
- the fire or explosion has a significant impact on the local community, or relates to a systemic health or safety issue of public interest; or

[37] Local Court Annual Review 2022, https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html.
[38] Local Court Annual Review 2022, https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html.

- the Attorney General, NSW Police Commissioner or delegate, Commissioner of Fire and Rescue NSW, Commissioner of NSW Rural Fire Service, or the NSW State Coroner requests the report of the fire or explosion.[39]

Where a person dies in a fire or explosion, a coroner will often hold an inquest into the person's death simultaneously while holding an inquiry into the cause and origin of the fire or explosion. While there will be one set of hearings in both matters, two coronial files would be created (one for the inquiry and one for the inquest).[40]

This section of the Report makes three recommendations focused on ensuring the inquiry process is consistent with the Act's policy objectives and that it reflects and improves upon current practice. In summary, we recommend:

- replacing the discretion to dispense with an inquiry with a discretion to hold an inquiry if there is a public interest in doing so
- allowing the Commissioner of the NSW Rural Fire Service to request an inquiry into any fire within the Commissioner's jurisdiction under the *Rural Fires Act 1997* and updating the reference to the 'Commissioner of NSW Fire Brigades'.

The current process

The jurisdiction and framework for the holding of inquiries concerning fires and explosions is set out in Chapter 3, Part 3.3 of the Act. If a fire or explosion has destroyed or damaged any property within NSW, coroners may:

- hold an inquiry to determine its cause and origin; and
- if directed by the State Coroner, hold a general inquiry into all of its circumstances (including its cause and origin).

The framework for holding inquiries is similar to holding inquests. Except for mandatory inquiries, a coroner has a general discretion to dispense with an inquiry under s. 31. A coroner may dispense with an inquiry if of the opinion that:

- the cause and origin of the fire or explosion are sufficiently disclosed; or
- an inquiry into the cause and origin of the fire or explosion is unnecessary.

An inquiry will be required to be held into fires and explosions in limited circumstances prescribed under s. 32. Generally, these are at the direction or request of the State Coroner, Minister or authorised public officials, as follows:

- an inquiry into the cause and origin of a fire or explosion is required if:
  - an authorised public official requests one: s. 32(1)(a)[41]
  - the State Coroner is of the opinion an inquiry should be held and directs for one (including where an inquiry has been dispensed with): ss. 32(1)(b) and 32(2).
- a general inquiry into all of the circumstances of a fire or explosion under s. 32(3) is required if the State Coroner directs for one:

[39] STATE CORONER'S BULLETIN No 22, October 2022, https://intranet.internal.justice.nsw.gov.au/Divisions/Pages/divisions/coroners-court/Coroners-court.aspx
[40] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [30.9].
[41] An authorised public official is defined to mean the Minister and, for some fires and explosions, the Commissioner of Fire and Rescue NSW and the Commissioner of NSW Rural Fire Service: s. 32(8).

- upon the request of an authorised public official: s. 32(4)(a)
- being of the opinion an inquiry should be held: s. 32(4)(b).

Discretion to hold an inquiry (rather than dispense with an inquiry)

Fewer matters concerning fires and explosions are reported to coroners than that of deaths, and few submissions made to the Review identified any concerns with the current inquiry framework. However, as with the current inquest framework, providing a discretion to dispense with an inquiry implies that conducting inquiries is the norm and also causes principal case management decisions to be framed in the negative.

We recognise the importance of providing consistency within an Act and recommend there be a new inquiries framework that mirrors the new inquests framework as outlined above. Therefore, we recommend that coroners be given a general discretion to hold, rather than dispense with, an inquiry into a fire or explosion if they determine there is a public interest in doing so. When determining whether there is a public interest or not the coroner must consider the following prescribed factors:

- whether the cause and origin of the fire or explosion is not sufficiently disclosed
- whether the inquiry into the cause and origin of the fire or explosion is necessary
- whether there are any issues of public health or safety to address
- whether there are any suspicious circumstances
- whether holding an inquiry is likely to provide additional information
- any request made by persons with sufficient interest in the circumstances of the fire for an inquiry to be held.

This approach has been supported by the State Coroner and the Chief Magistrate as it reflects the proposed changes to the process for holding inquests. Prescribing the factors to be considered will also promote consistency and transparency in decision-making.

Compared with the changes we have recommended to the process for determining whether to hold an inquest, we support a less prescriptive legislative framework for inquiries, and consider the current grounds to dispense with an inquiry are sufficient.

Recommendation 28

That the Act be amended to provide:

a) coroners with a general discretion to hold, rather than dispense with, an inquiry if there is a public interest in holding an inquiry into a fire or explosion

b) coroners must consider the following factors when exercising that discretion:

   i. whether the cause and origin of the fire or explosion is not sufficiently disclosed

   ii. whether the inquiry into the cause and origin of the fire or explosion is necessary

   iii. whether there are any issues of public health or safety to address

   iv. whether there are any suspicious circumstances

   v. whether holding an inquiry is likely to provide additional information

   vi. any request made by persons with sufficient interest in the circumstances of the fire for an inquiry to be held.

The Commissioner of the NSW Rural Fire Service to request an inquiry

Under s. 32 of the Act, a coroner is required to hold an inquiry into a fire or explosion at the request of 'authorised public officials'. An authorised public official is defined to include the Commissioner of the NSW Rural Fire Service if the fire is a bush fire within the meaning of the *Rural Fires Act 1997* (s. 32(8)(b)).

However, the Commissioner may respond to other fires (other than bush fires) within the rural fire district defined under the *Rural Fires Act 1997* for which they are responsible. There would be benefit in enabling the Commissioner to request inquiries into those other fires. We therefore recommend amending the definition of 'authorised public official' to enable the Commissioner to request an inquiry into any fire within their jurisdiction.

In 2011, the *Fire Brigades Act 1989* changed the name of the 'New South Wales Fire Brigades' to 'Fire and Rescue New South Wales', we therefore recommend that any references to the agency's new name be reflected in the Act.

Recommendation 29

That the Act be amended to:

a) allow the Commissioner of the NSW Rural Fire Service to request an inquiry into any fire within the Commissioner's jurisdiction under the *Rural Fires Act 1997*

b) amend the reference to the 'Commissioner of New South Wales Fire Brigades' to the 'Commissioner of Fire and Rescue New South Wales'.

6.7 Supplementary changes to the coronial process: inquests and inquiries

We have recommended a number of changes to the inquest and inquiry process, which are aimed at better reflecting and improving upon current practice. The recommendations that follow propose supplementary changes to the coronial process for the following discrete matters:

- revising standing provisions for fresh inquests and inquiries
- clarifying the effect of issuing open findings for fresh inquests and inquiries
- clarifying the process for holding concurrent inquests and inquiries.

Fresh inquests and inquiries

There are several reasons to justify holding a fresh inquest or inquiry. These are reflected in s. 83 of the Act, which provides that after an inquest or inquiry has been concluded, a fresh inquest or inquiry may be held where:

- a previous inquest was terminated or concluded because the person did not die, or it was uncertain whether the person died
- the remains of the person are found in NSW after the previous inquest.

An inquest must be held under subsection (4) if the State Coroner is of the opinion that the discovery of new evidence or facts makes a fresh inquest necessary or desirable in the interests of justice. Given the purpose of the provision and width of the criterion of 'interests of justice', it is clear that the phrase 'new evidence' should be read to include any evidence, which, for whatever reason, was not before the coroner at the original inquest or inquiry.[42]

Standing to apply for fresh inquests and inquiries

Under s. 83(5) only a police officer or a person who was granted leave to appear or be represented in the original inquest or inquiry can apply for a fresh inquest or inquiry.

Section 83(5) does not provide sufficient flexibility to meet the needs of persons with sufficient interest in the subject matter of the previous inquest or inquiry and the community, in two ways:

- it does not allow the coroner who conducted the inquest/inquiry, or the State Coroner, to order a fresh inquest/inquiry on their own motion on the basis of the prescribed criteria in s. 83. This does not support the inquisitorial nature of the coronial jurisdiction
- it creates an anomaly where persons with sufficient interest are not able to apply for a fresh inquest/inquiry unless that person was granted leave to appear in the original inquest/inquiry. This excludes persons who could have been granted leave to appear but were not because they were not aware of the inquest/inquiry and did not apply for leave to appear.

We recommend amending the Act to remove those restrictions in s. 83(5). Instead, the Act should allow coroners to conduct a fresh inquest or inquiry on their own motion and should allow any person with sufficient interest in the subject matter of the previous inquest or inquiry to make an application for the coroner to consider.

We also recommend retaining the existing standing for police officers to apply for fresh inquests or inquiries as investigating police officers play a distinct and important role in bringing such applications upon discovering new evidence or facts in concluded inquests or inquiries.

[42] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [83.9].

Recommendation 30

That the Act be amended to authorise:

a) a coroner who held an inquest/inquiry, or the State Coroner, to conduct a fresh inquest/inquiry on their own motion on the basis of the criteria in s. 83 of the Act

b) any person with sufficient interest in the subject matter of the previous inquest/inquiry to make an application for a fresh inquest/inquiry under s. 83, for the coroner to consider

Fresh inquests and inquiries following 'open findings'

An 'open finding' refers to when a coroner finds there is insufficient evidence on which conclusions can be drawn as to the particulars of the death. It is unclear if fresh inquests can be ordered following the making of an open finding or whether the inquest may simply resume (potentially many years after the open finding was issued). This follows obiter comments in *Fairfax Publications v Abernathy* [1999] NSWSC 820, which suggested that a coroner did not discharge their duty as a result of issuing an open finding [at 15].

Where open findings have been made, we consider it would be appropriate to hold a fresh inquest to reconsider the matter. A significant amount of time may have passed following the making of open findings, and there may be new evidence to consider in the matter.

We therefore recommend amending the Act to remove any doubt that when coroners issue an open finding they have discharged their duty and a fresh inquest or inquiry must be ordered if the matter is to be reconsidered. This will ensure a consistent approach is taken whenever open findings are issued.

Recommendation 31

That the Act be amended to clarify that, when a coroner issues an 'open finding', coroners have discharged their duty, such that any reconsideration of the matter would require a 'fresh inquest or inquiry' to be ordered under s. 83.

Concurrent inquests and inquiries

Stakeholders noted that where there are multiple deaths in the same incident it is usual practice to convene a concurrent inquest. However, it might also be appropriate to hold a concurrent inquest even if deaths occur at different times and places but the circumstances of each death appear similar. Additionally, stakeholders also suggested that concurrent inquests and inquiries should extend to those that may raise similar policy issues or risks.

The benefits of holding concurrent inquests include avoiding repetition of evidence (in particular, witness evidence), and reducing delay, inconvenience, and distress for witnesses in proceedings. These benefits also apply to concurrent inquiries into fires and explosions, particularly where they involve deaths that are subject to an inquest.

Concurrent inquests and inquiries are held in practice even though the Act does not specifically authorise this. This practice is supported by the Court of Appeal decision in *Maksimovich v Walsh* (1985) 4 NSWLR 318, which held that it was permissible for the coroner to hold concurrent inquests or inquires in order to secure the just and efficient discharge of the coroner's inquisitorial functions. In cases where a person dies in a fire, a

coroner often holds an inquest into the person's death simultaneously with holding an inquiry into the cause and origin of the fire. While there is one set of hearings in both matters, two coronial files are created, and two separate findings delivered (one for the inquiry and one for the inquest).[43]

We recommend amending the Act to explicitly provide for the holding of concurrent inquests and inquiries for the avoidance of doubt. Examples of such provisions exist in several other jurisdictions.[44]

We suggest the development of practice notes and guidelines to provide coroners with administrative guidance and ensure consistency in coronial practice as to when and how inquests and inquiries should be held concurrently. For example, these practice notes and guidelines would cover how to determine when to hold concurrent inquests and inquiries, the number of incidents that should be subject to concurrent inquests and inquiries, and the provision for separate findings to be delivered in respect of each death, fire, or explosion.

Recommendation 32

That the Act be amended to authorise the holding of concurrent inquests and inquiries where numerous incidents occur as a result of a single incident, in similar circumstances or where it is otherwise in the interests of justice to do so.

[43] *Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [30.9].*
[44] *Coroners Act 2008* (Vic), s. 54; *Coroners Act 2003* (Qld), s. 33; *Coroners Act 2006* (NZ), s. 84.

7. Supporting framework

There are many provisions in the Act that are largely directed at supporting the effective operation of the coronial framework. This section of the Report makes a number of recommendations to improve the operation of those supporting provisions and to ensure that they reflect the Act's policy objectives. In summary, we recommend:

- amending the Act to provide for the appointment of Counsel Assisting
- amending the Act to clarify that the prohibition on making statements or findings or guilt applies to all written reasons, and that such prohibition also applies to statements or findings that attribute civil liability
- amending the Act to strengthen referrals and timely provision of materials to other relevant investigative, prosecutorial or disciplinary agencies
- amending the Act to promote transparency and accessibility of coronial processes, such as access to the coroner's file and publication of findings about suicide
- amending the Act to strengthen transparency, consistency and transparency in relation to responses to coronial recommendations
- generating efficiencies by enabling the Chief Magistrate to appoint Deputies and modernising methods of service.

7.1 Counsel Assisting the coroner

The role of Counsel Assisting

Counsel Assisting is an independent person who ensures that all relevant information is presented to the coroner. In the majority of inquests in NSW, a police officer will appear and assist the coroner. In more complex cases, or where there would be a conflict of interest in a police officer assisting the coroner, the coroner may appoint a barrister or solicitor. Typically, this is facilitated by the Crown Solicitor's Office or the Legal Branch within the Department of Communities and Justice.

Counsel Assisting is critical to achieving procedural fairness without jeopardising the independence of the coroner. As Counsel Assisting performs the main role of questioning the witness and testing the evidence, the coroner is able to remain independent during the questioning process and may impartially rule upon objections to those questions. On behalf of the coroner, Counsel Assisting and their instructing solicitor liaise with the police investigator responsible for the matter.

Counsel Assisting's other roles include:

- supporting the coroner in their investigative role prior to the inquest hearing
- liaising with the legal representatives of persons with sufficient interest in the subject matter of the inquest
- assisting unrepresented persons with sufficient interest in the subject matter of the inquest.[45]

Express appointment of Counsel Assisting in the coronial process

[45] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [1.146].

Despite the integral role of Counsel Assisting in the coronial process, the Act does not expressly provide for their appointment, or their role and functions. The Act only makes the following references to such a position:

- the coroner may give case management directions to a person assisting the coroner: s. 49
- a person assisting the coroner may give an opening or closing address to a jury: s. 57(4)
- submissions made by any person, including a person assisting the coroner, regarding whether an inquest or inquiry should be suspended must not be published: s. 76.

While no doubt has been expressed regarding the validity of the appointment of Counsel Assisting, this should be clearly provided for in the Act for the sake of certainty and transparency. Coronial legislation in all other Australian jurisdictions explicitly provides coroners with the ability to appoint Counsel Assisting.[46] Similarly, legislation of other inquisitorial bodies within NSW explicitly provides for the appointment of Counsel Assisting, including the *Independent Commission Against Corruption Act 1987*,[47] the *Law Enforcement Conduct Commission Act 2016*,[48] and the *Judicial Officers Act 1987* (in respect of the Judicial Commission and Conduct Division).[49]

Based on stakeholder feedback and consultation with the State Coroner, it is also recommended that the Act explicitly provide that Counsel Assisting and the legal representatives of interested parties (where granted leave to appear) should have the power to cross examine a witness at an inquest or inquiry.

Recommendation 33

That the Act be amended to explicitly provide:

a) for the appointment of Counsel Assisting the coroner

b) that Counsel Assisting and the legal representatives of interested parties (where granted leave to appear) should have the power to cross examine a witness at an inquest or inquiry.

7.2 Prohibition in attributing findings of guilt and liability

Prohibition against making statements or findings of guilt

Sections 81(3) and 82(3) prescribe that a record of findings by coroners (or verdicts by juries) and recommendations by a coroner or jury 'must not indicate or in any way suggest that an offence has been committed by any person.' This is to avoid prejudicing the fairness of any future criminal trial. Coronial proceedings are inquisitorial and not bound by rules of evidence or procedure. Their function is not to make findings of guilt or determinations of liability. It is therefore appropriate for the legislation to prohibit statements and speculations

[46] For example, s. 60 of the *Coroners Act 2008* (Vic), s. 36 of the *Coroners Act 2003* (Qld), s. 46(2) of the *Coroners Act 1996* (WA), s. 41(2) of the *Coroners Act 1993* (NT), s. 15 of the *Coroners Act 2003* (SA), s. 53 of the *Coroners Act 1995* (TAS), and s. 39 of the *Coroners Act 1997* (ACT).
[47] *Independent Commission Against Corruption Act 1987* (NSW), s. 106.
[48] *Law Enforcement Conduct Commission Act 2016* (NSW), s. 64.
[49] *Judicial Officers Act 1987* (NSW), s. 47.

regarding findings of guilt, such as 'upon the evidence before me X may be guilty of murder' or 'it appears that X shot Y without legal justification'.[50]

However, there is some confusion regarding the interpretation and application of ss. 81(3) and 82(3), largely due to the use of the word 'suggest'. It creates confusion about the ability of coroners to make findings of fact relevant to the coronial proceedings, which might ultimately be relevant for a finding of guilt in future criminal proceedings. This is inconsistent with the general practice that a coroner is entitled to express views and make comments as to the appropriateness of actions or inactions of particular persons or agencies in the exercise of their functions.

The Act should reflect the generally accepted position that coroners should not offer opinions in terms of findings of guilt but may comment on where responsibility for the death lies. Ensuring the Act is clear in this respect could be achieved by adopting the approach taken in ss. 45(5) and 46(3) of the *Coroners Act 2003* (Qld), which prohibits a coroner from including any statement in findings or comments that a person 'is' or 'may be' guilty of an offence.

The prohibition against indicating or suggesting the commission of offences by 'any person' under s. 81(3) also presents difficulties when drafting coronial findings or recommendations, particularly where a person has already been convicted of an offence. Section 81(3) should be limited to making findings regarding offences committed by persons who are yet to be convicted of an offence. This would better fulfil the legislative purpose of the provision.

The prohibition in ss. 81(3) and 82(3) only applies to a record of findings and recommendations. There is no similar provision for written reasons, however, it is widely considered inappropriate for a coroner to speculate as to the commission of an offence in the course of giving reasons.[51] We recommend the Act be amended to recognise that coronial findings and recommendations are often accompanied by written reasons, and that the prohibition in ss. 81(3) and 82(3) also applies to these records of reasons.

Recommendation 34

That in relation to the record of Coronial Certificates or findings (including findings without inquest) by the coroner or verdicts by juries, and recommendations by a coroner or jury:

a) there be a prohibition on the making of any statements that a person is or may be guilty of an offence, unless that statement concerns an offence already found proven

b) any record of written reasons accompanying Coronial Certificates, findings (including findings without inquest) or recommendations must not contain any statements that a person is or may be guilty of an offence, unless that statement concerns an offence already found proven.

Findings and recommendations as to civil liability

Unlike criminal offences, there is no express provision prohibiting the coroner from making findings or recommendations in relation to civil liability. Submissions raised concerns that inquests are increasingly being used as civil litigation 'test runs'. A number of stakeholders

[50] *Perre v Chivell* (2000) 77 SASR 282 at [57] concerning a similar provision in SA.
[51] Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010) at [81.36] per Kirby J in *Attorney General v Maksimovich* (1985) 4 NSWLR 300 at 313.

submitted the Act should be amended to ensure all participants in the coronial process are aware of the limits of the coronial jurisdiction; as well as ensuring fair, cost efficient and time efficient proceedings.

Legal professional bodies and health agencies submitted that coroners should be restrained from making findings and recommendations attributing civil liability, citing examples in coronial legislation of other jurisdictions.[52] For example, s. 45(5) of the *Coroners Act 2003* (Qld) prohibits a coroner from including any statement in findings or comments that 'a person is, or may be, guilty of an offence or civilly liable for something'.

The State Coroner and Chief Magistrate advise that in practice coroners currently avoid making statements that attribute civil liability and support that the Act should reflect this. We agree the Act should reflect the generally accepted position that coroners should not offer opinions in terms of findings of guilt but may comment on where responsibility for the death lies. We recommend coroners should be prohibited from making findings (including findings without inquest), recommendations or issuing coronial certificates attributing civil liability as well (in the same terms to that provided for criminal offences under ss. 81(3) and 82(3)).

Recommendation 35

That the Act be amended to prohibit coroners from issuing Coronial Certificates, findings (including findings without inquest) or recommendations attributing civil liability in similar terms to the proposed prohibition on attributing findings of guilt in the previous Recommendation.

Referral to investigative, prosecutorial or disciplinary bodies

Under s. 78 of the Act, matters must be referred to the Director of Public Prosecutions where a coroner forms the opinion that an indictable offence has been committed. There is no express provision in the Act providing for the referral of matters to other relevant prosecutorial or disciplinary agencies for the purpose of investigating liability, generally. When making recommendations under s. 82 of the Act, a coroner has the general discretion to refer matters that are connected with the death to specified persons or bodies for investigation or review. However, this power is only available upon the conclusion of an inquest and the delivery of coronial findings.

The Act should be amended to provide coroners with an express power to refer matters connected to an inquest or inquiry (including information and material) to other relevant prosecutorial or disciplinary agencies (including Commonwealth agencies) where prosecutorial or disciplinary investigation might be warranted. For example, this may include referring matters to:

- SafeWork NSW for investigation into suspected breaches of work health and safety laws
- the Health Care Complaints Commission for investigation into suspected problems with health care provided by health practitioners
- the Law Enforcement Conduct Commission
- the Independent Commission Against Corruption

[52] Sections 45 and 46 of the *Coroners Act 2003* (Qld), s. 25 of the *Coroners Act 1996* (WA) and s. 25 of the *Coroners Act 2003* (SA).

- Comcare Australia
- the Australian Aged Care and Quality and Safety Commission

Such referrals should be able to be made independently of a coroner's duty to make findings, either with or without an inquest.

Recommendation 36

That the Act be amended to enable coroners to refer matters connected to an inquest or inquiry (including relevant information and material) to relevant investigative, prosecutorial or disciplinary agencies (including Commonwealth agencies), where appropriate.

7.3 Publication of, and access to, coronial matters

Consistent with principles of open justice, coronial proceedings are normally open to the public. This is particularly important given the coroner's role in providing the broader community (including those members specifically interested in a death) with an explanation as to the circumstances of the person's death and considering whether changes could reduce the likelihood of similar deaths or could otherwise contribute to public safety or improvements in the administration of justice.

However, information obtained during the coronial process can also be highly sensitive or distressing. Any public release of coronial information needs to be carefully considered against the interests of the public and the deceased person's family. The recommendations that follow aim to find a balance between the importance of making information about the coronial process available to the public against the need for confidentiality of sensitive information.

Notice of upcoming inquests and inquiries

The breadth of who might have an interest in coronial proceedings can present challenges for coroners to identify and find all persons with sufficient interest in the subject matter of the proceedings. In practice, steps are taken to ensure the public and targeted individuals are made aware of upcoming inquests and inquiries. The coronial jurisdiction's website generally posts the name, date, and location of upcoming inquests and inquiries. Coroner's staff members and legal representatives engaged in the Counsel Assisting role make contact with people who coroners anticipate are directly connected with the subject of the inquest or inquiry, or who might be the subject of adverse comment.

Despite this general practice, stakeholders have noted this practice has been applied inconsistently and would benefit from a legislative mechanism requiring the public notification of upcoming inquests and inquiries. Subject to any non-publication order, we recommend coroners be required to publish details of an upcoming inquest or inquiry on the coronial jurisdiction's website.

Providing a legislative requirement for general dissemination would strengthen the process of identifying relevant public interest groups and persons connected to the subject matter of the inquest. Similar provisions exist in s. 61 of the *Coroners Act 2008* (Vic) and s. 32 of the *Coroners Act 2003* (QLD).

Recommendation 37

That the Act be amended to require coroners to publish details of pending inquests and inquiries on the coronial jurisdiction's website.

Access to coronial matters

Most of the coroner's work involves matters of public interest. It is important that relevant information and documents can be made available to members of the public upon request in appropriate circumstances.

The current access regime established under s. 65 provides a person with access to a 'coroner's file' (or a part of that file). The 'coroner's file' is defined to mean 'the documents (including the depositions of witnesses, transcripts and written findings) that form part of the file kept by a coroner in respect of a death, suspected death, fire or explosion.'[53]

Access is granted if a coroner or assistant coroner is satisfied it is appropriate for the person to be granted that access, having regard to any relevant matter (which would include the views of the deceased person's family, if known) and the following specific matters listed under s. 65(3):

- the principle of open justice
- the impact access will have on the relatives of the deceased person
- the applicant's connection to the subject proceedings
- the reason access is sought.

The current access regime is limited in the following ways:

- it does not enable access to a broader range of evidentiary material beyond the types of documents that make up a coroner's file
- it does not expressly require a coroner or an assistant coroner to consider:
    - whether granting access may compromise coronial investigations or proceedings, a related criminal investigation or proceeding
    - whether granting access may reveal sensitive police methodology, or disclose or enable a person to ascertain the existence or identity of a confidential source of information relating to the enforcement of the law
    - the clinical implications of releasing certain sensitive information and whether the views of a forensic pathologist should be sought.
- it does not allow a coroner or assistant coroner to impose conditions when granting access to ensure items accessed are used according to the purpose for which access has been sought or prescribe any penalty for non-compliance with such conditions.

We recommend amending s. 65 to incorporate these matters to improve the access regime.

.

[53] Section 65(7) *Coroners Act 2009* (NSW)

Recommendation 38

That access to documents under s. 65 of the Act be amended to:

a) clarify that it applies to documents or other evidentiary material which are part of coronial proceedings (inquests and inquiries)

b) require coroners or assistant coroners to also have regard to:

   i. whether granting access may compromise a coronial investigation, coronial proceeding or criminal investigation or proceeding

   ii. whether granting access may reveal sensitive police methodology or disclose or enable a person to ascertain the existence or identity of a confidential source of information relating to the enforcement of the law; and

   iii. the clinical implications of releasing certain sensitive or potentially traumatising information and whether the views of a forensic pathologist should be sought on the matter

c) allow a coroner or assistant coroner to impose conditions upon access and provide for non-compliance to such conditions to be punishable by fine, and enable regulations to be made to specify the process for issuing and enforcing a fine.

Timely provision of relevant material to investigative agencies

Section 36 of the Act requires the State Coroner to provide the Ombudsman or the Commissioner of the NDIS Quality and Safeguards Commission with all relevant information they hold in certain circumstances (e.g., the death of a child in care; a death in a children's detention or correctional centre or lock up; the death of a resident in specialist disability accommodation).

The relevant material pertaining to these matters must be provided as soon as practicable after a matter is finalised. That is, after:

- a decision is made not to hold an inquest concerning the death or suspected death; or
- if an inquest is held—the conclusion or suspension of the inquest (s. 36(2)).[54]

Section 36 ensures that the Ombudsman or the Commissioner of the NDIS Quality and Safeguards Commission can access all relevant material to conduct their own investigations. However, the requirement in s. 36(2) that relevant material be provided only after a matter is finalised is impacting the timely provision of relevant material to these investigative bodies, especially where an inquest is held.

Stakeholders supported removing the requirement for matters to be finalised prior to providing relevant material to allow information sharing to occur sooner. Some stakeholders raised concerns about the potential for an ongoing investigation to be impacted or for the duplication of investigations.

We recommend that s. 36(2) be amended to require relevant material be provided as soon as practicable after its receipt by the State Coroner, but no later than a decision not to hold

[54] *Coroners Act 2009 (NSW)* s 36(2).

an inquest or the conclusion or suspension of an inquest. Further, we recommend that this amendment require consideration of any objections to the provision of information where it may expose or prejudice an ongoing investigation.

This amendment will ease the administrative burden on the coronial jurisdiction as relevant materials can be provided as and when they are received by a coronial support team with knowledge of the case, rather than requiring relevant materials to be identified, collated and sent after finalisation. It will enable timely access by the Ombudsman or the Commissioner of the NDIS Quality and Safeguards Commission to all relevant material held by the coronial jurisdiction to conduct their own investigations, with safeguards against the release of relevant material where this may expose or prejudice an ongoing investigation.

Recommendation 39

That s. 36(2) of the Act be amended to require relevant material be provided to the Ombudsman or the Commissioner of the NDIS Quality and Safeguards Commissioner:

a) as soon as practicable after its receipt by the State Coroner, but no later than a decision not to hold an inquest or the conclusion or suspension of an inquest; and

b) after considering any objections to the provision of the information on the grounds it may expose or prejudice an ongoing investigation.

7.4 Responding to coroners' recommendations

Premier's Memorandum M2009-12 *Responding to Coronial Recommendations* sets out the process for responding to coronial recommendations directed at Ministers and NSW Government agencies.[55] It provides that within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney General outlining any action being taken to implement the recommendation, or if no action is taken, the reasons why. Currently, these are published on the Department's website.[56]

The Select Committee recommended amendments to the Act to improve accountability of responses to coronial recommendations (recommendation 13). This included:

- a requirement that government and non-government entities must respond in writing within six months of receiving coroners' recommendations, noting the action being taken to implement the recommendations, or if no action is taken the reasons why
- a requirement that responses to recommendations, and any failure to respond to recommendations, be tabled in the Parliament of New South Wales
- granting the State Coroner the power to report to the Parliament of New South Wales on any relevant matters or issues, including but not limited to the progress and implementation of recommendations and matters of concern
- a power for the Coroners Court of New South Wales to require a response or further Response from any agency or body to which a recommendation is directed.[57]

[55] See https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/
[56] See https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx
[57] See https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=273#tab-reportsandgovernmentresponses

The requirement that government and non-government entities respond within 6 months also reflects recommendation 32 in the report by the *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* that was handed down in April 2021.[58] All stakeholders support the requirement that responses to coronial recommendations be provided within 6 months, and most support that it be extended to include non-government entities, such as hospitals and aged-care facilities.

We recommend that the Act be amended to require that a Minister, government agency or non-government entity write to the Attorney General within six months of receiving a coronial recommendation outlining the actions that they have taken to respond to the recommendation, or reasons for not taking any action. This will promote consistency and strengthen transparency and accountability across all entities in receipt of coronial recommendations. In some cases, a government agency may provide responses to recommendations from a centralised coordination point for both public and private entities, and where this is the case, the non-government entity need not respond. This is consistent with the approach in Victoria, where all entities that receive a coronial recommendation must provide a written response in the same manner and time frame.[59] The critical factor in determining whether a response is required is whether an entity receives a coronial recommendation, rather than whether it is a government or non-government entity.

Further, both Committees recommended a requirement to table responses to coronial recommendations in Parliament. Rather than require tabling of responses to coronial responses in Parliament, we consider that regular publication of coronial responses online provides a greater level of accessibility and transparency to members of the public who may wish to track and access such responses. The Select Committee recommended that the coronial jurisdiction's website is enhanced to ensure coronial findings, recommendations and responses to recommendations are published in an accessible manner.

We also recommend that the Act be amended to require the responses to coronial recommendations to be published online on the Coroners Court website as soon as practicable.

Other elements of Select Committee recommendation 13, including granting the State Coroner the power to report to Parliament on matters including progress and/or implementation of coronial recommendations or the coronial jurisdiction's power to require responses from government agencies are not supported. The function of monitoring and reporting on progress and/or implementation with respect to coronial recommendations may be better suited to an in-house unit such as a Coroner's Prevention Unit. The Department is considering opportunities to strengthen the preventative capacity of the coronial jurisdiction, such as the establishment of a Coroner's Prevention Unit.

[58] See https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=266 See https://www.parliament.nsw.gov.au/committees/listofcommittees/Pages/committee-details.aspx?pk=266
[59] Section 72, Coroners Act 2008 (Vic).

Recommendation 40

That the Act be amended to require that:

a) within six months of receiving a coronial recommendation, a Minister, government agency or non-government entity write to the Attorney General outlining any action being taken to implement the recommendation, or the reasons why no action has been taken

b) a non-government entity need not respond if a government agency responds to a recommendation directed to the non-government entity

c) the Minister, government agency or non-government entity's response be published online on the Coroners Court website as soon as practicable.

Publication of findings about a self-inflicted death

It is unlawful for findings about a self-inflicted death (suicides) to be published unless a coroner considers publication is in the public interest and makes a publication order: ss. 75(5) and (6).[60] In practice, most suicide findings are not published.

Stakeholders submitted that the prohibition against publication is counterproductive and reinforces the stigma associated with suicides and supported repeal of the prohibition on publishing suicide findings. Discussing suicide publicly can aid prevention strategies, raise general awareness, and ultimately assist in reducing suicide. NSW is the only Australian jurisdiction where there is a presumption against the publication of findings of suicide without the direct order of a coroner.

However, most stakeholders advised that any amendments should strike a balance between the public interest in favour of publication and the interests of affected families. For example, it was suggested that the views of families be taken into consideration and that consideration be given to what information is appropriate to publish.

We recommend that the Act is amended to remove the provision that prohibits the publication of reports of an inquest where there is a suicide finding unless the coroner has made a publication order. In order to protect the interests of families where appropriate, we recommend that the powers of coroners to make non-publication orders in relation to suicides is retained. For example, this would enable a coroner to order that the deceased's name, or that of a relative, be de-identified, where appropriate.

Recommendation 41

That the Act be amended to:

a) remove the provision that provides that reports of inquest proceedings with a suicide finding must not be published unless the coroner makes an order permitting the publication; and

b) retain the provisions that allow a coroner to make non-publication orders in relation to suicides.

[60] Any person who publishes findings about a suicide without the coroner's express authority is guilty of an offence with a maximum penalty of $1,100 ($5,500 for a corporation) or imprisonment for 6 months.

7.5 Administrative and procedural efficiencies

Service of documents and subpoenas

Electronic service of documents

Section 105 of the Act specifies how documents and notices may be validly served. This includes personal service, service by mail and facsimile, but not service by electronic means.

Providing that service may be effected electronically would save costs and enable faster delivery of notices under the Act. However, it is essential that any documents delivered electronically are actually received and read by the recipient. Clause 10.5 of the Uniform Civil Procedure Rules 2005 is a useful example of how this is managed. It only allows service by electronic means if the person is being served via a solicitor's office, and the solicitor's office has advised of an electronic address for service for that purpose. Clause 10.5 also authorises service of documents to a nominated DX address in similar circumstances.

We recommend that service under the Act should be permitted to be effected electronically if the recipient (or their legal representative) has provided an electronic address for service for that purpose. While some stakeholders have requested that the Act specify the use of DX as a method of effecting service, we consider the Act already provides for this through service by mail under s. 105(1)(a)(ii). We also recommend amending the Act to ensure that regulations can be made which may define the term 'electronic service.'

Recommendation 42

That the Act be amended to:

a) provide for the electronic service of documents, if the recipient (or their legal representative) has provided an electronic address for service for that purpose

b) provide that a regulation may define the term 'electronic service'.

Service of subpoenas

Subpoenas may be issued by the coroner under Pt 6 of the Act to require witnesses to attend hearings or require a person to produce a document or thing required for the purposes of evidence in the proceedings. In contrast to the general provisions for service of documents under s. 105, s. 68 provides that a police officer or, where the coroner or assistant coroner issuing the subpoena so directs, a Sheriff, must serve a subpoena. The police officer or Sheriff may serve the subpoena personally, or by mail, facsimile or electronic means depending on whether the recipient is a police officer, public officer, inmate or any other person (or their legal representative) under s. 68(2).

However, there are some matters where the coroner is not assisted by a police officer but by the NSW Crown Solicitor or by a solicitor employed by the Department. In these matters, it would be more efficient if subpoenas could be served by a process server or legal practitioner. We therefore recommend expanding the provision to allow coroners or assistant coroners issuing the subpoena to direct any person to effect service of a subpoena

(i.e. not limited to a Sheriff only). This would enable greater flexibility to effect service in a manner most efficient to each case.

For the reasons outlined above we also recommend that service of subpoenas by electronic communication should be limited to circumstances where the recipient (or their legal representative) has provided an electronic address for service for that purpose.

Recommendation 43

That the Act be amended to:

a) enable coroners or assistant coroners issuing subpoenas to direct any person to effect service of a subpoena

b) allow for the electronic service of subpoenas only in circumstances where the recipient (or their legal representative) has provided an electronic address for service for that purpose.

8. Practice notes, guidelines, and approved forms

Practice notes, guidelines and approved forms are common case management tools used in courts to provide guidance to judicial officers and court users, and to achieve greater consistency and efficiency in the conduct of court proceedings.

Throughout our consultation, stakeholders made a number of useful suggestions to improve coronial processes that could be implemented by more administrative guidance. A number of stakeholders submitted there is a general need for practice notes which would assist with the overall case management of coronial matters.

8.1 Extension beyond coronial proceedings

Under s. 52, the State Coroner can formulate practice notes for coronial proceedings and, after approval by the Chief Magistrate, issue them. The same section also enables the State Coroner to approve forms for use in coronial proceedings.

Section 46(1) provides that 'coronial proceedings' are any proceedings conducted by a coroner or assistant coroner for the purposes of this Act concerning the investigation of a death, suspected death, fire or explosion. Section 46(2) provides further guidance on what coronial proceedings are by listing the following:

- the holding of an inquest or inquiry
- proceedings to determine whether or not to hold, or to continue to hold, an inquest or inquiry
- proceedings of an interlocutory or similar nature (including proceedings to deal with evidential matters or case management issues).

The definition of 'coronial proceedings' appears to refer to proceedings heard in open court, which would prevent the development of practice notes and approved forms for use in coronial investigations and paper/chamber decisions.

We also recognise a number of matters outside of coronial proceedings, which may benefit from administrative guidance by the development of a practice note. To support these matters, we recommend that the State Coroner be able to formulate practice notes and approve forms outside of coronial proceedings as well.

Recommendation 44

That the Act be amended to allow the State Coroner to issue practice notes and approve forms for use in the coronial process.

8.2 Power to issue guidelines beyond coroners

We recognise a number of matters that may benefit from administrative guidance, some of which the State Coroner may consider would be better addressed by guidelines than practice notes.

While practice notes provide guidance on coronial practice and procedure, guidelines may provide guidance on a wider range of matters, including matters about decision-making functions under the Act. Guidelines also provide a more flexible administrative tool

compared to practice notes which are required to be published in the Gazette and cannot be issued without prior approval from the Chief Magistrate.

The Act currently only provides for the State Coroner to issue guidelines to coroners to assist them in the exercise or performance of their functions (s. 10(1)(d)). However, there are a number of persons other than coroners who also exercise functions under the Act. For example, medical investigators who exercise post-mortem investigation directions under s. 89, and medical practitioners who report deaths and advise coroners on whether to dispense with inquests under ss. 25 and 38. We therefore recommend amending the Act to allow the State Coroner to issue guidelines more broadly to persons exercising a function under the Act.

Recommendation 45

That the Act be amended to allow the State Coroner to issue guidelines to persons exercising a function under the Act (i.e. not limited to coroners).

8.3 Suggestions for practice notes and guidelines

Given the State Coroner is responsible for issuing practice notes and guidelines we are not making specific recommendations on this matter. Instead, we have summarised below matters raised in the Review that may benefit from some administrative guidance. It is a matter for the State Coroner to determine which of these matters need addressing, and whether to address them through practice notes, guidelines or other administrative means. In this process, the State Coroner may undertake further consultations with relevant experts and community members.

Table of suggestions for practice notes and guidelines

Issue	Matters for administrative guidance
Factors to be considered	• how to balance the factors • the appropriate referral pathways for the deceased person's family to access professional or other support • the procedure for notifying and informing the deceased person's family of particulars and progress of the investigation • the differing beliefs and practices surrounding death among differing cultures and religions.
Where the death was not the reasonably expected outcome of a health-related procedure	• the factors to consider in assessing the potential causal connection (including the appropriate timing for making that assessment) • the factors to consider in assessing the objective standard of an appropriately qualified registered medical practitioner by which the standard of reasonableness is to be made (including the appropriate timing for making that assessment). For example, guidance may be given to consider what is the clinically accepted

	range of risks, the views of an ordinary skilled practitioner or a professional peer of the treating practitioner.
Deciding whether to hold an inquest	• the procedure for notifying and consulting with the deceased person's family • how to balance the factors coroners must consider in exercising their discretion to hold an inquest or not.
Coronial Certificates and Determinations	• how to balance the factors, including the views of senior next of kin, that coroners must consider in exercising their discretion to issue a Coronial Certificate or Coronial Determination • the process for providing a Coronial Certificate or Coronial Determinations to the senior next of kin • the information to be included in a Coronial Certificate or Coronial Determination • the process for providing written reasons for issuing a Coronial Certificate or Coronial Determination to persons with sufficient interest in the circumstances of the death.
Determining who is senior next of kin	• the procedure for notifying and consulting with the deceased person's family • the procedure for notifying and consulting with the default senior next of kin in determining any competing claims.
Concurrent inquests and inquiries	• how to balance deciding when to hold concurrent inquests and inquiries against holding separate inquests and inquiries • the number of incidents that should be subject to concurrent inquests and inquiries • the provision for separate findings to be delivered in respect of each death, fire or explosion
Access to the coronial process	• the types of matters that may be 'any relevant matter' under s. 65(3), which coroners are required to consider in determining whether to grant access • how to balance the matters listed under s. 65(3), particularly for requests for access made outside of coronial proceedings • the application of common law rights to privilege and public interest immunity.

Appendix A: Written submissions received to the Review between 2014 to 2017

The following written submissions were received in response to the initial public call for submissions on the Review in 2014:

A.1 Former State Coroner, Mr Barnes (5 February 2015)

A.2 Individual views of the lawyers within the Inquiries Practice Group of the NSW Crown Solicitor's Office (29 August 2014)

A.3 NSW Police Force (10 November 2014)

A.4 Corrective Services NSW (15 September 2014)

A.5 Legal Branch, Department of Communities and Justice (25 September 2014)

A.6 The Law Society of NSW (16 September 2014)

A.7 NSW Bar Association (18 August 2014)

A.8 Legal Aid Commission of NSW (undated)

A.9 Aboriginal Legal Service (22 August 2014)

A.10 Victims Services (26 August 2014)

A.11 Family & Community Services (4 September 2014)

A.12 NSW Health (3 September 2014)

A.13 Transport for NSW (undated)

A.14 Justice Health & Forensic Mental Health Network (20 August 2014)

A.15 The Royal College of Pathologists of Australasia (20 August 2014)

A.16 Australian Medical Association NSW (14 August 2014)

A.17 Multicultural NSW (undated)

A.18 Public Interest Advocacy Centre Ltd (26 November 2014)

A.19 Henry Davis York (8 September 2014)

A.20 MDA National (22 September 2014)

A.21 Avant Mutual Group (25 August 2014)

A.22 Mr Ross Stone (various)

Additional written submissions received on the Review between 2016 and 2017:

A.23 Family & Community Services (now Department of Communities and Justice) (5 April 2016)

A.24 Australian Funeral Directors Association (12 April 2016)

A.25 Australian Baha'i Community (May 2016)

A.26 Mental Health Commission of NSW (24 May 2016)

A.27 Her Honour J Mottley, former Acting Chief Magistrate (14 September 2016)

A.28 The Law Society of NSW (30 May 2016)

A.29 NSW Health (6 June 2016)

A.30 NSW Society of Jewish Jurists & Lawyers (19 June 2016)

A.31 NSW Registry of Births, Deaths & Marriages (29 June 2016)

A.32 Aboriginal Legal Service (14 September 2016)

A.33 Mental Health Commission of NSW (September 2016)

A.34 Youth Justice (14 September 2016)

A.35 Aboriginal Affairs (undated)

A.36 Public Interest Advocacy Centre Ltd (14 September 2016)

A.37 Legal Aid Commission of NSW (September 2016)

A.38 Justice Health & Forensic Mental Health Network (15 September 2016)

A.39 NSW Police Force (14 September 2016)

A.40 Families and Friends of Missing Persons Unit, Victims Services (undated)

A.41 Corrective Services NSW (15 September 2016)

A.42 Australian Federal Police (16 September 2016)

A.43 Former State Coroner, Mr Barnes (16 September 2016)

A.44 Former Deputy State Coroner, Mr Dillon (20 September 2016)

A.45 Community Justice Centres (18 September 2016)

A.46 Family & Community Services (now Department of Communities and Justice) (19 September 2016)

A.47 The Law Society of NSW (19 September 2016)

A.48 Attorney-General's Department (Cth) (28 September 2016)

A.49 John Abernethy (former NSW State Coroner) (6 December 2016)

A.50 Hugh Dillon (former Deputy State Coroner) (20 June 2017)

A.51 Legal Branch, Department of Communities and Justice (21 June 2017)

A.52 Mental Health Commission of NSW (26 June 2017)

A.53 Office of the Director of Public Prosecutions (27 June 2017)

A.54 Victims Services, including Families and Friends of Missing Persons Unit (28 June 2017)

A.55 NSW Society of Jewish Jurists & Lawyers (28 June 2017)

A.56 Public Interest Advocacy Centre Ltd (28 June 2017)

A.57 Former Chief Magistrate, the Honourable Graeme Henson (28 June 2017)

A.58 Former State Coroner, Mr Barnes (29 June 2017 and 4 July 2017)

A.59 Legal Aid Commission of NSW (30 June 2016)

A.60 Fire & Rescue NSW (30 June 2017)

A.61 NSW Police Force (30 June 2017)

A.62 Police Association of NSW (3 July 2017)

A.63 NSW Health (5 July 2017)

A.64 NSW Bar Association (7 July 2017)

Appendix B: Stakeholder consultations on the Review from 2016 to 2017

A.1 Former State Coroner M Barnes and former Deputy State Coroner H Dillon (17 December 2015)

A.2 Aboriginal Legal Service (30 March, 6 April and 7 April 2016)

A.3 Law Society of NSW (30 March, 6 April and 7 April 2016)

A.4 Legal Aid Commission of NSW (30 March, 6 April and 7 April 2016)

A.5 NSW Bar Association (30 March, 6 April and 7 April 2016)

A.6 Public Interest Advocacy Centre Ltd (30 March, 6 April and 7 April 2016)

A.7 Corrective Services (5 April 2016)

A.8 Former Deputy State Coroner H Dillon (5 April 2016)

A.9 Family & Community Services (5 April 2016)

A.10 Lawyers from the Crown Solicitor's Office (5 April 2016)

A.11 NSW Police Force (5 April 2016)

A.12 Office for Police (5 April 2016)

A.13 Youth Justice (5 April 2016)

A.14 Former State Coroner M Barnes and former Deputy State Coroner H Dillon (12 April 2016)

A.15 Australian Federation of Islamic Councils (15 April 2016)

A.16 Buddhist Council of NSW (15 April 2016)

A.17 Hindu Council of Australia (15 April 2016)

A.18 Multicultural NSW (15 April 2016)

A.19 Muslims Australia (15 April 2016)

A.20 National Sikh Council of Australia (15 April 2016)

A.21 NSW Society of Jewish Jurists & Lawyers (15 April 2016)

A.22 NSW Council for Pacific Communities (15 April 2016)

A.23 Blackdog Institute (5 May 2016)

A.24 Coronial Information Support Program (5 May 2016)

A.25 Families and Friends of Missing Persons Unit (5 May 2016)

A.26 Former Deputy State Coroner H Dillon (5 May 2016)

A.27 Homicide Victims' Support Group (5 May 2016)

A.28 Suicide Prevention Australia (5 May 2016)

A.29 Victims Services NSW (5 May 2016)

A.30 Victims Support Australia Inc (5 May 2016)

A.31 Aboriginal Affairs (formerly, the Department of Education) (10 May 2016)

A.32 Aboriginal Services Unit (Department of Communities and Justice) (10 May 2016)

A.33 Australian Funeral Directors Association (16 May 2016)

A.34 Dtarawarra Resource Unit (10 May 2016)

A.35 Former Deputy State Coroner H Dillon (10 May 2016)

A.36 Former State Coroner M Barnes (16 May 2016)

A.37 NSW Health (16 May 2016)

A.38 NSW Justice Health & Forensic Mental Health Network (16 May 2016)

A.39 Royal College of Pathologists of Australasia (16 May 2016)

A.40 Former State Coroner M Barnes and former Deputy State Coroner H Dillon (30 June 2016)

A.41 Lawyers from the Crown Solicitor's Office (30 June 2016)

A.42 NSW Police Force (30 June 2016)

A.43 Office for Police (30 June 2016)

A.44 Corrective Services (22 September 2016)

A.45 Former Deputy State Coroner H Dillon (22 September 2016)

A.46 Coronial Information Support Program (22 September 2016)

A.47 Legal Aid Commission of NSW (22 September 2016)

A.48 Mental Health Commission of NSW (22 September 2016)

A.49 NSW Bar Association (22 September 2016)

A.50 NSW Justice Health & Forensic Mental Health Network (22 September 2016)

A.51 NSW Police Force (22 September 2016)

A.52 Office for Police (22 September 2016)

A.53 Public Interest Advocacy Centre Ltd (22 September 2016)

A.54 Aboriginal Legal Service (28 September 2016)

A.55 Community Justice Centres (28 September 2016)

A.56 Family & Community Services (28 September 2016)

A.57 Law Society of NSW (28 September 2016)

A.58 NSW Health (28 September 2016)

A.59 NSW Rural Fire Service (28 September 2016)

A.60 Office of the Director of Public Prosecutions (28 September 2016)

A.61 Office of Emergency Management (28 September 2016)

A.62 His Honour State Coroner M Barnes (28 September 2016)

A.63 Suicide Prevention Australia (28 September 2016)

A.64 Victims Services NSW (28 September 2016)

A.65 NSW Police Force (7 October 2016)

A.66 Office for Police (7 October 2016)

A.67 Belinda Baker[61] (19 October 2016)

A.68 Former State Coroner M Barnes and Belinda Baker (21 October 2016)

A.69 Former Chief Magistrate, the Honourable Graeme Henson (30 November 2016)

A.70 Former State Coroner M Barnes (31 May 2017)

A.70 Legal Branch, Department of Communities and Justice (27 July 2017)

A.71 NSW Health (4 August 2017)

A.72 Legal Aid Commission of NSW (8 August 2017)

[61] Belinda Baker is the co-author of the leading commentary on the Act, Waller's Coronial Law and Practice in NSW (4th Ed) Abernethy, Baker, Dillon and Roberts (Lexis Nexis 2010).

Appendix C: Written submissions received on the Review in 2023

A.1 NSW Registry of Births, Deaths and Marriages (21 June 2023)

A.2 Aboriginal Affairs NSW, Department of Premier and Cabinet (22 June 2023)

A.3 Transport for NSW (23 June 2023)

A.4 NSW Treasury (28 June 2023)

A.5 Judicial Commission of NSW (28 June 2023)

A.6 NSW Department of Customer Service (28 June 2023)

A.7 NSW Rural Fire Service (28 June 2023)

A.8 Victim Services, Department of Communities and Justice (29 June 2023)

A.9 Crown Solicitor's Officer (30 June 2023)

A.10 Adjunct Professor Hugh Dillon (20 June 2023; 6 July 2023)

A.11 Jumbunna Institute, University of Technology Sydney (28 June 2023)

A.12 Office of the Director of Public Prosecutions (30 June 2023)

A.13 Supreme Court of NSW (30 June 2023)

A.14 Public Interest Advocacy Centre (30 June 2023)

A.15 National Justice Project (30 June 2023)

A.16 NSW Jewish Board of Deputies (3 July 2023)

A.17 Coroner's Court of NSW (3 July 2023)

A.18 NSW Department of Planning and Environment (3 July 2023)

A.19 NSW Department of Education (3 July 2023)

A.20 NSW Justice Health and Forensic Mental Health Network (3 July 2023)

A.21 Domestic Violence NSW (3 July 2023)

A.22 The Cabinet Office (5 July 2023)

A.23 Corrective Services NSW (6 July 2023)

A.24 NSW Ministry of Health (7 July 2023; 13 July 2023)

A.25 Women's Legal Service NSW (7 July 2023)

A.26 Women, Family and Community Safety, Department of Communities and Justice (11 July 2023)

A.27 NSW Nurses and Midwives' Association (12 July 2023)

A.28 Law Society of NSW (12 July 2023)

A.29 Aboriginal Legal Service (NSW/ACT) (12 July 2023)

A.30 NSW Police Force (17 July 2023)

A.31 Police Association of NSW (17 July 2023)

A.32 Legal Aid NSW (18 July 2023)

A.33 NSW Crime Commission (19 July 2023)

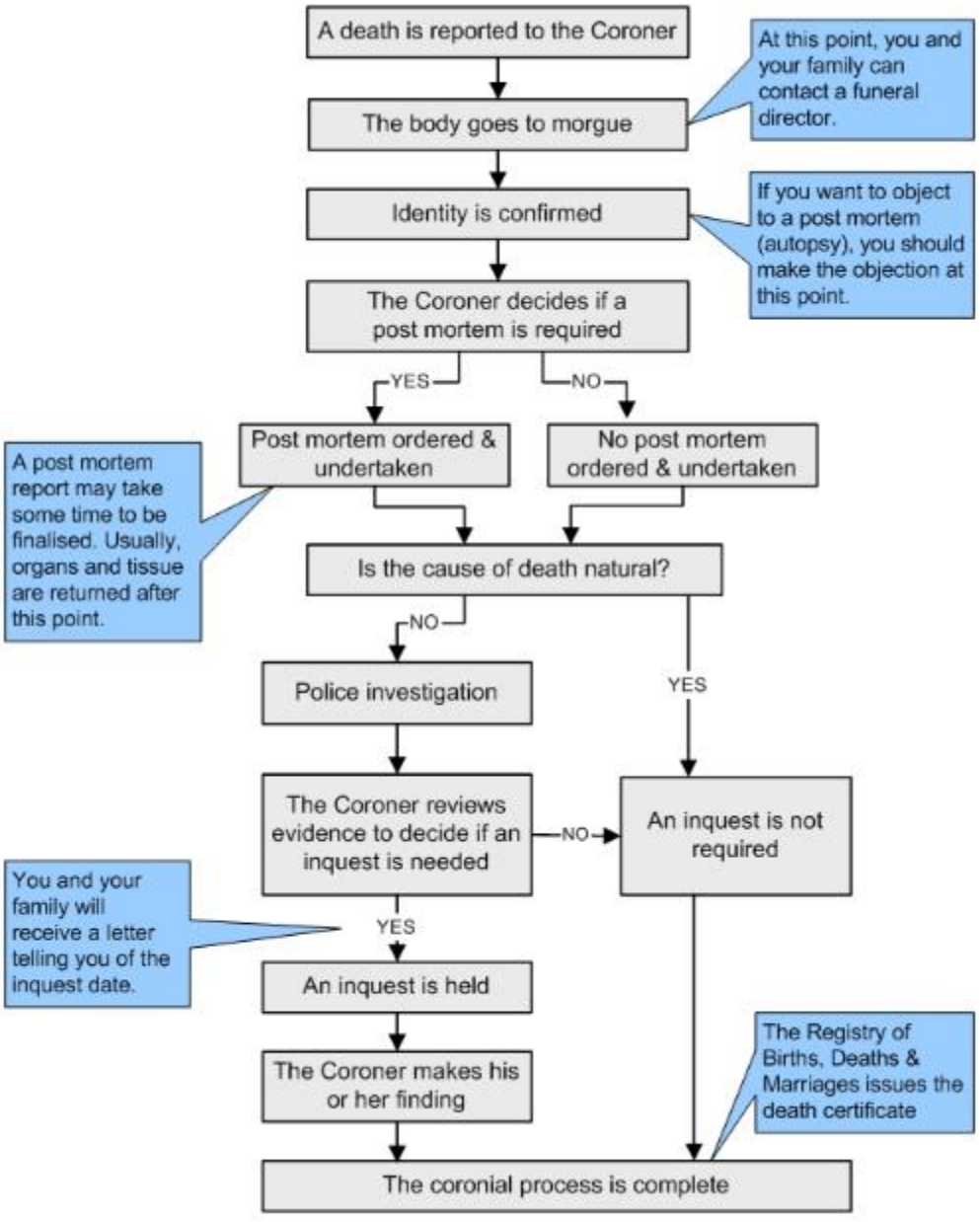
A.34 Women's Domestic Violence Court Advocacy Program Unit, Legal Aid NSW (19 July 2023)

A.35 NSW Bar Association (21 July 2023)

A.36 Department of Regional NSW (25 July 2023)

A.37 The Royal College of Pathologists of Australasia (11 August 2023)

Appendix D: Diagram of coronial process



[62]

[62] Available via the Coroners Court of NSW website, 'Overview of the Coronial process'https://www.coroners.nsw.gov.au/coroners-court/the-coronial-process/overview-of-the-coronial-process.html (accessed 21 February 2022).