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6 March 2023

Special Rapporteur on extrajudicial, summary or arbitrary executions

By email only: hrc-sr-eje@un.org

Dear Mr. Morris Tidball-Binz

CALL FOR INPUT: DEATHS IN CUSTODY

The National Justice Project (NJP) welcomes the opportunity to contribute to the Special Rapporteur on extrajudicial, summary or arbitrary executions inquiry into state practices for the investigation, documentation and prevention of deaths in custody in the criminal justice context.

About the National Justice Project

NJP is a not-for-profit human rights legal service. We fight for justice, fairness and inclusivity by tackling systemic discrimination through the power of strategic legal action, education and advocacy.

We represent individuals and families of loved ones who have been harmed or have died due to discrimination and government failures. We facilitate legal action and complaints against government, health and custodial institutions that have failed in their duty to eradicate systemic bias in the health and justice systems and in their duty to provide quality and respectful health care and equality before the law.

We are motivated and informed by the strength and experiences of our clients, their families and communities and it is from this perspective that we present this submission.

Call for input – Deaths in custody

We note your particular interest in existing practices for data gathering, analysis and reporting of deaths in custody.

In Australia, there is a critical lack of robust, nationally consistent data gathering, analysis and reporting of deaths in custody, and First Nations deaths in particular.

In 1991, the findings of the Royal Commission into Aboriginal Deaths in Custody ('Royal Commission') emphasised the importance of monitoring and maintaining data on First Nations deaths in custody. The Royal Commission made strong recommendations about data collection, in particular recommendations 40 – 47 below, none of which are being currently complied with.

> **Post-death investigations**
>
> 40. That Coroners Offices in all States and Territories establish and maintain a uniform data base to record details of Aboriginal and non-Aboriginal deaths in custody and liaise with the Australian Institute of Criminology and such other bodies as may be authorised to compile and maintain records of Aboriginal deaths in custody in Australia. (1:180)
>
> **Adequacy of Information**
>
> 41. That statistics and other information on Aboriginal and non-Aboriginal deaths in prison, police custody and juvenile detention centres, and related matters, be monitored nationally on an ongoing basis… [and] that responsibility for this be established within the Australian Institute of Criminology

and that all custodial agencies co-operate with the Institute to enable it to carry out the responsibility. The responsibility should include at least the following functions:

a. Maintain a statistical data base relating to deaths in custody of Aboriginal and non-Aboriginal persons (distinguishing Aboriginal people from Torres Strait Islanders);

b. Report annually to the Commonwealth Parliament; and

c. Negotiate with all custodial agencies with a view to formulating a nationally agreed standard form of statistical input and a standard definition of deaths in custody. Such definition should include at least the following categories:

i. the death wherever occurring of a person who is in prison custody or police custody or detention as a juvenile;

ii. the death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention;

iii. the death wherever occurring of a person who dies or is fatally injured in the process of police or prison officers attempting to detain that person; and

iv. the death wherever occurring of a person who dies or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention. (1:189)

42. That governments require the provision of and publish, on a regular and frequent basis, detailed information on the numbers and details of the people passing through their police cells. (1:195)

43. That a survey such as the 1988 National Police Custody Survey be conducted at regular intervals of, say, two to five years, with the aim of systematically monitoring and evaluating the degree to which needed improvements in legislation, attitudes, policies and procedures that affect police custody are implemented. (1:195)

44. That the Australian Institute of Criminology co-ordinate and implement the recommended series of national surveys. The experience of the first national survey points to the fact that careful planning with all the relevant authorities will be needed to ensure that the maximum amount of useful information is derived from the surveys. (1:195)

45. That the appropriate Ministerial Councils strive to achieve a commonality of approach in data collections concerning both police and prison custody. (1:196)

46. That the national deaths in custody surveys which I have recommended be undertaken by the Australian Institute of Criminology include the establishment of uniform procedures and methodologies which would not only enhance the state of knowledge in this area but also facilitate the making of comparisons between Australian and other jurisdictions, and facilitate communication of research findings. (1:196)

47. That relevant Ministers report annually to their State and Territory Parliaments as to the numbers of persons held in police, prison and juvenile centre custody with statistical details as to the legal status of the persons so held (for example, on arrest; on remand for trial; on remand for sentence; sentenced; for fine default or on other warrant; for breach of non-custodial court orders; protective custody or as the case may be), including whether the persons detained were or were not Aboriginal or Torres Strait Islander people. (1:197)

In response to the above recommendations, the Australian Government established the Australian Institute of Criminology's National Deaths in Custody Program (NDICP). However, it's worth noting that the NDICP only recently began reporting annually, in 2018 – after Guardian Australia, together with the Jumbunna Institute for Indigenous education and research at the University of Technology, Sydney created 'Deaths Inside', which tracks every known First Nations death in custody between 2008-2021.

Despite the NDICP, accurate, detailed and up-to-date information on First Nations deaths in custody is still hard to find as coronial inquests across all Australian jurisdictions are often plagued with lengthy multi-year delays, and individual agencies are not required, and are often reluctant, to publish their own data.

As a result of these failings, the onus continues to fall on families, advocates, human rights lawyers, researchers and the media to collect, publish and maintain deaths in custody databases and to monitor and evaluate government and institutional responses to and implementation of recommendations.

These inadequacies are further exacerbated by the failures of successive governments to meaningfully address systemic issues, such as non-reporting of Indigenous status by police and coroners; broad classification of natural cause deaths; lack of accountability for acts of neglect and excessive force by police and prison officers and healthcare workers in custodial settings; failing to provide access to adequate, culturally safe and trauma-informed physical and mental health care in custodial settings, with harmful and at times fatal consequences, including deaths by suicide; and the reluctance of coroners to refer matters for prosecution or disciplinary review.

In response to the second question relating to measures in place, including policies and good practices for investigating, documenting and preventing deaths in custody, we respectfully enclose:

1. NJP Submission to the New South Wales (NSW) Select Committee Inquiry into the coronial jurisdiction in NSW (July 2021). The submission is co-authored by the families of David Dungay Jr. and Jack Kokaua who died in custody in 2015 and 2018, respectively. The submission highlights the failure of successive State and Federal governments to implement the Royal Commission recommendations and calls for fundamental changes to re-establish the coronial system as a vehicle capable of delivering justice through truth, accountability and prevention, particularly for families whose loved ones have died in custody.
2. Report of the Select Committee Report into the coronial jurisdiction in NSW (April 2022), issuing 35 recommendations.
3. The NSW Government's extremely disappointing and grossly inadequate response to the Legislative Council Select Committee report on the coronial jurisdiction in NSW (October 2022). Of the 35 recommendations issued by the Select Committee, 20 recommendations were merely 'noted' and six 'supported in principle'.
4. The NJP Position Statement on First Nations Overincarceration and Deaths in Custody, which includes a detailed overview of Australia's policies and practices in relation to the coronial process and investigations into First Nations deaths in custody.

Furthermore, we refer to the complaint made by Ms Leetona Dungay to the United Nations (CCPR communication No. 4106/2022) on 21 August 2021. The complaint is in relation to the failures of the the NSW coronial system, and the Commonwealth and NSW government more broadly, to protect her son, David Dungay Jr.'s right to life, and the NSW Coroners failure to refer for disciplinary action the corrections officers involved in her son's death. The complaint, which was made in the hope for justice and accountability and for the government to acknowledge the issue of First Nations deaths in custody, is evidence of the fact that there are limited procedures in place for facilitating the participation of victims' families and their access to effective remedies.

Nationally, at least 516 First Nations people have died in custody since the findings of the Royal Commission were handed down in 1991. Of these, 24 deaths occurred between June 2021 and July 2022 alone, with more than one third of these deaths occurring in NSW – the largest number in more than 3 decades.

Genuine accountability for wrongdoing is critical for deterring future misconduct, and for providing justice for the families and communities of First Nations people who have died at the hands of police and prison staff. However, despite coroners having the power to refer for prosecution or disciplinary review, this rarely occurs. In Australia, police and corrections officers retain a significant role in

coronial inquests and are generally responsible for the initial fact-finding investigation. This lack of independence not only further entrenches the existing mistrust First Nations people have in the legal system but also denies First Nations individuals, families and communities a sense of justice following the death of a loved one in custody.

There is a critical lack of independence, impartiality and transparency in the coronial investigation process, and no obligation on government agencies, institutions and oversight bodies to make recommendations on systemic issues, and to monitor the implementation of recommendations coming out of inquiries to address these issues.

More than 30 years ago, the Royal Commission recommended that a coroner inquiring into a death in custody should make broad recommendations with the view to prevent further custodial deaths. In the Australian Capital Territory, the Northern Territory, Western Australia and Tasmania, where there is a death in custody coroners are mandated to make recommendations pertaining to the quality of care, supervision and treatment of the deceased to prevent similar deaths occurring. In NSW, making such findings remains at the coroner's discretion. However, even in jurisdictions where such recommendations are mandated, it is the general practice of coroners to deliberately confine their investigations to avoid addressing systemic issues relating to First Nations deaths in custody.

To those who are the victims of state violence, the existing investigative procedure lacks fairness and independence. An independent investigation requires that those conducting it have no interest in the outcome to ensure that unconscious bias does not influence the investigation. First Nations people can have no faith in a coronial inquest process that appears from the outset to be biased against the interests of the victim and in favour of the state.

Since the Royal Commission, there have been numerous reports and inquiries by human rights bodies, First Nations organisations and successive governments, as well as countless advocacy efforts and national campaigns, without meaningful action or improved circumstances. This ongoing failure to challenge systemic racism and hold governments, institutions and individuals accountable for their actions (and inaction) is not due to a lack of practical solutions but an absence of political will. This is a crisis that needs to be remedied with urgency.

Grieving families deserve better. They deserve a coronial system that can deliver justice through truth, accountability and prevention.

If you have any questions, please don't hesitate to contact me or my colleague, Ariane Dozer (arianed@justice.org.au).

Yours sincerely,

George Newhouse | Principal Solicitor

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Submission No 27

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: National Justice Project

Date Received: 12 July 2021

National Justice Project

Submission to NSW Select Committee's Inquiry into the Coronial Jurisdiction in New South Wales

July 2021

WARNING: *First Nations readers should be aware that this submission uses the names of deceased persons with permission from their families.*

ABOUT THE AUTHORS

THE NATIONAL JUSTICE PROJECT

The National Justice Project is a not-for-profit human rights legal service that works to eradicate institutional discrimination. Our mission is to fight for justice, fairness and inclusivity by eradicating systemic discrimination. Together with our clients and partners we work to create systemic change and amplify the voices of communities harmed by government inaction, harm and discrimination.

Our key areas of activity include health justice, specifically for persons with disability and First Nations communities; challenging misconduct in police, prisons and youth services; and seeking justice for asylum seekers and refugees. We receive no government funding and intentionally remain independent in order to do our work. We therefore rely on grassroots community, philanthropic and business support.

We create positive change through our key strategic areas:

- **Undertaking strategic legal action** including representing clients in public interest litigation, which leads to law reform, policy change, attitudinal change, improved services and accountability for people who have been harmed by injustice.
- **Delivering world class, practice-inspired and catalytic social justice education** for the community, and for current and future legal professionals and advocates, thus growing the next generation of social justice lawyers in Australia and the Pacific.
- **Supporting grassroots advocacy** built on ethical, rigorous and fact-based research that amplifies the voices of communities harmed by injustice, and leads to law reform and policy change driven by the experience of community.

This submission has been co-authored by staff of the National Justice Project: Mr George Newhouse, Director and Principal Solicitor; Ariane Dozer, Projects Manager and Solicitor; and Rosaleen Jeffries, Legal Clerk, together with the National Justice Project Clinic operating at Monash University under the supervision of Steven Castan. We respectfully acknowledge the contribution and testimony of the Dungay and Kokaua families who have revisited their painful experiences with the view to promote positive change. We too highlight their experiences in hope that much needed reform will be realised.

ACKNOWLEGDEMENT OF FIRST NATIONS PEOPLES' CUSTODIANSHIP

The National Justice Project pays its respects to First Nations Elders, past and present, and extends that respect to all First Nations peoples across the country. We acknowledge the diversity of First Nations cultures and communities and recognises First Nations Peoples as the traditional owners and ongoing custodians of the lands and waters on which we work and live.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The National Justice Project recognises that throughout history the Australian health and legal systems have been used as an instrument of oppression against First Nations Peoples. The National Justice Project seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

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OVERVIEW

EXECUTIVE SUMMARY

In this paper, the National Justice Project examines the fundamental changes required to re-establish the coronial jurisdiction as a vehicle capable of delivering justice through truth, accountability and prevention. We focus on the role of the coronial system in responding to deaths which occur in connection with police or corrective services. To demonstrate the harsh reality of the system as it stands, we draw on the strength of two families who were let down by the system in hope that their truth will be a source of momentum to drive change.

The right to life is one of the most core human rights and yet many avoidable deaths pass through the coronial system each year. An avoidable loss of life causes irreversible effects to families, communities and is a stain on society as whole. When a death occurs at the hands of state institutions, purportedly designed to serve and protect the community, additional scrutiny is required to promote accountability and prevent future deaths from occurring.

The coronial jurisdiction has a unique role in investigating the circumstances that lead to a death. This can be the ultimate opportunity to provide truth, healing, closure and justice to families. The Royal Commission into Aboriginal Deaths in Custody[1] envisaged that post death investigations would lead to systemic change. At present, the current coronial jurisdiction in New South Wales fails to implement those recommendations by generally avoiding addressing systemic issues where deaths are caused by systemic prejudice and racism.

> *The Royal Commission [into Aboriginal Deaths in Custody] recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.*[2]

[1] Australia, *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) ('*Royal Commission*')
[2] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 6.

TERMS OF REFERENCE

That a Select Committee be established to inquire into and report on the coronial jurisdiction in New South Wales, and in particular:

(a) the law, practice and operation of the Coroner's Court of NSW, including:

  (i) the scope and limits of its jurisdiction,
  (ii) the adequacy of its resources,
  (iii) the timeliness of its decisions,
  (iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
  (v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,
  (vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health,

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

(c) the most appropriate institutional arrangements for the coronial jurisdiction in New South Wales, and

(d) any other related matter.

KEY RECOMMENDATIONS

Inspired by guiding principles of justice, accountability, transparency, cultural safety and the sovereign rights of First Nations peoples, we make the following overarching recommendations that apply to all representations made in this submission:

1. Implement the recommendations from the Royal Commission into Aboriginal Deaths in Custody and all relevant subsequent enquiries.
2. The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. The investigative body should have the power to examine the death of a First Nations person under the control of state officials in broad contexts including in police custody, in prisons, any corrective services, during transport, in accessing health services, as well as in the interrelated decisions made by officials in these various bodies and any related death 'close to custody'. Such a body must have real powers to make recommendations, compel responses to recommendations, refer matters for prosecution or disciplinary action and to undertake regular prison and youth detention inspections.
3. Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.
4. First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

DETAILED RECOMMENDATIONS
TO IMPROVE THE CORONIAL JURISDICTION

Scope and limitations of the coronial jurisdiction

5. We recommend that the *Coroner's Act 2009* be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.
6. We recommend that the *Coroner's Act 2009* be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.
7. We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.
8. We recommend that the *Coroner's Act 2009* be amended to:
    a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and
    b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

9. We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.
10. We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

Resources

11. We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.
12. We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

Timeliness of decisions

13. We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

The outcomes and oversight of recommendations

14. We recommend that the *Coroners Act 2009* be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.
15. We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

Responding to cultural needs

16. We recommend that the *Coroners Act 2009* be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.
17. Until complete independence is established, at the very least, a First Nations consultative group must be established and resourced; with powers to liaise with Coroners and to consult with them regarding the scope of coronial investigations of First Nations deaths, to ensure the system is culturally safe at all times and that recommendations are made to address systemic factors that may have caused or contributed to the death of a First Nations individual.

Open Justice

18. We recommend that the *Coroner's Act 2009* be amended to encourage the public release of evidence - with family members' consent where appropriate.
19. We recommend that the *Coroner's Act 2009* be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.

CONTEXT

The National Justice Project ('**NJP**') made a detailed submission to the New South Wales Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody ('**the previous Select Committee Enquiry'**).[3] We stand by the recommendations set out in that submission, which, in our view, remain inextricably linked to the current inquiry. In this submission, we provide additional recommendations that are critical to developing a coronial system that is capable of discharging its obligations in response to deaths which occur in connection with police or corrective services.

Much of our submission focuses on the interaction of the New South Wales ('**NSW**') coronial system with First Nations peoples however we recognise that the systemic failings are not isolated to Australia's First Peoples, and we share a variety of experiences to provide the Committee with a clear understanding of current system's real and devastating impacts on families and communities.

Our submissions must be read together with the many substantive recommendations made to the previous Select Committee Enquiry,[4] together with the recommendations made in numerous other inquiries dating back to the Royal Commission into Aboriginal Deaths in Custody ('**RCIADIC'**),[5]. Throughout this submission, we refer to, and endorse, the recommendations articulated by our sector colleagues including the Jumbunna Institute for Indigenous Education and Research ('**Jumbunna Institute'**), many of which have been made repeatedly to other investigations. All that remains is for the executive and the NSW Parliament to implement them. We implore the Committee to prioritise the implementation of these oft repeated measures.

This submission is informed by the experiences of our clients and their interaction with the NSW coronial system, specifically in circumstances where the death of a family member has occurred in connection with police or corrective services. With permission, we specifically draw on the experiences of two brave families, the Kokaua family and the Dungay family, who despite having lost much loved family members, are willing to share their experiences with the Committee to prevent other families from going through similar experiences. The circumstances of their deaths are briefly set out below:

- Jack Kokaua, a 30-year-old Maori and Cook Islander man, described by his family as "a compassionate, loving guy" and "soft and gentle…despite all he has been through." Jack died on 18 February 2018 after being tasered multiple times by police and the inquest into his death occurred from 2019-2020. Testimony from the Kokaua family is located in Case Study A.

- David Dungay Jr, a 26-year-old Dunghutti man from Kempsey NSW, was very loved by his close-knit family. He enjoyed schooling, music and sports. David died on 29 December 2015 in Long Bay prison hospital when he was restrained and given a sedative after he refused to stop eating a packet of biscuits. Testimony from the Dungay family is located in Case Study B.

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[3] National Justice Project, Submission No 102 to the *Select Committee into the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Oversight and Review of Deaths in Custody* (August 2020).
[4] Select Committee into the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Parliament of New South Wales, *Oversight and Review of Deaths in Custody* (2020) ('*Select Committee Enquiry'*).
[5] *Royal Commission* (n 1).

SUBMISSIONS

We structure the following submissions in accordance with the Terms of Reference as set out by the Committee and we implore the Committee to consider the submissions and recommendations put forward in full.

(a) the law, practice and operation of the Coroner's Court of NSW, including:

(i) the scope and limits of its jurisdiction

1.1 In our view and in the view of our clients, there are significant legislative and cultural factors that limit the NSW coronial jurisdiction and reduce its ability to deliver "justice" to First Nations and Culturally and Linguistically Diverse ('**CALD**') families. The tendency of Coroners to apply a narrow interpretation to the scope of inquests and ultimately the breadth of their findings and recommendations is hindering more meaningful outcomes. The reach of the Coroners Court must be expanded so that Coroners are mandated to consider factors beyond the immediate cause and circumstances of a death.

1.2 Although, the Coroners Act 2009 (NSW) confers significant discretion to each coroner in relation to the scope of the inquiry, in the absence of an express requirement to look more broadly, Coroners routinely narrow the focus of inquests to the exclusion of systemic issues such as discrimination, bias and prejudice. Convincing a Coroner to expand the scope of an inquest is exceptionally difficult for families without legal representation and often for their legal representatives. The result is a missed opportunity to stop further deaths and lack of accountability, which is particularly unacceptable where:

(a) a person dies as a result of state sanctioned violence whilst they are interacting with or under the supervision of the State;
(b) a person dies in police custody, detention or prison or near to or close to custody;
(c) a person's death is the result of failings of procedures or systems; or
(d) where systemic factors have a direct bearing on how they died.

1.3 When investigating deaths related to the actions of police and corrections officers and health practitioners, the scope of the jurisdiction of the NSW Coroner's Courts must be expanded to mandate Coroners to:

- Prioritise protection and prevention of deaths;
- Investigate deaths near to or 'close to' custody;
- Consider the quality of care, treatment and supervision prior to a death;
- Make referrals to disciplinary bodies and prosecution authorities;
- Consider whether systemic discrimination, bias or prejudice caused or contributed to the death; and
- Enhance the substantive participation of families in a trauma informed and culturally safe manner.

Comparable models that demonstrate where the scope of the coronial system has been expanded in other jurisdictions to overcome its limitations is located below in Part B.

Protection and prevention

1.4 NSW coronial laws must be updated to prioritise the prevention of future deaths by formally recognising each Coroner's role in protection and prevention. Almost thirty years ago, RCIADIC noted that 'adequate post death investigations have the potential to save lives'[6]. The coroner's power to prevent unnecessary deaths lies in their ability to make recommendations and referrals at the conclusion of an inquest. These recommendations 'represent the distillation of the preventive potential of the coronial process'.[7]

1.5 The investigation and making of recommendations about deaths that occur in connection with police or corrective services, particularly for First Nations people, must be mandated to ensure similar deaths caused by or contributed to by actions of State agencies are prevented in the future, as was recommended in the RCIADIC.[8]

1.6 The coronial system and oversight of deaths in custody would be enhanced by regular detailed review and analysis of coronial findings to identify common themes and systemic issues, and to inform a coordinated NSW Government policy response designed to prevent unnecessary deaths.[9]

We recommend that the *Coroner's Act 2009* be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.

We also support and endorse the following recommendations made to the previous Select Committee Enquiry:

- Legal Aid NSW recommended the establishment of dedicated units to assist coroners in the development of prevention-focused coronial recommendations and to monitor and inform policy and systemic change in relation to deaths in custody, particularly First Nations deaths.[10]

- The Australian National University recommended that the coroner's office should be resourced and mandated to monitor and report on the implementation of recommendations arising from inquests into deaths in custody.[11]

Deaths 'close to' custody must be considered by the Coroner

1.7 NSW Coroners should to be mandated by legislation to investigate, issue findings and make recommendations relating to deaths that occur near to or 'close to' custody. The scope of the jurisdiction needs to be extended to ensure that all deaths related to any involvement of police or corrections are examined to prevent unnecessary deaths in the future.

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[6] *Royal Commission* (n 1) vol 1, 170 [4.7.4].
[7] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 Journal of Law and Medicine 173.
[8] *Royal Commission* (n 1) vol 5, Recommendation 13.
[9] An example of such a function in practice is the NSW Domestic Violence Death Review Team (DVDRT).
[10] Legal Aid NSW, Submission no 117 to *Select Committee Enquiry* (n 4) 13 [Recommendation 33].
[11] Australian National University Law Reform and Social Justice Research Hub, Submission no 109 *Select Committee Enquiry* (n 4) 11 [Recommendation 3.4].

1.8 Presently, section 23(1) of the *Coroners Act 2009* (NSW) outlines a number of circumstances in which a coroner can hold an inquest concerning the death or suspected death of a person. The jurisdiction does not extend to cover deaths which occur after, but proximate in time to, or 'close to' a period in custody. As a consequence, in certain cases, police may escape accountability for their actions, and families are denied an independent coronial investigation.

1.9 As an example, in one case, police arrested one of our clients, a First Nations mother and the victim of a vicious assault and took her into custody but they failed to make safe arrangements for her infant son. Hours later, 10-month-old Baby was brutally murdered by the same violent perpetrator who had seriously injured the child's mother. Despite continued advocacy, the role of the police in Baby's death has never been examined.

We recommend that the *Coroner's Act 2009* be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.

Quality of care, treatment and supervision must be in scope

1.10 The RCIADIC recommended that a 'Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.'[12] This recommendation recognises that inadequate care, treatment and supervision leading up to a death, often caused by bias against First Nations people, may contribute to deaths in custody. However, this recommendation has not been consistently implemented and the *Coroners Act 2009* (NSW) does not require a Coroner presiding over an inquest into a First Nations death in custody to consider the quality of care, treatment and supervision of the deceased before their death – let alone an extensive longitudinal review of their supervision, care and treatment. While NSW Coroner has a discretion to consider matters beyond the 'mere medical cause of death',[13] in practice, this discretion is exercised narrowly, foreclosing an investigation into the wider or systemic circumstances.

1.11 These limitations are particularly concerning in light of the experiences of people with mental health and cognitive conditions which are prevalent among people who come into contact with the criminal justice system.[14] Police and corrections continuously fail to operationalise a health and wellbeing-orientated response to mental health episodes. The coronial jurisdiction urgently needs to examine these failings in order to provoke lifesaving policy reform.

1.12 The frequent limitation by Coroners of the ambit of an inquest to the 'immediate cause and nature of the death', to the exclusion of broader factors is frustrating for First Nations families

[12] *Royal Commission* (n 1) vol 5, [12].
[13] *Lauw v McLean* (High Court of New Zealand, Hardie Boys J, 12 January 1988) cited in Kevin Waller and John Abernethy, *Waller's Coronial Law & Practice in NSW* (LexisNexis, 4th ed, 2010) 26-7 [1.116].
[14] Robert Parker and Helen Milroy, 'Mental Illness in Aboriginal and Torres Strait Islander Peoples' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2nd ed, 2014); Baldry et al, *A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system* (Report, October 2015).

as well as other diverse communities, who 'want the Coroner to examine the wider and related circumstances that contributed to the death'.[15]

1.13 The NJP acknowledges that some Coroners are prepared to expand the scope of an inquest to encompass health care and treatment, as was the case in the inquest into the death of **Naomi Williams**[16] or of **Jack Kokaua**. In the Inquest into the Death of Jack Kokaua, the State Coroner dealt with Mr Kokaua's mental health history and also considered how this affected the police interactions with him, and ultimately made powerful recommendations in respect to the management of individuals with mental health conditions by police and health services.[17] The full testimony of the Kokaua family's experiences with the NSW coronial system can be found in **Case Study A**.

1.14 By way of contrast, during the inquest into the death of **David Dungay Junior** ('**David Jr**'), the Dungay family and NJP raised concerns about the appropriateness of the mental health treatment provided to involuntary patients, who were also inmates in correctional settings.[18] However, the Coroner, on multiple occasions, deemed that 'broader issues relating to management of David's mental health', fell 'outside the parameters of the inquest'.[19]

1.15 In the inquest into David Jr's death the coroner refused to allow any evidence to be heard about the family's calls to consider the systemic question of why NSW prisoners are being detained in a prison hospital ward, instead of a public hospital - when no other State or Territory treat prisoners in need of health care this way. We suggest that the narrow interpretation applied by the Coroner was not in the interest of truth and justice. The full testimony of the Dungay family's experiences with the NSW coronial system is located in **Case Study B**.

1.16 The consideration of all factors that contributed to a person's death cannot be discretionary particularly in the light of the RCIADIC recommendations. Through the examination undertaken in the coronial process, life-threatening healthcare, procedural and capacity deficiencies of police and custodial officers can be properly assessed and addressed.

We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.

Referrals must be made for discipline and prosecution where appropriate

1.17 Coronial decisions not to refer individuals involved in deaths in custody to oversight bodies, and the reluctance to make emphatic, targeted recommendations, perpetuate the injustice of the

[15] George Newhouse, Daniel Ghezelbash and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76, 79 ('Newhouse, Ghezelbash, Whittaker') citing Alison Whittaker, 'Dragged 'Like a Dead Kangaroo': Can Australian Justice Systems Do Justice for Indigenous Deaths in Custody?' (LLM Thesis, Harvard University 2018).
[16] *Inquest into the Death of Naomi Williams,* 29 July 2018, 2016/2569.
[17] *Inquest into the Death of Jack Kokaua* (Unreported, Coroner's Court of New South Wales, State Coroner Teresa O'Sullivan, 12 May 2021) ('*Inquest into the Death of Jack Kokaua*').
[18] *Inquest into the Death of David Dungay* (Reported: 2015/381722, Coroner's Court of New South Wales, Magistrate Derek Lee, Deputy State Coroner 22 November 2019, 2015/381722, 17 [11.7] ('*Inquest into the Death of David Dungay*')
[19] Ibid.

deaths that occur as a result of state sanctioned violence or in, or soon after, incarceration. While Coroners have the power to refer individuals to prosecution or to disciplinary bodies, there has been a general reluctance to do so.

1.18 There needs to be accountability to drive change, and without it, the potentially therapeutic value of the coronial system remains unrealised. More than 475 First Nations people have died in custody since the RCIADIC in 1991.[20] Unfortunately in recent months, the number of deaths in custody has continued to grow and yet no police or prison officer has yet been held responsible.

1.19 Following the death of a loved one in custody, many families experience not only strong emotional trauma and grief, but a profound desire for justice and accountability, motivated more than anything else by a yearning to prevent another family from going through the horror of losing a loved one. When someone in the broader community is responsible for taking a life, society expects an expansive investigation and a legal process to bring the perpetrator to justice. However, the despite the coronial process forming a part of the justice system, the outcomes of coronial inquests almost always fail to deliver justice or provide answers for families involved. It is no wonder that First Nations families feel completely disengaged and excluded from the justice system. For First Nations families, the justice system is quick to arrest and incarcerate their people, but is reluctant to hold those responsible for state violence to account. This injustice is stark, sustained and a dark stain on the justice system.

1.20 David Jr lost his life, and the whole world has seen the irrefutable evidence, and yet David Jr and his family have been let down every step of the way and still there has been no accountability. Former USA police officer, Derek Chauvin, was recently sentenced to 22 years in prison for his role in the death of George Floyd, which has been likened to the death of David Jr. We hope that the unprecedented conviction of Derek Chauvin serves as encouragement to the Australian justice system and the coroner's jurisdiction in particular, that appropriate referrals to prosecution bodies, who have the resources and expertise to determine guilt should be engaged in the pursuit of justice.

1.21 A coronial inquiry is not concerned with allocating blame to any party or finding a party guilty of an offence.[21] However, due to the inquisitorial nature of an inquest, it can become clear that an offence may have been committed or that there has been misconduct or a breach of professional standards.[22] As such, it is important that a coroner not only has the power, but is mandated to refer a matter to the DPP or relevant complaint body to ensure that justice and accountability become possible.

1.22 Currently the law in NSW is unclear and does not ensure such just outcomes are achieved. The Coroners Act 2009 (NSW) does require a coroner to forward to the Department of Public Prosecutions ('DPP') the depositions taken at an inquest or inquiry but only when section 78 of

[20] Alexandra Gannoni and Samanthan Bricknell, "Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody," Australian Institute of Criminality (February 2019). <https://www.aic.gov.au/sites/default/files/2020-05/sb17_indigenous_deaths_in_custody_-_25_years_since_the_rciadic_210219.pdf>

[21] Derrick Hand, 'The Office of the State Coroner' (1991) 2(3) *Current Issues in Criminal Justice* 69, 70; *Coroners Act 2009* (NSW) s81(3); *Coroners Act 2008* (Vic) s69(1); *Coroners Act 1993* (NT) s34(3); *Coroners Act 2003* (Qld) s46(3); *Coroners Act 1995* (Tas) s28(4); *Coroners Act 1996* (Tas) s25(5).

[22] Hand (n 72) 70.

the Act applies.[23] Section 78 only applies when the coroner either understands that a person has been charged with an indictable offence that raises the issue of whether they caused the death[24] or if the coroner believes that the evidence is capable of satisfying a jury beyond reasonable doubt that a person has committed an indictable offence and there is a reasonable prospect that a jury would convict the person of the indictable offence that is relevant to whether the person caused the death.[25] Such a threshold, is ambiguous as the Act explicitly states that the Coroner 'must not indicate or in any way suggest that an offence has been committed by any person'[26] and yet to refer a matter to the DPP, the Act requires the Coroner to have contemplated whether a person is capable of being found guilty of an indictable offence. By creating such a high and convoluted threshold, the Act seemingly contradicts itself and creates a barrier for both the deceased and the deceased's family to access any form of genuine justice. In addition, Section 78 does not apply to non-indictable offenses and professional standards complaints. In most cases, without a coronial referral there is no practical pathway for family members to seek justice, particularly as investigatory authorities often hide behind the Coroner's failure to refer a matter to them as a reason to refuse to act.

1.23 Positively in NSW, along with Victoria, the ACT and Queensland, in circumstances where the Coroner meets their respective thresholds for referring a matter to the DPP, they must make the referral.27 Such a model promotes the perception that justice is possible and ensures that the correct processes are instigated in the appropriate circumstances. However, as NSW currently stands, Coroners remain unconfident to make referrals.

1.24 The Dungay family have petitioned and advocated consistently since David Jr's death for justice. The family of David Jr feel completely failed by the coronial system as well as the Commonwealth and the NSW government and their inability not only to protect David's right to life, but to hold anyone accountable. Lawyers and human rights advocates worldwide attest that there is sufficient evidence for charges to be laid by the DPP and SafeWork NSW, and yet the Coroner found that none of the five guards involved in David's death should face any disciplinary action.[28] The Coroner found that the conduct of the guards was 'limited by systemic deficiencies in training' and not motivated by 'malicious intent.'[29]

1.25 The Coroner in the inquest into David Jr's death implied that a lack of 'malicious intent' was a sufficient basis to reject the Dungay family's submission for a referral to the DPP. We suggest that the scope of the Coroner's referral power is misconceived as requiring an implicit perception by Coroner that a 'malice' threshold is met.

"I am going to fight until I live in a country where Black Lives Matter." – Ms Leetona Dungay

1.26 Following numerous unsuccessful attempts to instigate a legal process to cause those responsible for David Jr's death to be held accountable, the Dungay family have taken the

[23] *Coroners Act 2009* (NSW) s78(4)(a).
[24] *Coroners Act 2009* (NSW) s78(1)(a).
[25] *Coroners Act 2009* (NSW) s78(1)(b).
[26] *Coroners Act 2009* (NSW) s81(3).
[27] *Coroners Act 2009* (NSW) s78(4); *Coroners Act 2008* (Vic) s49(1); *Coroners Act 1997* (ACT) s58(3); *Coroners Act 2003* (Qld) s48(2).
[28] *Inquest into the Death of David Dungay* (n 18) 60.
[29] Ibid 60 [18.12].

matter direct to the United Nations30. The Dungay family have been forced to complain to the United Nations because they have no avenues to seek justice in Australia. The full testimony of the Dungay family's experiences with the NSW coronial system is located in **Case Study B**.

1.27 If made, a referral by the Coroner would not amount to a finding of guilt, but would invite the appropriate body to make their own assessment as to whether further disciplinary or criminal sanction is warranted. It must also be acknowledged that Coroners rely heavily on the co-operation of the police and corrective services in conducting their investigations, and this reliance may create a tension, deterring Coroners from referring individuals for discipline or prosecution. These potential reasons for Coroners reluctance to refer matters are best responded to by reducing the threshold for referrals, ensuring the statutory position is clear and setting up an independent body to overcome any potential tension.

We recommend that the *Coroner's Act 2009* be amended to:

a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and

b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

Further, we support and endorse the recommendations provided by the Jumbunna Institute to the previous Select Committee Enquiry that:

- the *Coroners Act 2009 (NSW)* be amended to provide standing to, and require the coroner to consider the views of the families of deceased persons in determining whether to exercise the power of referral to prosecutorial authorities;[31]
- the *Coroners Act 2009 (NSW)* be amended to provide a right of appeal to families of the deceased where the Coroner;[32]
- the Office of Director of Public Prosecutions Guidelines be amended to:
  - require Prosecutors to consult with families about decisions not to prosecute individuals involved in First Nation deaths where there has been a referral by a NSW Coroner; and
  - require Prosecutors to give written reasons to families where it refuses to consider prosecution of, or decides not to prosecute, individuals involved in a First Nation death in custody.[33]

Systemic discrimination must be considered

1.28 First Nations deaths in custody occur against a backdrop of overincarceration, dispossession, intergenerational trauma, and continued oppressive systemic discrimination. Australia's public systems were created and operated as an instrument of colonial control against First Nations people. They have resulted in extreme poverty and disadvantage among First Nations people

[30] National Justice Project, *Leetona Dungay to go to the United Nations for David Dungay Jnr*, Media Release 10 June 2021. <https://justice.org.au/leetona-dungay-to-go-to-united-nations-for-david-dungay-jnr/>
[31] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [10.2].
[32] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4), 52 [10.3].
[33] Jumbunna Institute, Submission No 115 to the *Select Committee Enquiry* (n 4) 52 [Recommendation 11.1-11.2].

and an over-representation in criminal justice system which in too many tragic circumstances leads to the coronial jurisdiction.

"We've got no law to help us Aboriginal people because it's a white man's law."
– Ms Leetona Dungay

1.29 First Nations people encounter discrimination at every stage of the criminal justice process, from police interactions and biased law enforcement, to the application of discretion and sentencing terms. The evidence of a prejudiced system is demonstrated in the well-known statistics, most notably encapsulated in the disturbing reality that Australia's First Nations peoples are the most incarcerated people on the planet.[34] Our First Nations peoples are also the oldest continuing cultures in the world and the well-evidenced systemic oppression that they face needs to be addressed with urgency.

1.30 The evidence of the extensive systemic oppression of First Nations people in the criminal justice system is overwhelming. As at March 2020, First Nations Peoples account for 28% of the national prison population despite only being 3% of the Australian population.[35] In parts of NSW, First Nations people are twice as likely to go to jail as non-Indigenous people for the same offence.[36] In the period from 1991-92 to 2015-16, NSW recorded the highest number of First Nations deaths in custody,[37] and today, First Nations people are still more likely to die in custody than non-Indigenous people.[38] It is within this context that significant numbers of deaths of First Nations people in custody come before the Coroners Courts each year. Yet in spite of the clear linkage between the lived experiences of First Nations people in their interactions with police and corrective services, Coroners routinely refuse to consider the broader circumstances surrounding the deaths of First Nations peoples in custody.

1.31 The former Western Australian State Coroner, Alistair Hope, took an expansive view of the Coroner's powers in the inquest into the death of Mr (Ian) Ward, endorsing the following statement from Watterson, Brown and McKenzie (2008: 6):

> *The Royal Commission [into Aboriginal Deaths in Custody] recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify*

[34] Thalia Anthony, 'FactCheck Q&A: Are Indigenous Australians the most incarcerated people in Earth?', *The Conversation* (6 June 2017). <https://theconversation.com/factcheck-qanda-are-indigenous-australians-the-most-incarcerated-people-on-earth-78528>
[35] Australian Bureau of Statistics, *Persons in Custody, Australia, March Quarter 2020* (Catalogue No 4512.0, 4 April 2020); Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016* (Catalogue No 3238.0.55.001, 31 August 2018).
[36] Ella Archibald-Binge, Nigel Gladstone & Rhett Wyman, 'Aboriginal people twice as likely to get a jail sentence, data shows', *The Sydney Morning Herald* (17 August 2020).
[37] Alexandra Gannoni and Samanthan Bricknell, "Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody," Australian Institute of Criminality (February 2019), <https://www.aic.gov.au/sites/default/files/2020-05/sb17_indigenous_deaths_in_custody_-_25_years_since_the_rciadic_210219.pdf>
[38] Laura Doherty and Samantha Bricknell, *Deaths in custody in Australia 2018-19* (Statistical Report No 31, Australian Institute of Criminology, December 2020.

its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.[39]

1.32 Unfortunately, Coroner Hope's approach of making findings on broader systemic issues to "identify underlying factors, structures and practices contributing to avoidable deaths"[40] is not being followed by other Coroners. At present, except for exceptional occasions,[41] NSW Coroners do not make findings to redress discriminatory systemic failings that contribute to deaths.

1.33 The NJP considers that the present coronial system is not responsive to the circumstances surrounding First Nations deaths, and does not provide for the adequate contextualisation of First Nations deaths as part of a history of intergenerational trauma, negative police interactions, systemic police discrimination, poor housing, family services, education and inadequate health treatment. The NJP thus considers that a distinct, independent First Nations-led investigatory body, capable of appreciating and responding to systemic issues, is necessary to inquire exclusively into the deaths of First Nations people in custodial and health settings.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

1.34 The adoption of a targeted approach in respect to domestic violence[42] provides some hope that a cultural shift in the coronial jurisdiction is possible in relation to deaths in custody. The Coroners Act 2009 (NSW) directly recognises the need to respond to the specific circumstances surrounding domestic violence deaths with the view to reducing the incidence of domestic violence deaths and facilitate improvements in systems and services[43], including any systemic and procedural failures which may have contributed to domestic violence deaths, and recommendations, legislative or otherwise, to prevent or reduce the likelihood of such deaths.[44] The establishment and functions of the Domestic Violence Death Review Team[45] is discussed further in Part B.

1.35 The same cannot be said of the treatment of the deaths of First Nations people in custody, despite being established as an issue of pivotal concern over 30 years ago.[46] The deaths of First

[39] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 6.
[40] Ibid.
[41] *Inquest into the Death of Tanya Day* (Reported: 2017/2569, Coroner's Court of New South Wales, Magistrate Caitlin English, Deputy State Coroner); *Inquest into the Death of Naomi Williams* (Reported: 2016/6424, Coroner's Court of Victoria, Magistrate Harriet Grahame, Deputy State Coroner).
[42] *Coroners Act 2009* (NSW) s 101A-P.
[43] *Coroners Act 2009* (NSW) s 101A.
[44] *Coroners Act 2009* (NSW) s101J (2)(a)-(b).
[45] *Coroners Act 2009* (NSW) s 101D-F.
[46] *Royal Commission* (n 1).

Nations people in custody also reveal a systemic problem, for which a targeted and holistic response is needed. We do not refer to the example of domestic violence provisions to suggest that an identical approach is appropriate in the context of First Nations deaths in custody, but that this model may serve as inspiration for a targeted and systemic response, in consideration of the broader factors relating to a First Nations death in custody. A coronial jurisdiction that is reaching its potential would mandate such systemic factors to be examined at Inquest and appropriately responded to.

We recommend that the *Coroners Act 2009* be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.

Substantive participation

1.36 The involvement of First Nations people in the coronial system is often significantly restricted to the detriment of the coronial process. Family members are often limited to providing 'narratives about their loved one's life, rather than the cause or circumstances of their death.'[47]

1.37 Given that the chief concern of families is typically seeking answers and accountability, preventing them from meaningfully participating denies them justice:

> *It shuts out Indigenous participation in the storytelling of indigenous death by making families authorities only on sentiment rather than substance, where they most urgently wish to be.*[48]

1.38 The family of **David Dungay Jr** Family felt disempowered by the adversarial nature of the coronial inquest, which provided no real opportunity for open discussion about what happened, nor did it accommodate the participation of the family. The testimony of the Dungay family can be found in **Case Study B**.

We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

(ii) the adequacy of its resources

2.1 The Coroners Court at present is a system which First Nations people regard with distrust, and which lacks adequate resources to ensure family members are properly supported and engaged throughout the process. The very nature of being involved in the Coronial process is the result of a tragic loss. Adequate resources need to be allocated to reduce the barriers that families currently face to participate in the coronial jurisdiction, implement in entirety the recommended reforms, including overhauling the coronial jurisdiction to ensure it is genuinely effective in discharging its functions, is conducted in a transparent way, and is culturally appropriate and responsive to the needs of First Nations people.

[47] Newhouse, Ghezelbash, Whittaker (n 15) 81.
[48] Ibid.

Supporting family engagement

2.2 Resources need to be allocated to implement reforms necessary to ensure that participate in the coronial process with a focus on supporting active participation and reducing the inevitable re-traumatisation of those involved. We refer to the Committee to the reforms outlined in a 2020 article published in the International Journal for Crime, Justice and Social Democracy,[49] including:

- Overcoming financial and geographic barriers to participation, particularly for families from remote and regional communities who face significant transport and accommodation costs, which can be considerable for 'lengthy inquests and often large groups'[50];
- Providing financial support to families to obtain legal representation with specialist knowledge of coronial practice,[51] which is particularly important when facing the often-disproportionate resources and representation that is utilised by the numerous State parties involved;[52]
- Appoint Aboriginal Liaison Officer's with each Coroner's Court to support the engagement of First Nations families throughout the process and ensure they are supported;[53] and
- Funding legal services to represent First Nations families at inquests with specialist skills and prioritisation of ensuring families are kept informed and supported throughout the process. [54]

We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.

Resourcing independence to restore confidence

2.3 There is a common perception among First Nations families that investigatory bodies, including the Coroner, will not provide them with due process, or a just outcome. To restore confidence and ensure that the coronial process is conducted without prejudice, resources need to be dedicated to overhaul the coronial jurisdiction.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

[49] Newhouse, Ghezelbash, Whittaker (n 15).
[50] Newhouse, Ghezelbash, Whittaker (n 15) 83.
[51] Newhouse, Ghezelbash, Whittaker (n 15) 81-2.
[52] Newhouse, Ghezelbash, Whittaker (n 15) 83.
[53] Newhouse, Ghezelbash, Whittaker (n 15) 86.
[54] Ibid.

Resourcing the jurisdiction to expedite matters

2.4 Traumatised families want to know the truth and have some closure as soon as possible. The consequence of an under-resourced coronial jurisdiction is that evidence gathering and investigations are slow and often drawn out over multiple years. The delay in gathering and processing of evidence can be prejudicial and put the integrity of the investigation at risk. The prolonged process is also traumatising and unfair to families who are grieving the loss of a loved one. Additional resources could also enable Coroners to hold a greater number of inquests and may help to encourage Coroners to exercise their discretion to investigate more cases.

We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

(iii) the timeliness of its decisions

3.1 Coronial inquests in NSW are often plagued with lengthy multi-year delays, which only serve to re-traumatise the families and communities involved. Long delays disrupt the grieving process of families and hinders their ability to achieve closure after the death of a loved one. At times, it can be years before an inquest is held, and then a further lengthy wait for findings to be made. Such lengthy delays between the date of death and the final report can prejudice the investigation and findings. The families involved deserve better.

3.2 The family of David Dungay Jr had to wait almost four years to receive answers concerning his death. The answers they did receive left them asking more questions.

***If there's any inquiry into an Aboriginal death in custody, witnesses will take all the time in the world to fix up their statements.* – Ms Leetona Dungay**

The Kokaua family also had to wait over three years, and they too were left with unanswered questions.

I believe the prolonging of Jack's case is a strategy created by the police supported by the system to weaken families in the fight against the police and their system.
– **Ms Pania Kokaua**

We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

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

4.1 Insightful, evidence-based recommendations are a critical source of improved policy, procedure and legislative reforms. However, without any impetus to implement recommendations, the community faces a never-ending cycle of unactioned recommendations for critical changes that have the ability to save lives.

4.2 One of the most significant issues undermining the role of the coronial system in NSW is the lack of administrative and legal mechanisms to mandate responses to coronial recommendations by government and other organisations.[55] There is currently no legislative procedure to monitor and evaluate how recommendations are being responded to or to measure trends.[56] Recommendations have limited utility without implementation. As was noted in the RCIADIC, to realise any meaningful part of its potential a coronial recommendation must be considered and receive a response.[57] The RCIADIC made specific recommendations requiring Coroners to make, publish, distribute, receive responses and monitor the implementation of recommendations.[58] This Inquiry must be the ultimate catalyst for a coronial system that drives meaningful reform.

4.3 People continue to die in custody without accountability, without answers, and without justice. The families and communities of people who have had loved ones die whilst in the care of the state deserve recommendations to be properly responded to and actioned. Notwithstanding a Royal Commission and numerous other related enquiries, the majority of the recommendations have not been implemented, and the coronial system and inquiries continue to produce recurring recommendations. Practical solutions and pathways forward have been provided time and time again, and yet families and communities continue to be left mourning and questioning. As an example, it seems incomprehensible that the RCIADIC recommended 30 years ago to remove all hanging points in cells,[59] and yet today Coroners are still making the same recommendation.[60] The utility of recommendations, and indeed the entire system, is dependent on measures to compel agencies to respond and act on recommendations.

4.4 The Coroners Act 2009 (NSW) empowers coroners to make recommendations that they deem 'necessary or desirable to make in relation to any matter connected with the death'.[61] While the Act provides that the Coroner must ensure that a record of the recommendations are provided to those to whom they are directed, including government authorities, there is no provision that requires a response from the appropriate person, body or authority.[62]

4.5 The value of a recommendation lies in the response it receives, as such, any legislation that does not mandate agencies respond to coronial recommendations is not pursuing just outcomes.[63] The *Coroners Act 2009* (NSW) does not mandate that government agencies respond to recommendations, instead a Premier's Memorandum suggests that the relevant NSW Government department should acknowledge receipt of a recommendation within 21 days and provide a response to the Attorney-General within six months.[64] The NSW Attorney-General must maintain a record of all recommendations and the responses received from government

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[55] Public Interest Advocacy Centre, *Review of the Coroners Act 2009 (NSW)* (Submission, 2014), 5.
[56] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[57] *Royal Commission* (n 1) vol 1, 155 [4.5.91], 157 [4.5.98].
[58] *Royal Commission* (n 1) vol 1, 172 [4.7.4] (rec 13-15).
[59] *Royal Commission* (n 1) vol 5, Recommendation 165.
[60] Indigenous Social Justice Association (ISIA), Submission No 122 to NSW Legislative Council Select Committee, *Inquiry into high Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (18 September 2020) 6.
[61] *Coroners Act 2009* (NSW), s 82(1).
[62] *Coroners Act 2009* (NSW), s 82(4).
[63] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[64] Department of Premier and Cabinet, 'M2009-12 Responding to Coronial Recommendations', *NSW Government: Premier & Cabinet* (Premier's Memorandum, 31 December 2014). <https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations>

agencies and produce a report collating that information twice a year.[65] However, the Memorandum gives a government agency a discretionary power to decide whether they'll respond to recommendations and thus does not induce public confidence that the circumstances that lead to someone's death have been addressed.[66] It also does not cover non-governmental organisations.

4.6 Without a legislative mandate, it is difficult to effectively measure the trends and impact of recommendations on public health and the prevention of death and importantly, there is no body designed to do so.[67] Without Coroners being made aware of why recommendations are being ignored, they can't better tailor their future recommendations to increase the chance of implementation and actually improve the reform process and achieve their preventive role.[68] There is also a public interest in the disclosure of government agency and non-governmental responses to recommendations.

4.7 The failure to implement recommendations perpetuates the feeling of families among First Nations people that have died in custody, that the coronial process does not provide any measure of assurance that the circumstances surrounding the death of their loved one will not be repeated, let alone offering redress or justice. David Jr's mother, Ms Leetona **Dungay**, acknowledged that while 'some recommendations came out of the inquest to improve the way the gaol operates... there has been no justice for me, my family and my people from the NSW State after the death of my son'.[69] The full testimony of the Dungay family is located in **Case Study B**.

4.8 Following the inquest into the death of **Jack Kokaua**, the NSW State Coroner made a number of recommendations oriented towards reforming police and health staff management of persons in custody with a known mental health illness.[70] However, all of these recommendations were prefaced with the words 'consideration be given'.[71] In circumstances where the Coroner has identified a deficiency in training or procedure as having contributed to the death of a person, the recommendations made must be sufficiently imperative to prevent future deaths from occurring. The full testimony of the Kokaua family is located in **Case Study A**.

Effectiveness of recommendations – related disciplinary issues

4.9 The issues connected with unimplemented recommendations are broader than the *Coroner's Act*[72] or the nature of agency responses. The issues also include the negative interaction of the coronial jurisdiction with the various complaint systems, especially in regard to 'non-fatal

[65] Ibid.
[66] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 355.
[67] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12 (Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[68] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 353.
[69] National Justice Project, Submission No 102 to the *Select Committee Enquiry* (n 4) 5.
[70] *Inquest into the Death of Jack Kokaua* (n 17) 93-4.
[71] Ibid 94 [528]-[529].
[72] *Coroner's Act 2009* (NSW).

misconduct'. Two legislative schemes, the *Police Act* 1990 (NSW)[73] and the *Health Care Complaints Act* 1993 (NSW)[74], highlight this issue in their respective handling of complaints that may arise following deaths in custody.

4.10 The *Police Act* provides a discretionary power to the Commissioner to choose not to investigate or address police misconduct if the conduct is the subject of a coronial inquest.[75] Similarly, the legislative scheme that manages health care complaints makes it lawful for not only an agency, but an *oversight* agency, to decline to investigate a complaint arising from a coronial inquest.[76] Effectually, disciplinary action and the pursuit of accountability is prohibited by both the coronial system and relevant agencies.

4.11 The Local Court Bench Book[77] correctly outlines that it is not appropriate for a Coroner to make *findings* regarding any disciplinary, criminal or civil liability issues arising from an inquest.[78] This direction however presupposes that another jurisdiction will handle issues arising during an investigation.[79] However, what we have repeatedly found is that government agencies utilise their discretion to do nothing, and without Coroner's referring the matters to the appropriate disciplinary or prosecution body for investigation, no action is taken. When an agency fails to take prosecutorial or disciplinary action, it is left to the family to pursue alternative action themselves. This often means advising a family that an inquest is not nearly the end of their traumatic journey through the legal system, and that they are likely to have further years to go.

We recommend that the *Coroners Act 2009* be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.

We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

We also support and refer the Committee to the recommendations made by the Jumbunna Institute to the previous Select Committee Enquiry including:[80]

- Stronger accountability to ensure recommendations are responded to, addressed and implemented in a timely manner by establishing a specialist unit to monitor and review deaths and track the implementation of recommendations.[81]

[73] *Police Act* 1990 (NSW).
[74] *Health Care Complaints Act* 1993 (NSW).
[75] *Police Act* 1990 (NSW) s 132.
[76] Ibid s 27 (1)(c).
[77] Judicial Commission of New South Wales, Local Court Bench Book (December 2020).
[78] Ibid.
[79] Ibid [44-220].
[80] Jumbunna Institute, Submission No 108 to *Select Committee Enquiry* (n 4).
[81] Jumbunna Institute, Submission No 108 *Select Committee Enquiry* (n 4) 16 [9.1].

- Amend the Coroners Act to embed a mandatory requirement for government departments and private institutions to respond to, and report on the implementation of recommendations made.[82]
- The NSW Government establish an independent merits review process to review decisions of Prosecutors not to investigate and/or prosecute deaths of First Nations people.[83]

We also support and refer the Committee to the recommendations made by the Aboriginal Legal Service (NSW/ACT) to the previous Select Committee Enquiry, including:[84]

- that the Coroners Act 2009 (NSW) be amended so that the Coroner is required to produce a written report to the relevant Minister containing both a summary of the details of the deaths or suspected deaths, and a summary of the recommendations and the responses received; and
- any agency of department to which a recommendation directed must report its response and actions taken to implement recommendations to the relevant Minister.

We similarly endorse the 2009 recommendation that in relation to deaths in custody, that Parliament as well as the Executive should be part of the process that responds to coroners' recommendations.[85] Again, we draw the Committee's attention to another inquiry in which solutions were given and insufficient action was taken.

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

5.1 In its current form, the coronial jurisdiction is unable to respond to the needs of First Nations people and other diverse groups. There is no justice for First Nations people in the justice system. The participation of First Nations peoples within the coronial jurisdiction must be understood in the context of the colonial legal system in which Coroner's Courts operate. What has been described as 'institutional trauma' inflicted on First Nations families by an inquest[86] stem from the systemic oppression inflicted through the operation of public systems including the justice and health systems since colonisation.

Failure to address systemic issues

5.2 The apparent inability of the coronial system, except in irregular cases, to address systemic issues such as discrimination in itself prevents the entire jurisdiction from being able to respond to the needs of systemically oppressed groups. Perpetuating a cycle of power imbalance, prejudice and abuse, the process only serves to re-traumatise families who have spent generations contending with institutions and officials who systematically fail to protect their most basic interests.

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[82] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.4].
[83] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 12].
[84] Aboriginal Legal Service (NSW/ACT), Submission No 120 to *Select Committee Enquiry* (n 4) 7 [14].
[85] Public Interest Advocacy Centre, *Review of the Coroners Act 2009 (NSW)* (Submission, 2014), 6.
[86] Newhouse, Ghezelbash, Whittaker (n 15) 86.

5.3 An example of the failings of the *Coroner's Act*[87] to address systemic problems is in health care and especially in relation to suicide. By focusing on the manner and cause of death, the Act allows systemic problems in health care to be denied the resources given to mandatory inquests.

5.4 This problem is amplified by the guidance given to regional coroners via the Local Court Bench Book[88] as to the Coroner's discretion to hold an inquest. The Bench Book refers to an example scenario where the evidence clearly indicates a suicide, and there are no additional suspicious circumstances, then this may be sufficient to satisfy a Coroner that an inquest is unnecessary.[89]

5.5 We suggest that this is the wrong approach to take. It suggests that a person died by suicide and that is all we need to know. It sends the message that systemic discrimination and the intergenerational trauma felt by First Nations people is not suspicious - that nothing is wrong. Moreover, it suggests that the Coroner's Court would not have any recommendations to make about preventing similar deaths.

5.6 These are the cases where the lack of resources for the Coroner's Court does its most insidious harm. Suicides should be presumed to be preventable deaths where an inquest would be useful, even where a person has a history of suicidal ideation. In NJP's experience of clients with suicidal ideation, it is regularly a client's response to improper or inhumane treatment, frequently at the hands of government agencies. People who are on Community Treatment Orders under the *Mental Health Act*[90], people on bail or parole, people whose children have been removed by the relevant Department – these are people whose suicides points to systemic failures in the operation of government. With the permission of the families, the actions leading to deaths by suicide should be examined at an inquest.

Cultural Safety

5.7 The concept of cultural safety, originally drawn from the work of Maori nurses in New Zealand has a broad application. Cultural safety can be defined as:

> *An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening*.[91]

5.8 By creating culturally-informed and safe justice systems, access to justice will be increased and First Nations and culturally diverse peoples will be more likely to have their legal needs and expectations met. Many First Nations families feel marginalised and excluded from the coronial process because of a lack of cultural sensitivity, a lack of institutional transparency and dissonance between the families' demands for justice and the statutory limits of the courts.

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[87] *Coroner's Act 2009* (NSW).
[88] Judicial Commission of New South Wales, Local Court Bench Book (December 2020).
[89] Judicial Commission of New South Wales, Local Court Bench Book (December 2020) [44-160]
[90] *Mental Health Act 2007* (NSW).
[91] Robyn Williams, 'Cultural Safety – what does it mean for our work practice?' (1999) 23(2) *Australian and New Zealand Journal of Public Health* 213.

Inquests ask a lot from family and community members, often without offering much in return for their significant efforts during deep bereavement.[92] Our clients have repeatedly reported to us that they feel their voices are not heard, they are discouraged from speaking up, their concerns are not explored and they are unable to exercise their cultural protocols during the process.

Cultural considerations

5.9 The Coroners Act and coronial process in NSW must specifically accommodate and respect cultural needs and considerations. There are a number of changes that are required in order for the coronial system to adequately respond to the needs of First Nations people.

5.10 The perspectives of First Nations families, and other groups that are over-represented in the justice system, must be central to coronial reform. The NSW Government must listen to the families whose loved ones have died in police or prison custody, and meaningfully and respectfully involve them in all relevant policy and legal reforms.

5.11 Without a specific legislative requirement to accommodate cultural needs, First Nations families as well as others from diverse cultural backgrounds are forced to plead with Coroner's to ensure cultural protocols and other considerations are adhered to.

5.12 The ability to fulfil cultural obligations are important part of the process both for families and to show respect for the deceased. For example, the family of **Jack Kokaua** were extremely appreciative that they were able to perform the Haka during the final tranche of the Inquest. The **Dungay** family organised a smoking ceremony outside of the Coroner's Court.

5.13 Coroners' courts often struggle with the plurality of personal and kinship interests that make up First Nations families.[93] The *Coroners Act 2009* (NSW) must be amended to allow for flexibility and expansion of definitions of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure.

5.14 The appointment of First Nations coroners in every state and territory would significantly improve the cultural appropriateness of the Coronial system. First Nations-led inquests could be held on-country, and the court processes adapted to be more culturally appropriate in consultation with Elders from the community. The coroner could sit with community Elders, and family members participating in the proceedings. Counsel Assisting could work with the family and Elders to both guide and take guidance from them on appropriate practice. In the interim, a First Nations consultative group could assist the coroner in this regard.

Respect for the body of the deceased

5.15 The failure to accommodate cultural and religious protocols related to the treatment of bodies of the deceased is a common concern of many families. Both the **Dungay** and the **Kokaua** families expressed concerns about the treatment of Jack and David Jr's bodies.

[92] Newhouse, Ghezelbash, Whittaker (n 15) 82.
[93] Ibid.

5.16 To ensure respect for cultural protocol, it has been recommended that forensic pathologists be specifically trained on First Nations peoples' cultural practices to do with bodies and how to respect those practices.[94] The RCIAIDC, recommended reforms to the Coroner's Act to ensure that the family of the deceased or their representative have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report.[95]

We recommend that the *Coroners Act 2009* be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.

First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

We support and endorse the recommendations made to the previous Select Committee Enquiry, in particular:

- The Jumbunna Institute's recommendation that in consultation with First Nations people, a number of of First Nations-specific roles, such as Liaison Officers, support staff, Registrar positions and support roles for Elders be created to improve engagement with the coronial system.[96]
- The Jumbunna Institute's recommendation that the *Coroners Act 2009 (NSW)* extend the definition of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure in different cultures (including First Nations).[97]
- The Legal Aid NSW recommendation that the creation of a culturally specific unit within the NSW Coroners Court, developed in consultation with First Nations, employing First Nations staff to act as a point of contact and provide support for First Nations families, and help build trust and informed participation in the system.[98]

[94] Newhouse, Ghezelbash, Whittaker (n 15) 86.
[95] *Royal Commission* (n 1) vol 5, Recommendation 25.
[96] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 51 [Recommendation 3-5].
[97] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.5].
[98] Legal Aid NSW, Submission no 117 to *Select Committee Enquiry* (n 4) 12.

- The Aboriginal Legal Service (NSW/ACT) recommendation that the NSW Government should resource and fund the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.[99]

(vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health

6.1 The integrity of the coronial system is jeopardised by the role of police. The notion of police investigating police is inherently flawed and prevents those who engage with the system from having confidence that the process is not prejudiced. The experience of many First Nations people, including many of our clients, is that the Australian criminal justice system is systemically structured against their interests. It is perceived as a tool for perpetuating the suffering, disadvantage and oppression of their families, while police and corrective services, under the sanction of the State, operate with impunity for the violence and suffering they inflict.

6.2 No Australian jurisdiction has established a system for a completely independent investigation into deaths in police custody.[100] This lack of independence has led to mistrust in the system by First Nations families seeking justice in relation to deaths in custody.[101] These concerns are relevant for all matters that come before the Coroner's Court, but particularly for First Nations people who have a historically unproductive relationship with the police.

Police investigation

6.3 Police retain a significant role in coronial inquests and are generally responsible for the initial fact-finding investigation.[102] Currently, in NSW, all deaths in police or corrective services custody must be reported to the Coroner.[103] NSW Police then conduct an internal investigation on behalf of the Coroner in accordance with the internal Critical Incident Guidelines and prepare a brief of evidence.[104] Once the Coroner is satisfied with the police investigation brief and the medical evidence including the post mortem report, the Coroner can complete their brief and hold an inquest.[105] Where the death concerned was a death in police custody, the use of a police brief may impact the independence and unbiased investigation of the death. The causative factors are explained from the perspective of police in the brief thus the neutrality of the brief is compromised.

6.4 The family of **Jack Kokaua** believe that the Coronial Brief was biased and prepared with a pro-police agenda. The brief detailed the causative factors from the perspective of police, compromising its neutrality. These concerns were reinforced by the selection of photos relied

[99] Aboriginal Legal Service (NSW/ACT), Submission No 120 *Select Committee Enquiry* (n 4) 8 [Recommendation 16].
[100] Human Rights Law Centre, Submission No 68, Australian Law Reform Commission, *Pathways to Justice - Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (4 September 2017).
[101] Ibid.
[102] Ibid [14.68].
[103] *Coroners Act 2009* (NSW) s 35.
[104] NSW Police Force, Critical Incident Guidelines (December 2019). <https://www.police.nsw.gov.au/__data/assets/pdf_file/0020/420392/Critical_Incident_Guidelines_External_Version_updated_23_Dec_2019.pdf>
[105] Judicial Commission of New South Wales, Local Court Bench Book (December 2020) [44-000].

upon to depict the footage. The footage was also not trusted by the family as it was pixelated and failed to show the times that Jack was hit or had fallen down due to tasering. This evidence 'painted Jack in a bad light' and failed to present a complete understanding of the incident and the events that took place. The full testimony from the Kokaua family can be found in **Case Study A**.

6.5 The family of **David Dungay Jr** have concerns about the mismanagement of evidence. They were disturbed to find that a crime scene was not declared in relation to David Jr's cell and that protocols to secure evidence were not adhered to. There is CCTV footage of David Jr on the date of his death that has never been found. The mismanagement of evidence has re-traumatised the family and has left them without closure. The full testimony from the Dungay family can be found in **Case Study B**.

Lack of independence

6.6 To those who are the victims of state violence, the existing investigative procedure appears to lack fairness and independence. An independent investigation requires that those conducting it have no interest in the outcome. Complete independence is the only way to ensure that unconscious bias will not influence the investigation. Because their first contact with the Coroner's office is usually through the police, First Nations people have little faith in a coronial inquest process that appears from the outset to be biased against the interests of the victim and in favour of the State.

6.7 A process in which 'police investigate police' or corrective services guards is far too vulnerable to both deliberate and unintentional perversion by investigators. It has been established in other jurisdictions that an eagerness to protect the reputation and interests of the force may impact on the ability to conduct an unbiased investigation,[106] and it is no different in NSW. This 'culture of loyalty' is well known in the community[107] and places the interests of police and allied officers in preserving their reputations over those of the civilians they are meant to serve and protect, including the First Nations people. To maintain the independence of the coronial process, it is important that the structure of the coronial investigation itself is independent of any involved parties, such as the police, thus removing both any cases of actual bias or perceived bias.

6.8 It is crucial that the primary investigation of the death itself be conducted independently. Although NSW police investigations may be subject to oversight by professional standards and disciplinary boards, this is no substitute for ensuring that initial investigations are properly conducted. It is crucial that critical and specific evidence, including at the location where the death took place, be properly collected and preserved for use in the coronial proceedings.[108] When protocols are not being adhered to, and the investigation is conducted by a party with a vested interest, the integrity of the investigation is automatically questioned, particularly by those who are marginalised by the justice system.

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[106] Office of Police Integrity, *Review of the Investigative Process Following a Death Associated with Police Contact* (2011) 8.
[107] Royal Commission into the New South Wales Police Service, (Final Report, 1997) vol 1, [2.1]-[2.79].
[108] An example is the investigation on Palm Island of the conduct of Senior Sergeant Christopher Hurley, discussed in Craig Longman, "Police investigators too in-house to probe deaths in custody," *The Conversation* (April 2011). <https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838>

6.9 The *Coroners Act NSW* allows the investigation of coronial scenes to be delegated to 'a police officer or other person'.[109] In the absence of a completely independent body, First Nations investigators should be engaged *in all cases* where there is a death of a First Nations person.

Transparency and Open Justice

6.10 Transparency is a critical component of the justice system. Requests are often made to Coroners during an inquest, for non-publication or suppression orders to be issued in respect to sensitive material, such as the identities of involved persons or evidence of the circumstances leading up to a death.[110] The NJP has contributed to a Submission to the NSW Law Reform Commission's Open Justice review together with the Jumbunna Institute and the Aboriginal Legal Service (NSW/ACT).[111] That submission stressed the importance of open justice in the Coroners Court, and the unique impact on First Nations families when Coroners close courtrooms or impose non-publication orders on evidence. While such orders can fulfil an important role in protecting personal details of the individuals involved, they are disproportionately invoked to protect government agents who were involved in the death, rather than promoting transparency, justice and accountability.

6.11 The increasing use of suppression and non-publication orders, particularly as concerns confronting CCTV footage of deaths in custody hinders the role of the Coroners Court.[112] For example, in the CCTV footage of David Dungay Jr's death only Mr Dungay himself is visible. Comparatively, during the inquest into the death of Aunty Tanya Day in Victoria, the Coroner permitted the unedited viewing of video footage capturing the circumstances of her death, which cumulated in a public campaign and a coronial referral to prosecutorial authorities.[113]

We recommend that the *Coroner's Act 2009* be amended to encourage the public release of evidence - with family members' consent where appropriate.

We recommend that the *Coroner's Act 2009* be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.

Adversarial nature of inquests

6.12 The adversarial nature of the coronial process contributes to the sense of disempowerment experienced by First Nations families. While coronial proceedings are 'ostensibly inquisitorial', they are increasingly conducted in an adversarial manner.[114] One consequence of this is that First Nations families feel 'as if they are on trial and that the process is more about suppressing

[109] *Coroners Act 2009* (NSW) ch 5.
[110] Newhouse, Ghezelbash, Whittaker (n 15) 80.
[111] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project, Submission to NSW Law Reform Commission - Open Justice review, NSW Department of Justice, *Open Justice Review* (March 2021).
[112] Ibid 17.
[113] Ibid 18.
[114] Newhouse, Ghezelbash, Whittaker (n 15) 82.

their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice.'[115]

6.13 The process can become a blame-shifting exercise which places the blame on the deceased, or their grieving family. As expressed by Caroline Anderson, the mother of Wayne Fella Morrison who died in Yalata prison, 'I feel like I'm on trial. I'm his mum, you know what I mean? I feel pressure. My parenting skills. How I raised him. It's like I'm on trial for their lack of care'.[116]

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

Until such oversight is established, Coroner's should consult with a First Nations Consultative Committee specifically on deaths in custody.

We similarly endorse the recommendations made previously by our sector colleagues regarding the need for an independent body and referrals for prosecution and disciplinary action, including by Deadly Connections Community and Justice Services Limited[117] and the Jumbunna Institute.[118]

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

In addition to the solutions advanced by NJP and our sector colleagues, we refer the Committee to a number of examples that we hope will inspire improvements to the NSW coronial jurisdiction.

Investigations

7.1 In New Zealand, an Independent Police Conduct Authority has been established as a statutory body to conduct independent investigations and oversight of police conduct, including instances of police detention.[119] The Authority is empowered to investigate complaints and has a

[115] Ibid.
[116] Royce Kurmelovs, 'Three missing minutes, and more questions: Why did Wayne Fella Morrison die in custody?', *NITV News* (online, September 2018) [3] <https://www.sbs.com.au/nitv/feature/three-missing-minutes-and-more-questions-why-did-wayne-fella-morrison-die-custody-1>
[117] Deadly Connections Community and Justice Services Limited, Submission No 126 *Select Committee Enquiry* (n 4) Recommendation 6.
[118] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.4].
[119] *Independent Police Conduct Authority Act 1988* (NZ).

legislative authority to operate completely independently from both the police force and other State agencies.[120]

7.2 In the Northern Territory a failure or refusal of police officers to follow the directions given by a Coroner to investigate elements of a death in custody carries with it criminal liability.[121]

Responding to recommendations

7.3 In Victoria, when the Coroner makes a recommendation to a Minister, public statutory authority or another entity, that body is required to provide a response directly to the Coroner which specifies what action they are taking.[122] Such an approach is preferable as it applies broadly, and requiring responses directly to the Coroner makes it easier for the public to access information and importantly enables Coroners to track their recommendations to inform future recommendations.[123]

7.4 The Northern Territory has a similar system to Victoria and mandates that when a death in custody occurs, any recommendations made to a relevant CEO or Commissioner of Police must provide a written response to the Attorney-General within three months[124] including a statement of the action they are taking.[125]

Enhancing the preventive role

7.5 The Victorian *Coroners Act 2008* introduced significant reforms to the Victorian jurisdiction, in particular enhancing the Coroner's role in the prevention of death.

7.6 The Coroner's Prevention Unit (CPU) in Victoria is a specialist service providing Coroners with expert assistance in developing prevention-focused recommendations. Among the central goals of the CPU is to increase the quality and implementation of recommendations made. The CPU reviews and analyses relevant deaths, and helps to track, publish and monitor the implementation of coronial recommendations.

7.7 A Domestic Violence Death Review Team ('DVDRT') has been established within the NSW coronial jurisdiction, charged with investigating the causes of domestic violence deaths in New South Wales, with the view to reducing the incidence of domestic violence deaths and facilitate improvements in systems and services. The DVDRT is able to review the circumstances of closed cases of domestic violence related deaths,[126] and 'any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths'.[127] The DVDRT must prepare a report every 2 years which is provided to each House of Parliament, and which includes identification of any systemic and procedural failures which may have contributed to

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[120] *Independent Police Conduct Authority Act 1988* (NZ) s 4AB; *Crown Entities Act 2004* (NZ).
[121] *Coroners Act 1993* (NT) s 25(2).
[122] *Coroners Act 2008* (Vic) s72(3).
[123] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 353.
[124] *Coroners Act 1993* (NT) s 46B(1).
[125] *Coroners Act 1993* (NT) s 46B(2).
[126] *Coroners Act 2009* (NSW) s 101G(1)(a
[127] *Coroners Act 2009* (NSW) s 101G (1)(d)

domestic violence deaths, and recommendations, legislative or otherwise, to prevent or reduce the likelihood of such deaths.[128]

Deaths in custody mandate

7.8 In the Australian Capital Territory, the Northern Territory, Western Australia and Tasmania, where there is a death in custody, coroners are mandated to make recommendations pertaining to the quality of care, supervision and treatment of the deceased to prevent similar deaths occurring.[129]

7.9 The RCIADIC recommended that a Coroner inquiring into a death in custody should make broad recommendations with the view to prevent further custodial deaths.[130] However, while the Northern Territory and Tasmania have incorporated this recommendation by making such findings mandatory,[131] in NSW, making such findings remains at the Coroner's discretion.[132]

7.10 In Western Australia, regulations can be made that would give effect to the recommendations of the RCADIC.[133]

A culturally responsive jurisdiction

7.11 In Victoria, there is also a culturally specific unit within the Coroners Court. The Coroners Court has recruited a Koori Registrar and a Koori List Engagement Registrar to manage Aboriginal coronial cases to ensure that coronial practices are culturally sensitive and appropriate.[134] Victoria is also in the process of engaging Aboriginal Elders in the Coroners Court to provide cultural advice to ensure that coronial practices are culturally appropriate and safe.[135]

7.12 The Victorian Aboriginal Justice Agreement, developed in response to recommendations from the RCIADIC and subsequent Summit[136] The strategies and opportunities contained in the Agreement are designed to strengthen First Nations oversight and focus on the important roles of family and therapeutic, cultural healing to tackle offending.[137] The Agreement aims to improve Aboriginal justice outcomes, family and community safety, and reduce over-representation in the Victorian criminal justice system.

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[128] *Coroners Act 2009* (NSW) s101J (2)(a)-(b).
[129] *Coroners Act 1993* (NT) s26(2); *Coroners Act 1996* (WA) s25(3); *Coroners Act 1995* (Tas) s28(5); *Coroners Act 1997* (ACT) s74.
[130] *Royal Commission* (n 1) vol 5, [13].
[131] *Coroners Act 1993* (NT) ss 26(2), 34(2), 124; *Coroners Act 1995* (Tas) s 28.
[132] *Coroners Act 2009* (NSW) s 82.
[133] *Legal Aid NSW, Submission no 117 Select Committee Enquiry* (n 4) 81.
[134] Victoria State Government, 'Goal 3.1: The needs of Aboriginal people are met through a more culturally informed and safe system', *Victorian Aboriginal Justice Agreement* (Webpage, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-met>
[135] Victoria State Government, 'Cultural advice in the Coroners Court', *Victorian Aboriginal Justice Agreement* (Web Page, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-9>
[136] Ministerial Summit on Indigenous Deaths in Custody, *Speeches and papers from the Summit / Ministerial Summit on Indigenous Deaths in Custody* (Compiled by the Commonwealth Attorney-General's Department and ATSIC, 1997).
[137] Victorian State Government, *Victorian Aboriginal Justice Agreement* (Webpage, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-caucus-co-chairs-foreword>

7.13 In Tasmania, the engagement of a First Nations organisation in mandatory where the Coroner suspects that a death involves human remains of a First Nations person.[138] This direction ensures the treatment of a First Nations person's body post-death can be conducted respectfully and that cultural protocols are adhered to.

Referrals to the Director of Public Prosecutions (DPP) and other disciplinary bodies

7.14 In most Australian jurisdictions, the threshold to allow a Coroner to refer a matter to the DPP is much lower than in NSW. Importantly, a Coroner is not required to make any implication or suggestion of guilt, as this is the role of the DPP following their investigation and independent decision to lay charges. A coroner may make a referral to the DPP if they:

- believe that an indictable offence may have been committed (Victoria, Northern Territory and Western Australia);[139]
- have reasonable grounds to believe an indictable offence has been committed (ACT);[140] or
- have a reasonable suspicion a person has committed an offence (Queensland).[141]

7.15 Queensland goes further in promoting accountability by mandating that coroners must refer any other matter, not prosecutable by the DPP, to the CEO of the relevant department who administers the legislation which creates the offence.[142] It also allows for the coroner to give information about corrupt conduct or police misconduct to the Crime and Corruption Commission.[143]

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

8.1 In light of all of the matters, we stand by our principal recommendations, in line with those made to the previous Select Committee Enquiry that in relation to First Nations deaths in custody, that independent oversight needs to be established.

First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

[138] *Coroners Act 1995* (Tas), s 23.
[139] *Coroners Act 2008* (Vic) s49(1); *Coroners Act 1996* (WA) s27(5)(a); *Coroners Act 1993* (NT) s35(3).
[140] *Coroners Act 1997* (ACT) s58(1).
[141] *Coroners Act 2003* (Qld) s48(2).
[142] *Coroners Act 2003* (Qld) s48(2).
[143] *Coroners Act 2003* (QLD) s48(3).

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

We endorse and support the recommendations put forward by the Jumbunna Institute that an independent body could operate as a specialised stream within the coronial system and draw on the existing models of the Koori Court and circle sentencing to promote First Nations self-determination.[144]

(d) any other related matter

Irrespective of any legislative changes and specific improvements to the form and operation of the NSW coronial system, the *culture* of the coronial system as a whole requires a dramatic shift. It cannot be the responsibility for individual Coroner's to establish the necessary system-wide changes. The impetus must be embedded at a system-wide level through policy, statutory amendments and the Executive. A renewed coronial system framework must embed substantive principles of truth, accountability, protection and prevention to enable the coronial jurisdiction to discharge its obligations.

Case Study A: From our case files - Inquest into the Death of Jack Kokaua

Background

Jack Kokaua was a 30-year-old Maori and Cook Islander man, described by his family as "a compassionate, loving guy" and "soft and gentle…despite all he has been through." He had a long history of mental illness dating from his adolescence.

The coronial process is an important vehicle to elicit the true circumstances surrounding a death and an opportunity to identify important changes to prevent future deaths from occurring. The circumstances surrounding Jack's death raised a number of important questions about police restraint techniques, taser use, gaps in mental health training and culturally safe care. There were many occasions in which a different intervention by police, mental health practitioners or his parole officer might have prevented Jack's ultimate fate.

On the morning of 18 February 2018, multiple witnesses called police expressing concern for Jack's safety after witnessing him struggling to ride a rental bike.[145] The responding police called an ambulance and Jack was transported to Royal Prince Alfred Hospital (RPA).[146] Jack subsequently absconded from RPA and was located by police. Jack was capsicum sprayed, tasered on three occasions and held down by multiple officers in the prone position.

[144] Jumbunna Institute, Submission No 108 to *Select Committee Enquiry* (n 4) Recommendation 6.
[145] *Inquest into the Death of Jack Kokaua* (n 17) 17 [92].
[146] Ibid 31 [173].

It was only after additional officers arrived at the scene that Jack's lips were observed as changing colour and an officer was instructed to check whether he was breathing.[147] Unfortunately, Jack had stopped breathing and could not be revived.

The Coroner's Findings

The Coroner found that the actions of police were inconsistent with NSW Police Policies. The officers did not seek the prompt attendance of an ambulance despite the fact that he was tasered three times.[148] The officers did not communicate with Jack for the purposes of reassurance and de-escalation, did not monitor his breathing and did not consider whether force was necessary during his restraint.[149]

The Coroner found that the police restraint techniques which lead to positional asphyxia and exertion as well as the uses of the taser, superimposed upon Jack's underlying occult coronary heart disease, ultimately resulted in Jack's death.[150]

Despite such findings and concerns surrounding the circumstances of Jack's death, jurisdictional limitations and system failures have left the Kokaua family with unsatisfactory information, unanswered questions and a distrust of the coronial process.

Kokaua family concerns with the coronial process:

The family of Jack Kokaua has expressed concerns in relation to their experience and their interaction with the coronial system in NSW.

Lack of resources and communication

The level of support and resources available to families of deceased persons throughout coronial investigations is inadequate. Inadequate lines of communication and limited access to information left the Kokaua family in the dark and waiting for extended periods for the truth to come out. These gaps in communication and support for families can create barriers for families' involvement in the investigation process such as a lack of knowledge of status of the police investigation, preparation of coronial brief and expectations around timeframes and the outcomes of an inquest.

Delayed investigation, communication and findings

Media reports wrongfully claimed that Jack was under the influence at the time of his death. It was later found that this was false, causing great harm and upset to the family for having to wait so long for answers and for the record to be set straight.

[147] Ibid 43 [250].
[148] Ibid 58 [344].
[149] Ibid 74 [421].
[150] Ibid 3.

Further, such failings are evidenced by the fact that the family had to wait for 19-months to hear the account of the involved officers. Pania, Jack's sister, believes that this delay was a strategy to 'wear us out' and allowed the police ample opportunity to cover their tracks and obstruct access to the truth. Most importantly, the delay prevented the family from being able to seek closure and grieve for their kin. The police claimed to have no notes and claimed that no discussions took place before the hearing however, such claims are not believed by the family.

The Kokaua family were greatly affected by the lack of timeliness in the findings being handed down. Two days before the findings were due to be handed down, the family was advised that there may be a delay, which did eventuate and the findings were finally handed down 6-weeks later. The family, though understanding the substantial evidence needed to be reviewed, were not prepared for such a significant delay. Jack's mother, Queenie Kokaua, had travelled from New Zealand to be present when the findings were due to be handed down and was not able to travel to and from Australia again. The postponement caused great stress to the family.

The Kokaua family also had to sit through 3 tranches and wait over two years after the first Directions hearing (2 May 2019) to hear the findings (12 May 2021). Reflecting on the more than 3-year gap in time between the date of Jack's death (18 February 2018) and the release of the findings, Pania states '**I believe the prolonging of Jack's case is a strategy created by the police supported by the system to weaken families in the fight against the police and their system**.'

Police Conduct

The police conduct during the proceedings was of great concern to the Kokaua family. The police received certificates under s 61 of the *Coroners Act 2009* (NSW)[151] which permitted them to testify without prejudice. While giving evidence, the police showed great disrespect for both Jack and his family. Officers said that they would not change anything in hindsight and made rude remarks which included a reference that likened Jack to a cockroach. The police lawyers were also seen to be disrespectful in Court. These interactions exacerbated the already existing unease of the family with the police, whose conduct contributed to Jack's death.

Investigation and evidence

The Kokaua family believe that a more thorough investigation should have taken place. The family believe that the Coronial Brief was biased and prepared with a pro-police agenda. As the police briefs play a key role in the finalisation of the Coroner's Brief, it is reasonable for the family to hold such concerns. Where the death concerned was a death in police custody, as it was in Jack's case, the use of a police brief may impact the independence and unbiased investigation of the death. The brief detailed the causative factors from the perspective of police, compromising its neutrality. These concerns were reinforced by the selection of photos relied upon to depict the footage. The footage was also not trusted by the family as it was pixelated and failed to show the times that Jack was injured or had fallen down due to tasering. This evidence 'painted Jack in a bad light' and failed to present a complete understanding of the incident and the events that took place.

[151] *Coroners Act 2009* (NSW) s 61.

Condition of the Jack's body and cultural protocol

The Kokaua family was upset about the condition of Jack's body when it was returned to them. The condition of Jack's body was left unaddressed at the Inquest. The family's embalmer identified that there was substantial decay to the body and stated that it was in the 'worst condition they had seen'. Such factors have led to great distrust of the autopsy process, concern as to how the body was kept and uncertainty as to whether the condition was tied to the police or the post-mortem process. Due to the condition of the body, the family were unable to have a 3-day viewing as part of their funeral customs.

Positive Experiences

Although the above-mentioned circumstances were extremely harmful to the Kokaua family, the respect shown by Counsel Assisting (Kristina Stern SC) and the Coroner (Magistrate Teresa O'Sullivan) was the first sight of hope for justice in the whole ordeal. The Counsel Assisting and the Coroner acted with dignity, integrity and respect at all times. Queenie Kokaua stated they "actually tried to make us feel comfortable in the most uncomfortable situation a family could find themselves in". In addition, the family appreciated that they were allowed to perform the Haka at the final tranche of the Inquest.

Case Study B: From our case files - Inquest into the David Dungay Junior

Background

David Dungay Jr ('**David Jr'**) was a 26-year-old proud Dunghutti man from Kempsey NSW. He was very loved by his close-knit family and was a mentor to his family members. He enjoyed schooling, music and was an excellent sportsman.

David Jr suffered from mental health issues and had a history of recurring psychosis. He was diagnosed with type 1 diabetes when he was just six years old and had been managing his insulin independently since then.

David Jr was being detained in Long Bay Prison and was receiving involuntary treatment in the sub-acute ward at Long Bay prison hospital as a mental health patient.[152] David Jr was in lawful custody at the time of his death on the 29th of December, only three weeks away from parole.

The Coroner stated that the events of 29 December 2015 and the circumstances surrounding David Jr's death raised a number of questions about the manner of his death.[153] The Inquest sought to explore key issues relating restraint techniques, appropriate use of force, compliance with policies and procedures, cultural sensitivity and appropriateness of steps taken following David Jr's death.

[152] *Inquest into the Death of David Dungay* (n 18) [1.1].
[153] Ibid [2.3].

On the day David Jr died, he was eating biscuits in his prison cell.[154] Despite David Jr always having self-managed his diabetes, concerns were raised about risk to his health posed by his eating of the biscuits. Prison guards asked David Jr to stop eating the biscuits, but he refused. No adequate attempt was made by the prison officers to remove the biscuits from David Jr or negotiate with him.[155] Instead, the officers called in the Immediate Action Team (IAT), which specialises in prisoner removals, to forcibly move David Jr from his cell.[156]

One of the six IAT officers stormed David Jr's cell with a riot shield, which David Jr collided with.[157] The other officers entered and restrained him by manoeuvring him face-down and handcuffed him behind his back.[158] David Jr was held in a prone position with at least one officer lying on top of him and three others holding him down, each with their knees on top of him. Then, they dragged him to another cell[159] and held him face down underneath their full weight.[160]

Under the weight of the guards, David Jr was spitting blood and was injected with a sedative while being held down.[161] David Jr called out "I can't breathe"[162] more than a dozen times in the final minutes before he passed. Despite these calls for help, David Jr continued to be restrained by multiple officers in a position that compromised his breathing.[163] By the time the guards realised he had stopped breathing, it was too late. Still, only two resuscitation attempts were undertaken.[164] It was less than 10 minutes after the cell move began that David Jr became unresponsive whilst restrained, and tragically died.

The Coroner's Findings

The Coroner found that David Jr died whilst being restrained in the prone position by prison officers. The consequent hypoxia, prolonged restraint and extreme stress and agitation as a result of the use of force and restraint contributed to David Jr's death.[165] However, the Coroner made no recommendation regarding charges or sanctions against the prison officers involved nor the medical staff assigned to David Jr's care.

It has been almost six years since the death of David Dungay Jr, and no-one has ever been referred for discipline or prosecution for David Jr's death. Despite an abundance of both testimonial and video evidence, and Findings of the circumstances surrounding David Jr's death, no justice has been afforded to David Jr's loving family.

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[154] Ibid [1.2].
[155] Ibid [1.2].
[156] Ibid [9.9].
[157] Ibid [9.13].
[158] Ibid [9.15].
[159] Ibid [9.16].
[160] Ibid [9.17].
[161] Ibid [9.18].
[162] Ibid [9.20].
[163] Ibid [9.20].
[164] Ibid [9.22].
[165] Ibid [24.23].

Dungay family concerns with the coronial process:

David Jr's family feel that the coronial system completely failed them as it provided no accountability, the coroner found 'systemic deficiencies in training' but did not make a referral to SafeWork NSW despite the admissions and apologies made by the Department of Corrective Services NSW and Justice Health. Since the findings, the family have criticized the Commonwealth and NSW governments for failing to protect David Jr's right to life or hold any individual or organisation accountable for his death.

Investigation and evidence

The Dungay family have raised concerns about the mismanagement of evidence. They were disturbed to find that a crime scene was not declared over David Jr's cell and that protocols to secure evidence were not adhered to, including that blood and DNA in David Jr's cell was cleaned against protocol. Although the destruction of evidence and government records may be a criminal offence, no one was held responsible for the breaches of those protocols and for breaches of the law. Rather, the Coroner underplayed those breaches and an *internal* corrective services investigation found that there was no criminal negligence.[166] Further, the polices' initial investigation found that his death was not suspicious which seemingly ignores the abundance of evidence regarding the prison officer's involvement in David Jr's eventual death.

Ms Christine Dungay, David Jr's sister, noted her frustration and heartbreak that a forensic and criminal investigation was not possible following David Jr's death, as all the physical evidence was cleaned up. David Jr's clothes and some of his belongings were never returned to his family which only added to the family's suspicions of improper conduct. Further, there is CCTV footage of David Jr on the date of his death that was destroyed and once again the Coroner made no adverse finding in that regard. The mismanagement of evidence, which may be a crime under NSW law, has re-traumatised the family and has left them without closure as has the failure of the Coroner to take issue with it or make recommendations to hold individuals or organisations accountable for their mismanagement or criminality.

Failure to refer anyone for discipline or prosecution

The Inquest held in 2019 found that David Jr died from cardiac arrhythmia, with contributing factors including the actions of the guards in restraining David Jr with significant physical pressure in a position which compromised his breathing, and extreme stress and agitation as a result of the use of force and restraint.[167] Despite such findings, the Coroner found that none of the guards involved in David Jr's death should face any disciplinary action.[168] The Coroner found that the conduct of the guards was 'limited by systemic deficiencies in training'[169] and not motivated by 'malicious intent'.[170]

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[166] Helen Davidson, 'The story of David Dungay and an Indigenous death in custody', *The Guardian* (11 June 2020) <https://www.theguardian.com/australia-news/2020/jun/11/the-story-of-david-dungay-and-an-indigenous-death-in-custody>.
[167] *Inquest into the Death of David Dungay* (n 18) [24.23].
[168] Ibid [18.12].
[169] Ibid [18.12].
[170] Ibid [18.12].

Lack of accountability

The family of David Jr believe that they have been unheard and denied justice by the coronial process. The family continue to organise protests and mount public campaigns to persuade the government to take long overdue action and hold the officers who stormed David Jr's cell, Justice Health or Correctional Services NSW accountable for their actions. Following continued advocacy and various unsuccessful attempts to convince authorities that someone must be held accountable, the Dungay family, led by Ms Leetona Dungay, have taken their call for justice to the United Nations.

"I am going to fight until I live in a country where black lives matter." – Ms Leetona Dungay

Timeliness of decisions

The Dungay family had to wait almost four years to receive answers concerning David Jr's death. The prolonged process was traumatising, particularly given the findings and recommendations delivered by the coronial process left the family dissatisfied.

Cultural responsiveness

The Dungay family have shared their concern about a lack of involvement of First Nations people and values throughout the coronial process, which reinforced their existing distrust in the justice system and re-traumatised their family. The Dungay family vocalise and advocate that there needs to be a First Nations Coroner and Investigators in NSW, alongside better First Nations representation in employment throughout the entire criminal justice system. The Dungay family acknowledge that this would have improved their own experience in the coronial system and would help them to build some level of trust in the system, which is currently diminished.

Notification

The Dungay family have expressed their disappointment in the insensitive notification of David Jr's death by NSW police. Their experience was far from RCIADIC recommended procedure for notifying families of those who have died in custody.[171]

> **"It wasn't very nice. They should have come to where I was directly. I'm his mum, I should have been told first." – Ms Leetona Dungay**

NSW Police communications with the Dungay family caused confusion, distress and anger for a family on top of their grief. Mr Dungay Jr's mother was not the first person to be notified of her son's death. Ms Leetona Dungay's eldest son, Ernest, was the person to inform her of David Jr's death. The police later contacted Ms Leetona Dungay to let her know over the phone.

David Jr's sister, Ms Christine Dungay, was notified of David Jr's death by the police coming to her house. Christine met the police officer at the fence of her yard in fear, noting that whenever the police had attended her residence prior to this occasion, the interactions were unproductive and

[171] *Royal Commission* (n 1) vol 1, Recommendation 19.

disrespectful. In this context of distrust, the NSW Police were not the best means by which to notify the Dungay family of their tragic loss. The inherent feeling of distrust in the system was only aggravated by these encounters.

The nature of the Inquest

The Dungay family felt disempowered by the adversarial nature of the coronial inquest, which provided no real opportunity for open discussion about what happened to David Jr, nor did it accommodate the participation of the family. David Jr's sister, Ms Christine Dungay, expressed that the lack of First Nations representation in the Coronial system, compounded by the amount of legal representation provided to the IAT guards, portrayed the image that the guards were victims, rather than her brother David Jr, who lost his life.

Transparency and Open Justice

To compound the hurt to the family, the pleas by Ms Leetona Dungay for all CCTV footage of the death of her son to be released publicly were refused after a protracted dispute. Even when the extracts were released the identities of guards were anonymised through pixilation. The family were left feeling that their requests were ignored or diminished and those of the guards who held David Jr down until he died were promoted.

Condition of David Jr's body

The Dungay family were extremely upset by the condition of David Jr's body when it was delivered to them. Ms Leetona Dungay and her eldest son Ernest, visited the morgue and took pictures of David Jr's body as they did not trust the investigation was conducted. The Dungay family believe that the circumstances of David Jr's death are suspicious and they did not trust the investigation that was being undertaken.

KEY RECOMMENDATIONS

Inspired by guiding principles of justice, accountability, transparency, cultural safety and the sovereign rights of First Nations peoples, we make the following overarching recommendations that apply to all representations made in this submission:

1. Implement the recommendations from the Royal Commission into Aboriginal Deaths in Custody and all relevant subsequent enquiries.
2. The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. The investigative body should have the power to examine the death of a First Nations person under the control of state officials in broad contexts including in police custody, in prisons, any corrective services, during transport, in accessing health services, as well as in the interrelated decisions made by officials in these various bodies and any related death 'close to custody'. Such a body must have real powers to make recommendations, compel responses to recommendations, refer matters for prosecution or disciplinary action and to undertake regular prison and youth detention inspections.
3. Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.
4. First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

DETAILED RECOMMENDATIONS
TO IMPROVE THE CORONIAL JURISDICTION

Scope and limitations of the coronial jurisdiction

5. We recommend that the Coroner's Act 2009 be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.
6. We recommend that the Coroner's Act 2009 be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.
7. We recommend that the Coroner's Act 2009 be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.
8. We recommend that the Coroner's Act 2009 be amended to:
    a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and
    b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

9. We recommend that the Coroner's Act 2009 be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.

10. We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

Resources

11. We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.

12. We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

Timeliness of decisions

13. We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

The outcomes and oversight of recommendations

14. We recommend that the Coroners Act 2009 be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.

15. We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

Responding to cultural needs

16. We recommend that the Coroners Act 2009 be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.

17. Until complete independence is established, at the very least, a First Nations consultative group must be established and resourced; with powers to liaise with Coroners and to consult with them regarding the scope of coronial investigations of First Nations deaths, to ensure the system is culturally safe at all times and that recommendations are made to address systemic factors that may have caused or contributed to the death of a First Nations individual.

Open Justice

18. We recommend that the Coroner's Act 2009 be amended to encourage the public release of evidence - with family members' consent where appropriate.

19. We recommend that the Coroner's Act 2009 be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.

LEGISLATIVE COUNCIL

SELECT COMMITTEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

Coronial jurisdiction in New South Wales

April 2022

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Select Committee on the Coronial Jurisdiction in New South Wales

Coronial Jurisdiction in New South Wales

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"April 2022"

Chair: Hon Adam Searle MLC

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Terms of reference

1. That a select committee be established to inquire into and report on the coronial jurisdiction in New South Wales, and in particular:

   (a) the law, practice and operation of the Coroner's Court of NSW, including:
      (i) the scope and limits of its jurisdiction,
      (ii) the adequacy of its resources,
      (iii) the timeliness of its decisions,
      (iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
      (v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,
      (vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health,

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

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

   (d) any other related matter.

2. That the committee report by 29 April 2022.[1]

[1] The original reporting date was end of December 2021 (*Minutes*, NSW Legislative Council, 6 May 2021, pp 2135-2136). The reporting date was later extended to 29 April 2022 (*Minutes*, NSW Legislative Council, 13 October 2021, p 2455).

Committee details

Committee members

Hon Adam Searle MLC	Australian Labor Party	*Chair*
Ms Cate Faehrmann MLC	The Greens	*Deputy Chair from 31 March 2022*
Mr David Shoebridge MLC	The Greens	*Deputy Chair until 30 March 2022*
Hon Catherine Cusack MLC	Liberal Party	*From 23 June 2022*
Hon Trevor Khan MLC	The Nationals	*Until 6 January 2022*
Hon Peter Poulos MLC	Liberal Party	*From 25 January 2022*
Hon Rod Roberts MLC	Pauline Hanson's One Nation	
Hon Penny Sharpe MLC	Australian Labor Party	
Hon Natalie Ward MLC	Liberal Party	*Until 22 June 2021*

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Chair's foreword

This inquiry was long overdue and concerns a part of our system of justice that, in my view, has not had the attention it should have had, given the importance of its work.

The inquiry was established to carry forward the important work undertaken by the select committee on the high level of First Nations people in custody and oversight and review of deaths in custody during 2019 and 2020. Evidence in that previous inquiry showed that the coronial jurisdiction had not been thoroughly examined since 1975. Given the many issues of concern identified in that earlier inquiry, it was clear that a root and branch review of the jurisdiction was necessary, focusing on the legislation, framework and operations of the Coroners Court of New South Wales, including its structure, the adequacy of its resources, the timeliness of its decisions and its support to bereaved persons and families. I note that the statutory review of the existing *Coroners Act 2009* (NSW) was due in 2014 and has been ongoing for some years now.

On behalf of the committee, I acknowledge that the Coroners Court of NSW and all those who work in the jurisdiction deliver a high quality service to the community. In meeting with the NSW State Coroner, Deputy State Coroners and the numerous staff across the various agencies and teams at the Court, the passion and sense of vocation shared by all was highly visible and admirable. However, despite everyone's best efforts, evidence given to this inquiry shows that the Court is experiencing very heavy workloads for coroners as well as for forensic and other staff, and lacks sufficient resources to undertake the important work before it. This has led to delays in finalising matters, further grief for bereaved persons and families and a significant and growing backlog of cases. There are workforce constraints across the system and the current structure of the court is out of date; it does not recognise and support the specialist nature of the jurisdiction and the unique role it plays in our system of justice.

The conclusions and recommendations in this report are intended to provide a roadmap to ensure that New South Wales has a modern, specialist and better resourced coronial jurisdiction which has at its centre the object of preventing future loss of life, while enhancing the therapeutic and restorative aspects of the jurisdiction. Key to this roadmap is rethinking the structure of the Coroners Court of NSW to harness specialisation and timely decision-making. To this end, the committee recommends the Coroners Court of NSW be restructured as an autonomous and specialist court associated with the Local Court, similar to the institutional arrangements for the Children's Court of NSW.

The committee has also tried to reimagine the way in which coroners discharge their duties, particularly in relation to preventing future loss of life, and how recommendations from inquests can better contribute to system wide changes. A key recommendation is the establishment of a specialist preventive death review unit, similar to the Coroners Prevention Unit in Victoria, to undertake specialised collection, analysis and review of research and data. The establishment of such a unit, dedicated to in-depth qualitative analysis of a much broader range of reported deaths, would better support coroners in fulfilling their important death prevention function. Together with specific and improved training for coroners, these changes would enhance the quality of coronial services and improve the jurisdiction's specialist skills and focus.

Regardless of whether these reforms are implemented, the evidence to this inquiry clearly establishes the need to better fund and resource the jurisdiction and the people and agencies working in it to address lengthy and the growing backlog of cases and meet the challenges facing the system going forward.

Other recommendations in this report include measures to strengthen the accountability and oversight of responses to coroners' recommendations, which is a particular weakness in the existing system, and to require responses by both government and non-government bodies, and proposed amendments to the Court's powers and scope, particularly in relation to findings, inquests and evidence. A number of our recommendations also relate to the need to provide more timely information and improved support to bereaved persons and families when engaging with the coronial system.

The committee also received evidence of the significant decline in coronial hearings into workplace deaths over the last two decades, meaning that there is often only limited fact-finding and a limited review of systemic causes of workplace fatalities and related issues, especially when a defendant pleads guilty and/or matters proceed by way of agreed statement of fact. Recommendations are made in the report that address this and other issues raised by unions and other inquiry participants in relation to deaths in the workplace.

The committee thanks all those who participated in this inquiry, through both submissions and oral evidence. I give particular thanks to the Chief Magistrate of the Local Court and the State Coroner and staff at the Court, who have all helped to shape this report.

I also wish to make particular mention to the families who have experienced the coronial jurisdiction first hand and who shared with the committee their views on how the coronial system can be improved. I acknowledge the painful and traumatic experience families have endured and again thank them for having the courage and resilience to share their stories.

Finally, I thank all my committee colleagues for their participation in this important inquiry and for working collaboratively to find a way forward on these issues, including those like the Hon Natalie Ward MLC who had to leave before the committee concluded its work. In this regard, and at the particular request of the committee, I extend my particular thanks to former Deputy Chair, Mr David Shoebridge MLC, and former committee member the Hon Trevor Khan MLC (now a magistrate of the Local Court), who have now both resigned from the Legislative Council, for their contributions to the inquiry.

I also thank the secretariat for their usual diligent and outstanding professional assistance.

Although there was a difference of opinion amongst committee members on one issue, the balance of this report was agreed to unanimously by members drawn from across the political spectrum. I believe this provides a strong foundation for the implementation of the report's recommendations.

I hope this report provides a roadmap for the NSW Government to deliver better outcomes for bereaved persons and families and broader public safety through the coronial system.

I commend the report to the House.

Hon Adam Searle MLC
Committee Chair

Recommendations

Recommendation 1 **17**

That the NSW Government finalise and publish the statutory review of the *Coroners Act 2009* (NSW) by the end of 2022.

Recommendation 2 **42**

That the NSW Department of Communities and Justice undertake a review into the collection, management and reporting of data in relation to coronial cases, with a view to identifying system improvements that would enable greater monitoring of the coronial jurisdiction's performance.

Recommendation 3 **42**

That the NSW Government allocate additional resources to the Coroners Court of New South Wales, including adequate funding and staffing, to ensure it can address current caseload pressures, delays and backlogs.

Recommendation 4 **66**

That the NSW Government restructure the Coroners Court of New South Wales to be an autonomous and specialist court within the Local Court framework, similar to the Children's Court of New South Wales, with these 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 New South Wales.

Recommendation 5 **67**

That the NSW Government ensure the Judicial Commission of New South Wales is sufficiently funded to design, develop and deliver a bespoke and comprehensive training and professional development program for coroners, with input from the current State and Deputy State Coroners and former coroners.

Recommendation 6 **68**

That the NSW Government provide in-house legal officers and registrars to each coroner or alternatively establish a pool of legal officers and registrars to assist all coroners.

Recommendation 7 **68**

That the NSW Government provide a greater level of case management, family liaison and administrative support for coroners, particularly for the triaging and management of natural cause deaths reported to the Coroners Court of New South Wales.

Conduct of inquiry

The terms of reference for the inquiry was referred to the committee by the Legislative Council on 6 May 2021.

The committee received 66 submissions and four supplementary submissions. The committee also held three public hearings at Parliament House on 29 September 2021, 30 November 2021 and 31 January 2022.

The committee also conducted site visits to the Forensic Medicine and Coroners Court Complex in Lidcombe, Sydney on 14 December 2021, and to the Coroners Court of Victoria in Southbank, Melbourne on 4 February 2022.

In addition, the committee held a virtual meeting with the Queensland State Coroner on 23 February 2022 and a virtual meeting with representatives from the Law Institute of Victoria on 25 February 2022.

Inquiry related documents are available on the committee's website, including submissions, hearing transcripts, tabled documents, correspondence and answers to questions on notice.

Chapter 1 The coronial jurisdiction in New South Wales

This chapter provides some background and context to the committee's inquiry. It provides a brief history of the coronial jurisdiction in New South Wales, an overview of current coronial processes, and a summary of previous and ongoing reviews of the jurisdiction.

Background to the inquiry

1.1 On 17 June 2020, the NSW Legislative Council established the Select Committee on the high level of First Nations people in custody and the oversight and review of deaths in custody (Select Committee on First Nations).[2] Throughout the Select Committee on First Nations' inquiry all non-government stakeholders advocated for a number of changes to be made to the coronial system, including the need for a comprehensive review of the coronial jurisdiction.[3] This was highlighted by Adjunct Professor Hugh Dillon, a former NSW Deputy State Coroner, who gave evidence that in NSW the coronial system has 'not been subject to a public review since 1975'.[4]

1.2 The Select Committee on First Nations' report, tabled in April 2021, found that it was clear that the coronial jurisdiction was in dire need of a comprehensive 'root and branch' review. The report recommended that the same committee 'be re-purposed to undertake an inquiry into the coronial system'.[5]

1.3 There were also a further four recommendations related to the coronial jurisdiction:

> **Recommendation 31** That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court of NSW can effectively undertake its role in investigating deaths in custody in a timely manner.
>
> **Recommendation 32** That the NSW Government amend the *Coroners Act 2009* to ensure that the relevant government department and correctional centre respond in writing within six months of receiving a Coroner's report, the action being taken to implement the recommendations, or if no action is taken the reasons why, with this response tabled in the NSW Parliament.
>
> **Recommendation 33** That the NSW Government amend the *Coroners Act 2009* to stipulate that the coroner is required to examine whether there are systemic issues in relation to a death in custody, in particular for First Nations people, with the coroner provided with the power to make recommendations for system wide improvements.

2 *Minutes*, Legislative Council, 17 June 2020, pp 1057-1059.

3 Select Committee on the High Level of First Nations People in Custody and Review of Deaths in Custody, NSW Legislative Council, *High level of First Nations people in custody and review of deaths in custody* (2021), p 125.

4 Submission 14, Adjunct Professor Hugh Dillon, p 4.

5 Select Committee on the High Level of First Nations People in Custody and Review of Deaths in Custody, NSW Legislative Council, *High level of First Nations people in custody and review of deaths in custody* (2021), p 150 (Recommendation 30).

> **Recommendation 34** That the NSW Government amend the *Coroners Act 2009* to mandate coroners to make findings on whether the implementation of any, some or all of the recommendations from the Royal Commission into Aboriginal Deaths in Custody report could have reduced the risk of death in all cases where a First Nations person has died in custody.[6]

1.4 Subsequently, on 6 May 2021, the NSW Legislative Council formally established a Select Committee on the Coronial Jurisdiction in New South Wales, with the same committee membership as the previous inquiry.[7]

1.5 Several months later, on 13 October 2021, the NSW Government tabled its response to the Select Committee on First Nations' report. The NSW Government drew attention to the increased funding and resources that has been directed to the coronial system in the 2021-22 State Budget, including an additional $56.1 million to the Local Court of New South Wales (Local Court) jurisdiction to appoint eight additional magistrates, including a full-time coroner. It also noted that the funding was expected to enhance the Coronial Case Management Unit located at the Forensic Medicine and Coroners Complex in Lidcombe, which is coronial jurisdiction's headquarters.[8] The Forensic Medicine and Coroners Complex in Lidcombe is also known, and will be referred to in this report, as the State Coroners Court.

1.6 The NSW Government also highlighted in its response that the Coroners Court of New South Wales recently established two Aboriginal Coronial Information and Support Program Officer roles, to provide support to the families of First Nations people whose deaths are reported to the coroner and enhance policies and procedures for engaging with First Nations families throughout the coronial process.[9]

Overview of the coronial jurisdiction in NSW

1.7 This section sets out a brief history of the coronial system, then turns to the legislative framework, structure and constitution of the Coroners Court of NSW.

Brief history

1.8 The coronial system plays an important role in our society. It involves an independent investigation of all sudden, unexpected, or unexplained deaths, along with fires, and explosions.[10]

6 Select Committee on the High Level of First Nations People in Custody and Review of Deaths in Custody, NSW Legislative Council, *High level of First Nations people in custody and review of deaths in custody* (2021), p 150.

7 *Minutes*, NSW Legislative Council, 6 May 2021, pp 2135-2136.

8 NSW Government response to the inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, 13 October 2021, p 3.

9 NSW Government response to the inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, 13 October 2021, p 4.

10 Submission 18, NSW Government, p 4.

1.9 The office of the coroner dates back to at least 1194 and possibly as far back as 871 BCE, though the role has changed considerably over the centuries. Adjunct Professor George Newhouse observed in his submission that 'initially, the Coroner's duties related to keeping the King's records and collecting his revenue. Modern coroners have quite a different role'.[11]

1.10 Adjunct Professor Hugh Dillon further explained that as the coroners' office evolved in England, it came to be accepted that the fundamental responsibility of the coroner was to investigate the causes and circumstances of deaths.[12]

1.11 The statute *De Officio Coronatorius* enacted in 1276 set out in detail the legal responsibilities of the coroner:

> The coroner should go to the place where any person is slain, or suddenly dead or wounded, or where houses are broken, or where treasure is said to be found, and should by his warrant to the bailiffs or constables summon a jury … to make inquiry upon view of the body; and the coroner and jury should inquire into the manner of killing and all circumstances that occasioned the party's death; who were present, whether the dead person was known, and where he lay the night before; they should examine the body to see if there be any signs of strangling about the neck, or of any cords about the members, or burns.[13]

1.12 While much has changed, the role of the current coroner is recognisably similar. A useful and concise history of the development of the ancient office of coroner from its common law origins to statute, in England and its arrival in NSW can be found in *Waller's Coronial Law and Practice in NSW*.[14]

1.13 The NSW structure of the coronial system was designed in 1901 when the Local Court (then known as the Magistrates Court) was given administrative responsibility for coroners. The early coroners held office in Sydney's The Rocks, and had the responsibility to answer five questions: Who died? When did they die? Where did the death take place? What were the cause and manner of death?[15]

1.14 Over time, the role of the coroner developed considerably from the 'five questions' and modern coronial theory has emphasised four primary purposes of the coronial death investigation:

- fact-finding in relation to reported deaths
- prevention of future deaths and inquiry
- therapeutic and restorative processes
- accountability of state agencies involved in reported deaths and support of human rights.[16]

11 Submission 28, Adjunct Professor George Newhouse, p 4

12 Submission 14, Adjunct Professor Hugh Dillon, p 7.

13 *Waller's Coronial Law and Practice in NSW* (LexisNexus Butterworths, 4th ed, 2010), p 4.

14 *Waller's Coronial Law and Practice in NSW* (LexisNexus Butterworths, 4th ed, 2010), pp 2-10.

15 Submission 14, Adjunct Professor Hugh Dillon, p 7.

16 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 8; Submission 17 New South Wales Bar Association, p 4

Legislative framework

1.15 The *Coroners Act 2009* (NSW) (Coroners Act) provides the legislative framework for the coronial jurisdiction in NSW. On 1 January 2010, the Coroners Act came into effect, repealing the *Coroners Act 1980*. The Coroners Act was the result of a substantial review of the previous Act by the Department of Attorney General and Justice in consultation with the State Coroner, the Chief Magistrate and a range of internal and external stakeholders. The Coroners Act modernised and simplified many provisions in the previous legislation and included amendments which sought to prevent natural deaths from being unnecessarily reported to coroners, so as to enable coroners to focus on deaths that were suspicious or unexplained.[17]

1.16 Prior to 2010, much coronial work was allocated to court registrars, who had experience and time to deal with the administrative tasks involved. Adjunct Professor Hugh Dillon acknowledged that the Coroners Act was partly enacted to lift the professional standards of the Local Court by replacing court registrars with magistrates to conduct coronial work and to re-impose the professionalism of coronial services provided in country and regional areas.[18]

Key provisions of the current legislation

1.17 The Coroners Act authorises coroners to examine unnatural, unexpected, sudden and suspicious deaths to determine the identity of the deceased and the date, place, circumstances and medical cause of death. Coroners also investigate suspected deaths, missing persons cases and fires and explosions that cause serious injury or damage to property.[19] In order to fulfil these roles, coroners rely on information obtained from police, general medical practitioners, specialist forensic pathologists, specialist physicians and other experts.[20]

1.18 Section 27 of the *Coroners Act 2009* (NSW) requires a senior coroner (State Coroner or Deputy State Coroner) to hold inquests in certain circumstances. These mandatory inquests include suspected homicides, deaths in custody or police operations (as prescribed under section 23 of the *Coroners Act 2009* (NSW)) and cases in which the evidence presented to the coroner does not sufficiently disclose whether the person has died, the identity of the deceased person, the date and place of death, or the manner and cause of death.[21]

1.19 Section 23 of the *Coroners Act 2009* (NSW) states that a senior coroner (State Coroner or Deputy State Coroner) has jurisdiction to hold an inquest concerning the death or suspected death of a person if it appears to the coroner that the person has died while in custody of police, while escaping or attempting to escape from police custody, as a result of police operations or while

17 See NSW Parliament, *Coroners Amendment Bill 2012 Second Reading* (2012), https://www.parliament.nsw.gov.au/bill/files/389/Coroner's%20Amdt%20-%20LC%202nd%20Read.pdf.

18 Submission 14, Adjunct Professor Hugh Dillon, p 4.

19 *Coroners Act 2009* (NSW), ss 3 and 6.

20 See Coroners Court NSW, *How the Coroners Court work – Jurisdiction* (2020), https://coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/jurisdiction.html.

21 Submission 18, NSW Government, p 7.

temporarily absent from a detention or correctional centre.[22] In 2020, 45 deaths subject to section 23 of the *Coroners Act 2009* (NSW) were reported to the State Coroner.[23]

1.20 Except where an inquest is mandatory, a coroner has the discretion to dispense with an inquest under section 25 of the *Coroners Act 2009* (NSW). A coroner will ordinarily dispense with an inquest if the identity of the deceased and the date, place, cause and manner of death are all clear and/or there is no particular issue of public health or safety to address. A matter can also be dispensed if there are no suspicious circumstances and no compelling request for an inquest has been made. If, on the other hand, there are questions about these issues, an inquest will usually be considered.[24]

1.21 Most coronial proceedings can be finalised by the coroner without the need for an inquest. In 2020, less than 2 per cent of all matters (112 matters) were subject to inquest.[25]

1.22 The NSW Government submission noted that coronial inquests are becoming increasingly lengthy and complex. In 2021, for example, the State Coroner conducted several inquests into the deaths in custody of First Nations people, and was part way through hearing the inquest into the twenty five deaths that occurred during the Black Summer Bushfires of 2019-2020. The State Coroner will also soon commence two significant inquests emerging from the COVID-19 pandemic (relating to the Newmarch House nursing home and the Ruby Princess cruise ship).[26]

Structure and constitution of the Coroners Court

1.23 As noted above, the Coroners Court of NSW forms part of the Local Court. The Coroners Act does not recognise the Coroners Court of NSW as a court of record, however, it has been recognised as such in case law.[27]

1.24 The State Coroner is appointed by the Governor of NSW and is responsible for the oversight and coordination of coronial services in NSW.[28] Under the Coroners Act, the State Coroner is subject to the control and direction of the Chief Magistrate of the Local Court.[29]

1.25 The State Coroner is supported by magistrates who have been appointed by the Governor as Deputy State Coroners.[30] Pursuant to the Coroners Act, all magistrates are coroners *ex officio*. This means that the jurisdiction and functions of coroners are conferred on all magistrates by virtue of their office as magistrate.[31]

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22 *Coroners Act 2009* (NSW), s 23.

23 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 8.

24 Local Court Bench Book, *Coronial Matters* (March 2022), https://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html#p44-160.

25 Submission 18, NSW Government, p 7.

26 Submission 18, NSW Government, p 13.

27 Submission 18, NSW Government, pp 4 and 23, quoting *Decker v State Coroner (1999)* 46 NSWLR 415*,* [6].

28 *Coroners Act 2009* (NSW), ss 7 and 10.

29 *Coroners Act 2009* (NSW), s 10(2). See also Submission 18, NSW Government, pp 4 and 23.

30 *Coroners Act 2009* (NSW), ss 7 and 10. See also Submission 18, NSW Government, p 23.

31 *Coroners Act 2009* (NSW), s 16.

1.26 The Chief Magistrate allocates magistrates to the coronial jurisdiction through the triennial rotation program and from time to time as required.[32] The NSW Government submission stated that, as at June 2021, there were 5.3 full-time equivalent judicial resources allocated to the Coroners Court of NSW, including five full-time coroner positions located at the State Coroners Court in Lidcombe. One of these positions is shared between two magistrates. In addition, there are two part-time coroner roles located in Newcastle and Wollongong. All eight magistrates appointed in full and part-time coroner positions are appointed as Deputy State Coroners.[33]

1.27 As part of the Chief Magistrate's triennial rotation program, magistrates can be subject to rotation every three years. The full-time specialist coroners in Lidcombe are generally able to remain in the coronial jurisdiction for at least two triennial rotations. Coronial appointments are discussed between the Chief Magistrate and State Coroner, although the Chief Magistrate has the power to allocate magistrates. A full-time magistrate in Newcastle also undertakes coronial work on a regular, part-time basis.[34]

1.28 In addition to these numbers, the Department of Communities and Justice advised the committee in February 2022 that extra funding was recently allocated for two additional coroners at the State Coroners Court, one to enable the continuation of centralised case management of initial coronial directions (discussed at paragraphs 1.36 to 1.38) and another to assist in large inquests due to be heard by the State Coroner (up until September 2022).[35]

1.29 In addition to the State Coroner and Deputy State Coroners, every Local Court magistrate in NSW is also a coroner by virtue of their office as a magistrate. As a result, NSW has a decentralised 'hybrid' coronial structure. Coronial matters in the Sydney metropolitan area are conducted by the State Coroner or one of the Deputy State Coroners at the State Coroners Court. Meanwhile, approximately 36 non-specialist regional Local Court magistrates were intended to manage the coronial work in regional NSW in addition to their usual criminal and civil workload.[36]

1.30 In addition, there are 200 assistant coroners who are appointed by the Attorney General to undertake administrative functions on behalf of coroners, including the issue of burial and post-mortem examination orders.[37]

Division of cases between the State Coroners Court and regional magistrates

1.31 Coroners in NSW investigate approximately 6,000 reportable deaths annually. Investigations into an average 3,500 deaths annually are coordinated through the State Coroners Court, while

32 Submission 18, NSW Government, p 23.

33 Submission 18, NSW Government, pp 4 and 23.

34 Submission 14, Hugh Dillon, pp 72-73.

35 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 4.

36 See, for example, Submission 14, Adjunct Professor Dillon, p 24; Submission 18, NSW Government, p 22; Submission 39, Gilbert + Tobin, p 7. See, Coroners Court NSW, *How the Coroners Court work – Coroners Court overview* (2020), https://coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/coroners-court-overview.html.

37 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 4.

investigations into a further 2,500 deaths per year are coordinated by coroners and assistant coroners in various rural and regional locations throughout NSW.[38]

1.32 Adjunct Professor Hugh Dillon, former NSW Deputy State Coroner, noted that 45 per cent of all reportable deaths are made to regional magistrates in their capacity as coroners.[39] This was fairly consistent with information provided by the Department of Communities and Justice, who provided data on the division of coronial work between regional magistrates acting in their capacity as coroners and coroners at the State Coroners Court.

- In 2020, regional magistrates received 44 per cent of all reported deaths, finalised 46 per cent of all investigations and undertook 16 per cent of all inquests.
- In 2019, regional magistrates received 48 per cent of all reported deaths, finalised 38 per cent of all investigations and undertook 32 per cent of all inquests.
- In 2018, regional magistrates received 45 per cent of all reported deaths, finalised 45 per cent of all investigations and undertook 33 per cent of all inquests.[40]

1.33 In this context, it is important to note that there are certain types of cases in which the State Coroner and Deputy State Coroners are responsible. First, there are certain categories of deaths which the Coroners Act prescribes are within the exclusive jurisdiction of the State Coroner or Deputy State Coroners, such as deaths in police custody and certain deaths of children and people with a disability.[41]

1.34 Second, since 2010, there has been a protocol in place which prescribes that regional magistrates acting as coroners must refer regional coronial matters to the State Coroner and Deputy State Coroner if the matter is a particularly complex inquest or the inquest is likely to run for longer than five days.[42] Further, and as noted by the New South Wales Bar Association, complex cases with inquests shorter than a week, namely medical or health-related cases, are also often transferred to the State Coroners Court.[43]

1.35 In addition, stakeholders have noted that when inquests are held in regional NSW they are frequently conducted by the State Coroner or Deputy State Coroners who travel from Sydney to the region for the inquest.[44]

38 See Coroners Court NSW, *Coroners Court Overview* (2020), https://coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/coroners-courtoverview.html.

39 Submission 14, Hugh Dillon, p 21; See also, Submission 17, New South Wales Bar Association, p 14.

40 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 5.

41 *Coroners Act 2009* (NSW), ss 22(1), 23 and 24.

42 See, for example, Submission 17, New South Wales Bar Association, p 14; Submission 18, NSW Government, p 23.

43 See, for example, Submission 14, Hugh Dillon, p 34; Submission 17, New South Wales Bar Association, p 14.

44 See, for example, Submission 17, New South Wales Bar Association, p 14; Evidence, Ms Kirsten Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 24.

Recent introduction of centralised initial coronial directions

1.36 In 2017 the Coronial Case Management Unit at the State Coroners Court was established to provide initial coronial directions for deaths in greater metropolitan Sydney. This process involves a multidisciplinary, inter-agency triage team to collectively manage the early stages of the coronial process for all metropolitan deaths. The team includes a Coronial Case Management Unit coordinator, a duty pathologist, a social worker from NSW Health Pathology Forensic Medicine, a social worker from the Department of Communities and Justice's Coronial Information and Support Program, a NSW Police Force representative and an Aboriginal Coronial Information and Support Program Officer, all of whom support the Duty Coroner to make directions.[45]

1.37 With respect to regional deaths, a Rural Triage Centre operated to avoid the unnecessary transfer of deceased persons from their communities.[46] In March 2020, in response to the COVID-19 pandemic, the State Coroner introduced administrative changes to implement further centralisation of initial coronial directions. As a result, a Duty Coroner at the State Coroners Court is now responsible for the making of coronial directions for all deaths across the state.[47]

1.38 According to the NSW Government, the centralisation of coronial decisions has assisted regional families by reducing the time taken for the coroner to make a direction regarding the need for a post-mortem examinations. The NSW Government also stated that centralisation has improved the average time to obtain a Medical Certificate of Cause of Death or a coroner's certificate for natural cause deaths, enabling faster access to death certificates for estate finalisation.[48]

An interagency model

1.39 As outlined above, the work of the Coroners Court of NSW involves three NSW Government agencies: the Department of Communities and Justice, NSW Health Pathology, and the NSW Police Force.[49]

- The Department of Communities and Justice is the lead agency overseeing court and justice services, including the coronial jurisdiction, and bringing together a number of NSW Government services.[50]
- NSW Health Pathology Forensic Medicine is responsible for conducting medical investigations into reportable deaths, as directed by the coroner.[51]
- The NSW Police Force is responsible for investigating all reportable deaths to the coroner, some of which may lead to an inquest and the compilation of a coronial brief of

45 Submission 18, NSW Government, p 14.

46 Submission 18, NSW Government, p 15.

47 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 15.

48 Submission 18, NSW Government, pp 5 and 14-15.

49 Submission 18, NSW Government, p 4.

50 Department of Communities and Justice, *Agency Information Guide* (1 April 2022), https://www.dcj.nsw.gov.au/about-us/gipa/agency-information-guide.html.

51 Submission 18, NSW Government, p 21.

evidence. These investigations are ultimately under the direction of the coroner. The NSW Police Force is also responsible for conducting a thorough investigation and for compiling briefs of evidence for all mandatory inquests.[52]

1.40 The State Coroners Court co-locates staff from the Department of Communities and Justice, NSW Health Pathology Forensic Medicine and the NSW Police Force. It was opened in December 2018, replacing a 40-year-old facility at Glebe. Key features of the complex include four court rooms, capacity to host large and complex inquests (including mass causalities), audio-visual technology allowing witnesses to give evidence remotely, private viewing rooms, clinical facilities for NSW Health Pathology's Forensic and Analytical Science Services, and clinical equipment to help determine cause of death in the least invasive manner.[53] The committee visited the State Coroners Court on Tuesday 14 December 2021 and observed first-hand many of these facilities.

1.41 The coronial jurisdiction is jointly funded by the Department of Communities and Justice, NSW Health, and the NSW Police Force.[54] The NSW Government submission identified that in addition to the judicial resources, there are currently 20 full-time equivalent registry staff and six full-time other court staff at the State Coroners Court. This includes the Manager of Coronial Services, Registrar, Deputy Registrar, Registry officers and staff from the Coronial Case Management Unit, the Domestic Violence Death Review Team and the Coronial Law Unit.[55]

1.42 The Coronial Law Unit based at the State Coroners Court consists of specialist police prosecutors who work as 'police coronial advocates' for the State and Deputy State Coroners, assisting with state-wide coronial proceedings when required. This unit is funded by the NSW Police Force.[56]

1.43 The police coronial advocates act as a conduit between the coroners and the officers in charge of the coronial investigations. Their duties include:

- identifying issues
- liaising with family members, including preparation of '30 day letters' which allow the deceased's family to request that an inquest be held when coroner proposes to dispense with an inquest
- liaising with investigating police and the coroner
- identifying witnesses
- engaging expert evidence
- preparing a matter for inquest and conducting coronial inquests.[57]

1.44 Police coronial advocates will generally assist a coroner in a coronial inquest or inquiry that does not involve complex issues or multiple agencies involved, or matters in which there is likely to

52 Submission 18, NSW Government, p 21.

53 Submission 18, NSW Government, p 13.

54 Submission 18, NSW Government, p 10.

55 Submission 18, NSW Government, p 11.

56 Submission 18, NSW Government, p 21.

57 Submission 18, NSW Government, p 21.

be significant public interest. For these latter matters, the Crown Solicitor's Office assists the coroner.[58]

1.45 As at July 2021, the Crown Solicitor's Office was assisting the State Coroner and Deputy State Coroners in approximately 200 inquests and inquiries and was representing NSW Government agencies in approximately 50 inquests and inquiries.[59]

1.46 The State Coroners Court at Lidcombe is co-located with the NSW Health Pathology Forensic Medicine service, which provide specialised coronial post-mortem examination services. Forensic Medicine also has dedicated facilities in Newcastle and Wollongong.[60]

1.47 As detailed by the Department of Communities and Justice in its submission, the coronial post-mortem examinations can only be performed by 'qualified and credentialed forensic pathologists who are supported by a specialist team of forensic mortuary technicians, forensic radiologists and radiographers, clinical nurse consultants and forensic medicine social workers'.[61]

1.48 Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine at NSW Health Pathology Forensic and Analytical Science Service, informed the committee at a hearing that there are currently 15 pathologists in NSW, five in Newcastle, and one in Wollongong.[62]

Overview of the coronial process

1.49 This section describes the processes involved when deaths are reported to the Coroners Court of NSW. In general, the coroner decides what kind of investigations are necessary, unless a mandatory inquest is required under section 27, for example, for deaths in custody cases.

1.50 Below is a brief overview of the coronial process in NSW:

- Police, medical, health, and emergency professionals have a statutory obligation to report sudden or unexplained deaths to the coroner. When a report is made the body of the deceased person is taken to the morgue.
- During the initial triage process, the coroner is to establish the identity of the deceased person and the date, place, medical cause and circumstances of their death. Investigations may be carried out by police, medical specialists and other experts, and is intended to support the coroner to make timely and appropriate decisions. The initial triage process occurs in the Coronial Case Management Unit located at the State Coroners Court.
- NSW Health Pathology Forensic Medicine may review the person's medical history and circumstances of death and provide support to general practitioners to issue a Medical Certificate Cause of Death. In some instances, a coroner will issue a coroner's certificate or alternatively advise if a post-mortem examination is required. A coroner's certificate may be issued where the coroner is satisfied, after obtaining relevant advice from police

58 Submission 18, NSW Government, p 21.

59 Submission 18, NSW Government, p 22.

60 Submission 18, NSW Government, p 21.

61 Submission 18, NSW Government, p 21.

62 Evidence, Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service, 30 November 2021, pp 41- 42.

officers and medical practitioners and consulting with the deceased person's senior next of kin, that the deceased person died of natural causes and the deceased person's family do not wish for a post-mortem examination to be conducted to determine the precise cause of death.

- If a coroner decides a post-mortem examination in necessary, this work will be undertaken by a specialist doctor in as least invasive a manner as possible. If the examination determines the cause of death was natural, no inquest will be held, and a death certificate will be issued.
- If the examination determines the cause of death was not natural, a police investigation will follow. The NSW Police Force will conduct investigations into the circumstances of death, including seeking reports from experts and statements from witnesses, including family and friends.
- A Coronial Information and Support Program from the Department of Communities and Justice social worker may consult with the family of the deceased person and report any stated wishes or concerns to the coroner.
- After reviewing evidence from police, social workers and others, the coroner will decide if an inquest is needed. If no inquest is required, then the coronial process is complete.
- If an inquest is mandatory or a coroner decides an inquest is required, the family of the deceased person will receive a letter advising of the inquest date. At an inquest, the coroner may call witnesses to give evidence, to determine the circumstances and cause of death. The length of the inquest will depend on the complexity of the case and the number of witnesses and relevant parties.
- Following an inquest, a coroner can make findings and recommendations to the government and other agencies with a view to improving public health and safety. The coroner has no power to enforce compliance with any recommendations made. It is a matter for the relevant government minister(s) or agencies to determine whether a coroner's recommendations are adopted. Details of the recommendations made by coroners are also recorded in a database kept by the Department of Communities and Justice.
- The NSW Premier's Memorandum sets out a process by which the relevant minister or government agency is to provide the Attorney General within six months of receiving recommendations the action being taken to implement the recommendation or the reasons why it is not to be implemented.[63]

1.51 The coronial investigation can be a complex and lengthy process. The majority of matters in which an inquest is held take longer than 12 months from the date of report of death to finalisation.[64] This will be explored further in the next chapter.

63 Submission 18, NSW Government, p 14. See, Coroners Court NSW, *Role of the Coroner* (2020), https://coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/role-of-the-coroner.html; Coroners Court NSW, *Overview of the Coronial process* (2020), https://www.coroners.nsw.gov.au/coroners-court/the-coronial-process/overview-of-the-coronial-process.html.

64 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 9.

Previous reviews of the coronial jurisdiction

1.52 Despite internal reviews resulting in two new Coroners Acts in 1980 and in 2009, the coronial system in NSW has not been subject to a specific comprehensive public review since the Law Reform Commission of New South Wales reviewed the *Coroners Act 1960* in 1975.[65]

1.53 There have, however, been comprehensive public reviews of comparable coronial systems undertaken in Victoria, Queensland, Western Australia, New Zealand, England, Wales, and Ontario.[66] The reviews in Victoria, Queensland and Western Australia are discussed briefly in the next section and in more detail in chapter 2.

Statutory review

1.54 Under section 109 of the *Coroners Act 2009* (NSW) the Attorney General is required to undertake a statutory review of the Coroners Act after a period of five years from the date of assent, with the outcome to be tabled in each House of Parliament within 12 months.[67]

1.55 This statutory review process commenced in 2015, with the Department of Justice consulting with key stakeholders via written submissions. A draft report was prepared in June 2017 but has not been published. The committee formally requested a copy of this report on 18 October 2021 from the Attorney General but the request was declined due to Cabinet confidentiality.[68]

1.56 The committee was informed that the review has not been finalised and is on hold pending the completion of work being undertaken as part of the NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce*.[69]

Improving the Timeliness of Coronial Procedures Taskforce

1.57 The *Improving the Timeliness of Coronial Procedures Taskforce* (Timeliness Taskforce) was established in July 2019 to identify ways to minimise delays in the coronial process that impact families. This joint agency initiative between NSW Health and the Department of Communities and Justice was tasked with examining the current coronial process from report of death to the coroner through case triage, transport of the deceased, autopsy, post-mortem report finalisation and return of remains to the family for burial.[70]

65 Submission 14, Adjunct Professor Hugh Dillon, p 4, quoting NSW Law Reform Commission, *Report on the Coroners Act 1960,* (1975), https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-22.pdf.

66 Submission 14, Adjunct Professor Hugh Dillon, p 4.

67 *Coroners Act 2009* (NSW), s 109.

68 Correspondence from Hon Mark Speakman, Attorney General, to Chair, 17 November 2021, p 1.

69 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 18.

70 Submission 18, NSW Government, p 5.

1.58 The Timeliness Taskforce included representatives from Department of Communities and Justice, the Coroners Court of NSW, the NSW Police Force, NSW Health Pathology, the NSW Ministry of Health, the Chief Magistrate and the State Coroner.[71]

1.59 In November 2021, the Attorney General provided the committee with the Timeliness Taskforce's *Progress Report on the Improving the Timeliness of Coronial Procedures* (Progress Report). Regarding the scope and focus of the Timeliness Taskforce, the Progress Report stated that 'the Taskforce has examined the coronial pathway, excluding processes involving inquests and the dispensing of coronial matters by a coroner'.[72]

1.60 The Timeliness Taskforce focused on four overarching objectives to improve the coronial system in NSW, including to:

- reduce the over reporting of natural deaths
- reduce delays in the release of deceased persons
- reduce delays in finalising post-mortem reports, and
- improve communication with families.[73]

1.61 The Progress Report stated that the Timeliness Taskforce was expected to conclude at the end of 2021 given 'many of the Taskforce's initiatives are now either complete or have entered the implementation phase'. Some of these initiatives included education and support for general practitioners to issue medical Certificates of Cause of Death to divert people who have died from natural causes away from the coronial system, along with reforms to the Coroners Act, process improvements and the centralisation of initial coronial directions for rural and regional deaths.[74]

1.62 In its report, the Timeliness Taskforce identified key performance indicators for agencies to measure the impact of these initiatives over time. The initiatives for each objective and the key performance indicators are listed in the Table 1 below, some of which will be discussed in more detail throughout this report.

71 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 10.

72 Correspondence from Brad Hazzard, Minister for Health and Medical Research and Mark Speakman, Attorney General, to Chair, 26 November 2021, p 4.

73 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 10.

74 See, for example, NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 10; Submission 18, NSW Government, p 5.

Table 1 Improving the Timeliness of Coronial Procedures Taskforce's objectives, initiatives and key performance indicators

Taskforce objectives	Initiatives	Key performance indicators
Reduce over reporting of natural deaths	Coroners Act reform removing the requirement to report a death to the coroner because the deceased person had not seen a medical practitioner in the six months before death Education and support to increase general practitioners' confidence in issuing Medical Certificates of Cause of Death	Proportion of coronial referrals which are for natural cause deaths
Reduce delays in the release of deceased persons	Coroners Act reform enabling preliminary examinations to commence earlier Facilitating direct access to electronic medical records and images for forensic pathologists Considering implementation of direct transfers for certain types of deaths	Proportion of cases requiring invasive post-mortem examination Median turnaround time from Forensic Medicine admission to postmortem examination for rural and regional deaths Median turnaround time from Forensic Medicine admission date to body release date for rural and regional deaths
Reduce delays in finalising post-mortem reports	Increasing forensic pathology resources and enhancing specialist capacity Developing a new statewide Forensic Medicine Information System Streamlining the post-mortem reporting process Exploring the appropriateness of the coroner basing their determination on the interim cause of death report	Median turnaround time for post-mortem report completion Monitoring post-mortem report clearance rate (ratio of post-mortem investigation reports completed to new post-mortem examinations performed)

Taskforce objectives	Initiatives	Key performance indicators
Improve communication with families	Enhancing social work services for families and loved ones Improved engagement with funeral directors Engaging with Aboriginal and Torres Strait Islander communities Engaging with Culturally and Linguistically Diverse (CALD) communities Improving the Coroners Court of NSW website	Deceased person's family receives initial contact from a Forensic Medicine social worker within 24 hours of admission Deceased person's family receives discharge contact from a Forensic Medicine social worker within 24 hours of completion of the medical investigation

Source: NSW Government, Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce (October 2021)

1.63 The Coronial Services Committee has oversight of ongoing Timeliness Taskforce initiatives beyond 2021, which is chaired by the State Coroner and has senior representatives from the Department of Communities and Justice, NSW Health Pathology Forensic Medicine and NSW Police and the Local Court.[75]

Coronial jurisdictions and courts in other states and territories

1.64 This section gives a brief overview of the coronial systems in Victoria and Queensland, in light of the coronial law, practice and operation in those jurisdictions being referred to during the inquiry.

Victoria

1.65 The Coroners Court of Victoria was established on 1 November 2009 when the *Coroners Act 2008* (Vic) came into effect. This was the most significant reform of the Victorian coronial jurisdiction in 25 years, replacing the State Coroners Office within the Magistrates Court with a specialist standalone court.[76]

1.66 The impetus for this reform was the report of the Parliament of Victoria's Law Reform Committee on the *Coroners Act 1985* (Vic) in 2006 which was highly critical of the hybrid system operating in Victoria. It made 136 recommendation and, as a result, a new *Coroners Act 2008*

75 Submission 17, New South Wales Bar Association, p 13.

76 Coroners Court of Victoria, *Annual Report 2020-21*, p 12.

(Vic) established a standalone Coroners Court of Victoria which has a key focus on reducing preventable deaths.[77]

1.67 As at October 2021, Victoria has 13 coroners based in Melbourne including the State Coroner.[78] While the State Coroner is a County Court judge, all other coroners are either magistrates or directly appointed as Coroners under the *Coroners Act 2008* (Vic). Unlike NSW, all magistrates in Victoria are not automatically coroners by virtue of their appointment.[79] Victoria's coroners are supported by several organisations to deliver coronial services, including the Coroners Prevention Unit, the Coroners Koori Engagement Unit, the Victorian Institute of Forensic Medicine and the Police Coronial Support Unit, along with registrars, administration officers, family liaison officers, and solicitors.[80]

1.68 Adjunct Professor Hugh Dillon, among others, have argued that Victoria's centralised model is best practice in terms of death and injury prevention.[81]

Queensland

1.69 The Coroners Court of Queensland sits within the structure of the Queensland Magistrates Court. It is headed by the State Coroner who has the status of a Deputy Chief Magistrate. Queensland has seven specialist coroners, including the State Coroner. Five coroners are based in Brisbane and South-East Queensland and two regional coroners in Cairns and Mackay. As in NSW, coroners are magistrates and all magistrates are coroners by virtue of their office. However, Queensland no longer uses local magistrates for coronial work.[82]

1.70 The Coroners Court of Queensland also has two coronial registrars based in Brisbane to triage deaths from apparent natural causes, review potentially reportable deaths, and provide advice to general practitioners about whether to issue a cause of death certificate.[83]

1.71 A report by the Queensland Auditor-General in 2018 on the Queensland coronial system strongly criticised the structure of the State's coronial system. It noted that the Queensland State Coroner, who was 'legally accountable' for coordinating the system had little functional control over the resources needed to effectively fulfil its responsibility.[84] The Auditor-General found that the system was stressed and under-resourced to meet its needs. The report observed that:

77 Submission 46, Legal Aid Commission of New South Wales, p 15.

78 Coroners Court of Victoria, *Annual Report 2020-*21, pp 7-11.

79 See, for example, Coroners Court of Victoria, *Annual Report 2020-21*, p 7; Submission 46, Legal Aid Commission of New South Wales, Attachment 1, Law and Justice Foundations of New South Wales Aboriginal Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences (2021), p 15.

80 Coroners Court of Victoria, *Annual Report 2020-21*, pp 4 and 13.

81 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 2; Submission 17 New South Wales Bar Association, p 46.

82 Submission 17, New South Wales Bar Association, p 44.

83 Coroners Court of Queensland, Annual Report 2019-20, p 12.

84 Submission 17, New South Wales Bar Association, p 12.

> The coronial system relies on the dedication of staff and good will amongst agencies but lacks system-wide cohesion, with no agency having responsibility for leadership, accountability, planning, and reporting across the system.[85]

Committee comment

1.72 The coronial jurisdiction plays a vital role in investigating all sudden, unexpected, or unexplained deaths. Although it has a long history in this state, the jurisdiction has not been subject to a comprehensive review for over 46 years. In our view, this inquiry was long overdue, and essential to determine whether the jurisdiction is appropriately structured, performing well and meeting the needs of families and communities.

1.73 This inquiry was especially needed given the statutory review process for the *Coroners Act 2009* (NSW) has not been finalised, despite having commenced in 2015. While the review's outcomes were put on hold pending the completion of work undertaken by the NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce*, it is time the process was finalised. To this end, the committee calls on the government to recommit to the progress and completion of this review process.

Recommendation 1

That the NSW Government finalise and publish the statutory review of the *Coroners Act 2009* (NSW) by the end of 2022.

1.74 In this context, the committee notes that this inquiry has centred on an examination of the operations of the Coroners Court, including its structure, the adequacy of its resources and the timeliness of its decisions. It has also considered the experiences of those involved in coronial processes, including families who understandably find the system a challenge to navigate during a time of profound grief.

1.75 Ultimately, the committee intends for this report and its recommendations to be a valuable basis for implementing significant reforms to the coronial jurisdiction. Like the many stakeholders that gave evidence to this inquiry highlighted, the committee believes it is essential that the coronial system be modernised, adequately resourced and that its underpinning foundations and practices reflect the centrality of bereaved families in the coronial process and the function of the Coroners Court in preventing future deaths.

1.76 In undertaking this comprehensive review, we wish to express our sincere thanks to a number of people who provided their expertise and insight. In particular, we thank State Coroner Teresa O'Sullivan and Chief Magistrate Peter Johnstone, and all the staff at the Lidcombe Forensic Medicine and Coroners Court complex, many of which we met during a visit to the Court on 14 December 2021.

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[85] Submission 17, New South Wales Bar Association, p 12, quoting Queensland Auditor-General, *Delivering coronial services*, Report No 6: 2018-19 (Brisbane: 2018), p 9.

1.77 The committee would also like to thank Judge John Cain, the Victorian State Coroner, for hosting the committee at the Coroners Court of Victoria on 4 February 2022. The valuable insights of Judge Cain and senior representatives from the Victorian Institute of Forensic Medicine, the Koori Engagement Unit, and the Coroners Prevention Unit, greatly assisted in formulating aspects of this report. We also express our thanks to Magistrate Terry Ryan, Queensland State Coroner, for meeting with the committee by video link on 23 February 2022, and to all the other organisations and agencies who made a valuable contribution to this inquiry.

1.78 Finally, the committee wishes to acknowledge the important contribution of individuals and families, many of whom shared their very personal experiences of the coronial system with the committee. Their openness and willingness to retell their personal stories have helped shape this report and the committee's views on how the coronial system can improve.

Chapter 2 Structural and resourcing concerns

This chapter examines stakeholders' concerns regarding the structure and resourcing of the Coroners Court of New South Wales. The first part examines whether the current institutional arrangements are fit-for-purpose in the context of modern coronial practice. The second part of the chapter focuses on resources and funding concerns, examining the adequacy of court resources according to various institutional performance measures, such as clearance rates, delays and backlogs. Towards the end, the chapter will consider the funding of coronial jurisdictions in other states.

Issues arising from the current structure of the Coroners Court of NSW

2.1 As noted in chapter 1, the Coroners Court of NSW is part of the Local Court framework, with specialist coroners attached to the State Coroners Court in either Lidcombe, Newcastle or Wollongong, and regional magistrates undertaking coronial work in regional areas by virtue of their appointment as a coroner *ex officio*. Under section 16 of the *Coroners Act 2009* (NSW) (Coroners Act) a magistrate by virtue of their office is taken to be a coroner.[86]

2.2 Before turning to some stakeholder concerns raised in relation to this framework, it is important to note the NSW Government's view that there are particular advantages to the current structure and arrangements, including:

- transferability of judicial officers and resources across jurisdictions, enabling prompt coronial appointments to occur on an as needs basis, as well as facilitating the rotation of coroners to the Local Court to manage any vicarious trauma
- enhanced judicial resources and training
- less duplication of administrative functions and costs.[87]

2.3 Several stakeholders, however, contended that there are structural and resourcing barriers impacting the capacity of regional magistrates to deliver timely and high quality coronial decisions. This section will consider these issues, drawing on the experience and views of former NSW Deputy State Coroner Adjunct Professor Hugh Dillon, former NSW State Coroner Mary Jerram AM and former NSW State Coroner and former Queensland State Coroner Michael Barnes, among other stakeholders.

Pressures on regional magistrates acting as coroners

2.4 A key concern among inquiry participants was the pressure experienced by regional magistrates acting in their capacity as coroners, and how this impacts the standard and timeliness of coronial services. In particular, stakeholders connected this pressure to the experience and capacity of regional magistrates, given the specialised nature of coronial work.

86 *Coroners Act 2009* (NSW), s 16(1).

87 Submission 18, NSW Government, p 24.

2.5 It was widely acknowledged by inquiry participants that the coronial jurisdiction is a specialist jurisdiction.[88] Adjunct Professor Hugh Dillon identified the following areas of expertise required for coronial practice that are not common to other judicial roles:

- making decisions about autopsies and other forms of medical investigation
- making decisions about investigation of the circumstances of a death
- making decisions about whether or not to hold an inquest
- managing inquests
- developing recommendations for the mitigation of risk of future deaths.[89]

2.6 Adjunct Professor Dillon contended that the current structure of the Coroners Court of NSW is based on the narrow theory of death investigations, where there are five relatively straightforward questions about the cause and manner of death. However, he argued that modern coronial practice broadly construes these questions to examine the circumstances leading to the deaths, and the preventability of the death and future deaths is a key objective of coronial practice.[90]

2.7 Adjunct Professor Dillon also contended that the model of regional magistrates acting as coroners is based on a long held assumption that magistrates are generalists and that specialisation in the magistracy reduced the interchangeability. Adjunct Professor Dillon argued that the current arrangements assume that because magistrates have criminal law expertise they are adept at transitioning between the criminal and coronial jurisdiction, however, criminal law skills are not necessarily translated into the specialist coronial field.[91]

2.8 The nature of coronial work was also reflected on by Mr Barnes, who suggested that transitioning into the inquisitorial nature of the coronial jurisdiction can present challenges for magistrates as their experience has often been developed in adversarial proceedings.[92] Additionally, with respect to magistrates in the regions, Adjunct Professor Dillon stated that a significant portion are recent appointments to the magistracy, undertaking their two years of regional service and, as such, are still developing their general bench skills.[93]

2.9 In addition to having high standard judicial and legal skills, stakeholders identified that exercising coronial duties requires specialist skills including skills in managing inquisitorial

88 See, for example, Submission 5, MIGA p 3; Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 14, Adjunct Professor Hugh Dillon, pp 21-22; Submission 17, New South Wales Bar Association, p 4; Submission 28, Adjunct Professor George Newhouse, p 5; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 17; Submission 41, Michael Barnes, pp 6-9; Submission 46, Legal Aid Commission of New South Wales, p 18.

89 Submission 14, Adjunct Professor Hugh Dillon, Appendix E, *Raising coronial standards of performance: Lessons from Canada, Germany and England*, (Report, 2015), p 27.

90 Submission 14, Adjunct Professor Hugh Dillon, pp 21-22.

91 Submission 14, Adjunct Professor Hugh Dillon, pp 21-23; Submission 14a, Adjunct Professor Hugh Dillon, p 8. See also Submission 17, New South Wales Bar Association, p 13.

92 Submission 41, Mr Michael Barnes, p 5; Evidence, Mr Michael Barnes, Queensland State Coroner from 2003 to 2013, and NSW State Coroner from 2014 to 2017, 29 September 2021, p 6.

93 Submission 14, Adjunct Professor Hugh Dillon, p 22.

proceedings, case management skills, multidisciplinary team management and investigation skills and interpretation of complex expert evidence including forensic medicine and science.[94] As noted by Adjunct Professor Dillon, while cases in which routine findings are made constitute the majority of reported deaths, there are complex cases which raise issues of public health and safety, human rights and system failure.[95]

2.10 Importantly, coroners must also appropriately balance competing interests at each step of the coronial process and assess whether a legal, restorative or preventative approach best fits the circumstances. Mr Barnes identified that it is only with considerable experience that corners can effectively recognise and balance the competing priorities of investigating the death at hand, death prevention and the assuaging of bereavement.[96]

2.11 In fact, in 2017 former State Coroner Barnes wrote to the Attorney General to raise concerns about the coronial structure, and in particular the performance of regional magistrates undertaking coronial work. Pointing to inconsistencies and errors in decision making by regional magistrates, as well as insufficient experience and demanding workload pressure, Mr Barnes sought to have coronial work removed from them, describing the arrangements for the delivery of coronial services outside the metropolitan area as 'sub-optimal'.[97] This did not occur.

2.12 The lack of specialist coronial training and professional development for all coroners, but particularly for regional magistrates, was a key point of concern for the former coroners who participated in the inquiry.[98]

2.13 On this point, the Department of Communities and Justice noted that prior to magistrates commencing the required period of country service, they have the opportunity to complete a short rotation at the State Coroners Court to gain experience in coronial proceedings while working alongside specialist coroners. The committee understand this practice has now been abandoned in favour of a two day induction course for new magistrates.[99]

2.14 However, as noted by Adjunct Professor Dillon, regional magistrates undertake relatively low volumes of complex coronial work and less inquests compared to coroners at the State Coroners Court, resulting in less opportunities to develop specialist skills by way of experience.[100]

2.15 In the experience of Adjunct Professor Dillon, even with the benefit of being a full-time specialist coroner, gaining experience through higher caseloads than regional magistrates and working with other specialist coroners and the multidisciplinary team at the State Coroners

94 Submission 17, New South Wales Bar Association, p 13; Submission 14, Adjunct Professor Hugh Dillon, Appendix E, *Raising coronial standards of performance: Lessons from Canada, Germany and England*, (Report, 2015), p 25.

95 Submission 14, Adjunct Professor Hugh Dillon, Appendix F, p 113.

96 Evidence, Mr Barnes, 29 September 2021, p 10.

97 Submission 14, Adjunct Professor Hugh Dillon, pp 24-25.

98 See, for example, Submission 14, Adjunct Professor Hugh Dillon, pp 26 and 45; Evidence, Ms Mary Jerram AM, NSW State Coroner from 2007 to 2013, 29 September 2021, p 5; Evidence, Adjunct Professor Hugh Dillon, Deputy NSW State Coroner from 2008 to 2016, and researcher in relation to coronial systems at the Law Faculty, University of New South Wales, 29 September 2021, p 5; Evidence, Mr Barnes, 29 September 2021, p 5. See also

99 Submission 23, Public Interest Advocacy Centre, p 3.

100 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 23.

Submission 14, Adjunct Professor Hugh Dillon, p 23.

Court, he only felt competent in coronial matters after two years and a developed a real degree of experience after five years.[101]

2.16 Similarly, Ms Jerram reflected on the imbalance in opportunities to develop expertise between regional magistrates and full-time Sydney-based coroners:

> In New South Wales, country magistrates with heavy daily workloads are expected to undertake some coronial work while having neither the opportunity properly to gain full experience and training in that field nor the benefits of the collegiate system pertaining in Sydney's head Coroners Court amongst the full-time coroners.[102]

2.17 Balancing high criminal and civil Local Court caseloads with coronial cases was another challenge identified for regional magistrates.[103] Adjunct Professor Dillon reported that in his interviews with other coroners, conducted in 2020 as research, a common theme which emerged was that regional magistrates found it challenging to undertake coronial work especially with a demanding Local Court caseload.[104] On this point, Ms Kristen Edwards, Member of New South Wales Bar Association Inquests and Inquiries Committee, also argued that it is impossible for regional magistrates to exercise their coronial duties in any way similar to the standards of the State Coroners Court due to their Local Court workloads.[105]

2.18 Adjunct Professor Dillon and the NSW Bar Association also made the point that regional magistrates make a limited contribution to preventing deaths as they hold few inquests, thereby making few recommendations. Adjunct Professor Dillon highlighted this by reporting that between 2010 and 2018, of the 164 regional inquests in which recommendations were made, 30 of those inquests were conducted by a regional magistrate acting as a coroner and the rest were carried out by the State Coroner or Deputy State Coroners.[106] That is, just over 80 per cent of the regional inquests in that period which generated recommendations were conducted by a specialist coroner.[107]

2.19 With recognition and respect given to the hard work, skill and competency of regional magistrates, Ms Jerram, Mr Barnes and Adjunct Professor Dillon contended that the combination of the above factors means that regional magistrates are under-trained and over-burdened when it comes to exercising coronial duties. In this regard, Adjunct Professor Dillon and Mr Barnes described the current coronial jurisdiction in NSW as a two-tiered coronial service: non-specialist and under-resourced regional magistrates for regional NSW and a specialist, multidisciplinary team for metropolitan deaths.[108]

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101 Submission 14, Adjunct Professor Hugh Dillon, pp 23-24. See also Evidence, Ms Jerram AM, 29 September 2021, p 2.

102 Evidence, Ms Mary Jerram AM, 29 September 2021, p 2.

103 Submission 41, Mr Michael Barnes, p 5.

104 Submission 14, Adjunct Professor Hugh Dillon, p 29.

105 Evidence, Ms Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 24.

106 Submission 14, Adjunct Professor Hugh Dillon, p 33; Submission 17, New South Wales Bar Association, p 16; Evidence, Adjunct Professor Dillon, 29 September 2021, p 5.

107 Submission 14, Adjunct Professor Hugh Dillon, pp 33-34.

108 Submission 14, Adjunct Professor Hugh Dillon, p 21; Submission 41, Michael Barnes, p 6.

2.20 Mr Barnes also commented on the standard and timeliness of coronial services and decisions for regional New South Wales in the context of a lack of training and resources provided to regional magistrates:

> Many Local Court magistrates have high criminal caseloads that prevent them dealing with coroner's cases in a timely and thoughtful manner. They are frequently required to make rushed decisions in court breaks about matters in which they lack sufficient background and understanding.
>
> …
>
> Deaths that are reported to a regional coroner may well be dealt with by a person with limited experience in the subtleties of the jurisdiction and inadequate time to make the inquiries necessary for the nuanced decision making required to address the competing interests many cases throw up.[109]

2.21 The NSW Bar Association also submitted that the combination of heavy workloads, inexperience in the jurisdiction, inadequate resources and lack of specialist coronial training undermines regional magistrates' ability to effectively and efficiently undertake inquest work.[110]

Is the structure of the Coroners Court of NSW out of step with other Australian jurisdictions?

2.22 Some submissions emphasised that other Australian coronial jurisdictions have moved away from the model of regional magistrates acting as coroners, suggesting that the current institutional arrangements for the Coroners Court of NSW are an outlier in Australian coronial practice. In all other states and territories, other than the Australian Capital Territory and Western Australia, designated specialist coroners complete all coronial work.[111]

2.23 Reflecting on the structure of NSW coronial system and the role of the Chief Magistrate, Adjunct Professor Dillon stated:

> the Coroners Act 2009, with its obsolete arrangements of the Chief Magistrate having control and direction of the jurisdiction and of country magistrates acting as coroners, reflects an anachronistic concept of coronership that has been abandoned in every other jurisdiction in Australia—and, I may say, practically everywhere else in the Commonwealth.[112]

2.24 Adjunct Professor Dillon explained that most Australian jurisdictions have recognised the specialist nature of coronial work and have reformed their jurisdictions to reflect this:

> With Queensland and Victoria leading, most Australian jurisdictions have gradually come to understand and embrace the concept that to be carried out at a high standard, coronial work cannot be performed by persons who, through no fault of their own, are amateurs in this field. Except in New South Wales, most coronial work of any

109 Submission 41, Michael Barnes, pp 5-6.

110 Submission 17, New South Wales Bar Association, p 16.

111 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 80; Submission 17, New South Wales Bar Association, p 14.

112 Evidence, Adjunct Professor Dillon, 29 September 2021, p 3.

> complexity is now done by full-time professional coroners who are judicial officers with the rank and title of Magistrate.[113]

2.25 As noted in chapter 1, prior to the establishment of the standalone Coroners Court of Victoria, the institutional arrangements were similar to current NSW arrangements, to the extent that coronial work was undertaken by both full-time specialist coroners in Melbourne and by magistrates for elsewhere in the State.[114] An inquiry by the Parliament of Victoria's Law Reform Committee in 2005, which was the impetus for the major reform of that jurisdiction, observed that the structure at that time did not provide adequate coronial services to regional Victoria.[115]

2.26 With respect to Queensland, the Coroners Court of Queensland sits within the structure of the Queensland Magistrates Court but operates independently. Prior to 2012 all coronial work was undertaken by magistrates. Since then, while coroners are appointed as magistrates, all coronial work is conducted by seven full-time specialist coroners located across Queensland, in addition to one part-time specialist magistrate and a specialist acting magistrate.[116]

2.27 Relevant to this, the Law Reform Commission of Western Australia undertook a review of coronial practice in Western Australia which examined the structure of having specialist coroners as well as magistrates acting as coroners in regional Western Australia. The report highlighted that the standard and timeliness of investigations was a matter of concern. Regional magistrates were under-trained and under-resourced, had competing caseloads, undertook a small number of inquests and delegated responsibilities to court registrars or clerks. The Law Reform Commission of Western Australia recommended that magistrates should no longer hold automatic *ex officio* appointments as coroners and that coronial regions across the State be established with a dedicated coroner assigned to each region.[117]

Independence of the State Coroner

2.28 Under section 10(2) of the *Coroners Act 2009* (NSW), the current structure and institutional arrangements for the Coroners Court of NSW put the State Coroner as being 'subject to the control and direction of the Chief Magistrate'.[118]

2.29 Some of the former coroners explained that the way in which the Chief Magistrate's authority is set out in the Coroners Act could give rise to certain challenges. Mr Barnes, in particular, noted that the Chief Magistrate has decision-making power over the workload of individual coroners, the manner in which cases are resolved and the budget of the Coroners Court of

113 Submission 14, Adjunct Professor Hugh Dillon, Appendix F, p 112.

114 Submission 14, Adjunct Professor Hugh Dillon, p 60.

115 Submission 14, Adjunct Professor Hugh Dillon, p 27, citing Parliament of Victoria, Law Reform Committee, *Coroners Act 1985 Report* (2006), https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf.

116 Submission 13, Coroners Court of Queensland, p 1. See also Submission 18, New South Wales Bar Association, p 44.

117 Submission 14, Adjunct Professor Hugh Dillon, p 28, citing Law Reform Commission of Western Australia, *Review of coronial practice in Western Australia* (2012), pp 14-17, https://www.wa.gov.au/system/files/2021-02/LRC-Project-100-Final-Report_0.pdf.

118 *Coroners Act 2009* (NSW), s 10(2).

NSW, all of which could undermine the authority of, and could be in conflict with, the State Coroner.[119] Ms Jerram also noted that the State Coroner 'has virtually no input' into the appointment of coroners.[120]

2.30 Further, Adjunct Professor Dillon argued that the Chief Magistrate's direction and control of the State Coroner infers that the Local Court's operations and interests supersede those of the Coroners Court of NSW.[121]

Funding and resource issues

2.31 A common theme emerging from evidence was the need for the Coroners Court of NSW to have a significant increase in funding and resources, in order to meet its caseload in a timely fashion and optimally perform its death investigation and prevention functions.

2.32 In this regard, it is important to note the recommendation from the inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, that the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court of NSW can effectively undertake its role in investigating deaths in custody in a timely manner.[122]

2.33 Adjunct Professor Dillon submitted that certain performance measures, such as delays and backlogs, indicate that the Coroners Court of NSW is not resourced to perform its objectives in a timely manner.[123] Several stakeholders agreed, including the Legal Aid Commission of New South Wales (Legal Aid NSW) and New South Wales Bar Association, arguing that the following factors indicate inadequate resourcing of the Court:

- the inadequacy of funding and staffing of the Coroners Court of NSW when compared to other Australian coronial jurisdictions
- significant delays in investigations and inquest
- the high and persistent backlog of mandatory inquests
- a decline in the number of inquests being held, and few discretionary inquests being held.[124]

119 Submission 41, Mr Michael Barnes, p 5.

120 Evidence, Ms Jerram AM, 29 September 2021, p 2.

121 Submission 14, Adjunct Professor Hugh Dillon, p 62.

122 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), p 150.

123 Submission 14, Adjunct Professor Hugh Dillon, pp 35-49.

124 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 14, Adjunct Professor Hugh Dillon, pp 35-49; Submission 17, New South Wales Bar Association, p 4; Submission 27, National Justice Project, p 21; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, Research Unit, p 9; Submission 39, Gilbert + Tobin, pp 16-17; Submission 41, Mr Michael Barnes, pp 4-5; Submission 46, Legal Aid Commission of New South Wales, pp 26, 29-33.

2.34 This section will explore these issues, starting first by looking at caseload and clearance rates for the Coroners Court of NSW.

Caseload and clearance rates

2.35 The NSW Government submission noted that data from the Productivity Commission demonstrated a 19 per cent increase in the caseload of the Coroners Court of NSW over the past five years with a corresponding increase in the pending caseload.[125]

2.36 The Department of Communities and Justice provided data on the number of deaths reported, cases finalised and inquests held between 2011 and 2022, demonstrating a steady increase in caseload, as represented in Table 2 below.

Table 2 Caseload from 2011 to 2020

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Deaths reported	5,694	5,369	5,340	5,610	5,766	5,960	6,602	6,264	6,673	6,374
Investigations finalised	5,939	4,147	4,514	5,354	6,376	5,731	6,450	5,887	6,203	7,040
Inquests held	290	148	142	140	150	120	84	111	113	112

Source: Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 5.

2.37 The NSW Government noted that 'inquests are becoming increasingly lengthy and complex'.[126] The scale and profile of inquests into events in recent years was noted, such as the two inquests into deaths arising from the COVID-19 outbreak at the Newmarch House nursing home and on board the Ruby Princess cruise ship, and the series of inquests into the bushfires from 2019-2020.[127]

2.38 In terms of the distribution of caseload between the State Coroners Court and regional magistrates, Adjunct Professor Dillon reported that since the State Coroners Court started triaging all deaths in NSW from March 2020, its overall workload has increased by approximately 20 per cent.[128]

2.39 The Department of Communities and Justice also provided data on the division of coronial work between regional magistrates acting in their capacity as coroners and coroners at the State Coroners Court between 2011 and 2022, as represented in Figure 1 below.

125 Submission 18, NSW Government, p 12.

126 Submission 18, NSW Government, pp 12-13.

127 See, for example, Submission 17, New South Wales Bar Association, p 30; Submission 18, NSW Government, pp 12-13.

128 Submission 14, Adjunct Professor Hugh Dillon, p 32.

Figure 1 Distribution of caseload between State Coroners Court and magistrates at regional Local Courts

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Deaths reported										
State Coroners Court	3128	2864	2807	2901	2989	3109	3550	3423	3470	3540
Other statewide	2566	2505	2533	2709	2777	2851	3052	2841	3203	2834
Total	**5694**	**5369**	**5340**	**5610**	**5766**	**5960**	**6602**	**6264**	**6673**	**6374**
Investigations finalised										
State Coroners Court	3805	2185	2305	3169	2950	3031	3508	3240	3834	3829
Other statewide	2134	1989	2209	2185	3426	2700	2942	2647	2369	3211
Total	**5939**	**4174**	**4514**	**5354**	**6376**	**5731**	**6450**	**5887**	**6203**	**7040**
Inquests-inquiries										
State Coroners Court	215	111	98	103	87	92	57	74	77	94
Other statewide	75	37	44	37	63	28	27	37	36	18
Total	**290**	**148**	**142**	**140**	**150**	**120**	**84**	**111**	**113**	**112**
Fires reported										
State Coroners Court	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	148
Other statewide	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	54
Total	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**202**

Source: Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 5.

2.40 The Department of Communities and Justice advised that measures such as clearance rates, backlog and pending caseload indicate whether a jurisdiction is efficiently managing its overall caseload in a timely manner.[129]

2.41 According to the Department, clearance rates are an indication of the timeframe within which matters are finalised, which are measured by dividing the number of finalisations in the reporting period by the number of lodgements in the same period.[130] While these rates are recognised as an international measure of court performance, the Department acknowledged that 'clearance rates are not an indication of the complexity of work involved in determining a matter'.[131]

2.42 The Productivity Commission releases data each year on the clearance rates of all Australian courts. Looking at the clearance rate of coronial cases finalised in NSW for 2019-2020, determined by dividing the number of cases finalised by the number of new cases, the clearance rate was 104.7 per cent. The NSW Government compared this result to Victoria, which had a clearance rate of 93.4 per cent, and to Queensland, which had at rate of 93.1 per cent.

129 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 14.

130 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 14.

131 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 14.

Comparison was also made between those jurisdictions on the percentage of cases finalised within 12 months and within 24 months, which is represented below in Table 3.[132]

Table 3 Clearance data for coronial courts in NSW, Victoria and Queensland

	New South Wales	Victoria	Queensland
Number of finalisations of deaths reported	6,862	6,841	5,744
Cases finalised < 12 months	83.6 %	81.8 %	80.4 %
Cases finalised < 24 months	97 %	94.5 %	93.1 %
Clearance indicator	104.7 %	93.4 %	102 %

Source: Submission 18, NSW Government, p 12.

2.43 Looking at clearance rates over time, Adjunct Professor Dillon noted that based on data from 2010 to 2019, the clearance rates for the Coroners Court of NSW have 'held steady' at or close to 100 per cent.[133] However, he highlighted that clearance rates are not a true indicator of how efficiently or effectively the Court is performing.[134] Adjunct Professor Dillon noted that clearance rates may not accurately reflect of the quality of services:

> … a clearance rate seems to suggest that nothing is wrong and that we have got a very efficient system, whereas it is actually hiding a lack of investigation. If you look at another jurisdiction, say Victoria, where they have a 93 per cent clearance rate, that might suggest actually that they are putting a greater effort into investigating the true causes and circumstances of deaths. A clearance rate can be utterly misleading in itself. Of course you should have high clearance rates if you can, but you should be doing good investigation simultaneously. Quality should not be dismissed at the expense of quantity.[135]

2.44 Similarly, Mr Barnes stated that the reported clearance rates of the Coroners Court of NSW do not reflect the quality of services but instead indicate workload pressures:

> Clearance rates are the mechanism by which overworked coroners cope with too much work … Coroners manage their workload simply by dispensing with matters. You could say that it is an easy way out for people who do not want to do more work than they need to; I do not think that is the case. I think it is overworked magistrates coping with too much work by simply dispensing—and that is reflected positively for them …[136]

2.45 Ms Jerram agreed on this point, stating that 'the clearance rate really does not reflect anything other than pressure on the coroners and nothing about quality'.[137]

132 Submission 18, NSW Government, p 12.

133 Submission 14, Adjunct Professor Hugh Dillon, pp 35-36.

134 Submission 14, Adjunct Professor Hugh Dillon, pp 35-41.

135 Evidence, Adjunct Professor Dillon, 29 September 2021, p 7.

136 Evidence, Mr Barnes, 29 September 2021, p 7.

137 Evidence, Ms Jerram AM, 29 September 2021, p 7.

Delays in investigations and inquests

2.46 Several stakeholders were concerned about the delays experienced in the coronial system and contended that enhancing the jurisdiction's resourcing would improve the timeliness of decisions and reduce the increasing backlog of cases.[138] Before outlining these concerns, it is relevant to set out the time standards within which coronial cases should be finalised.

2.47 Essentially, the coronial time standards require 95 per cent of coronial cases and inquests to be completed within 12 months and 100 per cent of coronial cases and inquests to be completed within 18 months.[139] There is also a Coroners Court of NSW protocol that establishes the time standards for various coronial matters to be completed, as set out in Table 4.

Table 4 Coroners Court of NSW time standards for matters

	95 per cent of cases to be finalised within	**100 per cent of cases to be finalised within**
Deaths by natural causes with no brief of evidence ordered	3 months	6 months
Deaths dispensed with a brief of evidence ordered	6 months	9 months
Deaths proceeding to inquest	12 months	18 months

Source: Submission 17, New South Wales Bar Association, Appendix B, p 1.

2.48 Despite these standards being in place, stakeholders reported delays at different stages of the coronial process, including:

- the length of time between a death reported to the Coroners Court of NSW and a decision on whether to dispense or hold an inquest
- the length of time between a decision to hold an inquest, the commencement of the inquest hearing and the findings and recommendations being delivered.[140]

2.49 On the second of these points, Adjunct Professor Dillon conducted a review in 2019 on the completion time for inquests by specialist coroners. He highlighted that this review was limited

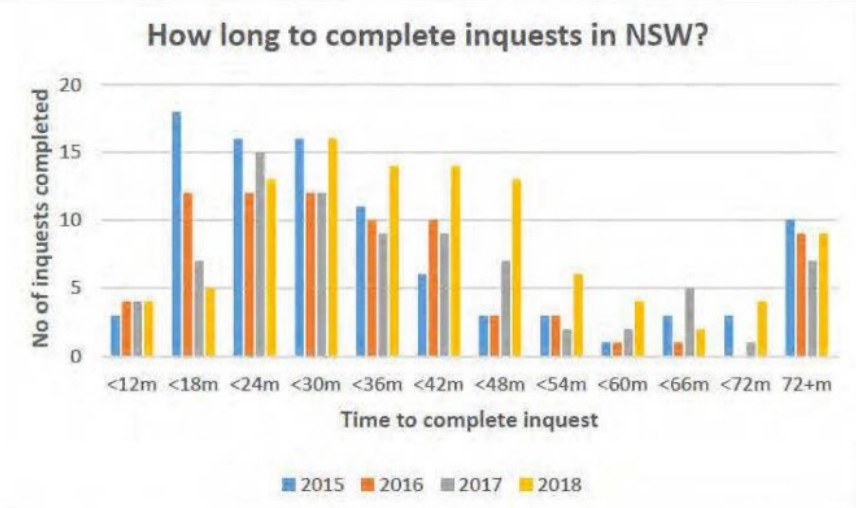
138 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 4; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9; Submission 35, Australian Medical Association (NSW), p 2; Submission 39, Gilbert + Tobin, pp 16-17; Submission 46, Legal Aid Commission of New South Wales, p 7; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch p 3; Submission 57, Public Service Association of New South Wales, pp 10-11; Evidence, Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid Commission of New South Wales, 29 September 2021, p 14; Evidence, Dr Louis Schetzer, Policy and Advocacy Manager and National Manager, Australian Lawyers Alliance, 29 September 2021, p 21.

139 Submission 9, The Law Society of New South Wales, Appendix 1, p 13.

140 See, for example, Submission 39, Gilbert + Tobin, p 17; Submission 46, Legal Aid Commission of New South Wales, p 28.

to inquests from 2015 to 2018, given the limitations in collection and publication of relevant data. The findings are represented in Figure 2.

Figure 2 Time to completion of inquests - Specialist coroners 2015-2018



Source: Submission 9, The Law Society of New South Wales, Appendix 1, p 15.

2.50 Other stakeholders also reported that there were substantial delays in the coronial system. With respect to the timeframes for decisions on whether to hold an inquest, Gilbert + Tobin noted that in one of its cases, four years have passed since their client's mothers death, with the decision on whether an inquest will be held still not having been made.[141]

2.51 Legal Aid NSW also advised that in its experience the time between death and the date of the coronial findings is between three and five years and in some of their cases an inquest has been held up to seven years after the death.[142]

2.52 In the few cases in which a regional magistrate holds a coronial inquest, evidence to the inquiry also detailed the impact of delays in terms of progress and completion of a matter. The Australian Lawyers Alliance provided an example of an regional inquest being finalised five years after the death:

> In one example reported by an ALA member, involving the death of 18-year old Thomas Redman in Barrington (near Gloucester) in December 2015, the inquest process took 5 years to be finalised. The inquest was heard by LCM Hudson with the first hearing dates being 16 and 17 May 2018. Further dates were not available until 12 and 13 June 2019. The findings were delivered on 24 January 2020 – five years after the death.[143]

2.53 As to what is contributing to these types of delays, Ms Kirsten Edwards, Member of the New South Wales Bar Association Inquests and Inquiries Committee, acknowledged that the reason

141 Submission 39, Gilbert + Tobin, p 26.

142 Submission 46, Legal Aid Commission of New South Wales, p 28.

143 Submission 6, Australian Lawyers Alliance, p 7.

for delays at the State Coroners Court and in regional NSW are 'multi-faceted' and that 'it is easy to say it is inadequate resourcing, but it operates at a number of levels'.[144]

2.54 The NSW Government made a similar observation, noting that the multiagency nature of the coronial system gives rise to various reasons for delay:

> … the timeliness of coronial processes is reliant on a range of complex and interdependent workflows, shared across each of the three key agencies involved … As such, the pending caseload may reflect delays across each stage of the coronial process. This includes delays which are outside of the direct control of the coroner, such as delays in the finalisation by Forensic Medicine of a post-mortem report, and delays in the preparation by NSWPF of the coronial brief of evidence.[145]

2.55 As to the length of delays, however, the Department of Communities and Justice advised that it was not able to provide data on the average timeframe from a decision to hold an inquest to the commencement of an inquest, or the average length of an inquest.[146] It was also unable to provide data on the average length of coronial inquest cases in metropolitan areas versus the regions, pointing to limitations it has in extracting this type of data from its systems.[147]

2.56 The committee was also informed that through the ongoing work of the NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce* (Timeliness Taskforce), the Department of Communities and Justice is currently developing capacity to extract and report a range of coronial data to enable monitoring over time of the impact of various initiatives being implemented through the Timeliness Taskforce's work, which is detailed below.[148]

2.57 An analysis provided by the NSW Bar Association indicated that the existing backlog of cases in the Coroners Court of NSW was about 130 cases and that only significantly increased resources would reduce it.[149]

Initiatives to improve timeliness

2.58 As noted in Chapter 1, the NSW Government's Timeliness Taskforce comprised senior representatives from the various government agencies involved in coronial process 'to identify ways of improving the timeliness of coronial procedures and the experiences of families and loved ones'.[150] The Timeliness Taskforce identified that the over-reporting of natural deaths and delays in finalising post-mortem reports contribute to delays in the coronial system in NSW.[151]

144 Evidence, Ms Edwards, 29 September 2021, p 24.

145 Submission 18, NSW Government pp 12-13.

146 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 9-10.

147 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 9-10.

148 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 10.

149 Submission 17, New South Wales Bar Association, p 35.

150 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 4.

151 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 10.

2.59 On this last point, the Timeliness Taskforce noted that the 'lengthiest phase of the coronial process is the post-mortem investigation'. A decision to dispense with or hold an inquest cannot be made until the coroner receives the final post-mortem report, which can take several months despite the examination being typically completed within three to five days of admission.[152]

2.60 In terms of the timeframes for post-mortem examinations and final reports, the Department of Communities and Justice advised that for November 2021 the median timeframe for a post-mortem examination was three days and the median timeframe for provision of the post-mortem report was 160 days, which has improved from four days for a post-mortem examination and 221 days for a post-mortem report in 2019.[153] The Department of Communities and Justice also noted that State Coroners Court registry uses a 'Priority Request' process to allow families to request an expedited post-mortem report but the request is subject to the NSW Health forensic pathologist capacity to accommodate these requests.[154]

2.61 One of the four objectives of the Timeliness Taskforce was to implement initiatives aimed at reducing delays in finalising post-mortem reports. Recognising the 'limited forensic medicine resources', the Timeliness Taskforce noted that one of the key reasons for delays in the final post-mortem report is 'the limited number of forensic pathologists, both in Australia and worldwide' and the 'extremely limited number of neuropathologists in NSW, which can impact timely completion of reports'.[155] This will be discussed further in chapter 3.

2.62 With respect to the over-reporting of natural cause deaths, the Timeliness Taskforce identified that reducing the over-reporting of natural cause deaths is expected to improve timeliness by alleviating pressure on the coronial system. It noted that 60 per cent of deaths reported to the Coroners Court of NSW were natural cause deaths. The Timeliness Taskforce found that there was a reluctance among general practitioners to issue a Medical Certificate of Death, due to concerns as to whether the patient's pre-existing condition resulted in the death, unfamiliarity with the patient or not having seen them recently.[156]

2.63 The Timeliness Taskforce concluded that improved guidance to general practitioners to certify natural cause deaths would allow coronial resources to 'focus on the deaths that warrant the scrutiny of a Coroner'.[157] To this end, the Coroners Act was amended in 2020 to remove the requirement to report a death to the Coroners Court of NSW if the deceased had not seen a medical practitioner in six months before their death.[158]

152 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 13.

153 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 8-9.

154 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 11.

155 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 14.

156 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 11. See also Submission 41, Mr Michael Barnes, p 2.

157 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 11.

158 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 11.

2.64 The Timeliness Taskforce is also developing timeliness standards for the key steps in the coronial process to support monitoring of performance. The NSW Government noted that 'these timeliness standards, in combination with clinical standards being developed, will form the basis against which each agency will monitor compliance against the standard and the key performance indicators'.[159]

2.65 Despite the work undertaken and initiatives implemented as part of the Timeliness Taskforce, some stakeholders still raised concerns with delays in post-mortem reports and over-reporting of natural cause deaths. For example, Legal Aid NSW expressed concern about the time taken for the completion of post-mortem reports and how this often delays the progress of a coronial investigation.[160] Legal Aid NSW explained that commonly a case is not allocated to a coroner and no further steps are taken until a post-mortem report is received. As such, a delay in obtaining a post-mortem report delays decisions on the cause of the death and delays the start of any inquest.[161]

2.66 On the volume of natural cause deaths, Mr Barnes expressed concern that more than half of all reportable deaths are natural cause deaths, noting the impacts of this on the court resources and families:

> This causes unnecessary intrusion into the lives of the bereaved at a most sensitive time; consumes significant resources of an under-funded system; delays the finalisation of matters more appropriately dealt with by a coroner; and serves little worthwhile purpose.[162]

2.67 In correspondence to the committee in April 2022, the Department of Communities and Justice advised that while data indicated that a reduction in the number of natural cause deaths reported to the Coroners Court of NSW for 2020, this trend did not continue in 2021. In addition, the data from the first quarter of 2022 indicated that the number of natural cause deaths reported are tracking at similar levels to 2021.[163] This data is demonstrated in Figure 3 below.

159 Submission 18, NSW Government, p 16.

160 Submission 46, Legal Aid Commission of New South Wales, p 29.

161 Submission 46, Legal Aid Commission of New South Wales, p 29.

162 See also Submission 41, Mr Michael Barnes, p 2.

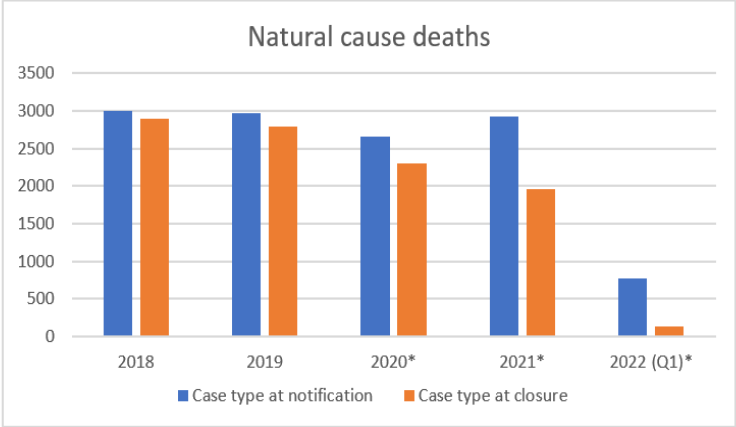
163 Correspondence from the Department of Communities and Justice, to Chair, 13 April 2022.

Figure 3 Natural cause deaths reported to the Coroners Court of NSW

	Natural cause deaths	
Year	Reported	Closed
2018	3002	2888
2019	2970	2792
2020*	2650	2295
2021*	2919	1956
2022 (Q1)*	776	126

*** Closed cases (% of all cases registered):**

2020	79.40%
2021	50.50%
2022 (Q1)	8.60%



Source: Correspondence from the Department of Communities and Justice, to Chair, 13 April 2022

Impact of delays

2.68 While the impact of delays on families is discussed in more detail in chapter 5, it is necessary to note in this chapter that a number of inquiry participants raised concern that the lengthy delays in the coronial system can exacerbate bereaved families' trauma, create uncertainty, stress and anxiety for families and prolong the mourning and healing process.[164] With particular regard to First Nations families, several stakeholders identified that in the context of First Nations people's experience with racism and relationship with the justice system, delays can add to an already existing distrust in the system and a sense of injustice.[165]

2.69 In addition to families feeling the adverse impacts of delays, the committee heard that delays also impact witnesses and persons of interest. The New South Wales Nurses and Midwives' Association explained that its members who make statements in coronial matters can be distressed by lengthy delays due to the prolonged uncertainty about whether they will be subpoenaed to give evidence, a wait which can be for up to five years.[166] The NSW Bar Association made a similar point, noting that delays in coronial matters have a wide impact:

> Members of the Association, and the legal profession more broadly, with experience in the jurisdiction point to delay as one of the most significant triggers of increased distress

164 See, for example, Submission 34, New South Wales Aboriginal Land Council, pp 2-3; Submission 36, Aboriginal Legal Service (NSW/ACT), p 7; Submission 39, Gilbert + Tobin, p 17; Submission 33, Katie Lowe, p 8; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 6; Evidence, Dr Schetzer, 29 September 2021, p 21.

165 See, for example, Submission 9, The Law Society of New South Wales, Appendix 1, pp 17-18; Submission 27, National Justice Project, pp 19 and 43; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9.

166 See, for example, Submission 51, New South Wales Nurses and Midwives' Association, p 6; Evidence, Ms Laura Toose, Legal officer, New South Wales Nurses and Midwives' Association, 31 January 2022, p 11. See also Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 6.

> and even re-traumatisation not only of family members but also of others, such as health workers, police officers and correctional staff.[167]

2.70 Several stakeholders also raised concerns about the impact of delays on the integrity and quality of coronial investigations. On this point, when evidence gathering occurs over multiple years, the quality and reliability of evidence can be affected if witnesses have a poor recollection of events that occurred years ago. This can be prejudicial to the investigation and impact its credibility and integrity.[168]

2.71 For example, Gilbert + Tobin reported that for an inquest into the death of their client's son, witnesses' evidence regarding the events leading to the death was of limited assistance due to witnesses' difficulty in remembering events that occurred four year earlier.[169]

2.72 The NSW Bar Association noted that, generally, many witness statements are obtained in a timely fashion and the most significant impact of delay is actually on the quality and reliability of additional evidence not previously included as part of the initial investigation.[170]

2.73 Questions were also raised about the utility and relevance of coroners' findings and recommendations when delivered after a lengthy period of time after the death. Adjunct Professor Dillon commented that when recommendations are made a significantly long time after the death, the death prevention potential of the recommendations is reduced because the incentive to take remedial action is diminished.[171] Similarly, the Royal Australian and New Zealand College of Psychiatrists stated that delays reduce the relevance of recommendations to services and clinicians and hinder changes being made that may have prevented future harm if they had been implemented in a timely way.[172]

2.74 The Independent Bushfire Group similarly raised this concern, highlighting that it can often be more than two years before a bushfire inquiry commences, and another year or more before the process concludes and hands down findings and recommendations. Reflecting on the impact these timeframes have on implementing recommendations, it stated:

> Given bushfires are an annual occurrence, the significant operational gains from the coronial recommendations could be lost or outdated by the time they are handed down. Bushfire lessons need to be identified and acted upon in a timely manner, especially in NSW where the same issues from one fire season can arise less than six months later and the stakes for life, property and the environment are so high.[173]

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167 Submission 17, New South Wales Bar Association, p 31.

168 See, for example, Submission 27, National Justice Project, p 21; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 4; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9; Submission 33, Katie Lowe, p 8; Submission 39, Gilbert + Tobin, p 17; Evidence, Dr Schetzer, 29 September 2021, p 21.

169 Submission 39, Gilbert + Tobin, p 17.

170 Submission 17, New South Wales Bar Association, p 37.

171 Submission 9, The Law Society of New South Wales, Appendix 1, p 18.

172 See, for example, Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 4. See also Submission 51, New South Wales Nurses and Midwives' Association, p 6.

173 Submission 37, Independent Bushfire Group, p 2.

2.75 The NSW Bar Association agreed that agencies and organisations may hold off on taking any remedial action until the coroner's findings and recommendations are delivered, however, in some cases, the fact that an inquest is on foot can prompt agencies and organisations to take remedial action prior to findings and recommendations being delivered.[174]

Backlog of mandatory death in custody inquest cases

2.76 In the context of funding and resource concerns, with delays being an indicator of the performance of the Coroners Court of NSW, several inquiry participants emphasised the impacts associated with a backlog of mandatory death in custody inquests, known as 'section 23 inquests'.[175]

2.77 The NSW Bar Association referred to the State Coroner's annual report highlighting that every year between 2000 and 2019 there have been 'unavoidable delays' in concluding section 23 investigations concerning deaths in custody and police operations.[176]

2.78 Indeed, several submitters reported significant delays with these types of inquests, highlighting the following specific cases as examples:

- Paigh Bartholomew died in 2012 and the inquest into her death was finalised in 2017, five years after her death.
- Danny Whitton died in 2015 and the inquest into his death was finalised in 2021, six years after his death.
- David Dungay Jr died in 2015 and the inquest into his death was finalised in 2019, four years after his death.
- Jack Kokaua died in 2018 and the inquest into his death of was finalised in 2021, just over three years after his death.[177]

2.79 Further, a study by Adjunct Professor Dillon in 2019 reported that between 2010 and 2019, the average annual clearance rate for mandatory death in custody inquests was 80 per cent.[178] For 2020, Legal Aid NSW noted that only 46 mandatory death in custody inquests had been finalised, with 96 mandatory death in custody inquests not completed. Legal Aid NSW noted that two of the 96 pending mandatory death in custody inquests are from 2015, one from 2016,

174 Submission 17, New South Wales Bar Association, p 38.

175 See, for example, Submission 14, Adjunct Professor Hugh Dillon, pp 12 and 39; Submission 17, New South Wales Bar Association, pp 31 and 37; Submission 34, Aboriginal Land Council, pp 2-3; Submission 36, Aboriginal Legal Service (NSW/ACT), p 7; Submission 46, Legal Aid Commission of New South Wales, pp 25-26.

176 Submission 17, New South Wales Bar Association, p 34.

177 See, for example, Submission 46, Legal Aid Commission of New South Wales, p 31; Submission 27, National Justice Project, pp36-38; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 6 and 8.

178 Submission 14, Adjunct Professor Hugh Dillon, p 39.

nine from 2017 and fifteen from 2018.[179] The Department of Communities and Justice informed that as at 24 November 2021, there were 141 pending mandatory death in custody inquests.[180]

2.80 The NSW Bar Association described the backlog of mandatory death in custody inquests as 'chronic' and stressed that delays and backlogs have exceeded the current capacity of the State Coroner and Deputy State Coroners to manage. In its view, the current backlog in relation to mandatory death in custody inquests is due in large part to the high level of incarceration, which disproportionately affects First Nations people, their families and communities.[181]

2.81 Adjunct Professor Dillon also recognised that during 2020 and 2021, the efforts of the State Coroner and Deputy State Coroners had seen a slowing down in the growth of the backlog of mandatory death in custody inquests. However, the backlog of mandatory death in custody inquests, and the resources concentrated on this subset of inquests in order to address the backlog, was viewed as having a significant impact on the availability of court resources to undertake other inquests.[182] Specifically, this backlog, in the context of insufficient court resources, can create a barrier to coroners undertaking discretionary inquests.[183]

2.82 In this regard, the NSW Bar Association stated that the coronial system 'is very stressed and is struggling to keep up with its incoming section 23 deaths in custody and police operations work, let alone reducing section 23 backlogs and undertaking valuable discretionary inquests'.[184] Adjunct Procession Dillon commented that little resources are left for conducting discretionary inquests over which the State Coroner and Deputy State Coroners have exclusive jurisdiction, such as the death of children or disabled people in care.[185]

2.83 In examining the 77 published inquest findings for 2020, the NSW Bar Association observed that mandatory inquests constituted two-thirds of all inquests and 'relatively few discretionary inquests into other possibly preventable deaths are being conducted'. In its view, the fact that 40 per cent of reported deaths are due to non-natural causes, yet a limited number of discretionary inquests are held, is likely a result of resource constraints.[186]

2.84 Related to this, with respect to the overall number of inquests being held, Adjunct Professor Dillon reported that since 2010 there has been a 'slow decline' in the total number of inquests being held.[187] Mr Barnes contended that discretionary inquests are not being held into deaths which warrant an inquest due to resourcing constraints:

> In my experience it means that matters which should go to inquest or should be further investigated do not receive that level of attention, simply because the coroners do not have the capacity to do it. You simply have to finalise about as many matters that are

179 Submission 46, Legal Aid Commission of New South Wales, p 26.

180 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 8.

181 Submission 17, New South Wales Bar Association, p 4.

182 Submission 14, Adjunct Professor Hugh Dillon, p 12.

183 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 12; Submission 17, New South Wales Bar Association, p 35; Submission 41, Mr Michael Barnes, pp 4-5.

184 Submission 17, New South Wales Bar Association, p 31.

185 Submission 14, Adjunct Professor Hugh Dillon, p 12.

186 Submission 17, New South Wales Bar Association, p 35.

187 Submission 14, Adjunct Professor Hugh Dillon, p 38.

> coming in or you will get buried in a backlog. That is only achieved by dispensing with inquests expeditiously, even though there might be legitimate questions that you would otherwise choose to investigate.[188]

2.85 Mr David Evenden, Solicitor Advocate in the Coronial Inquest Unit at Legal Aid NSW, held a similar view, reporting that 'matters that should be going to inquest are not because of resourcing issues—because there are not enough coroners'.[189]

Expenditure on coronial services across Australian jurisdictions

2.86 In comparison to other Australian coronial jurisdictions, stakeholders argued that NSW spends significantly less on its coronial system. According to Mr Barnes, the difference in funding levels infers that the NSW system is under-funded:

> New South Wales funds its coronial system at about one half of the per capita rate of Queensland and Victoria. No one with any insight into the workings of the coronial systems in those latter two states has suggested that their systems are overly funded or wasteful. There is no basis on which to hope that NSW could achieve efficiencies of operation that would compensate for the different rates of funding. Consequently, the only conclusion is that the NSW system is underfunded.[190]

2.87 Some stakeholders referred to data from the Productivity Commission to illustrate that the Coroners Court of NSW receives a similar number of reportable deaths per year with much less recurrent expenditure.[191] In 2019-20, there were 6,506 reported deaths in NSW, 5,631 in Queensland and 7,323 in Victoria. In that same period, the recurrent expenditure was $6,908,000 in NSW, $12,437,000 in Queensland and $21,549,000 in Victoria.[192] Based on these figures, the NSW Bar Association observed that in 2019-20 the Coroners Court of NSW received almost 25 per cent of all reported deaths nationally but spent only 12 per cent of the national expenditure on the coronial jurisdiction.[193]

2.88 The Productivity Commission data also reported the cost per finalised case for each jurisdiction.[194] For 2019-20, the cost was $990 in NSW, $1,779 in South Australia, $2,199 in Tasmania, $2,738 in Western Australia, $3,827 in the Northern Territory, $2,165 in Queensland, $3,150 in Victoria and $5,023 in the Australian Capital Territory. The national average cost per case was $2,195.[195]

188 Evidence, Mr Barnes, 29 September 2021, p 5.

189 Evidence, Mr Evenden, 29 September 2021, p 14.

190 Submission 41, Mr Michael Barnes, p 4.

191 See, for example, Submission 14a, Adjunct Professor Hugh Dillon, pp 11-12; Submission 17, New South Wales Bar Association, p 32; Submission 39, Gilbert + Tobin, p 17.

192 Submission 17, New South Wales Bar Association, pp 31-32.

193 See, for example, Submission 17, New South Wales Bar Association, p 32. See also Submission 14a, Adjunct Professor Hugh Dillon, pp 11-12; Submission 39, Gilbert + Tobin, p 17.

194 Productivity Commission, *Report on Government Services 2022* (February 2022), Tables 7A.2, 7A.12 and 7A.35.

195 Submission 14a, Adjunct Professor Hugh Dillon, p 11.

2.89 The Productivity Commission's most recent data was released in early 2022 for the period 2020-21. This largely demonstrated a consistent trend in the costs per finalised case for each coronial jurisdiction. There were 6,304 deaths reported in NSW, 5,714 in Queensland and 7,052 in Victoria. The recurrent expenditure was $7,971,000 in NSW, $12,136,000 in Queensland and $22,152,000 in Victoria. The cost per finalised case was $1,237 in NSW, $1,689 in South Australia, $2,126 in Tasmania, $3,695 in Western Australia, $4,262 in the Northern Territory, $2,076 in Queensland, $3,361 in Victoria and $11,885 in the Australian Capital Territory. The national average cost per case was $2,415.[196]

2.90 With respect to assessing the data, both the Department of Communities and Justice and Adjunct Professor Dillon commented on the extent to which the Productivity Commission's figures allow for an accurate funding comparison between jurisdictions.[197]

2.91 In the view of the Department of Communities and Justice, the funding for the Coroners Court of NSW is not directly comparable to the other coronial jurisdictions, including Victoria, given the structural and operational differences between each.[198] It also noted that the Productivity Commission's data for the Victorian spend on the coronial jurisdiction includes costs that are not included in the NSW figures, such as the costs for government assisted burials and cremations and certain inquest costs, like costs associated with briefing Counsel Assisting and independent expert reports.[199]

2.92 The Department of Communities and Justice also observed that the reported figures 'are for the State Coroners Court only, and do not take into account judicial and staff resources at regional Local Court locations … '.[200]

2.93 Adjunct Professor Dillon also highlighted how the Productivity Commission's data does not accurately reflect the true expenditure on the Coroners Court of NSW, noting that it does not include the cost of coronial work undertaken by the Local Court. In his view, the true cost per finalised case is likely closer to the expenditure in Queensland and the national average. Using the national average cost per case of $2,195, Adjunct Professor Dillon proposed that the annual recurrent expenditure of the Coroners Court of NSW, based on 6,500 cases finalised per year would be $14,250,000 which is approximately double the Productivity Commission's figure for NSW.[201] On this basis, Victoria's recurrent expenditure is $7 million per year more which, in Adjunct Professor Dillon's view, is largely attributable to the cost of operating the Coroners Prevention Unit (discussed in chapter 4).[202]

196 Productivity Commission, *Report on Government Services 2022* (February 2022).

197 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 4-7; Submission 14a, Adjunct Professor Hugh Dillon, pp 11-12.

198 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 6-7.

199 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 6. See also Submission 17, New South Wales Bar Association, p 33.

200 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 4.

201 Submission 14a, Adjunct Professor Hugh Dillon, pp 11-12. See also Submission 17, New South Wales Bar Association, p 33.

202 Submission 14a, Adjunct Professor Hugh Dillon, p 12. See also Submission 17, New South Wales Bar Association, p 33.

2.94 Another indicator of resourcing discussed in the inquiry was the number of coroners in NSW compared to other jurisdictions.[203] With respect to the comparative number of coroners, the Department of Communities and Justice reported that for 2020-21, there are 0.9 coroners in NSW and 1.6 coroners in Victoria per 1,000 finalisations.[204] Legal Aid NSW noted that Queensland's population is 63 per cent of that in NSW, yet it has seven specialist coroners, whereas Victoria's population is 82 per cent of that in NSW, yet it has 11 (and now 13 as at 30 June 2021) specialist coroners.[205]

2.95 According to the NSW Bar Association, coronial services in New South Wales have become more centralised, without proper statutory administrative foundation and with a very limited number of specialist coroners to undertake a high caseload compared to the number of specialist coroners in Victoria and Queensland.[206] The NSW Bar Association supported centralisation, however, it expressed concern that the State Coroners Court is assuming the administrative functions of regional magistrates when its resources are already 'over-stretched'.[207]

2.96 Mr Barnes' memorandum to the Attorney General in 2017 noted that the number of full-time equivalent administrative staff in NSW per 1,000 finalisations was lower than that in Victoria and Queensland.[208] For 2020-21, the full-time equivalent administrative staff per 1,000 finalisations in NSW was 5.9 in NSW and 17.5 in Victoria.[209]

Committee comment

2.97 It is clear to the committee that the Coroners Court of New South Wales does not have a structure that recognises and supports the specialist nature of the jurisdiction and the unique role it plays. Based on the evidence before it, the committee considers that the Coroners Court and all those who work in the jurisdiction deliver a high quality service to the community, but that heavy workloads across the system and a lack of resources means that there is significant room for improvement of the coronial system as a whole. Each of these issues will be explored and recommendations made to address them.

2.98 In the view of the committee, there are significant issues which stem from the current architecture of the Coroners Court of NSW. Firstly, the current structure suggests that coronial work is an offshoot of the criminal justice system, when the nature and objectives of the two jurisdictions are very different. The Coroners Court is uniquely placed to investigate systemic issues and systems failure within government administration and service delivery and coroners develop a range of specialist skills to fulfill this critical role.

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203 See, for example, Submission 6, Australian Lawyers Alliance, p 6; Submission 17, New South Wales Bar Association, p 12; Submission 39, Gilbert + Tobin, p 17; Submission 46, Legal Aid Commission of New South Wales, p 25.

204 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 6.

205 See, for example, Submission 46, Legal Aid Commission of New South Wales, p 25; Coroners Court of Victoria, *2020-2021 Annual Report* (2020), pp 7-11.

206 Submission 17, New South Wales Bar Association, p 15.

207 Submission 17, New South Wales Bar Association, p 13.

208 Submission 14, Adjunct Professor Hugh Dillon, Appendix B, p 80.

209 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 6.

2.99 Secondly, there has been a failure to achieve the objective which underpins the conferral of coronial duties on regional magistrates – the delivery of timely and quality coronial services in regional New South Wales. The framework and support to arm regional magistrates with the skills and resources necessary to achieve this objective has long been absent. Regional magistrates have not been given the opportunity to discharge their coronial duties with the same expertise and diligence as the coroners at the State Coroners Court, given their competing local court caseload and lack of specialist training and on-the-job experience in coronial matters.

2.100 Thirdly, recognising that regional magistrates are usually over-burdened, time-poor and under-resourced when it comes to coronial matters, the Coroners Court of NSW has evolved its practices and processes to better deliver consistent, standardised and high-quality decision-making across the state throughout the coronial process. Specialist full-time coroners now undertake all initial assessments and give coronial directions for all deaths in New South Wales, along with undertaking most inquests into regional deaths. The coronial process has become increasingly centralised, without the formal structure and funding in place to sufficiently support it.

2.101 While we consider some proposals to reform the Court's structure in the next chapter, it is clear that the coronial jurisdiction also needs to be significantly better funded and resourced to meet its death investigation and prevention objectives – regardless of what structure it takes.

2.102 In this regard, we wish to make a couple of observations. First, we would like to acknowledge that there are initiatives underway to improve timeliness in the coronial process through the work of the NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce* (Timeliness Taskforce). The Timeliness Taskforce has identified aspects of the coronial process contributing to delays and has implemented initiatives to improve timeliness outcomes. While this work is undoubtedly important, the scope of the Timeliness Taskforce meant that it has not looked at processes involving inquests and the dispensing of coronial matters by a coroner.

2.103 The second point is that the committee found it difficult to fully ascertain the extent to which resourcing constraints are impacting the Court's performance, given the limitations of data provided by the Department of Communities and Justice. We were unable to get a clear picture on the average timeframe from a decision to hold an inquest to the commencement of an inquest, nor the average length of an inquest in metropolitan areas versus the regions. We also found it challenging to look at funding for the Court in a holistic way, given the figures did not take into account the judicial and staff resources undertaking coronial work at regional local court locations.

2.104 Despite this, it was still very clear to the committee that the resources the Court has at its disposal are insufficient in meeting the growing number of complex cases it has to deal with and current caseload pressures. There are lengthy delays at various parts of the coronial system, and a significant backlog in mandatory section 23 death in custody inquests. These issues are deeply affecting the families involved in the coronial process, who understandably only want timely investigations into the circumstances of their loved one's death. We therefore make two recommendations related to these issues, with the first aimed at improving data collection, management and reporting of coronial cases.

Recommendation 2

That the NSW Department of Communities and Justice undertake a review into the collection, management and reporting of data in relation to coronial cases, with a view to identifying system improvements that would enable greater monitoring of the coronial jurisdiction's performance.

2.105 Second, and regardless of whether structural reforms are implemented to the coronial jurisdiction, it is vital that the NSW Government address the delays and backlogs in coronial cases by allocating additional funding, staffing and resources to the Coroners Court of NSW.

2.106 The committee recognises the skill, hard work and dedication of coroners and all staff involved in the coronial process from the Department of Communities and Justice, NSW Health Pathology Forensic Medicine, NSW Police Force and the Crown Solicitors Office, operating in the context of high workloads and limited recourses. We consider that a significant injection and maintenance of additional resources is required across different components of the coronial system. The committee considers this absolutely critical in enabling the Court to deliver quality and timely coronial services, effectively undertake its death investigation and prevention objectives and maximise its contribution to public safety outcomes.

Recommendation 3

That the NSW Government allocate additional resources to the Coroners Court of New South Wales, including adequate funding and staffing, to ensure it can address current caseload pressures, delays and backlogs.

Chapter 3 Structural and resourcing reforms

In the previous chapter, the focus was on issues related to the structure, funding and resourcing of the Coroners Court of New South Wales. This chapter will outline a number of proposed reforms to address these issues. The first part outlines two reform proposals to restructure the institutional arrangements of the court, in order to better reflect the jurisdiction's specialist nature and enhance its independence. The second part of the chapter considers proposed operational and funding improvements, to better support coroners in their death investigation and prevention duties.

Proposals to reform the institutional arrangements of the Coroners Court

3.1 As outlined in Chapter 2, there were various stakeholder concerns with the current 'hybrid' structure of the Coroners Court of NSW. In summary, this centered on coronial services in regional New South Wales being delivered by judicial officers with different experience, resources and capacity to undertake coronial work compared to the specialist full-time coroners at the State Coroners Court.

3.2 In recognition of the challenges arising from this model, alongside the increasing level of specialisation required for coronial work, two key reform proposals were advanced during the inquiry. Both of these centered on the Coroners Court of NSW being a specialist court, which a majority of stakeholders support. [210]

3.3 The first proposal was that the Coroners Court of NSW could become a standalone specialist court, separate to and independent from the Local Court. The second proposal was that the Coroners Court of NSW could be a specialist autonomous court remaining part of the Local Court framework, similar to the model of the Children's Court of New South Wales (Children's Court).

3.4 In exploring these proposals, consideration was given to whether a centralised or decentralised system best serves regional New South Wales, and how the structure and arrangements would enhance specialisation within the jurisdiction, including the training and professional development of coroners. This section discusses these models and considerations in turn.

[210] See, for example, Submission 5, MIGA, p 1; Submission 6, Australian Lawyers Alliance, p 5; Submission 14, Adjunct Professor Hugh Dillon, pp 2-3; Submission 17, New South Wales, Bar Association, pp 14 and 46-50; Submission 39, Gilbert + Tobin, pp 7-8; Submission 41, Mr Michael Barnes, pp 7-9; Submission 46, Legal Aid Commission of New South Wales, pp 17-18; Submission 48, Lindsay McCabe, p 5; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, pp 3-4; Submission 57, Public Service Association of New South Wales, p 9; Evidence, Dr Schetzer, Policy and Advocacy Manager and National Manager, Australian Lawyers Alliance, 29 September 2021, p 23; Evidence, Mr Timothy Bowen, Manager, Advocacy and Legal, Medical Insurance Group Australia, 30 November 2021, p 33; Evidence, Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre, 30 November 2021, p 18; Evidence, Mr Stuart Barnett, State Practice Group Leader, Slater and Gordon Lawyers, 31 January 2022, p 24; Evidence, Ms Rita Mallia, State President, Construction Forestry Mining and Energy Union, Construction and General Division, NSW Divisional Branch, 31 January 2022, p 25.

A standalone court model

3.5 The proposal for a standalone court was supported by range of inquiry participants, including Adjunct Professor Hugh Dillon, the Australian Lawyers Alliance, Gilbert + Tobin, the Medical Insurance Group Australia, the Mining and Energy Union and the Public Service Association of New South Wales.[211]

3.6 Adjunct Professor Dillon strongly advocated for this approach based on the Victorian model, which is discussed in a case study below, under paragraph 3.15.[212] Ms Jerram also 'strongly believed' that the Court should be a standalone court.[213]

3.7 The key features of the standalone model are the independence of the jurisdiction and the State Coroner from the Local Court, with all coronial functions performed by full time specialist coroners appointed to the court, from beyond the pool of existing magistrates.

3.8 According to Mr Michael Barnes, having a head of jurisdiction completely independent of the Local Court and committed to coronial service delivery would mean the Court would no longer need to balance its interests or priorities with another jurisdiction.[214] Ms Jerram considered independence from the Local Court would enable it to move from a 'subsidiary of the Local Court' to a specialist jurisdiction 'being answerable only to the Attorney General'.[215]

3.9 The New South Wales Bar Association also suggested that a standalone court may be preferable, given that the purpose and culture of the criminal and coronial jurisdictions are significantly different and being combined in the same court can lead to tensions.[216]

3.10 Several stakeholders, including Adjunct Professor Dillon and Mr Barnes, highlighted that a standalone court would include the appointment of full-time specialist coroners. Under this model, while magistrates could be appointed as coroners, they would not automatically be coroners by virtue of their office as magistrates.[217]

3.11 The advantages of having specialist full-time coroners appointed to the Court would include enhanced opportunities for training and professional development for coroners, and the capacity to make a greater contribution to public health and safety to prevent the future loss of life.[218]

211 See, for example, Submission 5, MIGA, p 1; Submission 6, Australian Lawyers Alliance, p 5; Submission 14, Adjunct Professor Hugh Dillon pp 75-76; Submission 39, Gilbert + Tobin, pp 7-8; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, pp 3-4; Submission 57, Public Service Association of New South Wales, p 9.

212 Submission 14, Adjunct Professor Hugh Dillon pp 71-76.

213 Submission 16, Ms Mary Jerram AM, p 1.

214 Submission 41, Mr Michael Barnes, p 8.

215 Evidence, Ms Mary Jerram AM, NSW State Coroner from 2007 to 2013, 29 September 2021, p 2.

216 Submission 17, New South Wales Bar Association, p 50; Evidence, Dr Kristina Stern, Chair, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 26.

217 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 75; Submission 39, Gilbert + Tobin, p 8; Submission 41, Mr Michael Barnes, p 8; Submission 57, Public Service Association of New South Wales, p 9.

218 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 75; Submission 39, Gilbert + Tobin, p 8.

3.12 Building on those advantages, Mr Barnes emphasised that specialist coroners would have or could develop specialist legal principles in coronial law and practice, an understanding of the conventions and customs in culturally and linguistically diverse communities and knowledge of forensic medicine and incident investigation in the coronial context. Additionally, coroners could build professional relationships with the multi-disciplinary professionals and practitioners working in the coronial system and work collaboratively to make informed decisions aligned with coronial objectives.[219]

3.13 In terms of selecting coronial appointments, stakeholders identified advantages and limitations to appointing coroners from outside the magistracy. Adjunct Professor Dillon, Gilbert + Tobin and the NSW Bar Association argued that recruiting coroners from beyond the magistrates pool would be advantageous as it would add a range and depth of experience and expertise to the jurisdiction, which would be significant given its multidisciplinary nature. In addition, Adjunct Professor Dillon argued that this model could make the recruitment of First Nations lawyers as coroners more feasible.[220]

3.14 In the view of Mr Barnes, however, there are some drawbacks associated with breaking the nexus with the Local Court with respect to the recruitment and retention of coroners. First, challenges may arise in finding suitable practitioners who wish to work solely in the coronial jurisdiction, given the taxing and different nature of the cases and the needs and interest of bereaved families of the deceased. Mr Barnes contended that these unique pressures may not be apparent to practitioners who may be interested in an appointment as coroner because coronial inquests are only one part of a coroner's role. Secondly, a standalone model could remove the transferability of coroners to and from the Local Court, which would limit the options where a coroner is appointed who may end up being not as suited to the role.[221]

3.15 With respect to the Victorian approach of appointing coroners for a term of five years with the option to be reappointed (as discussed in the case study below), both Mr Barnes and Adjunct Professor Dillon emphasised the principle of judicial independence that comes with proper tenure, with judicial officers not being removed until retirement unless there is proven misconduct. In their view, a limited term of office and requirement to seek reappointment risks undermining the actual or perceived independence of coroners, particularly given coroners investigate and make findings and recommendations about government bodies. Adjunct Professor Dillon emphasised that specialist coroners as part of a standalone court model should have the same tenure as other judicial officers.[222]

219 Submission 41, Mr Michael Barnes, p 8.

220 Submission 14, Adjunct Professor Hugh Dillon, p 76; Submission 39, Gilbert + Tobin, p 8; Evidence, Dr Stern, 29 September 2021, p 26.

221 Submission 41, Mr Michael Barnes, p 8.

222 Submission 41, Mr Michael Barnes, p 9; Evidence, Adjunct Professor Hugh Dillon, Deputy NSW State Coroner from 2008 to 2016, and researcher in relation to coronial systems at the Law Faculty, University of New South Wales, 29 September 2021, p 9.

Case study: The Coroners Court of Victoria

The Coroners Court of Victoria is one example of a standalone coronial court. The coronial jurisdiction in Victoria broke away from the Magistrates Court in 2009 when the *Coroners Act 2008* (Vic) established the standalone Coroners Court of Victoria.[223] The State Coroner is a Judge of the County Court and the Deputy State Coroner is a magistrate, both who may hold office for five years and can be re-appointed.[224]

All Victorian coroners are either magistrates or directly appointed under the *Coroners Act 2008* (Vic). To be directly appointed, a coroner must be an Australian lawyer who has been practising for at least five years. The State Coroner and Chief Magistrate may jointly assign a person who is appointed as a magistrate to be a coroner either exclusively or in addition to any other duties.[225] When making this assignment, regard must be had to the experience and knowledge of the magistrate or reserve magistrate in relation to coronial investigations, investigations into deaths and fires and the identification of preventative measures following such investigations.[226]

There are currently 13 coroners based at the Coroners Court of Victoria in Melbourne.[227] While magistrates, judges or former judicial officers may be appointed as coroners, Adjunct Professor Dillon highlighted that Victorian coroners have a wide range of legal and non-legal backgrounds such as workplace health and safety, nursing, personal injury legal practice, public law practice and medico-legal practice.[228]

Victorian coroners are appointed for five years and appointments may be renewed until retirement age. Coroners receive the salary and conditions of magistrates, but not the title, and can only be removed from office in the same way magistrates can.[229]

3.16 The clear direction of evidence to the committee was that a standalone Coroners Court, separate from and independent of the Local Court, was better because it would:

- recognise that coronial functions, objectives and processes differ significantly and materially from those of the Local Court
- recognise the coronial jurisdiction for its complex and multidisciplinary nature, unlike the current structure which implies that the jurisdiction is a minor and relatively unimportant adjunct jurisdiction of a large, mainly criminal court
- be more responsive and flexible to changing demands within the jurisdiction

223 *Coroners Act 2008* (Vic), pt 1, div 8.

224 *Coroners Act 2008* (Vic), ss 91, 92 and 93.

225 Coroners Court of Victoria, *2020-2021 Annual Report* (2020), p 7.

226 *Coroners Act 2008* (Vic), s 93(2).

227 Coroners Court of Victoria, *2020-2021 Annual Report* (2020), pp 7-11.

228 Submission 14, Adjunct Professor Hugh Dillon, p 71.

229 Submission 14, Adjunct Professor Hugh Dillon, p 73.

- enable more tailored and effective development and management of the jurisdiction's processes and practices
- enable the efficient and effective development and delivery of therapeutic and restorative processes
- separate the coronial system and the criminal jurisdiction which would assist in reducing apprehensions of bias by coroners to police and correctional officers, which for First Nations families in particular is a concern
- facilitate focused resourcing, planning and governance for the coronial system without a need to consider the differing and sometimes competing objectives, interests and resources of the Local Court
- allow for the development of more appropriate performance measures and standards, therefore enhancing transparency and accountability
- enhance the capacity of the Coroners Court of NSW to build relationships with external public health and safety bodies and organisations.[230]

An autonomous court attached to the Local Court

3.17 Another model given consideration was having an autonomous specialist Coroners Court of NSW which would remain attached to the Local Court. Mr Barnes strongly supported this model and advocated for similar institutional arrangements to the Children's Court, which is discussed in the case study under paragraph 3.26.[231]

3.18 This model is characterised by the nexus it would maintain with the Local Court while retaining independence of the jurisdiction and the State Coroner. Similar to the standalone model, it could be constituted by specialist coroners. Yet unlike the standalone model, coroners would only be selected from the magistrates pool.[232]

3.19 Adjunct Professor Dillon recognised an advantage of reforming the Coroners Court of NSW to have similar institutional arrangements to the Children's Court is that it is a familiar model in this state, adoption of which would 'be an evolutionary development'. A further benefit would be the economies of scale with respect to shared resources across the two jurisdictions.[233]

3.20 In terms of creating independence for the State Coroner, Mr Barnes and Ms Jerram recommended that like the President of the Children's Court, the State Coroner should be a Judge of the District Court.[234] Mr Barnes contended that this would place the head of the coronial jurisdiction at the same level in the judicial hierarchy as the Chief Magistrate of the Local Court, who can either be a magistrate or a judge of the District Court, therefore preserving the independence of coroners. As the role of the State Coroner and their relationship with the

230 See, Submission 14, Adjunct Professor Hugh Dillon, p 75; Submission 17, New South Wales Bar Association, pp 49-50; Submission 39, Gilbert + Tobin, p 8.

231 Submission 41, Mr Michael Barnes, pp 8-9.

232 Submission 14 Adjunct Professor Hugh Dillon, p 71.

233 Submission 14, Adjunct Professor Hugh Dillon, p 71.

234 Submission 41, Mr Michael Barnes, p 9; Evidence, Ms Jerram AM, 29 September 2021, p 2.

Chief Magistrate would be modelled on that of the President of the Children's Court, the Chief Magistrate would not be able to intervene in coroners' cases.[235]

3.21 The inquiry received evidence of a variety of institutional arrangements concerning Coroners in the different jurisdictions, and other specialist tribunals. The State Coroner in Victoria is a County Court judge, equivalent to the NSW District Court. The State Coroner in Western Australia is apparently equivalent to a Supreme Court judge.[236] The NSW Civil and Administrative Tribunal, which hears a wide spectrum of matters from anti-discrimination, freedom of information, building and other commercial cases as well occupational licensing and regulatory matters, is also headed by a NSW Supreme Court judge. The NSW Drug Court is composed of District Court judges. A District Court judge is President of the NSW Personal Injury Commission, which hears workers' compensation and motor accident cases. The committee heard evidence that the work of the Coroners Court of NSW was no less important than each of those bodies.[237]

3.22 Similar to a standalone court, under this model the Coroners Court could be constituted by full-time specialist coroners and coroners that would be simultaneously appointed as Local Court magistrates. This would mean that if appointments as coroner remained time limited as they presently are, upon the expiry of an appointment or retirement as coroner, an appointment as a Local Court magistrate would continue.[238] It was submitted that a Coroners Court attached to the Local Court with specialist full-time coroners could deliver the same advantages as noted above in paragraph 3.12.[239]

3.23 Advantages and limitations were identified with the proposal of coroners being selected only from the existing pool of magistrates. Such an approach may limit the diversity of backgrounds, experience and expertise that non-magistrates could bring to the role of coroner.[240]

3.24 That aside, in terms of advantages of this model, Mr Barnes emphasised that there could be benefits in giving the option for coroners and magistrates to transfer between courts with the agreement of the Chief Magistrate and State Coroner.[241] As Mr Barnes put it in his submission:

> An advantage of the coronial jurisdiction being an autonomous part of the Local Court would be that magistrates could be rotated in and out of the role of coroner with the agreement of the Chief Magistrate and State Coroner. Those who the State Coroner concluded were not suited, or whom themselves came to the conclusion that they would prefer to preside elsewhere could transition to the general bench either permanently or for a period. The autonomy of the Coroners Division would need to include a mechanism which prevented the Chief Magistrate transferring a coroner out of the

235 Submission 41, Mr Michael Barnes, p 9.

236 Evidence, Mr Barnes, 29 September 2021, p 12.

237 Evidence, Ms Jerram AM, 29 September 2021, p 12; Evidence, Adjunct Professor Dillon, 29 September 2021, p 12; Evidence, Mr Barnes, 29 September 2021, p 12.

238 Submission 41, Mr Michael Barnes, p 9.

239 Submission 41, Mr Michael Barnes, p 9. See also Submission 14, Adjunct Professor Hugh Dillon, p 71; Submission 17, New South Wales Bar Association, pp 49-50.

240 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 71; Submission 17, New South Wales Bar Association, p 49. See also Evidence, Dr Stern, 29 September 2021, p 26.

241 Submission 41, Mr Michael Barnes, p 9.

division when the State Coroner and the coroner in question wished to continue in the role.[242]

3.25 In addition, with respect to the current arrangements whereby coroners are able to remain in the coronial jurisdiction for at least two triennial rotations, Adjunct Professor Dillon noted that in 2016 several Deputy State Coroners in New South Wales transferred back to the Local Court or retired when informed that they would not be permitted another coronial rotation. Importantly, Adjunct Professor Dillon highlighted the consequential performance impact on coronial services as new appointees often experience an adjustment period.[243]

3.26 Mr Barnes observed that a further benefit of magistrates remaining as coroners *ex officio* was that magistrates would have the power to make urgent orders if a specialist coroner was unavailable and 'provide surge capacity if high demand overwhelms the contingent of full-time coroners'.[244] According to the NSW Bar Association, the benefits of maintaining the nexus with the Local Court are highlighted when considering coronial services in regional New South Wales as the cooperation and resources of the Local Court throughout the state could continue to be accessed if the circumstances warranted.[245]

Case study: The Children's Court of NSW

The Children's Court is established under the *Children's Court Act 1987* (NSW).[246] The President of the Children's Court is a judge of the District Court appointed by the Governor. The President is responsible for the administration of the Children's Court including providing leadership to the Court, arranging the sittings of the Court, developing recommendations for rules in relation to the Court's practice and procedure, issuing Practice Notes, consulting with stakeholders on matters involving children and the Court and overseeing the training of Children's Magistrates.[247]

Children's Magistrates are appointed by the Chief Magistrate in consultation with the President. Children's Magistrates are selected from the general pool of magistrates appointed to the Local Court having regard to their knowledge, qualifications, skills and experience in dealing with children, young people and their families.[248] Children's Magistrates are appointed for periods of up to five years and may be reappointed.[249] In the instance that a Children's Magistrate resigns from that office or their term of office expires, they continue to be a magistrate of the Local Court.[250] There are currently 15 specialist Children's Magistrates.[251]

242 Submission 41, Mr Michael Barnes, p 9.

243 Submission 14, Adjunct Professor Hugh Dillon, p 73.

244 Submission 41, Mr Michael Barnes, p 9.

245 Evidence, Dr Stern, 29 September 2021, p 26.

246 *Children's Court Act 1987*, s 4.

247 *Children's Court Act 1987*, ss 4, 6A and 16.

248 *Children's Court Act 1987*, s 7.

249 *Children's Court Act 1987*, sch 1, cl 2.

250 *Children's Court Act 1987*, sch 1, cl 6.

251 Children's Court of New South Wales, *Court Structure* (10 September 2020) https://childrenscourt.nsw.gov.au/childrens-court/about-the-court/court-

The Children's Court sits within four specific courthouses in Parramatta, Surry Hills, Broadmeadow and Woy Woy. It also sits at courts in Campbelltown, Port Kembla, Sutherland, Nowra, and Wyong, on a full-time or part-time basis.[252] There is a Children's Court registry at each location where the Children's Court sits, with some separate to the Local Court registry and others located therein.[253]

For sittings outside the abovementioned locations, specialist Children's Magistrates conduct a number of circuits in regional and rural areas. In addition, at other locations, Local Court magistrates conduct Children's Court matters when a specialist Children's Magistrate is not available.[254]

Children's Magistrates are aided by Children's Registrars who have certain delegated functions under legislation, such as the making of certain orders and directions and conduct of dispute resolution conferences.[255]

Costs associated with a reformed structure

3.27 Of course, there would be additional costs associated with reforming the Coroners Court of NSW to become a specialist jurisdiction.

3.28 Essentially, Adjunct Professor Dillon acknowledged that a standalone Coroners Court of NSW would be more expensive to operate than the current system.[256] The Productivity Commission's estimate of real recurrent costs of the standalone Coroners Court of Victoria in 2020-21 was $22,152 million whereas those of the Coroners Court of NSW were $7,971 million.[257]

3.29 Adjunct Professor Dillon argued that while NSW Government's real recurrent expenditure on coronial services would rise in order to operate a standalone Coroners Court of NSW, this rise may not be as expensive as the Productivity Commission's estimates. Moreover, the expenditure would be justified in respect of the improved potential to prevent future deaths:

> In 2019, the Australian Government placed a value of $4.9 million on an Australian statistical life, with each year prematurely lost being valued at $213,000…
>
> …

structure.html#:~:text=In%20NSW%2C%20the%20Children's%20Court,time%20or%20part%2Dtime%20basis. *Children's Court Act 1987*, s 4.

252 Children's Court of New South Wales, *Court Structure* (10 September 2020).

253 Children's Court of New South Wales, *Court Structure* (10 September 2020).

254 Children's Court of New South Wales, *Court Structure* (10 September 2020).

255 *Children's Court Act 1987*, s 10A; Children's Court Rule 2000, cl 19; *Children and Young Persons (Care and Protection) Act 1998*, s 65.

256 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 73. See also Submission 17, New South Wales Bar Association, p 33.

257 Productivity Commission, *Report on Government Services 2022* (February 2022), Table 7A.15. See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 73; Submission 17, New South Wales Bar Association, p 32.

> If a NSW Coroners Court was placed on a similar footing as Victoria, its real recurrent expenditure would rise but its capacity and potential to produce death preventive data and recommendations would be greatly enhanced. Given the value of a statistical life, a few saved lives would economically justify the expenditure.[258]

3.30 In the submission he made to the select committee inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, Adjunct Professor Dillon stated that aggregating the work performed by regional magistrates to the State Coroners Court of NSW would be theoretically 'cost neutral' as it is 'the same amount of work to be done, just differently distributed', although he acknowledged that 'in reality there is likely to be some transaction cost'.[259]

3.31 According to Adjunct Professor Dillon, a costs-benefit analysis justifies the establishment of a specialist Coroners Court of NSW for the following reasons:

- the additional costs appear small in the context of recurrent expenditure budgets on justice and public safety
- the coronial services would improve and their delivery would be more efficient
- inquests would be more effective and the contribution to public health and safety would be enhanced
- the coronial system would be fiscally transparent and accountable in ways the current system is not.[260]

Coronial services in regional New South Wales – should they be centralised or decentralised?

3.32 Relevant to both models discussed above is the delivery of coronial services to regional New South Wales. Some stakeholders highlighted the significance of holding inquests in, or close to, the community of the deceased person.[261] With respect to the death of a First Nations person, holding an inquest on Country is a particularly important cultural consideration.[262]

3.33 Both a standalone court and a Children's Court style model for the coronial jurisdiction could adopt either a centralised or a decentralised system. For example, the Coroners Court of Victoria is a centralised standalone court, meaning that the coroners at the Coroners Court of Victoria in Melbourne deal with all coronial matters in Victoria.[263]

3.34 By comparison, the Coroners Court of Queensland is an autonomous court attached to the Queensland Magistrates Court which adopts a decentralised model, with full-time specialist

258 Submission 14, Adjunct Professor Hugh Dillon, pp 74-75.

259 Submission 9, The Law Society of New South Wales, Appendix 1, p 26.

260 Submission 14a, Adjunct Professor Hugh Dillon, pp 12-13. See also Submission 17, New South Wales Bar Association, p 33.

261 See, for example, Submission 17, New South Wales Bar Association, p 14; Submission 44, Susan Slatcher, p 2.

262 Submission 27, National Justice Project, p 27; Submission 33, Katie Lowe, p 16.

263 Submission 14, Adjunct Professor Hugh Dillon, p 2; Submission 46, Legal Aid Commission of New South Wales, Appendix 1, p 16.

coroners located across Queensland. There are three Brisbane coroners, in addition to a Brisbane-based State Coroner, who investigate deaths in the Greater Brisbane and Sunshine Coast and South Queensland regions. The Deputy State Coroner is also currently appointed as the South Eastern Coroner located in Southport, Gold Coast, who investigates deaths in the Gold Coast area, Beenleigh and Logan. The Central Coroner based in Mackay investigates deaths from Proserpine and the Whitsundays to Gayndah and a Northern Coroner based in Cairns who investigates deaths in the regions from Bowen to the Papua New Guinea border and as west as Mount Isa.[264]

3.35 The evidence given by inquiry participants on the delivery of coronial services to regional areas, with a reformed structure for the Coroners Court of NSW favoured a centralised model. For example, the NSW Bar Association recommended that regional inquests should continue to be held by specialist coroners who travel from Sydney to hold the inquest in the locality where the death occurred.[265] Similarly, Ms Jerram supported a standalone court model where the decision about whether a full-time specialist coroner would travel from the State Coroners Court to the regional area to investigate regional deaths, or the regional matter is transferred to the State Coroners Court, would be made on an 'as needs' basis.[266]

3.36 Mr Barnes, Ms Jerram and Adjunct Professor Dillon identified the following challenges of a decentralised coronial system involving full-time specialist coroners located in separate regional areas:

- with less resources than a central metropolitan court, the efficiency of regional coroners may be limited
- there may be an actual or perceived impact on the independence and professionalism of a judicial position when the judicial officer is also a member of the community.[267]

3.37 On the other hand, Mr Barnes also noted the following benefits of a decentralised approach:

- the building of relationships with services and agencies involved in the coronial process, such as the local hospital superintendent, chief of police and forensic pathologist
- the capacity of regional coroners to serve a social as well as institutional function within local communities by building connections and becoming familiar with and in the community.[268]

3.38 However, the overall flavor of the evidence to the inquiry on this point was best encapsulated by Adjunct Professor Dillon when he said that:

> In terms of being a local coroner, if the coroners did inquests or if they tried to make recommendations which prevented local deaths, I think there might be an argument for keeping coroners in the locality, but they actually don't. Very rarely do you see this being

264 Submission 13, Coroners Court of Queensland, p 1; Coroners Court of Queensland, *2019-20 Annual Report* (2020), pp 10-11.

265 Submission 17, New South Wales Bar Association, p 14; Evidence, Ms Kirsten Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 24.

266 Evidence, Ms Jerram AM, 29 September 2021, p 11.

267 Evidence, Adjunct Professor Dillon, 29 September 2021, p 11; Evidence, Mr Barnes, 29 September 2021, p 11; Evidence, Ms Jerram AM, 29 September 2021, p 11.

268 Evidence, Mr Barnes, 29 September 2021, p 11.

> done. In fact, I did a study—over a 10 year period I think there were 30 cases in which regional coroners made recommendations to prevent future deaths. So that is three a year out of 6,000 cases or 3,000 cases being reported in country areas. It is not a system that works very well.[269]

A focus on training and professional development for coroners

3.39 Regardless of the structure of the Coroners Court of NSW, the committee received evidence highlighting the importance of training and professional development for coroners.

3.40 Both Adjunct Professor Dillon and Ms Jerram informed the committee that an initial period of training for new coroners involves a rotation at the State Coroners Court, where new coroners will learn from experienced coroners. Ongoing professional development entails annual training sessions, such as one training session as part of a three-day annual conference, as well as an online interactive training programme in basic coronial skills.[270]

3.41 In a 2014 report by Adjunct Professor Dillon, entitled *Raising Coronial Standards of Performance: Lessons from Canada, Germany and England*, it was noted that specialist training for coroners is not usually delivered in line with national standards:

> While there is an Australian national standard of five days professional development training for members of the judiciary, it is rare in NSW for full-time coroners to receive five days of professional training or development in their own specialist field.[271]

3.42 Emphasising that induction and preliminary training of new coroners is critical, given the expertise required in the role and complexities of the jurisdiction, Adjunct Professor Dillon in his report stated that 'coronial training in Australia … has largely been conducted internally by experienced coroners, but not necessarily in a structured or sustained fashion'.[272]

3.43 Recognising that enhanced training and professional development programs for coroners is important, Adjunct Professor Dillon's paper presented key components that should be part of coroners' training, including:

- the development of an effective induction and training program for new coroners, designed and presented by senior coroners in line with adult education principles
- the development of a coronial training curriculum, which should:
  - build familiarity with relevant legislation and practice
  - develop an understanding of the experience of bereaved people
  - build an understanding of principles to apply in making decisions about an autopsy, in particular the principle of ordering the least invasive procedure appropriate to the case

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269 Evidence, Adjunct Professor Dillon, 29 September 2021, p 11.

270 Evidence, Ms Jerram AM, 29 September 2021, p 5; Evidence, Adjunct Professor Dillon, 29 September 2021, p 5; Submission 14, Adjunct Professor Hugh Dillon, Appendix F, p 115.

271 Submission 14, Adjunct Professor Hugh Dillon, Appendix E, *Raising coronial standards of performance: Lessons from Canada, Germany and England*" (Report, 2015), p 27.

272 Submission 14, Adjunct Professor Dillon Hugh Dillon, Appendix E, *Raising coronial standards of performance: Lessons from Canada, Germany and England*" (Report, 2015), pp 26-27.

  - develop an understanding of the basics of forensic medicine
  - build understanding about factors to apply in deciding whether to hold a discretionary inquest
  - develop skills for conducting and managing inquisitorial proceedings
  - build skills to generate effective recommendations
- a focus on complex case types and management of complex inquests, such as hospital cases, accident investigation and suicides, as well as the use of data to identify systemic issues.[273]

3.44 In the view of Adjunct Professor Dillon, the appropriate body to deliver this training would be the Judicial Commission of New South Wales.[274]

Proposals to enhance the operational arrangements of the Coroners Court

3.45 As outlined in previous chapters, coroners exercise their functions with the assistance of a variety of other professionals, including police who investigate deaths, forensic pathologists who undertake medical investigations into the deaths, and police officers or government solicitors who assist the coroner in preparing and conducting inquests. Essentially, the delivery of efficient and quality coronial services relies on the performance of these teams individually and in collaboration with one another.

3.46 This section will consider various proposals put forward to enhance the operational arrangements of the Coroners Court of NSW, including the appointment of additional coroners and enhancements to the legal, administrative, case management, investigative and forensic medicine aspects of the coronial system. Before outlining these matters, it is important to note that these proposals are not necessarily dependent on a significant restructure of the Court and its operational arrangements.

Appointment of additional coroners

3.47 Several stakeholders called for the appointment of additional coroners, to not only address current caseload pressures and backlogs, but to also enhance the capacity of the Coroners Court of NSW more broadly in fulfilling its death prevention role.

3.48 The Legal Aid Commission of New South Wales (Legal Aid NSW) submitted that there is an 'insufficient numbers of coroners in comparison to the number of inquest matters to be held'.[275] Ms Jerram also commented on this point, reflecting that the capacity of the Coroners Court of NSW to deal with an increasing number of inquests related to natural disasters, such as bushfires and floods, is limited with its current number of coroners.[276]

273 Submission 14, Adjunct Professor Dillon, Appendix E, *Raising coronial standards of performance: Lessons from Canada, Germany and England*" (Report, 2015), pp 45-46.

274 Submission 14a, Adjunct Professor Hugh Dillon, p 10.

275 Submission 46, Legal Aid Commission of New South Wales, p 32.

276 Evidence, Ms Jerram AM, 29 September 2021, p 6.

3.49 In the view of Adjunct Professor Dillon, more specialist coroners are needed to manage mandatory death in custody inquests and to conduct discretionary inquests.[277] Adding to this, Adjunct Professor Dillon argued that reducing the backlog of mandatory death in custody inquests is 'insurmountable without additional resource or diversion of effort from other mandatory and discretionary inquests' given that the rate of mandatory death in custody inquests is matching the rate of incoming cases to the Coroners Court of NSW.[278]

3.50 Similarly, the NSW Bar Association agreed that there is 'dismal' chance of reducing the mandatory death in custody inquests unless a significant investment of additional resources is made to the Coroners Court of NSW.[279] The National Justice Project agreed, proposing that additional resources could allow coroners to exercise their discretion to investigate more cases and hold more inquests.[280]

3.51 The NSW Bar Association commented on the necessity to increase judicial resources in the context of implementing reforms for the Coroners Court of NSW to become a standalone court or a court which adopts similar institutional arrangements to the Children's Court. With respect to the latter model, Dr Louis Schetzer, Policy and Advocacy Manager and National Manager at the Australian Lawyers Alliance, stated:

> One would have to be very cautious that in resourcing the coroners' jurisdiction with the appointment of judicial figures and enabling them to be part of the judiciary that you are not then draining resources from the local court as well and then basically shifting the resource problem down to the Local Court as well. It needs to be an additional injection of resourcing for coroners that does not come at the cost of magistrates in the Local Court as well.[281]

Greater resourcing of legal counsel

3.52 As noted in chapter 1, legal assistance for coroners may be provided by police coronial advocates or solicitors from the Crown Solicitor's Office or Department of Communities and Justice. Police coronial advocates are specialist police prosecutors from the Coronial Law Unit located at the State Coroners Court, who assist the State Coroner and Deputy State Coroners in coronial investigations and inquests, as well as regional magistrates on request. They liaise with family members and investigating police, prepare matters for inquest, identify witnesses and engage expert evidence and conduct coronial inquests.[282]

3.53 Solicitors from the Crown Solicitor's Office will also assist the coroner instead of a police coronial advocate when the proceedings raise more complex issues or when multiple agencies are involved. They will also assist when there is likely to be significant public interest in the matter or when it would be inappropriate for the police coronial advocate to act because of an

277 Submission 14, Adjunct Professor Hugh Dillon, p 39.

278 Submission 14, Adjunct Professor Hugh Dillon, p 39.

279 Submission 17, New South Wales Bar, p 35.

280 Submission 27, National Justice Project, p 21.

281 Evidence, Dr Schetzer, 29 September 2021, p 27.

282 Submission 18, NSW Government, p 22.

actual or perceived conflict of interest.[283] Further to this, Mr Evenden noted that the Crown Solicitor's Office will always assist in relation to matters involving First Nations deaths.[284]

3.54 If the Crown Solicitor's Office has a conflict of interest, solicitors from the Department of Communities and Justice Legal division will assist.[285] Both agencies may instruct a private barrister to appear at the inquest hearing as Counsel Assisting if required. In matters of any complexity or which raise issues of public importance, barristers from the private bar are engaged through the Crown Solicitor's Office or Department of Communities and Justice Legal to act as Counsel Assisting in matters. This will occur on the decision of the presiding coroner. Where the barrister is a Senior Counsel, the approval of the Attorney General must be sought and granted. The practice is to submit a short list of names to the Attorney, with a recommendation. Where the barrister to be engaged as Counsel Assisting is not a Senior Counsel, they will almost always be a senior junior barrister. In such cases, the choice is left to the coroner and the Crown Solicitor's Office.[286]

3.55 Whichever unit, agency or private practitioner is acting as counsel assisting, if the matter goes to inquest, they assume responsibility for liaising with interested parties, including families, and act as the point of contact.[287]

3.56 Inquiry stakeholders acknowledged the calibre and diligence of the solicitors within these teams and the high standard of legal assistance provided to coroners.[288] Adjunct Professor Dillon, in particular, commented that the legal assistance from the Crown Solicitor's Office, Department of Communities and Justice Legal and the NSW Bar is 'one of the major strengths of the NSW coronial system'.[289]

3.57 Some inquiry participants, including Legal Aid NSW and NSW Bar Association, expressed concern, however, that the Crown Solicitor's Office and Department of Communities and Justice are under-resourced to meet the significant workload of complex coronial matters in a timely manner.[290]

3.58 The New South Wales Nurses and Midwives' Association stated that this under-resourcing is demonstrated by 'employees of those agencies regularly working and communicating with

283 Submission 18, NSW Government, p 22.

284 Evidence, Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid Commission of New South Wales, 29 September 2021, p 16.

285 Submission 18, NSW Government, p 22.

286 Submission 18, NSW Government, p 22; Submission 14, Adjunct Professor Hugh Dillon, p 18.

287 See, for example, Evidence, Mr Evenden, 29 September 2021, p 18; Evidence, Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, 30 November 2021, p 46.

288 Submission 14, Adjunct Professor Hugh Dillon, pp 17-18; Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6; Evidence, Ms Edwards, 29 September 2021, p 24.

289 Submission 14, Adjunct Professor Hugh Dillon, pp 40-41.

290 See, for example, Submission 14, Adjunct Professor Hugh Dillon, pp 40-41; Submission 46, Legal Aid Commission of New South Wales, p 31; Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6; Evidence, Ms Edwards, 29 September 2021, p 24; Evidence, Ms Laura Toose, Legal Officer, NSW Nurses and Midwives' Association, 31 January 2022, p 9.

parties via email at unsociable hours - indicating significant workloads'.[291] Ms Kirsten Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, also highlighted that in the context of declining resources of the Crown Solicitor's office and the Department of Communities and Justice, 'there is a lot of weekend work and then there is a lot of night work with those organisations'.[292]

3.59 Following on from this, Ms Edwards also commented on the constrained capacity of the Crown Solicitor's Office and the Department of Communities and Justice to respond in a timely manner to coroners' requests for information:

> Then government departments are being faced with a large amount of what we call requisitions—requests for information, requests for statements. They do not necessarily have specific resources allocated to responding to requests from the coroners. We find that almost inevitably deadlines that are set by the coroners go begging without any real recourse.[293]

3.60 Some stakeholders, including Legal Aid NSW, argued that insufficient resourcing of these agencies is also indicated by the delays experienced in preparing and serving briefs and preparing matters for inquest.[294] The NSW Nurses and Midwives' Association noted that in its regular engagement with the Crown Solicitors Office and Department of Communities and Justice Legal, there is an increasing trend for decisions to be made about issues and witnesses closer to the commencement of the inquest hearings, which impedes proper preparation for all parties. It also stated that the brief of evidence can be provided in a piece-meal fashion shortly before, and sometimes after, the hearing.[295]

3.61 The NSW Nurses and Midwives' Association, Adjunct Professor Hugh Dillon and Legal Aid NSW recommended that the level of resourcing for the Crown Solicitor's Office and Department of Communities and Justice Legal be reviewed given its workload, reported delays and its 'centrality to the effectiveness of the coronial process in complex matters'.[296] Stakeholders contended that additional resourcing would improve processes, enable the faster preparation of briefs, reduce delays associated with matters not being ready for hearing and therefore allow for an earlier commencement of inquests.[297]

3.62 Gilbert + Tobin also highlighted the potential for the transfer of coronial cases from the Coronial Law Unit to the Crown Solicitor's Office and the Department of Communities and Justice Legal to add to delays with the coronial process, as well as inadequate communication around these transfers contributing to families' distress. [298]

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291 Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6.

292 Evidence, Ms Edwards, 29 September 2021, pp 24-25.

293 Evidence, Ms Edwards, 29 September 2021, p 25.

294 Submission 46, Legal Aid Commission of New South Wales, p 31.

295 See, for example, Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6; Evidence, Ms Toose, 31 January 2022, p 9.

296 See, for example, Submission 14, Adjunct Professor Hugh Dillon, pp 40-41; Submission 46, Legal Aid Commission of New South Wales, p 31; Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6.

297 See, for example, Submission 46, Legal Aid Commission of New South Wales, p 31; Submission 51, New South Wales Nurses and Midwives' Association, pp 5-6.

298 Submission 39, Gilbert + Tobin, p 26.

3.63 An additional point raised by Ms Laura Toose, Legal Officer at the NSW Nurses and Midwives' Association, related to the transfer of coronial matters between staff within a department. Ms Toose contended that when carriage of a particular case may transfer between solicitors due to changes within teams and departmental rotation programs, there is the potential to add to existing delays.[299]

3.64 Reference was made to the legal assistance model used in Victoria, which is detailed in the below case study.[300]

Case study: In-house legal service at the Coroners Court of Victoria[301]

Each coroner at the Coroners Court of Victoria has a designated legal officer who assists in all aspects of an investigation, including analysing evidence, preparing draft findings, preparing matters for inquest and appearing as counsel to assist the coroner at inquests. The legal officer also has carriage of Supreme Court appeal proceedings that may arise from coronial matters and advises the Court and coroners on other legal matters and policy.

Since the introduction of in-house legal services in 2011, the Court's costs for legal services have reduced, and other benefits have been realised, such as enhanced expediency of file closure, reduced delays in coronial investigations and the development of expert legal knowledge within the Court.

Prior to the establishment of the in-house legal service, the Police Coronial Support Unit provided assistance to coroners. For coronial investigations which scrutinised the conduct of police, independent lawyers were engaged instead to assist the coroner, as well as in technical or complex investigations. In light of the increasing complexity of inquests and in an effort to reduce the rising costs of engaging private legal assistance, in 2011 the Court established a pilot in-house legal service with two full-time solicitors to assist coroners in investigations where the relevant circumstances involved the examination of police or police behaviour.

In 2013-14, the Court implemented a new operating model which included a permanent in-house legal service and expanded it to include a team of solicitors to assist the coroners. The team was further

299 Evidence, Ms Toose, 31 January 2022, p 13.

300 Evidence, Adjunct Professor Dillon, 29 September 2021, p 10.

301 See, for example, Coroners Court of Victoria, *The Coroners Process – Information for Family and Friends* (May 2020), p 20, https://www.coronerscourt.vic.gov.au/sites/default/files/2020-10/Coroners%20Process%20Booklet%20-%20CCOV.pdf; Coroners Court of Victoria, *Annual Report 2016-17* (2017), https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/coroners%2Bcourt%2Bof%2Bvictoria%2Bannual%2Breport%2B2016-17.pdf; Coroners Court of Victoria, *Annual Report 2020-21* (2021), https://www.coronerscourt.vic.gov.au/sites/default/files/2021-10/Coroners%20Court%20of%20Victoria%20-%20Annual%20Report%20-%202020-21.pdf; Coroners Court of Victoria, *Annual Report 2014-15* (2015), https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/coroners%2Bcourt%2Bannual%2Breport%2B2014-15.pdf.

expanded in 2016-17 with the recruitment of seven further legal officers. In the Court's 2020-21 Annual Report, there were 25 full time equivalent staff in the Legal Services team.

In addition to providing legal assistance in coronial matters, the in-house legal service has also assisted the State Coroner to develop a number of internal and joint protocols as well as practice guidelines.

Role of registrars

3.65 The committee considered the case management and administrative support provided to coroners, including the role of assistant coroners and registrars, and whether their functions need to be enhanced, particularly in relation to the management of natural cause deaths.

3.66 In particular, the submission from the Coroners Court of Queensland noted the function of registrars in triaging natural cause deaths, and the committee was briefed during its site visit to the Coroners Court of Victoria about its model where each registrar is allocated a coroner.[302]

3.67 In New South Wales, coroners are assisted by approximately 200 part-time assistant coroners across the state who fulfil this function in addition to their role as Local Court registrars. Pursuant to section 13 of the *Coroners Act 2009* (NSW) (Coroners Act), those 'employed in the Department of Communities and Justice' can be appointed assistant coroners by the Attorney General.[303] The Department of Communities and Justice advised that the assistant coroners in NSW have completed an 'Assistant Coroner Course'.[304] Under section 15 of the *Coroners Act 2009* (NSW), they 'provide administrative assistance' to coroners and undertake delegated functions including 'issuing post mortem investigation directions' and 'the function of dispensing with the holding of inquests if a death results from natural causes'.[305] At the State Coroners Court, there is also a registrar and deputy registrar.[306]

3.68 In Queensland, there are currently two coronial registrars in Brisbane who assist coroners by triaging and investigating less complex matters, including deaths from apparent natural causes.[307] These registrars triage and investigate deaths reported to police because a death certificate has not been issued and review potentially reportable deaths reported by medical practitioners or funeral directors. Registrars also provide advice over the phone to clinicians on whether a death is reportable.[308]

302 Submission 13, Coroners Court of Queensland, p 2.

303 *Coroners Act 2009* (NSW), s 13.

304 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 4.

305 *Coroners Act 2009* (NSW), s 15; Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 4.

306 Submission 18, NSW Government, p 11.

307 Submission 13, Coroners Court of Queensland, p 1.

308 Queensland Courts, *Our Coroners* (19 January 2022), https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/coroners-list#:~:text=Coronial%20registrar,-Current%20coronial%20registrar&text=Located%20in%20Brisbane%2C%20the%20registrars,medical%20practitioners%20or%20funeral%20directors.

3.69 The Queensland Audit Office's 2018 report on *Delivering Coronial Services* concluded that efficiencies were achieved by 'the appointment of a coronial registrar to filter some non-reportable deaths from the system and divert some reportable deaths from unnecessary autopsy and a full coronial investigation'.[309]

3.70 The submission from the Coroners Court of Queensland explained that the second registrar position was created in 2019. It also noted that the registrars' triage process is multidisciplinary, involving Queensland Police Service and Queensland Health:

> The 'triaging' approach is a multidisciplinary one that engages forensic pathologists, clinical nurses, forensic medical officers, coronial nurses and counsellors to divert non-reportable deaths from the unnecessary application of full coronial resources by reviewing medical records and liaising with families to determine if there are any concerns and authorise a cause of death certificate.[310]

3.71 Further, the Coroners Court of Queensland noted that the objectives and rationale of this registrar model are:

- to reduce the number of natural cause deaths reported to police and the number of deceased persons who undergo an autopsy unless required
- to ensure that only deaths which require investigation enter the coronial system, thereby reducing where possible unnecessary contact with the system for families
- the use of less invasive autopsy procedures
- improved case finalisation timeframes
- to increase the capacity of coroners to focus on more complex investigations.[311]

3.72 As discussed in chapter 2, the volume of natural cause deaths in NSW has also been identified as an issue for timeliness and unnecessarily absorbing coronal resources. The NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce* (Timeliness Taskforce) Progress Report identified that an over-reporting of natural cause deaths to the Coroners Court of NSW was contributing to delays in the coronial system. To address this, the Coroners Act was amended in 2020 to amend the circumstances in which a death must be reported to the coroner so as to reduce the number of natural cause deaths in the coronial system, as well as enhance education to general medical practitioners about reportable deaths.[312]

3.73 In this context, it is worth noting that at the Coroners Court of Victoria each registrar is allocated to a coroner to assist in the case management of coronial matters.[313] The key functions of these

309 Queensland Audit Office, *Delivering Coronial Services – Report 6: 2018-19* (2018), p 9.

310 Submission 13, Coroners Court of Queensland, p 2.

311 Submission 13, Coroners Court of Queensland, p 2.

312 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 11.

313 *Coroners Act 2008* (Vic), s 102A; Victorian Government Solicitor's Office, *Through the Looking Glass: An Insight into Coronial Inquests and Investigations* (14 October 2021), https://www.vgso.vic.gov.au/through-looking-glass-insight-coronial-inquests-investigations; Coroners Court of Victoria, Annual Report 2015-16 (2016), p 40,

judicial registrars are to communicate directly with the senior next of kin and families, liaise with other internal and external participants and agencies and provide case management and administrative support including the coordination of inquests, hearings and delivery of findings.[314]

Role of police investigators

3.74 The challenges arising from the roles of NSW Police in conducting investigations on behalf of coroners, preparing matters of inquest and assisting coroners in coronial proceedings was highlighted during the inquiry.

3.75 The NSW Police Force investigates all reportable deaths under the direction of the coroner. Section 51(2) of the *Coroners Act 2009* (NSW) provides that a 'coroner may give a police officer directions concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings'. The investigations are usually carried out by those police who already have carriage of the particular matter.[315]

3.76 Some of these investigations may lead to an inquest and compilation of a coronial brief of evidence. The officer in charge will compile the coronial brief of evidence and a police coronial advocate from the Coronial Law Unit assists the coroner in preparing and conducting the inquest. The police coronial advocate acts as the conduit between coroners and the officers in charge in conducting the investigation. The Coronial Law Unit also provides training to operational police and investigators on the coronial jurisdiction.[316]

3.77 Some stakeholders reflected on the varying experience of police officers in coronial matters, including experience in compiling a coronial brief of evidence. For example, Ms Edwards noted that this, among other issues, can contribute to delays within the coronial process. She explained:

> A brief, when it arrives, needs to be assessed by somebody and then, depending on the quality of the brief—some homicide briefs, for example, are exceptionally well prepared; some briefs are put together by a constable in their first six months of practice and they cannot possibly be expected to have the skill—and they have no specific training in these matters—to do it well. So it might be that the first brief has to be almost reinvented again with a series of requisitions, and that will again potentially add six months, one year to the process.[317]

https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cc0001_annualreport_2016_v8.pdf.

314 Coroners Court of Victoria, *The Court* (29 January 2021), https://www.coronerscourt.vic.gov.au/about-us/our-people/court; Victorian Government Solicitor's Office, *Through the Looking Glass: An Insight into Coronial Inquests and Investigations* (14 October 2021), https://www.vgso.vic.gov.au/through-looking-glass-insight-coronial-inquests-investigations; Coroners Court of Victoria, Annual Report 2015-16 (2016), p 40, https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cc0001_annualreport_2016_v8.pdf.

315 *Coroners Act 2009* (NSW), s 51(2).

316 Submission 18, NSW Government, pp 21-22.

317 Evidence, Ms Edwards, 29 September 2021, pp 24-25.

3.78 According to the New South Wales Nurses and Midwives' Association, this is a result of the way in which reportable deaths are assigned to officers:

> Due to the manner in which the investigation of reportable deaths are allocated by NSW Police, it is not uncommon that the police officer who is deemed the Officer in Charge (OIC) is someone who has never been involved with a coronial matter nor have they ever received any training specific to the conduct of coronial investigations.[318]

3.79 For its members, the New South Wales Nurses and Midwives' Association commented that the lack of guidance for officers in charge with respect to obtaining witness statements has led to witnesses being required by the officer to make a statement sometimes without the benefit of legal advice or access to relevant records. With the objective of improving the quality and consistency of investigations and briefs by officers in charge, the New South Wales Nurses and Midwives' Association recommended that the current process for allocating police officers as officer in charge be reviewed, including the adequacy of training.[319]

3.80 Ms Toose suggested a greater investment of resources at the beginning of an investigation may serve to reduce delays in the completion of an inquest:

> With respect I do not think police officers, particularly those who are not trained or quite inexperienced, trying to work out who they need to get statements from in a complicated death in a health setting—it is probably not the best way to minimise the time between death and inquest because, I think, there is a lot of time that is probably wasted in that process where they are trying to work out what is going on here, what has happened.
>
> They do not have, necessarily, any medical or nursing knowledge. They are trying to put together—"Who do I need to get statements from? What do we need to do?" They have got a deadline to get something to the coroner, but there may then be delays before a coroner can review that material as well. If we want to identify issues early on, I think, it should be a matter of changing how that process works from the get-go.[320]

Deaths in custody

3.81 Relevant to the role police investigators play in the coronial process, evidence to this inquiry highlighted the specific challenges experienced when police are involved in coronial investigations for First Nations deaths in custody. This was the focus of the previous inquiry into the high level of First Nations deaths in custody and oversight and review of deaths in custody.

3.82 The National Justice Project explained the functions of police in a death in custody case as follows:

> Currently, in NSW, all deaths in police or corrective services custody must be reported to the Coroner. NSW Police then conduct an internal investigation on behalf of the Coroner in accordance with the internal Critical Incident Guidelines and prepare a brief of evidence. Once the Coroner is satisfied with the police investigation brief and the

318 Submission 51, New South Wales Nurses and Midwives' Association, p 6.

319 Submission 51, New South Wales Nurses and Midwives' Association, pp 6-7.

320 Evidence, Ms Toose, 31 January 2022, p 12.

> medical evidence including the post mortem report, the Coroner can complete their brief and hold an inquest.[321]

3.83 The Public Interest Advocacy Centre emphasised the importance of 'robust, transparent and independent investigations' into deaths in custody, to instil public confidence in the coronial system.[322] As reported in the inquiry into the high level of First Nations deaths in custody and oversight and review of deaths in custody, several stakeholders noted that there can be an actual or perceived conflict of interest by police being involved in the investigation of deaths in custody, contributing to a perceived lack of independence and bias in the investigation.[323]

3.84 The National Justice Project contended that police involvement in the coronial investigation compromises the process, particularly in terms of trust for First Nations deaths in custody:

> The integrity of the coronial system is jeopardised by the role of police. The notion of police investigating police is inherently flawed and prevents those who engage with the system from having confidence that the process is not prejudiced. The experience of many First Nations people, including many of our clients, is that the Australian criminal justice system is systemically structured against their interests.[324]

3.85 There were various recommendations proposed to address these issues. The Public Interest Advocacy Centre recommended that 'a specialist unit within the Coroners Court be established to undertake investigations into deaths in custody'.[325]

3.86 The National Justice Project recommended that there be 'a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system'.[326] The Jumbunna Institute of Indigenous Education and Research, Research Unit, also recommended that the investigation process of First Nations deaths in custody be 'institutionally, practically, culturally and politically independent' of the NSW Police Force.[327]

3.87 Relevant to this, the committee was informed that the Chief Magistrate and State Coroner were in the process of drafting a revised Practice Note which will set out guidelines for the case management of deaths in custody. This will refer to the State Coroner's Protocol for the case management of mandatory death in custody inquests involving First Nations people.[328]

3.88 This protocol was finalised by the State Coroner in March 2022, a copy of which was provided to the committee. The protocol, which commenced in April 2022, states that the solicitors from the Crown Solicitors Office or Department of Communities and Justice Legal will be the

321 Submission 27, National Justice Project, p 29.

322 Submission 23, Public Interest Advocacy Centre, p 5.

323 See, for example, Submission 23, Public Interest Advocacy Centre, p 5; Submission 27, National Justice Project, p 30; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 15; Submission 32, Elizabeth Jarrett, p 1.

324 Submission 27, National Justice Project, p 29.

325 Submission 23, Public Interest Advocacy Centre, p 5.

326 Submission 27, National Justice Project, p 32.

327 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 15.

328 See, for example, Submission 17, New South Wales Bar Association, p 5; Submission 18, NSW Government, p 20.

solicitor assisting the coroner in relation to the proceedings for First Nations deaths in custody.[329]

Additional forensic pathologists

3.89 In the context of addressing workload pressures and delays within the coronial system, the committee also received evidence highlighting the need for additional forensic pathologists.

3.90 This was a particular issue noted in the Timeliness Taskforce Progress Report, with the report noting that the limited forensic pathology resources in NSW are impacting the length of time taken to provide a post-mortem report. It also noted that these delays have a real flow on impact to the delays in the coronial process as coroners use the post-mortem report to inform their decision on whether to dispense without an inquest or hold an inquest.[330]

3.91 NSW Health Pathology Forensic Medicine is implementing various initiatives from the Timeliness Taskforce's report to reduce delays in the finalisation of post-mortem reports. This includes the recruitment of two forensic pathologists and a clinical training coordinator. It is also expanding the forensic pathology training program, which has four forensic pathology trainees, and is developing the neuropathology skillsets of its forensic pathologists. Forensic Medicine is also developing a new information management system and internal templates to streamline its processes.[331]

3.92 The NSW Government stated that there has been improvements in the timeliness of post-mortem reports since the Timeliness Taskforce, as illustrated by the following statistics.

- The average number of post-mortem reports finalised per month between 2018 and March 2021 increased by 10 per cent.
- In the 18-months prior to June 2021, there was a 45 per cent reduction in the number of post-mortem reports awaiting finalisation for longer than six months.
- In March 2021, the median completion time for post-mortem reports relating to rural and regional cases was four months and 81 per cent were completed within six months.[332]

3.93 With respect to recruiting more forensic pathologists, the NSW Government reported that there is a worldwide shortage, noting that it has undertaken extensive national and international searches to source forensic pathologists.[333] At a hearing, Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine at NSW Health Pathology Forensic and Analytical Science Service, informed the committee that there are currently 15 pathologists in

329 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cl 5.6. See, for example, Submission 17, New South Wales Bar Association, Appendix C, p 57. See also Evidence, Mr Evenden, 29 September 2021, p 16.

330 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), pp 13-14.

331 Submission 18, NSW Government, p 13; NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 14.

332 Submission 18, NSW Government, p 16.

333 Submission 18, NSW Government, p 13.

NSW, with five in Newcastle and one in Wollongong, and the intention to recruit between two and five further forensic pathologists, with particular attention to recruiting a second pathologist for Wollongong.[334]

3.94 In terms of the forensic pathology training program, Dr Brouwer advised that a second forensic pathologist at Wollongong would enable the facility to take on trainees, as have the facilities in Sydney and Newcastle, given all three facilities have been accredited by the Royal College of Pathologists of Australasia as training facilities. Currently in Wollongong, junior medical officers from Wollongong Hospital rotate through Forensic Medicine via the Resident Medical Officer program.[335]

Committee comment

3.95 The committee commented in chapter 2 that the coronial process has become increasingly centralised and specialised without the formal structure and funding in place to sufficiently support it. In this chapter, we outlined the proposals put forward by stakeholders, both of which aimed to enhance the independence of the Coroners Court of New South Wales and its operational arrangements.

3.96 While both models have merit, the committee ultimately supports the proposal for the Coroners Court of NSW to be restructured so that it is an autonomous and specialist court associated with the Local Court, similar to the institutional arrangements of the Children's Court of New South Wales.

3.97 As part of this model, it is the committee's view that coronial duties should be undertaken only by specialist coroners appointed specifically to the Coroners Court of NSW. Coroners should also be appointed as Local Court magistrates to maximise the advantages which flow from transferability between the jurisdictions. To uphold the actual and perceived independence of coroners, the committee considers that it is best not to have a limited term on any appointment to the office of coroner.

3.98 With the aim of not only symbolising but practically upholding the independence of the State Coroner and the jurisdiction, we believe that the State Coroner should be a Judge of the District Court. This would place the State Coroner on equal footing with the Chief Magistrate. The State Coroner would then have the responsibility of making coronial appointments, in consultation with the Chief Magistrate, if those appointments are drawn from the existing members of the Local Court. Where appointments to the coroner's court are not persons already holding the office of magistrate, it is envisaged that appointments would occur in the same way as appointments to the Local Court are currently selected with consultation occurring between the Attorney General and the head of jurisdiction (in this case, the State Coroner) but with a clear focus on the work of the coronial jurisdiction. The committee considers there should be no term limit on holding the office of coroner. Further, that persons appointed as coroners who are not already magistrates should also be appointed to the Local Court. This would retain the nexus between the two courts and there could be a sharing of resources, or transfers between the courts, with the concurrence of the State Coroner and Chief Magistrate. Of course, there

334 Evidence, Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine at NSW Health Pathology Forensic and Analytical Science Service, 30 November 2021, pp 41 and 43.

335 Evidence, Dr Brouwer, 30 November 2021, pp 41 and 43.

would also need to be consultation with the Chief Magistrate in relation to any such appointment.

3.99 In addition, the committee considers that along with the other heads of courts in New South Wales, the State Coroner should be a member of the Judicial Commission of New South Wales, to reflect the importance of the work of the jurisdiction and to represent and advocate on behalf of the Coroners Court of NSW.

3.100 Under this model, regional magistrates would no longer undertake coronial duties. This change would require increased funding for the Coroners Court of NSW, in order to appoint a greater number of dedicated coroners. In this context, we acknowledge stakeholder's concerns that the additional resources needed for an independent Coroners Court should not come at the expense of the Local Court.

3.101 Finally, the committee notes the importance of reported deaths in regional communities being investigated locally. The grief and trauma experienced by families can be compounded by the emotional and financial costs of needing to travel to metropolitan areas to participate in the coronial process. Accordingly the committee recommends that in addition to the coroners located in Newcastle and Wollongong, a sufficient number of dedicated full-time coroners should be appointed and located across each regional area, including in the north, south and west of the state. Coroners in these regions could travel to the communities in which the death occurred if the circumstances require.

Recommendation 4

That the NSW Government restructure the Coroners Court of New South Wales to be an autonomous and specialist court within the Local Court framework, similar to the Children's Court of New South Wales, with these 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 New South Wales.

3.102 With this model leading further to specialisation of the coronial jurisdiction, it will be necessary to develop a comprehensive training program for coroners, including a thorough induction program and ongoing professional development. The work of Adjunct Professor Dillon on the requirements and curriculum of best-practice coronial training should inform the development of this program, with further input from the State Coroner and other experts in the field. We agree that it would be appropriate for the Judicial Commission of New South Wales, in conjunction with the State Coroner, to design, develop and deliver this program. The matters

raised in the New South Wales Bar Association submission concerning providing more guidance to coroners through a Bench Book or State Coroner's guidelines should be more thoroughly assessed in that process.

Recommendation 5

That the NSW Government ensure the Judicial Commission of New South Wales is sufficiently funded to design, develop and deliver a bespoke and comprehensive training and professional development program for coroners, with input from the current State and Deputy State Coroners and former coroners.

3.103 In our view, restructuring the institutional arrangements of the Coroners Court of NSW is only one half of the picture in creating a more efficient and fit-for-purpose coronial system. The other half is adequate resourcing, funding, training and staffing to support the Court to effectively and efficiently carry out its death investigation and death prevention objectives.

3.104 While the need for operational improvements and greater resourcing is amplified if the Court becomes a specialist jurisdiction, the recommended enhancements to and additional resourcing of the Court should be implemented regardless of whether any structural changes occur.

3.105 A key benefit of this inquiry has been the suggestions put forward by inquiry stakeholders on how the Coroners Court of NSW could be resourced to achieve better outcomes. Like others, we consider that there is value to be gained in reimagining the way in which coroners are supported to discharge their duties. In this regard, we have given particular consideration to the applicability and implementation of roles, systems and processes used in other jurisdictions, especially Victoria and Queensland.

3.106 During February 2022, the committee had the benefit of visiting the Coroners Court of Victoria and holding a virtual meeting with the Coroners Court of Queensland. We were given a comprehensive briefing by the respective State Coroners and court staff. We are grateful for having had the opportunity to learn about the strengths and operations of the two jurisdictions.

3.107 In particular, we acknowledge the potential benefits of the Victorian 'coroners' team model' whereby each coroner is allocated a legal officer and registrar. The benefits of this model are particularly apparent for a coronial jurisdiction which has full-time specialist coroners performing all coronial work across NSW.

3.108 In our view, a designated solicitor or legal officer for each coroner would not only enable the development of high level expertise and knowledge within the Court, it would also create a repository of knowledge to assist coroners outside of investigations and inquests, for example, in the development of internal protocols and guidelines. In addition, the committee understands that the coroners' legal officers at the Coroners Court of Victoria act as the central point of contact with families and loved ones, providing clear and timely information about the progress of cases, which is particularly essential in matters where a family is not legally represented (as will also be discussed in chapter 5).

3.109 With respect to the efficiencies that registrars could bring to the coronial system, the committee acknowledges the benefits the registrars' role in triaging natural case deaths has brought to the distribution and expenditure of coronial resources in Queensland. We also recognise the

previous measures that have been taken to reduce the number of natural cause deaths reported in NSW. In any case, we suggest that the NSW Government explore whether a greater level of support is needed for coroners in managing natural cause deaths and whether the triaging of these cases is sufficient in the context of other models, such as that in Queensland. Further, the general case management, family liaison and administrative support provided to coroners should also be examined. One model to be considered is the 'coroners' team model' in Victoria, where registrars assist coroners to improve the timeliness of coronial processes by assuming case management, communications and administrative functions.

3.110 In our view, the work of specialist coroners would be greatly supported by having an allocated in-house legal officer and registrar, as is done in Victoria. We therefore recommend that the NSW Government provide in-house legal officers and registrars to each coroner or alternatively establish of a pool of legal officers and registrars to assist all coroners.

Recommendation 6

That the NSW Government provide in-house legal officers and registrars to each coroner or alternatively establish a pool of legal officers and registrars to assist all coroners.

Recommendation 7

That the NSW Government provide a greater level of case management, family liaison and administrative support for coroners, particularly for the triaging and management of natural cause deaths reported to the Coroners Court of New South Wales.

3.111 The committee also acknowledges the specialist support currently provided by Police Coronial Advocates within the Coronial Law Unit. In our view, if coroners were to have in-house legal officers, along with increased support from registrars, both the legal officer and registrar would have roles in communicating with families. As a result, the capacity of the Coronial Law Unit to guide and support officers in charge in their investigations and preparation of the brief of evidence could be enhanced, which we believe could deliver more timely and consistent briefs of evidence.

3.112 We also recognise that the importance of comprehensive training for operational and investigating police on the coronial jurisdiction, including the role of the Coronial Law Unit in this space. The possible changes to the distribution of functions envisaged by the committee could also create increased capacity for the Coronial Law Unit to enhance training and development, which the committee sees as integral to delivering timely and quality briefs of evidence and, in turn, more efficient and effective coronial investigations and inquests.

Recommendation 8

That the NSW Police Force improve its training of police officers on coronial processes, including:

- regular, comprehensive and specialist training for investigative police
- specific training for officers in the preparation of high quality and timely coronial briefs of evidence.

3.113 In the context of a national and worldwide shortage of forensic pathologists, the committee commends the initiatives already undertaken by NSW Health Pathology Forensic Medicine to search for and recruit more forensic pathologists and expand its clinical training program to develop local expertise and workforce capacity. Despite these actions, it is clear that the number of forensic pathologists is insufficient to meet current workload demands. Given the post-mortem investigation is the lengthiest phase of the coronial process, often beset by delays, it is crucial that there is capacity within the forensic pathology workforce to meet this workload. To this end, we consider it vital for the NSW Government to enhance financial and professional incentives for forensic pathologists, in order to attract, recruit and retain more of these specialists in New South Wales and ensure both current and future workforce needs are met.

3.114 The NSW Government should also work with relevant professional bodies and educational institutions, including universities, to ensure there are sufficient opportunities for the training and qualification of all necessary forensic medical staff.

Recommendation 9

That the NSW Government, to attract, recruit and retain more forensic pathologists:

- work with relevant professional bodies and educational institutions, including universities, to ensure there are sufficient opportunities for the training and qualification of forensic pathologists
- enhance financial and professional incentives for forensic pathologists in New South Wales.

Chapter 4 Objectives, findings and recommendations

This chapter considers whether the coronial jurisdiction is currently able to best perform its role in examining systemic issues and preventing further deaths, taking into account legislative and resourcing deficiencies. It sets out suggested amendments to the objectives and guiding principles in the *Coroners Act 2009* (NSW), along with other changes that would improve the oversight, transparency and accountability of coronial findings and recommendations.

Objectives and guiding principles of the Coroners Act

4.1 According to some stakeholders one inadequacy of the *Coroners Act 2009* (NSW) (Coroners Act) is that its objects do not reflect the fact that preventing the future loss of life is a central tenet of modern coronial practice in New South Wales.[336] Evidence was given to the inquiry of other Australian coronial jurisdictions where there is an express object in legislation of preventing future deaths.[337]

4.2 The New South Wales Bar Association, the Legal Aid Commission of New South Wales (Legal Aid NSW) and Adjunct Professor Dillon contended that a new Coroners Act is required which establishes 'a purpose-built structure', adopts 'modernised objectives', sets out the provisions in a logical order and is 'centred on death prevention and the needs of bereaved families'.[338]

4.3 With respect to the objects of the Coroners Act, these are set out in section 3 and state:

> The objects of this Act are as follows—
>
> (a) to provide for the appointment of coronial officers,
>
> (b) to provide that magistrates are coroners by virtue of 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,

336 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 1; Submission 14, Adjunct Professor Hugh Dillon, pp 8 and 66-68; Submission 17, New South Wales Bar Association, pp 4, 5 and 10; Submission 33, Katie Lowe, p 5; Submission 46, Legal Aid Commission of New South Wales, p 19; Submission 18, NSW Government, p 9.

337 See, for example, Submission 14, Adjunct Professor Hugh Dillon, pp 53-57; Submission 46, Legal Aid Commission of New South Wales, p 20; Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 2-3.

338 See, for example, Submission 9, The Law Society of New South Wales, Appendix 1, p 5; Submission 17, New South Wales Bar Association, p 22; Submission 46, Legal Aid Commission of New South Wales, p 18.

> (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.[339]

4.4 In his submission to the statutory review of the Coroners Act in 2014, Mr Michael Barnes, former NSW State Coroner and former Queensland State Coroner, stated that this provision enables coroners to make recommendations but does not articulate the purpose of coronial recommendations.[340]

4.5 Legal Aid NSW and the NSW Bar Association argued that a deficiency of the current Coroners Act is that it does not mention the Court's preventative objective, despite this function being recognised by the NSW Government 'a central tenet of the coronial jurisdiction'.[341]

4.6 Adjunct Professor Dillon highlighted that this differs to the approach in Queensland and Victoria where the preventive objective of the coronial jurisdiction is expressly stated in legislation.[342] For example, the *Coroners Act 2008* (Vic) states that one of its purposes is 'to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners'.[343] One of the objects of the *Coroners Act 2003* (Qld) is to 'help to prevent deaths from similar causes happening in future'.[344]

4.7 Both Legal Aid NSW and the Aboriginal Legal Service (NSW/ACT) argued that the Coroners Act should include a preventative objective similar to that in Victoria.[345] The Aboriginal Legal Service (NSW/ACT) supported amending the Coroners Act to include similar wording to the Victorian provision because:

- it would make explicit that a key role of the coronial jurisdiction is death prevention
- coroners would have death prevention measures at the forefront of their investigation consideration and make recommendations that consider systemic causes and factors behind First Nations peoples incarceration and interaction with police

339 *Coroners Act 2009* (NSW), s 3.

340 Submission 14 Adjunct Professor Hugh Dillon, Appendix D, p 98.

341 See, for example, Submission 17, New South Wales Bar Association, pp 10-11; Submission 18, NSW Government, p 9; Submission 46, Legal Aid Commission of New South Wales, p 19.

342 Submission 14, Adjunct Professor Hugh Dillon, p 53.

343 *Coroners Act 2008* (Vic), s 1(c). See also Submission 46, Legal Aid Commission of New South Wales, p 20.

344 *Coroners Act 2003* (Qld), s 3(d).

345 Submission 46, Legal Aid Commission of New South Wales, p 20; Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 2-3.

- it is consistent with the recommendation of the Royal Commission into Aboriginal Deaths in Custody that for deaths in custody, the coroner is required to make recommendations, as appropriate, with a view to preventing further deaths.[346]

4.8 In addition, Adjunct Professor Dillon noted that the *Coroners Act 2008* (Vic) states a number of factors to be taken into account when functions under that Act are exercised, such as 'distress of family members and others, cultural beliefs and practices, the family's need for information and the desirability of promoting public health and safety and the administration of justice'.[347] Legal Aid NSW also recommended that similar family-orientated factors should be included in the legislation.[348] Mr Barnes also stated in his evidence that 'the Victorian Act has a lengthy list of guiding principles which I think is essential and we would definitely recommend importing that into our legislation'.[349]

4.9 The NSW Bar Association recommended that a new Act should adopt features from the *Coroners Act 2008* (Vic) and the *Coroners Act 2006* (NZ), in particular the statutory objects, which are prevention orientated and express respect for families and cultural diversity.[350] The NSW Bar Association suggested the following factors should be the focus of legislative objectives:

> The objects should emphasise:
> - the centrality of the experience and needs of bereaved families, and others affected by reported deaths, in the conduct of coronial investigations;
> - the unique and honourable place of First Nations people within the Australian community as the First Nations of the land;
> - the unique needs of First Nations people within the coronial system given the impact of colonisation, dispossession and systemic discrimination upon First Nations people';
> - the role of First Nations coroners and First Nations commissioners (or similar title) to sit on all inquiries relating to the death of a First Nations person;
> - the need, as far as possible to apply therapeutic and restorative processes when conducting investigations;
> - the need for the court to conduct proceedings in a way that is flexible and responsive to the particular circumstances of each investigation;
> - the pivotal role of the coronial system in the prevention of future death and serious injury; and
> - its role in providing one form of accountability, and supporting and protecting human rights, by investigating deaths caused or contributed to by state agencies and agents.[351]

346 Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 2-3.

347 Submission 14, Adjunct Professor Hugh Dillon, p 54.

348 Submission 46, Legal Aid Commission of New South Wales, p 20.

349 Evidence, Mr Michael Barnes, Queensland State Coroner from 2003 to 2013, and NSW State Coroner from 2014 to 2017, 29 September 2021, p 12.

350 Submission 17, New South Wales Bar Association, p 5. See also Submission 46, Legal Aid Commission of New South Wales, p 16.

351 Submission 17, New South Wales Bar Association, p 5.

Coroners' findings

4.10 This section summarises the reported difficulties experienced by families when they seek to have an inquest into their loved one's death to no avail. Without an inquest, findings on the manner of death cannot be made nor recommendations. The process to request a review of the decision to dispense with an inquest is outlined, followed by consideration of the different approaches in Victoria and Queensland where coroners can make findings without inquest.

4.11 Several submissions to the inquiry were made by families of deceased persons whose death was reported to the Coroners Court of New South Wales, as well as from organisations who commented on families' experience with the coronial process.[352] A common theme was that families looked to the coronial process for answers about their loved one's death and the circumstances surrounding and leading to the death. In some cases, families informed the committee that they were seeking or had sought that an inquest into the death take place.[353] The committee also received evidence highlighting how families are left with many unanswered questions when a coroner decides to dispense with an inquest.[354]

Decision to dispense with an inquest and review and appeal processes

4.12 Section 25 of the *Coroners Act 2009* (NSW) sets out the circumstances in which a coroner may dispense with an inquest, excluding matters in which a mandatory inquest is required, such as death in custody cases.[355]

4.13 Under section 25(2) a coroner may dispense an inquest in the following circumstances:

> … if the coroner is satisfied (after obtaining relevant advice from police officers and medical practitioners and consulting with a senior next of kin of the deceased person and any other person that the coroner considers appropriate) that—
>
> (a) the deceased person died of natural causes (whether or not the precise cause of death is known), and
>
> (b) a senior next of kin of the deceased person has indicated to the coroner that it is not the wish of the deceased person's family that a post mortem examination be conducted on the deceased to determine the precise cause of the deceased's death.[356]

352 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 37; Submission 27, National Justice Project, p 19; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 5; Submission 33, Katie Lowe, p 6; Submission 40, Tracy Mackander, p 3; Submission 45, Mark McKenzie, p 45; Submission 46; Legal Aid Commission of New South Wales, p 28; Submission 58, Jacci Quinlivan, p 58.

353 See, for example, Submission 58, Jacci Quinlivan, pp 1-2; Evidence, Ms Patrizia Cassaniti, Mother of Christopher Cassaniti, 31 January 2022, p 3; Submission 22, Lynda Newnam, p 2; Submission 39, Gilbert + Tobin, p 26.

354 Submission 46, Legal Aid Commission of New South Wales, Appendix, Fourth Reference Report: Rights to Appeal Coronial Findings and Re-Open Investigations, Coronial Council of Victoria (2017), p 44.

355 *Coroners Act 2009* (NSW), s 25.

356 *Coroners Act 2009* (NSW), s 25(2).

4.14 After considering the brief of evidence and post-mortem report, the coroner can form a preliminary view that the evidence satisfactorily discloses the answers to the questions concerning identity, date, place, cause and manner of death, and therefore an inquest is not required. This decision will also take into account whether it is necessary or desirable in the interests of justice to hold the inquest.[357] The senior next of kin is also consulted as to their views, which is filed with the brief of evidence by the officer in charge.[358]

4.15 If a coroner decides to dispense with an inquest, the family receives written correspondence of the outcome of the investigation and the manner and cause of death.[359] If a family has requested an inquest and the coroner proposes to dispense, a letter is sent to the family inviting them to provide a response within 30 days outlining any further concerns that they believe require an inquest to be held.[360]

4.16 Any submission received in response to the letter is considered by the coroner in making the final decision about whether to dispense with an inquest. In dispensing with an inquest, coroners use a single page form to provide written reasons addressing the statutory objects of the coroner's investigation. This is placed in the coronial file and can be made available to the senior next of kin on request via an email to the registry.[361]

4.17 Under section 29 of the *Coroners Act 2009* (NSW), a State Coroner is able to review a coroner's reasons for dispensing with an inquest and can direct that an inquest be held if that is their view.[362] Specifically, in reviewing this decision, section 29 requires the State Coroner to consider 'the coroner's reasons for dispensing with the inquest and any other matters that the State Coroner considers relevant'.[363]

4.18 Mr Don McLennan, Manager of Coronial Services NSW, advised the committee that this review process occurs 'regularly'.[364] Additionally, section 84 of the *Coroners Act 2009* (NSW) permits that 'on the application of the Minister or by any other person', the Supreme Court can order an inquest be held if 'satisfied that is it necessary or desirable to do so in the interests of justice'.[365]

4.19 The committee tried to explore whether decisions to dispense with an inquest are being made as a result of resource constraints. Mr McLennan was asked specifically about this and whether workload levels are taken into account in the making of decisions about whether or not to dispense with an inquiry. Mr McLennan disagreed this is given consideration by coroners, stating

357 Submission 7, Associate Professor Laura Grenfell, Associate Professor Julie Debeljak, and Dr Anita Mackay, p 35.

358 See, for example, Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 14; Evidence, Ms Cassaniti, 31 January 2022, p 3.

359 Submission 36, Aboriginal Legal Service (NSW/ACT), p 18.

360 Submission 18, NSW Government, p 22.

361 See, for example, Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 22; Evidence, Mr Don McLennan, Manager of Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, 30 November 2021, p 53.

362 *Coroners Act 2009* (NSW), s 29; See also, Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 17.

363 *Coroners Act 2009* (NSW), s 29(1).

364 Evidence, Mr McLennan, 30 November 2021, p 53.

365 *Coroners Act 2009* (NSW), s 84.

'I do not think it plays a predominant role'. When pressed further on this issue, he stated: 'Each coroner does have a very high workload, but to my knowledge I am not aware that they do not hold inquests because of that workload capacity. Where an inquest is necessary, my view is that they will hold an inquest if it is required'. [366]

4.20 When questioned on what guidelines or criteria exist to help coroners make these decisions, the Department of Communities and Justice advised that the *Local Court Bench Book* provides guidance on the matters a coroner will generally consider, including:

- whether the deceased's identify is known and the date and place of death are satisfactorily disclosed
- whether the cause and manner of death are satisfactorily disclosed on the evidence
- whether the deceased's family requests and inquest and provides a cogent reason(s) for doing so
- whether the case raises issues of public health or safety, and
- whether an inquest is likely to lead to recommendations that will assist with the prevention of future deaths of a similar kind.[367]

Findings without inquest

4.21 In NSW findings on the manner of death can only be made if an inquest in held. The impact of this is that there can only be limited discovery about how the death occurred or the circumstances in which it occurred, which can be particularly difficult for the families and loved ones of the deceased.[368]

4.22 This practice also impacts the data reported to the National Coronial Information System by the Coroners Court of NSW. As the National Coronial Information System receives its data from each state and territory, and inquests are only held in approximately two per cent of all reportable deaths received in New South Wales, there is a large data gap.[369]

4.23 Some stakeholders called for an extension to the current scope of coroners' powers in New South Wales, including Mr Barnes and Adjunct Professor Dillon, contending that coroners should be able to make findings even in cases where no inquest is held.[370] Mr Barnes views in this regard were part of his submission to the statutory review of the Coroners Act in 2014.[371]

4.24 The committee learnt that in Victoria, the Coroners Court may make 'chamber findings' which are findings made without an inquest, also known as 'findings made without an inquest'.[372]

366 Evidence, Mr McLennan, 30 November 2021, p 54.

367 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 13.

368 Submission 17, New South Wales Bar Association, Appendix D, p 71.

369 Submission 14a, Adjunct Professor Hugh Dillon, p 7.

370 See, for example, Submission 17, New South Wales Bar Association, Appendix D, p 71; Submission 14, Adjunct Professor Hugh Dillon, p 66.

371 Submission 17, New South Wales Bar Association, Appendix D, p 71.

372 Submission 14, Adjunct Professor Hugh Dillon, p 69.

Coroners have the power to make findings on the identity of the deceased and the cause and circumstances of their death without an inquest and may comment on any matter relating to public health and safety and the administration of justice.[373] Coroners in Queensland and Tasmania also have the power to deliver chamber findings.[374]

4.25 Adjunct Professor Dillon supported chamber findings to be delivered in certain cases in New South Wales, including matters where no issues of serious public interest arise or where families do not request an inquest. Adjunct Professor Dillon cautioned, however, that there would be particular cases where the benefits of a pubic inquest mean that it should not be replaced by chamber findings for efficiency proposes.[375]

4.26 Adjunct Professor Dillon also acknowledged that there may be challenges in regional magistrates undertaking this task due to the lack of time, specialisation and experience required to craft considered and effective recommendations.[376]

Coroners' recommendations

4.27 A number of inquiry participants acknowledged the important role the Coroners Court of NSW plays in preventing future deaths by making recommendations. In this manner, the NSW Government emphasised that 'a central tenet of the coronial jurisdiction is the prevention of future loss of life'.[377]

4.28 However, many stakeholders argued that the Coroners Court of NSW is inadequately empowered through legislation or supported through sufficient resources to properly fulfil its death prevention function.[378] This section looks at these concern, examining the basis and need for recommendations to focus on systemic issues to prevent deaths, particularly in relation to the deaths of First Nation people. It also looks at the accountability framework for recommendations, including the timeliness and transparency of agencies' responses to recommendations.

373 Submission 14, Adjunct Professor Hugh Dillon, p 65.

374 Submission 1, Magistrates Court of Tasmania, p 3.

375 Submission 14, Adjunct Professor Hugh Dillon, p 66.

376 Evidence, Adjunct Professor Hugh Dillon, Deputy NSW State Coroner from 2008 to 2016, and researcher in relation to coronial systems at the Law Faculty, University of New South Wales, 29 September 2021, p 5.

377 Submission 18, NSW Government, p 9.

378 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 1; Submission 12, Justice Action, pp 1 and 4; Submission 14, Adjunct Professor Hugh Dillon, pp 1, 11 and 8; Submission 17, New South Wales Bar Association, pp 3, 5 and 11; Submission 18, NSW Government, p 9; Submission 23, Public Interest Advocacy Centre, p 2; Submission 27, National Justice Project, p 11; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 4; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 5; Submission 36, Aboriginal Legal Service (NSW/ACT), p 6; Submission 38, Deadly Connections Community & Justice Services, p 6; Submission 41, Mr Michael Barnes, p 2; Submission 46, Legal Aid Commission of New South Wales, p 19.

The need for recommendations to focus on systemic issues to prevent deaths

4.29 Pursuant to section 82 of the *Coroners Act 2009* (NSW), coroners may make recommendations on 'public health and safety' as 'the coroner … considers necessary or desirable to make in relation to any matter connected with the death'.[379] The Public Interest Advocacy Centre noted that according to case law, 'this role is not considered to be a part of the "primary duty" of a coroner'.[380] According to Adjunct Professor Dillon, the Act's objects and legal authority suggest that 'death prevention would appear to be a secondary consideration of the NSW legislation'.[381]

4.30 Much of the evidence on this issue focused on the need for recommendations to address systemic issues in the context of First Nations deaths in custody.[382] This was also a key issue in the Select Committee's report on the high level of First Nations death in custody and oversight and review of deaths in custody (Select Committee on First Nations).[383]

4.31 In the context of deaths in custody, the Coroners Court of NSW recognises the function of coronial investigations in identifying systems failures and preventing future deaths in its Coronial Practice Note on case management of mandatory inquests involving section 23 deaths:

> When a death or suspected death falls within the scope of section 23 of the Act, the purpose of the coronial investigation are to:
> - Signify respect for life,
> - Ensure, as far as possible, that the full facts are brought to light,
> - Ensure accountability by identifying and systems failures or conduct warranting criticism and recommend remedial action for any such matters, and
> - Reassure the family and friends of the deceased that lessons learned from these deaths may save lives in the future.[384]

4.32 In the experience of the National Justice Project and Jumbunna Institute of Indigenous Education and Research, Research Unit (Jumbunna), coroners often take a narrow interpretation of their discretion to consider matters beyond the medical cause of death, therefore 'foreclosing an investigation into the wider or systemic circumstances'.[385] Jumbunna highlighted that this approach can undermine families experience of systemic issues:

> Usually this approach not only preferences biomedical issues within the scope of investigation and inquest, but also subordinates many of the concerns of First Nation

379 *Coroners Act 2009* (NSW), ss 82(1) and 82(2)(a).

380 Submission 23, Public Interest Advocacy Centre, p 2.

381 Submission 14a, Adjunct Professor Hugh Dillon, p 3.

382 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 27, National Justice Project, p 12; Submission 33, Katie Lowe, p 6; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 5.

383 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), pp 146-149.

384 Local Court of New South Wales, *Coronial Practice Note No 3 of 2021 – Case Management of Mandatory Inquests involving Section 23 Deaths* (24 August 2021), cl 3.

385 Submission 27, National Justice Project, p 12.

> families who have lived experiences of how systemic issues impacted on how their loved one came to both be in custody and to have died.[386]

4.33 Regarding the nature of systemic issues associated with First Nations deaths in custody, Ms Sarah Crellin, Acting Principal Legal Officer at the Aboriginal Legal Service (NSW/ACT), emphasised that the coronial systemic is 'uniquely placed to deal with systemic factors that lead to over-incarceration of Aboriginal people', yet the existing legislation does not allow for consideration of such factors.[387] Several 'extra-legal and socio-historical' factors relevant in the context of First Nations deaths in custody were highlighted by stakeholders, including:

- historical context of colonialism and its intergeneration impacts
- relationship between First Nations people and the state and police
- continued disadvantage and unequal position in social, economic and cultural domains
- presence of racism and unconscious bias
- appropriateness of arrests
- adequacy of care and protection while under state custody
- drivers or high rates of mortality.[388]

4.34 On this issue, the Aboriginal Health and Medical Research Council of NSW and the NSW Aboriginal Land Council contended that the effectiveness of inquests in addressing the needs of First Nations communities is hampered by the limited scope of jurisdiction that coroners choose, in their discretion, to exercise. The Aboriginal Health and Medical Research Council of NSW stated that the current Coroners Act 'has not enabled coroners to fully comment on prisoners' quality of health care and safety before their deaths' which leads to gaps in findings and recommendations for deaths in custody.[389] The National Justice Project agreed, noting that there are barriers to an inquest's scope being expanded:

> Although, the Coroners Act 2009 (NSW) confers significant discretion to each coroner in relation to the scope of the inquiry, in the absence of an express requirement to look more broadly, Coroners routinely narrow the focus of inquests to the exclusion of systemic issues such as discrimination, bias and prejudice. Convincing a Coroner to expand the scope of an inquest is exceptionally difficult for families without legal representation and often for their legal representatives. The result is a missed opportunity to stop further deaths and lack of accountability … [390]

4.35 Although the National Justice Project recognised that systemic issues and institutional failings are increasingly examined in inquests, it contended that the examination of healthcare and

386 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 5.

387 Evidence, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), 30 November 2021, p 13.

388 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 27, National Justice Project, p 12; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 5; Submission 33, Katie Lowe, p 7.

389 Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3. See also Submission 34, New South Wales Aboriginal Land Council, p 2.

390 Submission 27, National Justice Project, p 10.

quality of care and services in police or custodial settings 'cannot be discretionary'.[391] The National Justice Project highlighted two First Nations deaths in custody cases in which different approaches were taken to consider systemic issues.

- In the inquest into the death of Jack Kokaua, the impact of the deceased's mental health history on his experience with police led to recommendations aimed at the practices of police and health services when interacting with individuals with mental health conditions.
- In the inquest into the death of David Dungay Junior, issues relating to the deceased's mental health treatment to involuntary patients in correctional settings fell 'outside the parameters of the inquest'.[392]

4.36 Deadly Connections Community & Justice Services also commented on how these limitations can often impact families, noting that when inquests fail to provide a view on institutional failings which could have contributed to the death, the ability of the coronial system to address impacts of colonisation is limited and families and communities can be re-traumatised by the coronial process.[393]

4.37 Separately, when asked about the recommendations focused on systemic issues in the mental health context at a hearing, the representatives from the Royal Australian and New Zealand College of Psychiatrists commented that recommendations of that nature are made on an inconsistent basis.[394]

4.38 Some stakeholders suggested consideration could be given to how legislative provisions in other jurisdictions operate to address scope issues and enable recommendations on systemic issues to be provided to prevent future deaths, particularly for deaths in custody.

4.39 The Public Interest Advocacy Centre supported the inclusion of a provision similar to that which exists in the *Coroners Act 1995* (Tas) whereby for all deaths a coroner 'must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate'.[395] In the view of Mr Jonathon Hunyor, Chief Executive Officer at the Centre, introducing such a provision in New South Wales would create a 'clear legislative mandate for coroners to make appropriate recommendations to address systemic issues connected with a death'.[396]

4.40 Mr Hunyor referred to examples of recommendations made to prevent deaths from the Coroners Court of Tasmania, including recommendations on improved community education on sudden infant deaths and co-sleeping risks, driver safety promotion, mandatory use of life jackets, prison redesign to limit hanging points, improved medication dispensing practices in

391 Submission 27, National Justice Project, p 13. See also Submission 33, Katie Lowe, p 6.

392 Submission 27, National Justice Project, p 13.

393 Submission 38, Deadly Connections Community & Justice Services, p 3.

394 Evidence, Dr Andrew Ellis, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, 30 November 2021, p 39; Evidence, Dr Christina Matthews, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists, 30 November 2021, p 39.

395 Submission 23, Public Interest Advocacy Centre, p 2.

396 Evidence, Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre, 30 November 2021, p 18.

hospitals, enhancing regulations for pool fencing and improved mental health outreach and out-patient services dedicated to at-risk youth.[397]

4.41 The Royal Australian and New Zealand College of Psychiatrists highlighted the value of examining systemic issues in mental health related deaths, also supporting the introduction of a requirement that coroners examine and make recommendations on systemic issues where appropriate.[398] The Australian Medical Association (NSW) also supported a requirement for coroners to make recommendations, where appropriate, to improve public health and safety and prevent future deaths.[399]

4.42 For all deaths in custody, the Public Interest Advocacy Centre supported the inclusion of a similar provision in New South Wales to that which exists in the *Coroners Act 1995* (Tas) where in the case of deaths in custody or care, 'the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care'. The NSW Bar Association also supported this amendment.[400]

4.43 The Public Interest Advocacy Centre highlighted that this requirement in Tasmania accords with the recommendation of the Royal Commission into Aboriginal Deaths in Custody that 'broader powers be granted to coroners in order to prevent death'.[401]

4.44 Other jurisdictions also have similar requirements. In the Australian Capital Territory, for deaths in custody, coroners 'must include in a record of the proceedings of the inquest findings about the quality of care, treatment and supervision of the deceased that, in the opinion of the coroner, contributed to the death'. Similarly, for deaths in custody in the Northern Territory, coroners must report on the care, supervision and treatment of the person while being held in custody and may report on any issues of public health or safety or the administration of justice relating to the death.[402]

4.45 Related to this, in the context of deaths in custody, the State Coroner's Protocol on mandatory death in custody cases involving First Nations peoples states that the factors to be considered in coronial investigations may include, but is not limited to, the care, treatment and supervision of the deceased.[403]

4.46 On the specific issue of First Nations deaths in custody, there was also support for a requirement in New South Wales that coroners examine and make recommendation on systemic issues contributing to the death.[404] The Aboriginal Legal Service (NSW/ACT) argued that a

397 Answers to question on notice, Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre, 17 December 2021, p 1.

398 Evidence, Dr Ellis, 30 November 2021, p 39; Evidence, Dr Matthews, 30 November 2021, p 39.

399 Submission 35, Australian Medical Association (NSW), p 2.

400 Submission 17, New South Wales Bar Association, p 41.

401 Submission 23, Public Interest Advocacy Centre, p 2.

402 Submission 17, New South Wales Bar Association, p 40.

403 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cl 8.

404 See, for example, Submission 6, Australian Lawyers Alliance, p 9; Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 36, Aboriginal Legal Service (NSW/ACT),

requirement of this type 'in combination with the adoption of the Victorian formulation on purpose would contribute to some robust change and improve accountability mechanisms'.[405]

4.47 The Aboriginal Health and Medical Research Council of NSW and the NSW Aboriginal Land Council, among others, supported the recommendation of the Select Committee on First Nations that the Coroners Act be amended 'to stipulate that the Coroner is required to examine whether there are systemic issues in relation to a death in custody, in particular for First Nations people, with the Coroner provided with the power to make recommendations for system wide improvements'.[406]

4.48 The National Justice Project supported an expanded version of this recommendation, proposing that the Coroners Act be amended to require a coroner to consider and comment on systemic factors as well as 'discrimination and bias including by police corrective services and health services'.[407] In its view, this requirement is necessary because 'except for exceptional occasions, NSW Coroners do not make findings to redress discriminatory systemic failings that contribute to deaths'.[408]

4.49 In addition, Jumbunna and Deadly Connections Community & Justice Services supported the need for coroners to consider systemic discrimination and whether implementation of recommendations from the Royal Commission into Aboriginal Deaths in Custody could have reduced the risks of death in cases of First Nations death in custody.[409]

The need for improved accountability and transparency with responses to recommendations

4.50 In terms of the process governing responses to recommendations, it is important to note that a Premier's memorandum is currently in place to set out the process for ministers and government agencies to respond to coronial recommendations.[410]

4.51 This memorandum states that ministers and government agencies to whom coroners' recommendations are directed should write to the Attorney General within 21 days acknowledging receipt of the recommendation. Within six months, they must write to the

p 6; Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), p 3.

405 Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), p 3.

406 See, for example, Submission 6, Australian Lawyers Alliance, p 9; Submission 8, Aboriginal Health and Medical Research Council of NSW, p 4; Submission 33, Katie Lowe, p 14; Submission 34, New South Wales Aboriginal Land Council, p 4; Submission 38, Deadly Connections Community & Justice Services, p 5.

407 Submission 27, National Justice Project, p 19.

408 Submission 27, National Justice Project, p 18. See also Submission 34, New South Wales Aboriginal Land Council, p 4.

409 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 6; Submission 38, Deadly Connections Community & Justice Services, pp 2 and 5. See also Submission 34, New South Wales Aboriginal Land Council, p 5.

410 NSW Government, *M2009-12 Responding to Coronial Recommendations*, Premier and Cabinet (31 December 2014), https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/.

Attorney General outlining any action being taken to implement the coronial recommendation and in the circumstances where it is proposed that a recommendation will not be implemented, the reasons why.[411] The Department of Communities and Justice website publishes a list of the status of responses to recommendations and, where received, the response to the recommendation.[412]

4.52 The NSW Government outlined particular agencies' processes in relation to responding to coronial recommendations.

- Corrective Services NSW's Management of Deaths in Custody Committee, established in 2009, meets quarterly and is responsible for responding to and actioning coroners' recommendations from deaths in custody. The Oversight Review Committee, established in 2016, meets biannually and is responsible for reviewing, monitoring and reporting on the implementation of coronal recommendations.
- NSW Heath has a System Management Branch which coordinates responses to coroners' recommendations. It provides monthly reports to the Secretary of NSW Health advising of coronial recommendations directed to NSW Health and holds bi-monthly meetings with the Clinical Excellence Commission to consider any recommendations to local health districts and specialty health networks.
- Justice Health and Forensic Mental Health Network's Close the Loop Committee provides oversight of all coronial and Serious Adverse Event Review recommendations and reviews evidence on implementation of recommendations.
- The NSW Police Force Executive is responsible for acknowledging the receipt of coronial recommendations and approving an organisation response to the Attorney General. It creates action items for the necessary steps for implementation allocated to the relevant commands and receives updates on these at regular intervals which it then reports to the Attorney General.
- Youth Justice NSW's Executive Leadership Team is responsible for the implementation, oversight and periodic reporting on coronial recommendations.[413]

4.53 Despite these processes and mechanisms being in place, there were stakeholder concerns about the rate of response by departments and agencies to coronial recommendations. Adjunct Professor Dillon, among others, noted that responses are often late or not provided at all.[414]

4.54 In fact, Legal Aid NSW noted that for the ten inquests in which they appeared in 2019, there are outstanding responses for 18 per cent of the 59 recommendations made. For the five

411 NSW Government, *M2009-12 Responding to Coronial Recommendations*, Premier and Cabinet (31 December 2014), https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/. See also Submission 46, Legal Aid Commission of New South Wales, p 58.

412 Submission 46, Legal Aid Commission of New South Wales, p 57.

413 Submission 18, NSW Government, pp 17-19.

414 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 45; Submission 17, New South Wales Bar Association, p 39; Submission 46, Legal Aid Commission of New South Wales, p 58.

inquests for which they appeared in 2020 where recommendations were made, a response is outstanding for 94 per cent of 35 recommendations.[415]

4.55 Adjunct Professor Dillon noted that the current approach to responding to coroners' recommendations 'reflects a poor understanding of the purposes and potential value of coronial recommendations and responses' and 'inhibits research and development of preventive public policy'.[416]

4.56 Highlighting the importance of responses to recommendations, particularly in the context of First Nations deaths in custody, the National Justice Project referenced the Royal Commission into Aboriginal Deaths in Custody finding that 'to realise any meaningful part of its potential a coronial recommendation must be considered and receive a response'.[417]

4.57 Some inquiry participants considered the Premier' Memorandum to be inadequate in ensuring a response to recommendations for the following reasons:

- it does not have 'the force of law' or mandate a response
- it applies only to government agencies
- only the Attorney General's summary of the responses from agencies is provided to the State Coroner and published, not the responses themselves.[418]

4.58 Several stakeholders highlighted that in New South Wales there is currently no legislative requirement mandating a response to coroners' recommendations, unlike other jurisdictions such as Victoria, the Australian Capital Territory, and Northern Territory.[419] In the view of the National Justice Project, the inability to require a response from government entities is a significant deficiency in the coronial system.[420]

4.59 On this, the Select Committee on First Nations commented that that current coronial system 'lacks concrete mechanisms to hold the relevant government departments … to account in implementing recommendations'. It recommended that the Coroners Act be amended to include a requirement that government departments respond to recommendations within six months, noting the 'action being taken to implement the recommendations, or if no action is taken the reasons why, with this response tabled in NSW Parliament'.[421]

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415 Submission 46, Legal Aid Commission of New South Wales, p 56.

416 Submission 14, Adjunct Professor Hugh Dillon, p 46.

417 Submission 27, National Justice Project, p 22.

418 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 46; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 10; Submission 39, Gilbert + Tobin, p 21; Submission 46, Legal Aid Commission of New South Wales, p 59.

419 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 46; Submission 17, New South Wales Bar Association, pp 40-41; Submission 27, National Justice Project, p 22; Submission 39, Gilbert + Tobin, p 21; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 10; Submission 46, Legal Aid Commission of New South Wales, p 59.

420 Submission 27, National Justice Project, p 22.

421 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), p 151.

4.60 Numerous inquiry participants called for this to be change to be made in legislation, so that responses to recommendations are required to be provided within a set timeframe.[422] In the view of Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies at the University of Sydney, a legislative requirement to mandate a response within a set timeframe 'is the right thing to do in a system which hinges on the espousal of death prevention at its modern heart'.[423]

4.61 Looking to other jurisdictions, the committee received evidence that the *Coroners Act 2008* (Vic) requires that a public statutory body or entity which is the subject of a recommendation must provide a written response within three months after receiving the recommendation, specifying what action, if any, will be taken in relation to the recommendation.[424] There is also a legislative requirement in South Australia to respond to coronial recommendations.[425]

4.62 In the coronial systems in the Australian Capital Territory and Northern Territory, there is a legislative requirement that responses to coronial recommendations be provided to the respective Attorney General within three months. In the Australian Capital Territory, this is for deaths in care and deaths in custody, whereas in the Northern Territory it applies to deaths in custody.[426]

4.63 In terms of the timeframe for responses in New South Wales, some stakeholders recommended a three-month timeframe,[427] while others suggested six months.[428]

422 See, for example, Submission 6, Australian Lawyers Alliance, p 9; Submission 12, Justice Action, p 9; Submission 14, Adjunct Professor Hugh Dillon, p 46; Submission 17, New South Wales Bar Association, pp 41-42; Submission 27, National Justice Project, p 22; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 10; Submission 34, New South Wales Aboriginal Land Council, p 4; Submission 36, Aboriginal Legal Service (NSW/ACT), p 11; Submission 39, Gilbert + Tobin, pp 23-24; Submission 46, Legal Aid Commission of New South Wales, p 58-60; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 6; Submission 57, Public Service Association of New South Wales, p 7; Evidence, Ms Crellin, 30 November 2021, p 14; Evidence, Dr Louis Schetzer, Policy and Advocacy Manager, Australian Lawyers Alliance, 29 September 2021, p 21; Evidence, Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney, 29 September 2021, p 35.

423 Evidence, Dr Scott Bray, 29 September 2021, p 35.

424 Submission 46, Legal Aid Commission of New South Wales, p 59.

425 Submission 39, Gilbert + Tobin, p 22.

426 Submission 17, New South Wales Bar Association, p 40.

427 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 46; Submission 17, New South Wales Bar Association, pp 41-42; Submission 27, National Justice Project, p 22; Submission 36, Aboriginal Legal Service (NSW/ACT), p 11; Submission 46, Legal Aid Commission of New South Wales, p 58-60; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 6; Submission 57, Public Service Association of New South Wales, pp 7.

428 See, for example, Submission 6, Australian Lawyers Alliance, p 9; Submission 12, Justice Action, p 9; Submission 39, Gilbert + Tobin, pp 23-24.

4.64 The National Justice Project argued that there would be several benefits to having a legislative requirement to respond to recommendations:

> Without a legislative mandate, it is difficult to effectively measure the trends and impact of recommendations on public health and the prevention of death and importantly, there is no body designed to do so. Without Coroners being made aware of why recommendations are being ignored, they can't better tailor their future recommendations to increase the chance of implementation and actually improve the reform process and achieve their preventive role. There is also a public interest in the disclosure of government agency and non-governmental responses to recommendations.[429]

4.65 Some inquiry participants also recommended that any legislated requirement to provide a response should apply to all recipients of recommendations, including non-government entities.[430] In this regard, it is important to note that non-government entities, such as private hospitals, correctional centres and aged-care facilities, can currently be the subject of coronial recommendations.[431] Some stakeholders highlighted that deaths resulting from transport, agricultural and industrial accidents often involve non-government entities.[432]

4.66 Gilbert + Tobin highlighted the importance of a legislative requirement extending to non-government bodies 'in light of the increasing privatisation of public functions'. In its view, the requirement should apply to all deaths, not just deaths in custody or care, 'given the coroner's role in ensuring public health and safety'.[433] This view was shared by the NSW Bar Association in its submission which also noted that a deficiency in both the NSW and Victorian systems was that 'coroners do not have statutory power to follow up recommendations'.[434]

4.67 On this point, the Australian Medical Association (NSW) reflected that it 'has been noted that [coronial] recommendations are made without reference to the costs involved in implementing those recommendations'. It suggested that when to comes to recommendations that affect public and private health services and facilities, 'there is a need for recognition of the costs as a part of the process' particularly for matters like the use of equipment, development of new IT systems, information sharing platforms, and the costs involved with education and training for clinicians.[435]

429 Submission 27, National Justice Project, p 23.

430 See, for example, Submission 12, Justice Action, p 9; Submission 14, Adjunct Professor Hugh Dillon, p 45; Submission 17, New South Wales Bar Association, pp 41-42; Submission 27, National Justice Project, p 23; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 10; Submission 34, New South Wales Aboriginal Land Council, p 4; Submission 39, Gilbert + Tobin, p 23; Evidence, Ms Kirsten Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 25.

431 Submission 14, Adjunct Professor Hugh Dillon, p 46.

432 Submission 14, Adjunct Professor Hugh Dillon, p 46.

433 Submission 39, Gilbert + Tobin, p 23.

434 Submission 17, New South Wales Bar Association, p 41.

435 Submission 35, Australian Medical Association (NSW), p 4.

The need for greater oversight of responses to recommendations

4.68 One of the most common issues raised by inquiry participants was the lack oversight of coronial recommendations. In the context of responses often being late or not received at all, or inadequate implementation, stakeholders contended that there is an insufficient oversight or accountability framework in place to monitor responses to and implementation of recommendations, nor the ability to follow up on recommendations to government and non-government entities once an inquest is finalised.[436]

4.69 One individual argued that the prevention contribution to be made by recommendations requires 'proper mechanisms for accountability' rather than the current 'lackadaisical' accountability measures.[437]

4.70 There were several proposals put forward to improve the oversight and accountability of responses to coronial recommendations, including the introduction of:

- a process to enable reporting in Parliament of responses to recommendations[438]
- a power for the Coroners Court of NSW to require a response or further response[439]
- an oversight body to monitor and review responses to recommendations.[440]

4.71 In terms of introducing a process to enable a report to be provided to Parliament on the responses to recommendations, different models were proposed.

- Legal Aid NSW, the Aboriginal Legal Service (NSW/ACT) and the Public Interest Advocacy Centre, among others, recommended that the Coroners Act be amended to enable the tabling of responses to recommendations in Parliament.[441]

436 See, for example, Submission 17, New South Wales Bar Association, p 39; Submission 46, Legal Aid Commission of New South Wales, pp 56-61; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12; Submission 57, Public Service Association of New South Wales, p 7; Submission 48, Lindsay McCabe, p 2; Submission 39, Gilbert + Tobin, p 22.

437 Submission 48, Lindsay McCabe, p 2.

438 See, for example, Submission 17, New South Wales Bar Association, p 40; Submission 46, Legal Aid Commission of New South Wales, p 59; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12.

439 See, for example, Submission 17, New South Wales Bar Association, pp 6 and 41-42; Submission 46, Legal Aid Commission of New South Wales, p 60; Evidence, Adjunct Professor Dillon, 29 September 2021, p 12; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12; Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 4-5.

440 See, for example, Submission 46, Legal Aid Commission of New South Wales, pp 60-61; Submission 48, Lindsay McCabe, pp 2-3; Evidence, Dr Kristina Stern, Chair, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 20.

441 See, for example, Submission 46, Legal Aid Commission of New South Wales, p 59; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12; Evidence, Dr Schetzer, 29 September 2021, p 21; Submission 57, Public Service Association of New South Wales, p 7; Evidence, Ms Crellin, 30 November 2021, p 14; Evidence, Mr Hunyor, 30 November 2021, p 19.

- The Australian Lawyers Alliance proposed that the Coroners Court of NSW should be able to report to Parliament on the progress and implementation of previous recommendations.[442]
- The New South Wales Bar Association supported a requirement for the State Coroner to report to Parliament, through the Attorney General, if no response, or an inadequate response, is received within the time allowed.[443]

4.72 Examples of the ability to report to Parliament in other jurisdictions were discussed.

- In the Australian Capital Territory, if a coroner comments or makes recommendations about issues of public safety, the relevant minister must present the report to the Legislative Assembly and present a response to the report.[444]
- In the Northern Territory, the Attorney General must respond to the coroner's report or recommendations via a report to the coroner which is also tabled in the Legislative Assembly.[445]
- In South Australia, the relevant minister subject to the coronial recommendations must within eight sitting days after a six-month period since receiving the findings and recommendations, table a response in each house of Parliament.[446]

4.73 Adjunct Professor Dillon noted that the Coroners Court of NSW and the NSW Ombudsman both have an inquisitorial function, yet each have different powers in relation to tabling reports in Parliament. The NSW Ombudsman has the power to make reports to Parliament if there is no response or an unsatisfactory response to recommendations.[447]

4.74 By contrast, the Coroners Court of NSW can only report to Parliament annually on investigations of deaths in custody and police operations. Adjunct Professor Dillon recommended that the Coroners Court of NSW report to Parliament every year in relation to all recommendations.[448] Additionally, he recommended that the Coroners Court of NSW should have a power similar to the NSW Ombudsman to report, through the Attorney General, to the Parliament on matters of concern such as persistent failures by government entities to respond, or respond in a timely or adequate way, to coronial recommendations.[449]

4.75 Legal Aid NSW also argued that a mandatory response regime over which there is parliamentary oversight would benefit families involved in the coronial process as well as enhance the Court's death prevention function:

> … provide greater hope to families who take comfort from targeted systemic changes arising after the death of a loved one. It would also enhance the transparency of the

442 Submission 6, Australian Lawyers Alliance, p 9.

443 Evidence, Dr Stern, 29 September 2021, p 20.

444 Submission 17, New South Wales Bar Association, p 40.

445 Submission 17, New South Wales Bar Association, p 40.

446 Submission 17, New South Wales Bar Association, p 41; Submission 39, Gilbert + Tobin, p 22.

447 Submission 14, Adjunct Professor Hugh Dillon, p 47; Evidence, Adjunct Professor Dillon, 29 September 2021, p 12.

448 Evidence, Adjunct Professor Dillon, 29 September 2021, p 12.

449 Submission 14, Adjunct Professor Hugh Dillon, p 47.

> coronial process and the accountability of government agencies, together with providing substantial improvements to the ability of the coronial system to prevent death and injury.[450]

4.76 There was also strong support for the Coroners Court of NSW to be able to require a response or a further response from government and non-government entities to recommendations if required, as a further accountability mechanism.[451]

4.77 In this context, Legal Aid NSW described the current limitations of the Coroners Court of NSW once inquests have been finalised and recommendations delivered:

> … in practice, NSW coroners do not usually follow up on recommendations made in relation to inquests that have been finalised. They are neither empowered nor resourced to do so. This results in a coronial system with limited traction, and without any clear imperative for government agencies to tackle difficult issues raised at inquest.[452]

4.78 As one solution, the NSW Bar Association recommended a broad power be vested in the State Coroner to require a response if one is not filed within a particular timeframe, as well as the power to require a further response if the initial response is inadequate or unsatisfactory.[453] In its view, this power would give the Coroners Court of NSW an ability to ensure that recommendations are actively considered after the finalisation of inquests.[454] The NSW Bar Association also recommended that consideration be given to whether there was an appropriate role for a standing committee of the NSW Parliament to regularly review the adequacy of responses to coronial recommendations.[455]

4.79 Legal Aid NSW, Adjunct Professor Dillon and the Aboriginal Legal Service (NSW/ACT) also supported the introduction of this kind of 'follow-up' power.[456] Legal Aid NSW and the Aboriginal Legal Service (ACT/NSW) noted that a requirement to call for further explanations and information, including reports on action taken regarding recommendations, would be consistent with the recommendations of the Royal Commission into Aboriginal Deaths in Custody.[457]

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450 Submission 46, Legal Aid Commission of New South Wales, p 61.

451 See, for example, Submission 17, New South Wales Bar Association, pp 6 and 41-42; Submission 46, Legal Aid Commission of New South Wales, p 60; Evidence, Adjunct Professor Dillon, 29 September 2021, p 12; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12; Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 4-5.

452 Submission 46, Legal Aid Commission of New South Wales, p 60. See also Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 4-5.

453 Submission 17, New South Wales Bar Association, pp 6 and 41-42. See also Evidence, Dr Stern, 29 September 2021, p 20.

454 Submission 17, New South Wales Bar Association, p 42.

455 Submission 17, New South Wales Bar Association, pp 6 and 42.

456 Evidence, Adjunct Professor Dillon, 29 September 2021, p 12; Submission 36, Aboriginal Legal Service (NSW/ACT), pp 11-12; Submission 46, Legal Aid Commission of New South Wales,

457 p 60.

Submission 36, Aboriginal Legal Service (NSW/ACT), p 10; Submission 46, Legal Aid Commission of New South Wales, p 60.

4.80 Acknowledging the practical challenges potentially associated with this approach, the Aboriginal Legal Service (NSW/ACT) also suggested the introduction of change in process which would enable the coroner to deliver preliminary findings after an investigation, finalising the court process but the not entirely closing the matter. This would allow entities subject to recommendations a set amount of time to respond and give the coroner the power to call for further explanation or information, if required. Under this proposal, the matter would become finalised once the coroner delivers final findings and recommendations. The Aboriginal Legal Service (NSW/ACT) argued that this process would provide more certainty for families and increase the level of accountability for implementation of recommendations.[458]

4.81 Different proposals were also made about the appropriate body or entity to monitor compliance with the requirement to respond to and implement recommendations, including:

- oversight by a standing parliamentary committee[459]
- establishment of an in-house specialist research and data unit akin to the Coroners Prevention Unit in Victoria (discussed below)[460]
- establishment of an independent Ombudsman office.[461]

Improving access to and transparency of recommendations and responses

4.82 As noted above, the Department of Communities and Justice website has a list of the status of responses to recommendations and, where applicable, the response to the recommendation.[462] Coroners' recommendations are also published on the Coroners Court of NSW website.[463]

4.83 Despite these methods of publication, a number of stakeholders raised concerns related to the accessibility of this information, with some commenting that recommendations and responses are not provided together on a user-friendly website.[464]

4.84 In particular, the format in which the responses are published and the timeliness of their publication was a concern. Dr Scott Bray noted that the recommendations are uploaded annually onto the webpage, accessible via 'clunky' word documents, one which displays the recommendations and the responses in alphabetic order of the deceased's name, and the other which sets out coroners' findings and recommendations by categories.[465] Adjunct Professor

458 Answers to question on notice, Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT), pp 4-5.

459 Evidence, Dr Stern, 29 September 2021, p 20.

460 Submission 46, Legal Aid Commission of New South Wales, pp 60-61.

461 Submission 48, Lindsay McCabe, pp 2-3.

462 Submission 46, Legal Aid Commission of New South Wales, p 57.

463 Submission 17, New South Wales Bar Association, p 39.

464 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 4; Submission 12, Justice Action, p 12; Submission 14, Adjunct Professor Hugh Dillon, pp 45-46; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 6; Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney, 29 September 2021, p 35.

465 Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney, 29 September 2021, p 35.

Dillon also commented that responses to recommendations are not always linked to the recommendation in a timely manner.[466]

4.85 Adjunct Professor Dillon suggested a 'more logical repository' for responses to coronial recommendations on the Coroners Court of NSW website where they can be linked to the relevant coronial finding and recommendation.[467] Looking to the accessibility of recommendations and responses in other jurisdictions, the NSW Bar Association referenced the Victorian approach where recommendations and responses are found on the Coroners Court of Victoria website.[468]

4.86 With the objective of enhancing transparency and public scrutiny, the NSW Bar Association and Adjunct Professor Dillon supported the publication of recommendations and responses on the Coroners Court of NSW website in a more accessible and transparent manner.[469]

Specialist research and data support

4.87 In addition to enhancing the death prevention function exercised by coroners, as has been the focus of the first part of this chapter, many stakeholders supported the need for greater research and data analysis capacity within the court, to assist coroners with broader investigations into trends and systemic issues.

4.88 Stakeholders reflected on the current capacity of the Coroners Court of NSW in this area, particularly in terms of research assistance provided to coroners when undertaking inquests. The NSW Bar Association noted that coroners' current resources include *ad hoc* research by the legal team assisting the coroner and evidence from expert witnesses.[470]

4.89 In this regard, Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW, contended that complex inquests are conducted by under-resourced coroners with little support:

> Effectively, what we have in New South Wales is regional magistrates virtually running no inquests at all and overworked deputy State coroners and the State Coroner with very little or no research support—in fact, no research support that I am aware of—who are required to run these large inquest matters.[471]

4.90 The NSW Bar Association noted that increasingly complex inquests are being held, often involving more than four parties and simultaneously investigating multiple deaths, such as inquests into deaths at music festivals, deaths in quad bike accidents, deaths due to drug overdoses and multiple rock-fishing deaths.[472]

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466 Submission 14, Adjunct Professor Hugh Dillon, pp 45-46.

467 Submission 14, Adjunct Professor Hugh Dillon, pp 45-46.

468 Submission 17, New South Wales Bar Association, p 39, citing *Coroners Act 2008* (Vic), s 72.

469 Submission 14, Adjunct Professor Hugh Dillon, p 46; Evidence, Dr Stern, 29 September 2021, p 20. See also Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 6.

470 Submission 17, New South Wales Bar Association, p 31.

471 Evidence, Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW, 29 September 2021, pp 17-18.

472 Submission 17, New South Wales Bar Association, p 30.

4.91 As a result, and in the view of Adjunct Professor Dillon, systemic issues such as these 'are investigated reactively and sometimes serendipitously' when trends are identified by individual coroners.[473]

4.92 Regarding the development of recommendations, Mr Jonathon Hunyor, Chief Executive Officer at the Public Interest Advocacy Centre, explained that in some instances, individuals or organisations involved in coronial matters can take on more of an 'intervener' or 'amicus curiae' role and make submissions on systemic issues and recommendations.[474]

4.93 Another key mechanism contributing to the death prevention objective is the analysis and review of data received through the process of reportable deaths. Adjunct Professor Dillon stated that 'a public health approach to death prevention has at its central tenet data collection and analysis of key data, and systemic reform'.[475] Given that in 2020, 6,374 deaths were reported to the Coroners Court of NSW but an inquest was held for less than two per cent of cases, Adjunct Professor Dillon noted that the 'public health value' of this data to strengthen the death prevention objective of the Court 'has not been understood well' and is being 'wasted'.[476]

4.94 With respect to the use of and access to coronial data, the NSW Bar Association and Legal Aid NSW, among others, explained that the Coroners Court of NSW is inadequately resourced to collect and analyse coronial data, including inquest findings and recommendations, so as to inform intervention strategies to reduce or prevent future deaths.[477]

4.95 This was supported by evidence from the Department of Communities and Justice which noted that the Court's case management system is 'not purpose built for data extraction or analysis', providing the following reasons.

- The data must be manually entered by registry staff, impacting timeliness and accuracy.
- As hard copy files are the primary record of the proceeding, not all information from the hard copy file are entered into the case management system due to 'manual processing and system limits'.
- The case management system is used across NSW courts and is not purpose built for coronial proceedings, meaning it is not capable of capturing some information which is unique to the inquisitorial nature of the coronial jurisdiction.[478]

4.96 The NSW Government submission noted that the National Coronial Information System, a national database, 'supports the work of coroners, investigators, researchers and the broader

473 Submission 14, Adjunct Professor Hugh Dillon, Appendix E, p 50.

474 Evidence, Mr Hunyor, 30 November 2021, p 19.

475 Submission 14a, Adjunct Professor Hugh Dillon, p 5.

476 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 40; Submission 14a, Adjunct Professor Hugh Dillon, p 4; Submission 18, NSW Government, p 12.

477 See, for example, Submission 12, Justice Action, p 15; Submission 14, Adjunct Professor Hugh Dillon, p 40; Submission 14a, Adjunct Professor Hugh Dillon, p 4; Submission 17, New South Wales Bar Association, p 31; Submission 41, Mr Michael Barnes, p 5; Submission 46, Legal Aid Commission of New South Wales, p 61.

478 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, pp 2-3.

community' by providing reports on a request basis and data reporting to support court governance and caseload management.[479]

4.97 The database includes coronial data from Australia and New Zealand, and is accessible to death investigators (coroners, registrars, court staff and police) and researchers.[480] For those with 'a bona fide interest or professional role in public health and safety or a statutory requirement to collect and publish data', requests for access can be granted.[481]

4.98 The National Coronial Information System is governed by a Board of Management and administration is provided by the Victorian Department of Justice and Community Safety.[482] Together all Australian states and territories, the Commonwealth and New Zealand fund this database. In 2020-21, the annual contribution from NSW was $165,008.[483]

4.99 Regarding the quality and range of data, Adjunct Professor Dillon argued that 'the database is only as valuable as the data provided to it' and that the 'NSW coronial system presents as one of the least efficient in Australia in providing full sets of coronial data to the national database'. In his view, the New South Wales data in this database is 'sub-optimal' due to the following challenges and deficiencies.

- With respect to police reports, regional Local Courts often do not provide the police report of death to the database.
- The manner of death is determined in NSW only if an inquest is held. As such, the database receives coroners' findings in relation to the manner of death in only two per cent of all reportable death received by the Coroners Court of NSW. This data gap cannot reliably be filled by the information from the police report of death because, as noted above, they are often not provided to the database from regional Local Court matters.
- The provision of the police report, autopsy report, toxicology report and coroners findings to the database can lack coordination as they are from multiple agencies.[484]

4.100 Justice Action, an organisation who represents people in institutions and their families who are impacted by deaths in custody, noted some limitations of the National Coronial Information System. From a user-perspective, Justice Action commented that when searching the database, the effectiveness of a search in obtaining results relies on the use of broad and generalised search terms. Moreover, the result of searches can be limited if the searcher is not granted full access to all the information held by the National Coronial Information System.[485]

4.101 With respect to public access to the data, the National Coronial Information System operates a search tool called 'Fatal Facts' which provides access to coronial recommendations from

479 Submission 18, NSW Government, p 6.

480 Submission 14, Adjunct Professor Hugh Dillon, p 56; Submission 18, NSW Government, p 6.

481 National Coronial Information System, *Data access*, https://www.ncis.org.au/data-access/.

482 Submission 12, Justice Action, p 15.

483 Submission 18, NSW Government, p 6.

484 Submission 14a, Adjunct Professor Hugh Dillon, pp 5-6.

485 Submission 12, Justice Action, p 15.

Australian states and territories for closed coronial cases since 2000.[486] Justice Action contended that from its experience in using the search engine, it is not regularly updated and may not include all coronial recommendations.[487]

4.102 Relevant to the discussion about research and data, the NSW Government noted that the Coroners Court of NSW collects and reviews data on certain categories of deaths:

> The coronial jurisdiction is engaged in a number of initiatives intended to identify systemic issues arising across particular categories of death. This contributes to policy developments aimed at improving service responses to prevent future loss of life.[488]

4.103 In particular, stakeholders acknowledged the significant intervention and prevention contribution made by the Domestic Violence Death Review Team since it was established in the Coroners Court of NSW in 2010, which is discussed in the case study below.[489]

Case study: The Domestic Violence Death Review Team[490]

Deaths occurring in the context of domestic violence are subject to review by the Domestic Violence Death Review Team, as established by Chapter 9A in the *Coroners Act 2009* (NSW). This team is convened by the State Coroner and includes statutory members from relevant government agencies and non-government organisations. The secretariat comprises two experts in data collection and qualitative review.

The functions of the Domestic Violence Death Review Team include:

- to review closed cases of domestic violence deaths occurring in New South Wales
- to analyse data to identify patterns and trends relating to such deaths
- to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths
- to establish and maintain a database (in accordance with the regulations) about such deaths
- to undertake, alone or with others, research that aims to help prevent or reduce the likelihood of such deaths.

486 National Coronial Information System, *Fatal Facts*, https://www.ncis.org.au/research-and-publications/fatal-facts/.

487 Submission 12, Justice Action, p 15.

488 Submission 18, NSW Government, p 9.

489 See, for example, Submission 14a; Adjunct Professor Hugh Dillon, p 4; Submission 18, NSW Government, p 9; Submission 27, National Justice Project, p 33; Submission 46, Legal Aid Commission of New South Wales, pp 62-63.

490 Submission 46, Legal Aid Commission of New South Wales, pp 63-4.

With respect to open cases, the Domestic Violence Death Review Team provides expert advice on domestic and family violence in open coronial cases. It also operates a database and conducts research aiming to prevent or reduce domestic violence deaths. In addition, it provides biannual reports to Parliament, reports to which the NSW Government has publicly responded.

4.104 Adjunct Professor Dillon also noted the establishment of the Suicide Register in October 2020, which is an inter-agency project by the NSW Health, Department of Communities and Justice and NSW Police Force, responsible for collecting and reporting on suspected and confirmed suicides in NSW.[491]

4.105 In addition, the State Coroner must report annually to the Attorney General and NSW Parliament on mandatory inquests into deaths in custody as per section 23 of the *Coroners Act 2009* (NSW). In 2021, the State Coroner also presented a report on First Nation's Deaths in Custody in NSW for the period 2008-2018.[492]

4.106 In terms of data collection and analysis on other categories of deaths, Legal Aid NSW also highlighted the NSW Ombudsman's role in reviewing the deaths of people with a disability and certain child deaths.[493]

4.107 Despite these measures, some stakeholders contended that improvements to data collection and analysis for the purposes of systemic reform are needed, particularly in relation to certain categories of deaths such as for deaths by suicide.[494]

4.108 Similarly, Legal Aid NSW recognised the missed opportunity to maximise the contribution that death review could have to inform death prevention and reduction:

> As a result, much of the good work being undertaken in inquests does not result in publicly available research to inform prevention and reduction of deaths such as those in custody, deaths as a result of police operations, and deaths from suicide, drug overdose or sub-standard healthcare.[495]

4.109 In this regard, several inquiry participants argued that the capacity of the Coroners Court of NSW to examine systemic issues and death prevention should be enhanced and resourced.[496] According to Mr Barnes, additional funding for data analysis would improve the system's contribution to death prevention:

491 Submission 14, Adjunct Professor Hugh Dillon, p 67.

492 Submission 18, NSW Government, pp 9-10.

493 Submission 14a, Adjunct Professor Hugh Dillon, p 4; Submission 46, Legal Aid Commission of New South Wales, pp 62-63.

494 See, for example, Submission 22, Lynda Newnam, pp 2-4 ; Submission 27, National Justice Project, p 26.

495 Submission 46, Legal Aid Commission of New South Wales, p 61.

496 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, pp 1-2; Submission 14, Adjunct Professor Hugh Dillon, p 40; Submission 17, New South Wales Bar Association, p 15; Submission 47, Legal Aid NSW, p 18.

> If the system were better funded … more analysis could identify trends in various types of deaths and more effort could be devoted to understanding the factors contributing to them and their prevention.[497]

4.110 There was wide support for the establishment of an in-house specialist research and data unit akin to the Coroners Prevention Unit in Victoria, which is discussed in the case study below.[498]

Case study: The Coroners Prevention Unit

One of the objectives of the *Coroners Act 2008* (Vic) is to 'contribute to the reduction of the number of preventable deaths … through the making of recommendation by coroners'.[499] To assist this purpose, the Victorian Government established the Coroners Prevention Unit within the Coroners Court of Victoria.

This unit was the first of its kind is Australia, comprising a multidisciplinary team of specialists who support coroners to strengthen their death prevention function by identifying patterns and trends, to aid coroners in the development of evidence-based and practical preventative recommendations.[500]

There are five sub-teams in the unit: health and medical; mental health and disability; family violence; research and data; and the knowledge and management team.[501] The Victorian Family Violence Death Review and management of the Victorian Suicide Register are located within the unit. As at 20 June 2021, there were 21.4 full-time equivalent staff in the Coroner's Prevention Unit, with a headcount of 30 people.[502]

The goals of the Coroners Prevention Unit are to improve the quality and applicability of coronial recommendations, increase the uptake and implementation of coronial recommendations and contribute to the reduction of preventable deaths in Victoria.

497 Submission 41, Mr Michael Barnes, p 5.

498 See, for example, Submission 12, Justice Action, p 4; Submission 14, Adjunct Professor Hugh Dillon, p 40; Submission 17, New South Wales Bar Association, p 31; Submission 23, Public Interest Advocacy Centre, p 4; Submission 27, National Justice Project, pp 11 and 33; Submission 46, Legal Aid Commission of New South Wales, pp 60-64.

499 *Coroners Act 2008* (Vic), s 1(c).

500 Submission 14a, Adjunct Professor Hugh Dillon, p 5.

501 Submission 14, Adjunct Professor Hugh Dillon, p 61.

502 Coroners Court of Victoria, Annual Report 2020-21 (2021), https://www.coronerscourot.vic.gov.au/sites/default/files/2021-10/Coroners%20Court%20of%20Victoria%20-%20Annual%20Report%20-%202020-21.pdf.

The Coroners Prevention Unit reviews a range of reportable and reviewable deaths, collects and analyses data relating to those deaths, assists coroners with the development of prevention-focused recommendations and receives and publishes coronial recommendations.[503]

The unit may contribute at any stage of the coronial process, including:

- when a death is first reported – advice can be used by coroners to decide the direction of the investigation, ensure essential evidence is obtained and identify prevention opportunities relevant to an individual or group of similar cases
- in the development of recommendations – advice to coroners on the nature and extent of risk factors, evidence on countermeasures, identify relevant stakeholders who may be affected by any recommendations, information on legislation, standards, codes of practice and similar or previous cases and recommendations
- in the finalisation of recommendations – under the direction of coroners, engage with stakeholders to ensure proposed recommendations are reasonable, viable and likely effective
- after recommendations have been made – receiving and collecting information on the responses and implementation of recommendations.[504]

Throughout the 2020-21 reporting period, the Coroners Prevention Unit received 647 referrals from coroners about deaths under investigation. The advice coroners sought input on included:

- the circumstances in which the death occurred, including factors that may have contributed to the outcome
- the frequency of previous and subsequent similar deaths in Victoria, and common risk factors
- previous interventions that have been proved or are suspected to reduce the incidence of future similar deaths
- regulations, standards, codes of practice or guidelines that might be relevant to reduce similar deaths
- previous coronial recommendations and other feasible, evidence-based, recommendations to reduce similar deaths.[505]

503 Submission 46, Legal Aid Commission of New South Wales, p 62. See Coroners Court of Victoria, Coroners Prevention Unit, https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cpu%2B6pp%2Bdl%2B2013%2Blr.pdf.

504 See Coroners Court of Victoria, Coroners Prevention Unit, https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cpu%2B6pp%2Bdl%2B2013%2Blr.pdf.

505 Coroners Court of Victoria, Annual Report 2020-21 (2021), https://www.coronerscourt.vic.gov.au/sites/default/files/2021-10/Coroners%20Court%20of%20Victoria%20-%20Annual%20Report%20-%202020-21.pdf.

Additionally, the Coroners Prevention Unit conducts research projects to assist coronial investigations, in order to achieve a better understanding of preventable deaths in Victoria and identify intervention opportunities.[506]

4.111 Stakeholders considered that a similar unit in New South Wales would greatly assist coroners and improve the quality of coronial services delivered in New South Wales. Such a unit would:

- collect, aggregate and analyse data, including findings and recommendations, to identify emerging patterns, trends and systemic issues[507]
- provide research support to coroners and *ad hoc* advice to other agencies[508]
- assist coroners in developing evidence-based and prevention-focused recommendations[509]
- monitor and inform policy and systemic change in relation to deaths in custody, particularly First Nations deaths[510]
- monitor and follow up on recommendations after they have been delivered, to promote action by government agencies and non-government bodies.[511]

4.112 In supporting the creation of this type of unit, the Australian Lawyers Alliance also expressed support for the establishment of a specialist death review team 'to monitor and inform policy and systemic change for all deaths in custody, particularly Aboriginal and Torres Strait Islander deaths'.[512] In this regard, the committee noted evidence from Adjunct Professor Dillon on the Domestic Violence Death Review Team, which he reflected 'is a very good example of how coronial data can be aggregated and analysed for public health and safety purposes'.[513]

4.113 The committee also notes the evidence of Domestic Violence NSW not only as to the importance of the Domestic Violence Death Review Team and the work it does, but also for the need to strengthen the accountability measures in the system and, specifically, improving

506 See Coroners Court of Victoria, Coroners Prevention Unit, https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/cpu%2B6pp%2Bdl%2B2013%2Blr.pdf.

507 See, for example, Submission 14, Adjunct Professor Hugh Dillon, p 40; Submission 12, Justice Action, p 4; Evidence, Mr Hunyor, 30 November 2021, p 19; Evidence, Mr Evenden, 29 September 2021, pp 17-18.

508 Submission 17, New South Wales Bar Association, p 46.

509 See, for example, Submission 6, Australian Lawyers Alliance, p 8; Submission 23, Public Interest Advocacy Centre, p 3; Submission 27, National Justice Project, pp 11 and 33; Submission 46, Legal Aid Commission of New South Wales, p 64; Evidence, Mr Hunyor, 30 November 2021, p 19.

510 Submission 27, National Justice Project, p 11.

511 See, for example, Submission 46, Legal Aid Commission of New South Wales, p 64; Submission 23, Public Interest Advocacy Centre, p 4.

512 Submission 6, Australian Lawyers Alliance, p 8.

513 Submission 14a; Adjunct Professor Hugh Dillon, p 4.

the oversight of responses to coronial findings. This point is dealt with below in several recommendation, particularly recommendation 13.[514]

Committee comment

4.114 The Coroners Court of New South Wales is uniquely placed to play a pivotal role in the prevention of future deaths. Unfortunately, the evidence demonstrates that this critical role of the Court is currently constrained. Not only does the structure and resources of the Court limit the capacity of coroners to focus on its death prevention objective, the Coroners Act itself has deficiencies which limit the scope of inquests and recommendations being made on systemic issues contributing to deaths.

4.115 The committee agrees that the objects of the legislation should be amended to reflect that the prevention of future loss of life is a central tenet of modern coronial practice. We agree with Adjunct Professor Dillon and other stakeholders that the legislation needs to have as a key object the purpose of the Court in contributing to the reduction of preventable deaths. We also support amendments which would enable a broader number of factors to be taken into account when functions under the Coroners Act are being exercised, including those which emphasise the centrality of the experience and needs of bereaved families, as well as those that express respect for families and cultural diversity. Such provisions are found in the legislation in Victoria and other jurisdictions.

Recommendation 10

That the NSW Government review and propose amendments to the objects of the *Coroners Act 2009* (NSW) 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.

4.116 The committee acknowledges that bereaved families look to the coronial system for answers about what happened to their loved ones and the circumstances of their death. We recognise that the decision of whether to hold an inquest or not is critical in families' eyes.

4.117 While we accept that a coroner will provide reasons in cases where an inquest is dispensed with, and that families can have some input into the process, we acknowledge that families may view the process as quite unsatisfactory, given reasons are generally confined to the statutory objects of the Act and review and appeal options are limited. On this latter point, we note that the options for appealing a decision are in practice limited due to the prohibitive costs of commencing action in the Supreme Court.

4.118 In considering further options which could be introduced to address this issue, we see merit in the model used in Victoria and Queensland where findings can still be made even in matters where an inquest is not held. We caution that although findings without inquest may present efficiencies, it would not be an appropriate option in all cases and there will always be cases where a full inquest is the most appropriate investigative process.

514 Submission 60, Domestic Violence NSW, p 2.

4.119 Nonetheless, the committee envisages that there may be certain categories of death for which findings without inquest could comfort bereaved families in ascertaining more information about the circumstances of the death. It would potentially also supplement the number of cases for which the manner of death can be examined and reflected in data and reviews.

4.120 In our view, this option would be best exercised by experienced and specialist coroners in a sufficiently resourced coronial jurisdiction. It may not be as well suited to the current hybrid structure of the Coroners Court of NSW. Therefore, the committee recommends that the NSW Government consider amending the *Coroners Act 2009* (NSW) to introduce a power for coroners to make findings without inquest.

Recommendation 11

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a power for coroners to make findings without inquest.

4.121 With regard to the scope of coronial inquests and the findings and recommendations which come from them, the evidence to this inquiry leads us to repeat the comments made in the report on the high level of First Nations people in custody and oversight and review of deaths in custody that there appears to be an inconsistent approach to investigating broader systemic issues.

4.122 In the First Nations report, the committee recommended that the Coroners Act stipulate that the Coroner is required to examine whether there are systemic issues in relation to a death in custody, in particular for First Nations people, with the coroner provided with the power to make recommendations for system wide improvements. We support this recommendation and consider that it should apply to all deaths investigated by the Coroners Court. Coroners should examine whether systemic issues played a role leading to any death, and have clear power to make recommendations that may prevent future loss of life.

4.123 The committee also agrees that, for the reasons set out in the First Nations report, coroners should be required to make findings on whether the implementation of any recommendation of the *Royal Commission into Aboriginal Deaths in Custody* report could have reduced the risk of death in all cases where a person has died in custody.

Recommendation 12

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to require coroners to examine whether systemic issues played a role leading to any death, including:

- an explicit power to make such recommendations as the coroner considers necessary or desirable, including in relation to any systemic issues connected with a death, suspected death, fire or explosion
- a requirement to consider and report on whether the implementation of any recommendation of the *Royal Commission into Aboriginal Deaths in Custody* report could have reduced the risk of death in all cases where a person died in custody.

4.124 Turning now to the effectiveness of coronial recommendations and accountability and transparency concerns regarding implementation of recommendations. The committee agrees that for the impact of a recommendation to be realised, there must be a system in place which supports them to be effectively and efficiently considered and implemented.

4.125 In this regard, we are disappointed that some, perhaps many, recommendations do not receive an adequate or timely response, if any. If preventing future deaths is central to the coronial jurisdiction, there are missed opportunities.

4.126 In our view, consistent with the recommendation from the inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, there must be a legislative requirement for every agency and body to which a recommendation is addressed to respond within a certain timeframe. While the committee considers that reducing the required timeframe from the current six months to three months would be highly desirable, it is doubtful whether such a change would result in any practical benefit. Instead, the committee has focussed on strengthening other accountability requirements.

4.127 To this end we consider that responses to coronial recommendations should indicate what action is being taken to implement those recommendations or, if no action is to be taken the reasons for this should be stated. Responses to coronial recommendations, or any failures to respond within the time required, should be communicated to and tabled in Parliament. We also agree that there would be benefit in expanding the powers of the State Coroner to report to the NSW Parliament on any issues they see fit, including the progress and implementation of previous recommendations as well as matters of concern such as failures to respond, or respond in a timely or adequate way, to recommendations.

Recommendation 13

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to improve the accountability of responses to recommendations, including:

- 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

4.128 In addition to responses being tabled in NSW Parliament, the committee recommends that all findings, recommendations and responses be published in a timely fashion on the Coroners Court of NSW's website, in an accessible manner.

Recommendation 14

That the Coroners Court of New South Wales, in consultation with key stakeholders, enhance its website to ensure coronial findings, recommendations and responses to recommendations are published in an accessible manner.

4.129 As suggested by the NSW Bar Association in its submission, the committee does consider that there would be a useful role for a standing committee of the NSW Parliament to regularly review the adequacy of responses to coronial recommendations. It is considered that the current joint committee on the Law Enforcement Conduct Commission, the Ombudsman and Crime Commission would be a suitable body to undertake such work.

Recommendation 15

That the Parliament of New South Wales widen the remit of the joint parliamentary committee on the Law Enforcement Conduct Commission, the Ombudsman and Crime Commission so that it regularly reviews the adequacy of responses to coronial recommendations.

4.130 The committee also heard during this inquiry the limited research support provided to coroners in open death investigations and inquests. In particular, we note that the State Coroner and Deputy Coroners do not have research staff or support and are not well placed to conduct reviews into the vast data received by the Court on reportable deaths. Indeed, we heard anecdotally that coroners have to undertake their own research, even for highly specialised or complex matters, all in the context of high workloads. We are also concerned that there could be better use of the repository of coronial data held by the Court.

4.131 If we approached this differently and armed coroners with better research support, the functions of the Court in looking at systemic issues could be significantly enhanced. In this regard, the committee had the benefit of visiting the Coroners Court of Victoria in February 2022 and were given a comprehensive briefing by the Victorian State Coroner, Deputy State Coroners and staff from the Coroners Prevention Unit. We are grateful for having had this opportunity to learn about the strengths and operation of that unit.

4.132 In our view, the work and output of the Coroners Prevention Unit in Victoria is impressive, and a strong example of the benefits that can be achieved through specialised collection, analysis and review of research and data. To support an expanded legislative scope to examine systemic issues and prevent future deaths, we consider a similar specialist preventive death review unit should be established in New South Wales, to better facilitate coroners in fulfilling their important death prevention function. We believe that this type of unit would assist coroners in the direction of an investigation when a death is first reported, as well as in the development and finalisation of prevention-orientated recommendations.

4.133 With regard to the function of collecting, analysing and reviewing a range of reportable deaths data, the committee acknowledges the data analysis already being undertaken by the Domestic Violence Death Review Team. The capacity of the Coroners Court of NSW should be enhanced to expand the processes already established for the Domestic Violence Death Review Team, so that in-depth qualitative analysis of a much broader range of reported deaths can be undertaken, including First Nations deaths, deaths by suicide and drug-related deaths. Enhancing the system

in this way would enable improved analysis of the effectiveness of various approaches, which will inform targeted prevention initiatives and other reform measures that may be appropriate.

4.134 As noted by stakeholders, when coronial recommendations are delivered years after a death, they often lose their impact and relevance. In our view, a specialised review system could specifically address this issue as insights into systemic issues and trends, for example, could be shared in real time with stakeholders.

4.135 Adjunct Professor Dillon, for whose work and contributions to this inquiry we are very grateful, emphasised that a key tenet to death prevention is data collection, analysis of key data and systemic reform. A specialist preventive death review unit would undoubtedly assist coroners in exercising their functions in a timely fashion, and the benefits of this unit could be especially harnessed if the court becomes a specialist court, as we recommended in the previous chapter.

Recommendation 16

That the NSW Government establish and fund a specialist preventive death review unit in the Coroners Court of New South Wales which:

- is modelled on the goals and functions of the Coroners Prevention Unit in the Coroners Court of Victoria
- expands on the processes of the NSW Domestic Violence Death Review Team to undertake in-depth qualitative analysis of a broad range of reported deaths, including but not limited to First Nations deaths, domestic violence deaths, suicide deaths and drug-related deaths.

4.136 The committee also considered whether domestic violence deaths should be included as mandatory for inquests, given the continued high incidence of deaths connected to domestic relationships; mainly of women at the hands of their current or former spouse or domestic partner. After some reflection, the committee formed the view that the work of the Domestic Violence Death Review Team fulfils substantially the same public policy objective and in many ways is more comprehensive than an inquest.

4.137 However, the committee also notes the observation of Domestic Violence NSW that only two members of the Domestic Violence Death Review Team are from non-government providers. The committee does consider that the membership of the team should be expanded to include more non-government front line service providers, who would have a wealth of knowledge and experience to being to bear on the work of the team.

Recommendation 17

That the NSW Government ensure the membership of the Domestic Violence Death Review Team is expanded to include more non-government service providers.

Chapter 5 Support and information for families

> The Coronial Inquest Process must be made more inclusive, respectful to the families involved, personalised and relevant to individual circumstances. This may include taking into account ethnicity, religious beliefs, financial constraints, disability access, as well as special circumstances that may apply to a particular family. There should not be a "one size fits all," approach. These families must be treated as human beings primarily, but their individual and personal circumstances must form part of the equation. Respect is paramount.
>
> - Leesa Topic, mother of Courtney Jayde Topic[515]

This chapter focuses on families' experience of the coronial process. It starts by exploring the level of involvement families have in coronial proceedings and their access to information. It also looks at a range of other issues, including the impact of delays and access to counselling, legal and financial support. Towards the end, the chapter considers the ability of the Coroners Court of NSW to respond to the needs of culturally and linguistically diverse and First Nations families and communities.

Families' experience of the coronial jurisdiction

5.1 Throughout the inquiry the committee heard directly from family members who have firsthand experience of the coronial jurisdiction. Generally, their evidence highlighted how the coronial system can be complicated, confusing and emotionally challenging to navigate.

5.2 In a literature review report on the experience of Aboriginal and Torres Strait Islander Families in Australian Coroners Courts attached to the submission provided by the Legal Aid Commission of New South Wales (Legal Aid), it was noted that:

> The very nature of these types of deaths and the uncertainty surrounding the details may cause a compounding of grief and re-living or re-traumatising process for families involved with the coronial system. This requires sensitivity and consideration for families in order to not add to their distress.[516]

5.3 There was also evidence that the coronial system may provide a healing opportunity for families after a devastating loss. The National Justice Project stated that the 'coronial jurisdiction has a unique role in investigating the circumstances that lead to a death. This can be the ultimate opportunity to provide truth, healing, closure and justice to families'.[517] Adjunct Professor Hugh Dillon, a former NSW Deputy State Coroner, described that the coronial system 'seeks, or hopes for, certain outcomes, such as reducing the distress of relatives by providing answers to questions they have about the cause or circumstances of death'.[518]

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515 Submission 11, Leesa Topic, p 1.

516 Submission 46, Legal Aid Commission of New South Wales, Attachment 1, Law and Justice Foundations of New South Wales, *Aboriginal Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences* (2021), p 5.

517 Submission 27, National Justice Project, p 5.

518 Submission 14, Adjunct Professor Hugh Dillon, p 37.

5.4 Ms Leesa Topic, mother of Courtney Jayde Topic who died after being shot by police in February 2015, told the committee that in spite of numerous delays and challenges the family faced, they were appreciative of what the coronial inquest was able to achieve:

> Ten recommendations came out of the Inquest. In response to the Findings, and in speaking to Police Commissioner Mick Fuller, he assured us that nine out of ten of the recommendations had been implemented and the tenth was in progress. We are eternally grateful to all concerned for this positive outcome that will prevent another family going through the trauma and loss that we do and will continue to do for our lifetime.[519]

5.5 The New South Wales Bar Association also identified a number of studies which have shown that inquests can be both a negative and positive experience for families, with one notable Australian study acknowledging that coronial investigations:

> … sought to identify systemic failures, assisted family members with understanding why the fatality occurred. This information enabled healing process to begin as family members sensed that justice had finally been achieved for their loved one.[520]

5.6 This section will consider families' experience in the coronial process, which is relevant to considering whether the coronial system is best serving the needs of bereaved families. In particular, it will look at the legal basis for families to participate in the coronial process and whether access to key information is provided. It will also consider the provision of social, counselling, legal and financial support to family members of the deceased.

Role of families in the coronial process

5.7 Although families can and often do participate in the coronial process, stakeholders reflected on the limits of the legislation in capturing the importance and extent of their involvement.

5.8 Reference was made to section 57 of the *Coroners Act 2009* (NSW) (Coroners Act) which permits coroners to grant families the right to participate in coronial proceedings:

> The coroner in coronial proceedings may grant leave to any person, who in the opinion of the coroner has a sufficient interest in the subject-matter of the proceedings, to appear in person in the proceedings or to be represented by an Australian legal practitioner.[521]

5.9 Stakeholders also drew the committee's attention to the role of the senior next of kin in the coronial process, including the definition under 6A which states that the senior next of kin can be:

- the deceased person's spouse, or

519 Submission 11, Leesa Topic, p 9.

520 Submission 17, New South Wales Bar Association, p 16, citing Mark Ngo, Lynda R Matthews, Michael Quinlan, and Philip Bohle, 'Bereaved family members' views of the value of coronial inquests into fatal work accidents (2021) 82(3) *Omega-Journal of Death and Dying,* pp 446-466.

521 *Coroners Act 2009* (NSW), s 57(1).

- if the deceased person did not have a spouse – any of the deceased person's children who are adults, or
- if the deceased person did not have a child – either of the deceased person's parents, or
- if the deceased person did not have living parents – any of the deceased person's brothers or sisters who are adult, or
- if the deceased person did not have brothers or sisters – any person who is named as executor of the deceased person's will or the deceased person's legal representative.[522]

5.10 Gilbert + Tobin highlighted that although families involved in the coronial process are generally 'the people most deeply affected by its investigation', the Coroners Act has limited provisions which relate to families, often only requiring the coroner to consider the view of the senior next of kin.[523] In this regard, sections 25 and 96 of the legislation require the coroner to consider the views of the senior next of kin in relation to dispensation of inquests and post-mortem examinations.[524]

5.11 In relation to the forensic post-mortem examination of the deceased, the Department of Communities and Justice explained that the senior next of kin is supported through this initial process by a specialist social worker from the Forensic Medicine Social Work service.[525]

5.12 Reflecting on the legal basis for families' involvement, Legal Aid NSW stated that the Coroners Act lacks provisions to 'cement the importance of families'.[526] Likewise, the Jumbunna Institute of Indigenous Education and Research, Research Unit (Jumbunna) contended that 'there remains an unclear standing for families throughout the coronial death investigation process'.[527]

5.13 In making this point, Jumbunna noted that the family of a deceased are generally granted leave to be a party to an inquest, whereas this legal basis does not translate to family engagement with the investigation phase, which can be 'central to the determination of the scope of an inquest'.[528]

Impact of delays

5.14 As was expressed during the inquiry of the select committee inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody (Select Committee on First Nations), many stakeholders were concerned that delays in coronial cases compound and prolong the trauma and grief experienced by families. Evidence to the inquiry showed that delays can cause uncertainty, stress and anxiety for families, prolonging the mourning and

522 *Coroners Act 2009* (NSW), s 6A.

523 Submission 39, Gilbert + Tobin, p 20.

524 *Coroners Act 2009* (NSW), ss 25 and 96. See also Submission 39, Gilbert + Tobin, pp 20-21.

525 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 11.

526 Submission 46, Legal Aid Commission of New South Wales, p 20.

527 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 12.

528 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit p 12, citing Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2020), pp 37-38.

healing process.[529] As stated by Adjunct Professor Dillon in the submission he made to Select Committee on First Nations, delays in a coronial case create several stresses for families:

> Studies have demonstrated that lengthy delay in conducting inquests causes significant distress to bereaved families. The attrition of evidence, financial strain and prolonged grieving, as well as the enforced experience of recounting information years after a fatal event are of particular concern.[530]

5.15 This was confirmed via the testimony provided by Mr Ron and Mrs Leesa Topic, who experienced delays with the coronial system after the death of their daughter Courtney. There was a three year wait for investigations to be completed before an inquest date was set. Following the inquest, there was an additional wait for some months before the findings were handed down. The Topic family stated that 'the disjointedness of the whole process' added to their trauma:

> There was no conscious thought for timeliness in decisions made, throughout the process. This of course, factored into the decline of our mental and emotional wellbeing. Those that were involved with us throughout the journey were all the utmost professional. They completed the specified role that was assigned them. It was quite disconcerting though when you'd go into the Court for a hearing and a date still hadn't been assigned. We went to Inquest just over three years after Courtney was shot dead. We couldn't begin to grieve the loss of our Courtney throughout this period as we were constantly going over and through everything again and again.[531]

5.16 Another individual who shared their first-hand experience of the coronial system with the committee, Ms Susan Slatcher, commented on the impact of the lengthy delays experienced during the inquest into her son's death:

> Investigating police indicated that the Inquest would be held eighteen months to two years after my son's death. We had several delays prior to the COVID pandemic and the Inquest wasn't held until February of this year. This was not only due to the onset of COVID, but also delays by various legal teams in presenting their evidence on time and other factors. The Inquest has been held, but over four years later we are waiting for the Coroner to make her findings. These delays have been very stressful for all the family and we feel that we can't reach closure while we don't know these findings.[532]

5.17 With particular regard to First Nations families, it was highlighted by some inquiry participants that delays compounded by insufficient support and information can exacerbate an already existing distrust in a system which at times is 'culturally unsafe'.[533] In this respect, in his

529 See, for example, Submission 34, New South Wales Aboriginal Land Council, pp 2-3; Submission 36, Aboriginal Legal Service (NSW/ACT), p 7; Submission 39, Gilbert + Tobin, p 17; Submission 33, Katie Lowe, p 8; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 6; Evidence, Dr Louis Schetzer, Policy and Advocacy Manager and National Manager, Australian Lawyers Alliance, 29 September 2021, p 21.

530 See, for example, Submission 9, The Law Society of New South Wales, Appendix 1, p 17. See also Submission 46, Legal Aid Commission of New South Wales, p 28.

531 Submission 11, Leesa Topic, p 8.

532 Submission 44, Susan Slatcher, p 1.

533 See, for example, Submission 27, National Justice Project, p 19; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9.

submission to the Select Committee on First Nations, Adjunct Professor Dillon placed delays in coronial matters in the context of First Nations people's experience with racism and relationship with the justice system:

> It may be even more traumatic for Indigenous families. In addition to their losses of loved ones, they have, as a people, always had troubled relationships with courts and a justice system imposed on them. Delay, which is endemic in the NSW coronial system, must afflict them with an added burden of grief and perhaps amplify their sense of injustice.
>
> For people whose historical experience has been one of racism and disrespect, it must be difficult to interpret lengthy delay in the coronial system in any other way than as a lack of recognition of their human worth and dignity as a people, and perhaps as a sign of disrespect to them personally.[534]

5.18 In terms of the length and impact of delays, Jumbunna described the delays in the coronial system as 'obscene' and as having a harmful impact on families by 'cutting off opportunities to mourn and delaying answers to critical questions about how their loved one died'.[535]

5.19 A number of other inquiry participants also highlighted the adverse impacts of delays on families. The Australian Lawyers Alliance was concerned about the 'distress and trauma to grieving families' caused by delays, as was the Royal Australian and New Zealand College of Psychiatrists.[536] In its submission, Legal Aid NSW highlighted the impact of delays on families when combined with a lack of information:

> Families involved in the coronial process frequently experience difficulties and delays in getting information about the circumstances surrounding their loved one's death. Timelines provided to families are vague, and they are often left to repeatedly make requests for information about a loved one's death, and updates on the progress of a case.
>
> …
>
> Typically, there have been delays of three or four years and more before many inquests are heard and findings delivered. This delay causes undue distress to family members. A further complication of existing arrangements is that family members engaged in the inquest process are usually not given timely access to information. They wait for extended periods, often without any access to brief materials or an adequate understanding of what took place in relation to the death of their loved ones.[537]

534 Submission 9, The Law Society of New South Wales, Appendix 1, pp 17-18.

535 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9.

536 Submission 6, Australian Lawyers Alliance, p 7; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 6.

537 Submission 46, Legal Aid Commission of New South Wales, p 34.

5.20 At a hearing, Mr David Evenden, Solicitor Advocate from the Coronial Inquest Unit at Legal Aid NSW, commended the attitude of families even when subject to lengthy delays:

> I have represented some families who have been through terrible experiences who somehow are incredibly respectful of the process and are able to deal with the massive delays and the sort of inadequacies that exist.[538]

Access to information and coronial documents

5.21 Alongside the impact of delays on families, stakeholders also discussed the adequacy of information communicated to families throughout the coronial process and the challenges associated with accessing coronial documents.

5.22 Legal Aid NSW was a key voice on this issue, highlighting that families involved in the coronial process often experience difficulties and delays in getting information about the circumstances of their loved one's death. It stated:

> Timelines provided to families are vague, and they are often left to repeatedly make requests for information about a loved one's death, and updates on the progress of a case. Requests for evidentiary material, including expert reports, are often denied pending the acquisition of further material, despite all material being ultimately available to them in a brief of evidence.[539]

5.23 In relation to delays in receiving the brief of evidence, Legal Aid NSW reported that a brief may not be made available to the family or their representatives until four to six weeks before the inquest, often containing many volumes of information. Consequently, it has been the experience of Legal Aid NSW that in these instances the family does not have sufficient time to discuss the evidence and, therefore, are unable to prepare and engage meaningfully in the process.[540]

5.24 Legal Aid NSW noted that various studies have reflected on the impact a lack of information can have on families. In particular, it highlighted from one study this statement:

> These studies revealed that families were concerned and frustrated by infrequent updates, a poor understanding of their rights and whether an inquest would be held, and delays that prolonged stress and impaired witness memory. Families valued inquests, and perceived a sense of justice or enhanced trust in the outcomes, when: (a) provided direct access to previously inaccessible evidence, (b) treated with greater respect than in other investigations, (c) permitted to raise opinions or questions in the inquest directly or through legal representation, or (d) the inquest revealed previously unidentified systemic failings that contributed to the death.[541]

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538 Evidence, Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid Commission of New South Wales, 29 September 2021, p 19.

539 Submission 46, Legal Aid Commission of New South Wales, p 34.

540 Submission 46, Legal Aid Commission of New South Wales, pp 30-31.

541 Submission 46, Legal Aid Commission of New South Wales, p 34, citing Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10(2322) *Frontiers in Psychology*, p 3.

5.25 Legal Aid NSW stated that it was aware that material that could be provided immediately to families is not provided for a year or more after it has been given to the Crown Solicitors Office and the coroner. A large component of any brief is material that could be provided immediately to families because it is unlikely to change and is unlikely to attract protective orders. This includes medical records, witness statements, electronic materials and, when available, expert reports.[542] With delays and the late provision of materials to family members, Legal Aid NSW stressed the need for family members to be kept informed of key developments and the detail of any investigation, stating this is 'paramount to the success of the coronial system'. In this respect, it called for strict requirements to be placed on the provision of information to family members.[543]

5.26 Relevant to this, Legal Aid NSW discussed how families can access coronial documents, including statements by witnesses, transcripts, and written findings. It noted section 65 of the *Coroners Act 2009* (NSW) which sets out the circumstances in which a coroner can provide access to a coronial file, including the factors to be considered when making a determination as to whether it is appropriate to grant a person access to a file.[544]

5.27 Legal Aid NSW also noted various practice notes issued by the Coroners Court of NSW over the last few years which have included provisions related to access to information for family members. It highlighted how these practice notes have been limited in application:

- Coronial Practice Note 1 of 2018 included no requirement to provide brief material to family
- Coronial Practice Note 2 in 2018 was limited to mandatory inquests involving critical incident investigations
- Coronial Practice Note 3 of 2021 was also limited to mandatory inquests under section 23 and did not contain a specific requirement to provide families with comprehensive information and brief material at an early stage, although it does recognise the importance of providing families information and updates.[545]

5.28 Legal Aid NSW stressed to the committee that 'family members want detailed information from an early stage about the death of a loved one, including documents and electronic materials'.[546] It also contended that the Coroners Act should be amended, or Practice Notes issued, which place the onus on coroners to provide relevant material to family of the deceased 'as soon as it is available unless there are compelling reasons to delay or not provide the information'.[547]

5.29 For First Nations families involved in section 23 mandatory death in custody inquests, the *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (First Nations Protocol) has in its objects the principle that families should be provided with information in a timely manner, and regular updates regarding the status of the coronial investigation, including advice in relations to delays. Families in these cases are allocated within

542 Submission 46, Legal Aid Commission of New South Wales, p 34.

543 Submission 46, Legal Aid Commission of New South Wales, p 35.

544 *Coroners Act 2009* (NSW), s 65.

545 Submission 46, Legal Aid Commission of New South Wales, p 35.

546 Submission 46, Legal Aid Commission of New South Wales, p 36.

547 Submission 46, Legal Aid Commission of New South Wales, p 37.

48 hours an Aboriginal Coronial Information and Support Program Officer who is responsible for providing information about the purpose of the coronial process. This officer also provides information and options for legal representation and can help to communicate cultural and ceremonial considerations.[548]

5.30 Additionally, in section 23 mandatory death in custody inquests, the solicitor assisting the coroner, in consultation with the Aboriginal Coronial Information and Support Program Officer, must ensure that the family or their legal representative is kept informed about the progress of the coronial investigation regularly, which is specified to be at a minimum every two months. Families must also be provided with updates following the completion of the stages of the coronial process and be advised of any delays and reasons for those delays.[549]

5.31 The committee understands that after materials are filed with the Coroners Court they are then supplied to the Crown Solicitor's Office or Department of Communities and Justice Legal to determine if there are any omissions requiring additional information, reports or statements, or any sensitive matters requiring protective orders. The brief is then returned to the Coroners Court when finalised.

5.32 Some stakeholders discussed the approach taken by the Victorian and Queensland coronial jurisdictions in ensuring family members are kept properly supported and informed throughout the coronial process.

5.33 In Victoria, section 115 of the *Coroners Act 2008* (Vic) governs access to documents, and Practice Note 2 of 2011 ensures that the registrar must provide the senior next of kin with any post-mortem reports, and any interested party with an inquest brief.[550]

5.34 As part of its statutory purpose, the *Coroners Act 2008* (Vic) emphasises the importance of communications with grieving families. Section 8(d) states 'that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation'.[551]

5.35 Legal Aid NSW also pointed to the *Queensland State Coroners Guidelines 2013* which guarantee families be given 'adequate and timely information about their loved one's death in order for them to participate meaningfully'. The Guidelines state:

> Families of deceased persons should not be denied information about the death just because it has been reported to the coroner. The general principle is that the families are entitled to any and all information concerning the death as soon as it is available unless there is a basis for suspecting that to release the information may compromise a criminal investigation.[552]

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548 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cls 3.1(c) and 7.2(c).

549 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cl 9.1.

550 Submission 46, Legal Aid Commission of New South Wales, p 37.

551 *Coroners Act 2008* (Vic), s 8(d).

552 Submission 46, Legal Aid Commission of New South Wales, p 36, citing Coroners Court Queensland, State Coroner's Guidelines 2013, *Chapter 2 The rights and interests of family members* (2013), pp 4-5.

5.36 Legal Aid NSW submitted that the Victorian and Queensland coronial jurisdictions 'provide a strong example of the care and attention that is required to ensure family members are kept properly informed'.[553]

5.37 Adjunct Professor Dillon also highlighted the approach taken in the New Zealand's coronial system. The New Zealand Coronial Services website states that 'families can be involved as much as they want to be', with families having 'a right to be kept informed'. Section 23 of the *Coroners Act 2006* (NZ) also specifically provides that coroners must give notice of 'significant matters' to interested parties.[554]

Access to social support and counselling

5.38 Concerns were also raised about the level of social support and counselling provided to families. Legal Aid NSW noted the limited availability of counselling and support for families involved in the coronial system is a gap in services raised by its clients.[555] It did, however, acknowledge the initial counselling provided by the NSW Health Pathology's Forensic Medicine Service to families dealing with an unexpected or sudden death, although it noted that once a post-mortem procedure is finalised 'there is no handover to any ongoing counselling or support service for families'.[556]

5.39 Dr Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine at NSW Health Pathology, addressed concerns regarding bereaved family members' support needs. Dr Brouwer acknowledged the work of Forensic Medicine social workers who 'liaise closely with families whose loved ones are referred to the Coroner and provide compassionate support for viewing of deceased and identification'.[557] According to Dr Brouwer there are 14 social workers employed by Forensic Medicine, which she stated 'reflects a recent increase in staffing of 25 per cent'.[558]

5.40 Dr Brouwer also drew the committees attention to a 2019 Forensic Medicine report which identified key service issues and improvement opportunities:

> In 2019 Forensic Medicine published a social work model of care, which informs all aspects of support provided to bereaved families. At Forensic Medicine, we are committed to delivering a world-leading service in support of bereaved families across New South Wales to provide the answers and support they need.[559]

5.41 Forensic Medicine's appointment of additional social workers and the introduction of the new model of care were also noted by the NSW Government's *Improving the Timeliness of Coronial*

553 Submission 46, Legal Aid Commission of New South Wales, p 37.

554 Submission 14, Adjunct Professor Hugh Dillon, p 54.

555 Submission 46, Legal Aid Commission of New South Wales, p 39.

556 Submission 46, Legal Aid Commission of New South Wales, p 39.

557 Evidence, Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service, 30 November 2021, p 40.

558 Evidence, Dr Brouwer, 30 November 2021, p 40.

559 Evidence, Dr Brouwer, 30 November 2021, p 40.

Procedures Taskforce (Timeliness Taskforce) as initiatives to improve communication and support to families.[560]

5.42 Legal Aid NSW also referred to the assistance provided by the Coronial Information and Support Program at the Coroners Court of NSW, noting it is limited to providing practical information about the inquest process, court familiarisation and access to viewing of sensitive material, with no capacity for individual counselling or ongoing support services.[561]

5.43 Likewise, Ms Tracey Mackander, who was involved in the coronial investigation into her son Bailey's death, also commented on the 'real lack of support and counselling' provided by the Coroners Court, highlighting that the Coronial Information and Support Program does not provide ongoing support or counselling to families.[562]

5.44 The committee received further evidence on this issue by family members who have been directly involved in the coronial process. Ms Slatcher spoke of her distress when unexpected and disturbing evidence was presented at the inquest into her son's death. Observing that there was a 'lack of emotional support for the family by [the] court based counsellors', Ms Slatcher added: 'The family were sometimes shocked and distressed by some of the unexpected evidence, and having support during those times would have made things easier'.[563]

5.45 Mrs Leesa Topic echoed this view, highlighting how witnesses involved in inquests may also benefit from support. Reflecting on the inquest into her daughter Courtney's death, and the experience of other witnesses, Mrs Topic stated:

> I know of some of those witnesses are extremely traumatised and had to source their own counselling and psychological help. Some of those witnesses have since contacted us to offer their sympathies and to share the trauma that they have experienced and continue to experience.[564]

5.46 Mrs Topic detailed to the committee her experience in getting support throughout the coronial investigation into her daughter Courtney's death, as outlined in the case study below.

Case study: Death of Ms Courtney Jayde Topic[565]

Ms Courtney Jayde Topic died as a result of a police shooting in February 2015. An inquest into her death was held in March 2018. Courtney's parents, Mr Ron Topic and Mrs Leesa Topic, provided a submission to the inquiry and gave evidence at a hearing, where they shared their experience of the coronial process, including the support provided by the Court.

560 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), pp 13-15.

561 Submission 46, Legal Aid Commission of New South Wales, p 39.

562 Submission 40, Tracy Mackander, p 5.

563 Submission 44, Susan Slatcher, p 1.

564 Submission 11, Leesa Topic, p 6.

565 Submission 11, Leesa Topic, pp 2-3; Evidence, Mrs Leesa Topic, 30 November 2021, pp 6-7.

In the initial stages they felt 'excluded from the process' and were distressed and frustrated about the initial lack of communication from police during the investigation. Mr and Mrs Topic also noted that they were not informed of legal and social work services until many months into the coronial process.[566]

The Topic family highlighted that after many months, they found support in a Forensic Medicine social worker who they described as going 'above and beyond' in providing support. Mrs Topic stated:

> This lady got permission from her superiors to stay with us throughout our journey and she sat with us through the nine days of the Coronial Inquest. I cannot emphasise the importance of this beautiful person and the impact that she had on us, at one of the most traumatizing and vulnerable times of our lives. She was also our connection to the Coronial Inquest Process.

Mrs Topic explained that this same social worker supported them throughout the entire inquest process, which was over three years – a service which was well beyond the standard scope and level of support provided by Forensic Medicine social workers.[567] Mrs Topic explained that this was possible as their social worker was granted departmental approval to continue supporting the family through the inquest process:

> She was part of the forensic side of the Coroners Court. She was there to meet and greet us. We were there to identify Courtney and that is where her jurisdiction had stopped. She was to meet and greet us, she was to comfort us and she was to give us support during that process and then that was to be the end. But we sort of took an attachment to her in that horrific moment of our lives and she saw the stress and distress that we were in and she took it upon herself to be in our lives for the next three years through part of the whole process.[568]

In terms of the support provided, Mrs Topic noted that the social worker provided regular counselling over the phone and in person, communicated with them about progress of the autopsy and explained reasons for delay. She also provided a tour of the courtroom prior to the inquest hearing, attended each day of the inquest hearing with them and supported the family by being with them when viewing sensitive evidence.

5.47 In terms of improving the support provided to families, Legal Aid NSW called for the provision of counselling and ongoing support to all families involved in the coronial process. It noted that in the Australian Capital Territory a free Coronial Counselling Service is offered by Relationships Australia and is available during the coronial process and for up to three months after it has concluded. In this context, Legal Aid NSW emphasised how profound and distressing a death can be for families, and how debriefing and support is necessary post-inquest.[569]

566 Evidence, Mrs Topic, 30 November 2021, p 2.

567 Evidence, Mrs Topic, 30 November 2021, pp 6-7.

568 Evidence, Mrs Topic, 30 November 2021, p 7.

569 Submission 46, Legal Aid Commission of New South Wales, p 39.

5.48 The Royal Australian and New Zealand College of Psychiatrists also commented on the limited mental health support available to bereaved families involved in coronial inquests. The College submitted that 'the Forensic Social Work service should be adequately resourced to seek referral to psychiatrists to manage grief when considered warranted'.[570]

5.49 Relevant to how families are best supported throughout the coronial process, some stakeholders reflected on the benefits that could be achieved if the coronial system was to adopt a more therapeutic and trauma informed approach.

5.50 Ms Katie Lowe, an intern at Jumbunna who completed a research thesis on First Nations experience in the coronial system and therapeutic jurisprudence, urged the committee 'to consider the potential applicability of therapeutic jurisprudential principles and practices, that aim to consider the way in which the court can minimise trauma for involved persons'.[571] As outlined by Ms Lowe, 'therapeutic jurisprudence aims to promote reflective practices within legal settings and emphasises consideration for the wellbeing of legal participants'.[572]

5.51 Similarly, the Australian Lawyers Alliance stated that 'there is a need for the NSW coronial system to adopt a more therapeutic, trauma-informed care approach within the conduct of the coronial processes so that these processes do not further traumatise grieving families and communities'.[573]

5.52 This sentiment was echoed by the NSW Bar Association, who discussed the implementation of therapeutic jurisprudence within the coronial system through the use of an 'empathetic and imaginative use of flexible procedures' at the inquest into the suspected death of Ben Dominick. This was a missing person case in a very remote community. As the NSW Bar Association explained: 'Evidence was taken using walk through and recorded evidence from witnesses at the scene, as well as by roundtables in court'. This unique approach taken by State Coroner O'Sullivan and counsel assisting was reported to be ' … both forensically and professionally rewarding. It is an example of how adapting processes in the coronial jurisdiction can enhance both the core and therapeutic functions of the jurisdiction'.[574]

Access to legal representation

5.53 A common concern of inquiry participants was the lack of legal assistance available for families involved in coronial proceedings. As noted by Gilbert + Tobin, there is 'no general provision of legal assistance'.[575]

5.54 In 2006, Legal Aid NSW established the Coronial Inquest Unit to provide free advice and assistance in coronial matters. The Coronial Inquest Unit also represents families of the

570 Submission 30, The Royal Australian and New Zealand College of Psychiatrists, pp 3-4.

571 Submission 33 Katie Lowe, p 18.

572 Submission 33, Katie Lowe, p 11.

573 Submission 6, Australian Lawyers Alliance, p 7.

574 Submission 17, New South Wales Bar Association, p 17, quoting Ann Bonnor 'Changing the landscape: inquest into the disappearance of Ben Dominick' (2021), *The Journal of the NSW Bar Association,* https://barnews.nswbar.asn.au/autumn-2021/40-changing-the-landscape-inquest-into-the-disappearance-of-ben-dominick/.

575 Submission 39, Gilbert + Tobin, p 18.

deceased in coronial inquests. Legal Aid NSW noted in its submission that many families have benefited from the expertise of the Coronial Inquest Unit 'as they navigate the complex and emotionally draining experience of inquest proceedings'.[576]

5.55 Mr David Evenden, Solicitor Advocate from the Coronial Inquest Unit at Legal Aid NSW, highlighted the value legal representation brings to families in the coronial process:

> For a family, having a lawyer means they have a voice. They can get answers in this foreign and often bewildering system. Legal representation of families brings integrity and vigour to the process and serves an important therapeutic role.[577]

5.56 Ms Slatcher provided a submission to the inquiry which reflected on the value of legal representation during the inquest into the death of her son in 2017:

> Having legal representation at my son's Inquest proved to be extremely important. The Legal Aid team thoroughly investigated all the evidence and kept us up to date. The decisions and submissions were made after a lot of consultation with the family and we feel very lucky to have been represented by such a caring and empathetic team.[578]

5.57 According to Legal Aid NSW, of the 220 inquests that were completed in 2018 and 2019, families were represented in just one-third. Of these families, '40% were represented by the Coronial Inquest Unit, or their legal representation was funded by Legal Aid NSW'.[579] Mr Evenden stated that there is a need for better resourcing for legal representation for families within the coronial system.[580]

5.58 As noted in correspondence from the Department of Communities and Justice, unless an inquest falls under section 23 or section 24 of the *Coroners Act 2009* (NSW), families have two options to access legal representation: either they apply for Legal Aid, or if the family do not meet the requirements for Legal Aid, they seek legal representation at their own expense.[581]

5.59 Stakeholders highlighted that it is often prohibitive to obtain private legal representation, and there are very few legal services that provide free legal representation to families. Gilbert + Tobin explained that obtaining Legal Aid is only possible in limited circumstances: a family member must meet the Legal Aid means test, the inquest must be in the public interest, or the inquest must relate to a First Nations person who died in custody.[582]

5.60 Mr Mark Levenson noted the struggle to access legal support during the inquest into the death of his son Matthew:

> As novices to this process it was put to us that we should have some form of legal representation for the family during the course of the inquest. Fearing the Inquest may carry on beyond the two weeks set down and the daily cost of lawyers, we sought legal

576 Submission 46, Legal Aid Commission of New South Wales, p 12.

577 Evidence, Mr Evenden, 29 September 2021, p 14.

578 Submission 44, Susan Slatcher, pp 1-2.

579 Submission 46, Legal Aid Commission of New South Wales, p 13.

580 Evidence, Mr Evenden, 29 September 2021, p 14.

581 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 25.

582 Submission 39, Gilbert + Tobin, p 18.

> aid. We did not qualify, as our income and assets breached the threshold for assistance NOR was it considered a public interest matter.[583]

5.61 Many families who cannot afford a lawyer attend inquests without legal representation. As Gilbert + Tobin stated, 'if families cannot find accessible legal representation at inquests, there is a power imbalance in the inquest, that cannot be easily remedied'. For disadvantaged families, or those where English is not their first language, these problems are magnified.[584]

5.62 Unlike Legal Aid NSW, the Aboriginal Legal Service (NSW/ACT) has no dedicated coronial unit and represents First Nations families predominantly in mandatory section 23 deaths in custody inquests. The Aboriginal Legal Service (NSW/ACT) acknowledged that there is no government funding to provide comprehensive legal support for First Nations people to help navigate the coronial system:

> The ALS does not receive funding to represent families in coronial inquiries despite an ever-increasing demand for representation. In 2021 alone, to date, 9 Aboriginal and Torres Strait Islander people across Australia have died in custody or in a police operation. All those deaths will require mandatory inquests. In order for the Court to function, all parties involved need to be adequately resourced to appear.[585]

5.63 Reflecting on the adequacy of access to legal assistance and representation for families involved in coronial proceedings, Mr Evenden stated:

> Legal Aid and the Aboriginal Legal Service do not have the resources they need to adequately provide proper representation and assistance to all families who require it. It is highly likely that Aboriginal people through New South Wales are over-represented in deaths reported to the Coroner. Much more can be done to cater for those from culturally and linguistically diverse communities and, in particular, the many Aboriginal people who come into contact with the coronial system … It is a sign of a civilised society that it is willing and able to review certain deaths, especially avoidable deaths, and learn from its mistakes; more so, that it is willing to support the families of those who die in avoidable or unusual circumstances, giving them hope that some change may come about with the death of their loved one.[586]

5.64 Additionally, Mr Evenden stated that the best solution for many families was early engagement with ' … lawyers that are culturally competent'. He advocated for the Aboriginal Legal Service (NSW/ACT) to be provided with additional staffing and resources to manage more than just section 23 mandatory inquests.[587]

5.65 The Aboriginal Legal Service (NSW/ACT) also recommended an increase in funding for its services so as to 'provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes'.[588]

583 Submission 15, Mark Leveson, p 1.

584 Submission 39, Gilbert + Tobin, p 18.

585 Submission 36, Aboriginal Legal Service (NSW/ACT), pp 1 and 7.

586 Evidence, Mr Evenden, 29 September 2021, p 14.

587 Evidence, Mr Evenden, 29 September 2021, p 19.

588 Submission 36, Aboriginal Legal Service (NSW/ACT), pp 15-16.

Access to financial support

5.66 Another area of concern raised in evidence to this inquiry was the lack of financial assistance provided to families to attend and participate in inquests.

5.67 Aboriginal Legal Service (NSW/ACT) stated that 'there are also significant social, emotional and financial costs to families being able to meaningfully engage and participate in the coronial process'.[589] Similarly, Legal Aid NSW noted that the expenses associated with transport, accommodation, time off work, childcare, counselling and food can hinder participation in the coronial process. Inquests often last a week or more, and as Legal Aid NSW noted, these expenses can be 'an unfair a burden on families'.[590] Similar evidence was given in the First Nations inquiry.[591]

5.68 Legal Aid NSW advised that Corrective Services NSW can reimburse accommodation costs for inquests involving a death in custody but for all other matters, except where a family member has been subpoenaed to give evidence, there is usually no reimbursement for accommodation and travel. This can result in disadvantaged families facing challenges in actively participating in the coronial process.[592]

5.69 Alison Whittaker, Senior Researcher at the Jumbunna Institute of Indigenous Education and Research, also spoke about the practical barriers and expenses which prevent First Nations families from participating in the inquest process:

> A lot of these inquests for the more complex and serious matters, especially the First Nations deaths in custody, go for up to two weeks—the period that is extraordinarily difficult in which to get a large group of people who might comprise that about that person's kin and loved ones. It is very difficult to find that kind of accommodation at late notice, extraordinarily expensive, and very difficult to organise that transport. There is nothing systematic about that support and it relies a lot on community goodwill that is already is so, so stretched.[593]

5.70 Professor Megan Williams, Head of Girra Maa Indigenous Health Discipline at the University of Technology Sydney, emphasised that the costs associated with participating in the coronial process are not only financial, but also associated with time and wellbeing:

> We must note that this comes at a cost. Those costs are not borne or considered – that is, financial costs if people take time off work, child care, costs to health and wellbeing, as well as to participation in other elements of community life that others then have to take on, or that there are gaps when that occurs. We need to not only pay but to cover those broader costs and urgently think through practical strategies to do that.[594]

589 Submission 36, Aboriginal Legal Service (NSW/ACT), p 16.

590 Submission 46, Legal Aid Commission of New South Wales, p 40.

591 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), p 139.

592 Submission 46, Legal Aid Commission of New South Wales, p 40.

593 Evidence, Ms Alison Whittaker, Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit, 29 September 2021, p 36.

594 Evidence, Professor Megan Williams, Head of Girra Maa Indigenous Health Discipline at the University of Technology Sydney, 29 September 2021, p 36.

5.71 This sentiment was echoed by Dr Scott Bray, Associate Professor of Criminology and Socio-Legal Studies at the University of Sydney, who noted that 'the cost is acutely felt in other areas: missed work due to illness and bereavement, delays which compound trauma and pain for years in the lives of families'.[595]

5.72 Adjunct Professor Newhouse referenced one recent case study of the family of Gomeroi man Tane Chatfield, who were forced to fundraise in order to attend the inquest. According to Adjunct Professor Newhouse: 'when families are from remote, rural and regional communities, these expenses include accommodation and transport for often-lengthy inquests and often-large groups'.[596]

5.73 As noted by the National Justice Project, resources must be allocated to implement reforms in order to ensure that families are supported to actively participate in the coronial process, including 'overcoming financial and geographic barriers to participation, particularly for families from remote and regional communities who face significant transport and accommodation costs, which can be considerable for "lengthy inquests and often large groups"'.[597]

5.74 Jumbunna and Aboriginal Legal Service NSW/ACT called for relevant organisations, including their organisations, to be funded to provide financial assistance and holistic support to First Nations families facing an inquest. Jumbunna explained that funds would be used to meet the logistical expenses associated with the coronial process.[598]

Cultural considerations

5.75 A number of the submissions to the inquiry highlighted the need for improvements and reforms to the coronial jurisdiction in New South Wales in order to meet the needs of First Nations people and culturally and linguistically diverse communities.

The needs of First Nations families and communities

5.76 In the Select Committee on First Nations' report, stakeholders gave evidence that the coronial system lacked cultural considerations within its structure and processes to create a culturally safe process for First Nations families. Stakeholders called for the coronial system to adopt more therapeutic, culturally safe processes and approaches.[599]

595 Evidence, Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney, 29 September 2021, p 29.

596 Submission 28, Adjunct Professor George Newhouse, p 7.

597 Submission 27, National Justice Project, p 20, quoting George Newhouse, Daniel Ghezelbash and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76, p 83.

598 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 19; Submission 36, Aboriginal Legal Service (NSW/ACT), p 15.

599 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), pp 136 and 138-142.

5.77 In evidence to this inquiry, the National Justice Project emphasised that First Nations peoples' participation in the Coroners Court must be viewed in the context of the wider justice system. The National Justice Project, along with other participants, noted that since colonisation First Nations people have been subjected to institutionalised trauma and systemic oppression.[600] As such, as noted by Justice Action, many First Nations families experience re-traumatisation during the coronial process due to the lack of cultural sensitivity, lengthy delays, absence of spiritual customs and rituals, and the 'dissonance between the demands for justice and the statutory limitations of the Coroners Court'.[601]

5.78 Legal Aid NSW highlighted that First Nations people continue to be overrepresented in nearly every category of death reported to the Coroners Court of NSW. In spite of this, it stated that New South Wales is one of two jurisdictions in Australia with a Coroners Act which does not include any provisions that specifically address cultural considerations for First Nations people.[602]

5.79 Without specific legislative requirement to accommodate cultural needs, the National Justice Project noted that First Nations families are forced to rely on coroners' discretion to incorporate cultural customs and ensure protocols are adhered to.[603]

Culturally sensitive protocols

5.80 Justice Action submitted that current coronial processes fail to address cultural concerns regarding the respectful treatment of First Nations people. Justice Action stressed the importance of integrating culturally sensitive protocols within the coronial process. It stated:

> Coronial inquests fail to accommodate cultural and religious concerns regarding the respectful treatment of bodies of the deceased. For instance, bodies are often subject to an autopsy prior to the family having seen the body of the deceased and without consent. This can be particularly traumatising for those Aboriginal and Torres Strait Islander families who seek to uphold religious or cultural practices which require them to refuse an autopsy or deliver a more timely burial.[604]

5.81 The National Justice Project contended that the ability of the Corners Court of NSW to fulfil cultural obligations are an important part of the healing process for families and can show respect for the deceased. It noted instances in which cultural protocols were appreciated by the families, including the family of Maori and Cook Islander man Jack Kokaua who were able to perform the Haka during the final tranche of the inquest, and the family of Dunghutti man

600 Submission 27, National Justice Project, pp 16-17. See also, Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 6; Submission 33, Katie Lowe, p 5; Submission 34, New South Wales Aboriginal Land Council, p 4; Submission 38, Deadly Connections Community & Justice Service, p 3.

601 Submission, 12 Justice Action, p 10, citing George Newhouse, Daniel Ghezelbash and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76, p 89.

602 Submission 46, Legal Aid Commission of New South Wales, pp 52-53.

603 Submission 27, National Justice Project, p 27.

604 Submission 12, Justice Action, p 10.

David Dungay Jr, who were able to organise a smoking ceremony outside of the Coroners Court.[605]

5.82 However, the National Justice Project also reflected on the concerns expressed by the Kokaua and Dungay families with respect to the failure to accommodate cultural and religious protocols related to the treatment of bodies of the deceased.[606]

5.83 Related to this, Legal Aid NSW commented that the provisions of the Coroners Act relating to exhumations and objections to the exercise of post-mortems do not require the coroner to take into account cultural considerations. It noted that to its knowledge, there are no guidelines and publications from the Coroners Court or Forensic Medicine on post-mortem processes and issues relating to cultural considerations. In its experience, many of the grievances experienced by First Nations people related to families contact with Forensic Medicine shortly after a death. To address this, Legal Aid NSW recommended that Forensic Medicine, in consultation with the State Coroner 'develop a publicly available guideline that deals with post-mortem issues including in relation to cultural considerations'.[607]

5.84 Likewise, the National Justice Project recommended that 'forensic pathologists be specifically trained on First Nations people's cultural practices to do with bodies and how to respect those practices'. More generally, the National Justice Project called for amendments to the Coroners Act to 'specifically accommodate and respect cultural needs and considerations' at all stages of the coronial process, which includes cultural practices at inquest hearings and in relation to the body of the deceased. It also recommended amendments to the definition of senior next of kin to recognise 'the plurality of personal and kinship interests that make up First Nations families'.[608]

5.85 In its submission, the NSW Government stated that it is committed to improving the coronial jurisdiction to ensure processes are culturally safe and respectful, and to prevent future loss of life for First Nations people. The NSW Government outlined the efforts it had made to respect cultural requests such as 'smoking ceremonies, memory collation, painting, and placing of important possessions with the deceased person'.[609]

5.86 The Coroners Court of NSW has also appointed two Aboriginal Coronial Information and Support Program Officers, and stated in correspondence to the committee that it is focusing on strategies for improving consultation with First Nations people and peak bodies.[610]

5.87 As noted above, the First Nations Protocol commenced in April 2022 and as noted above in paragraph 5.29 and contains provisions relevant to culturally sensitive protocols for First Nations deaths in custody. The objects of the First Nations protocol include that:

- investigation and inquests 'are conducted in a culturally sensitive and appropriate matter which is respectful to the needs to First Nations people'

605 Submission 27, National Justice Project, p 27.

606 Submission 27, National Justice Project, pp 27-28.

607 Submission 46, Legal Aid Commission of New South Wales, pp 53-55.

608 Submission 27, National Justice Project, pp 27-28.

609 Submission 18, NSW Government, p 19.

610 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 29.

- the families of First Nations Peoples are 'engaged early and meaningfully in the coronial process and provided with a dedicated pathway through which they can raise any cultural considerations relevant to the conduct of the investigation and inquest, and any issues and concerns surrounding the conduct of coronial investigation, including concerns in relation to the circumstances of the death'.[611]

5.88 The First Nations Protocol states that there is recognition that First Nations peoples have 'an extended family structure and complex and dynamic system which defines where a person fits into their family and community' and the importance of these structure to support wellbeing and experience in the coronial process. As such, it states the meaning of the term 'family' within the First Nations Protocol 'should be interpreted flexibly and with respect for these structures and systems'.[612]

5.89 First Nations Protocol also provides that families or their representatives can raise cultural considerations in relation to the body of the deceased (viewings, port-mortem and release of the body) as well as for the investigation and inquest with the Aboriginal Coronial Information and Support Program Officer at the family meeting.[613]

5.90 With respect to the conduct of inquest hearings, the First Nations Protocol states coroners will ensure that inquests are 'conducted in a culturally sensitive and appropriate manner, including by adhering to any cultural considerations raised by the family', such as the name of the deceased to be used during hearings and appropriate warnings about the use of names during hearings, holding an inquest on country, a welcome or acknowledgement of country, smoking ceremonies and display and use of symbols and items of cultural significant to the deceased and their family.[614]

5.91 Several stakeholders expressed their support for this protocol. The NSW Bar Association, in particular, stated that it supports all efforts taken by the State Coroner and other to ensure coronial investigations are 'as culturally safe and supportive as possible for First Nations families and their communities'.[615]

5.92 Similarly, Adjunct Professor stated that the draft protocol is one of the measures that indicates an 'innovative attitude to improving the performance of the coronial system and making it more restorative and therapeutic'.[616] The Aboriginal Legal Service (NSW/ACT) and Legal Aid NSW, among others, also expressed support for the First Nations Protocol.[617]

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611 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cls 3.1(a) and 3.1(b).

612 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cls 6.1 and 6.2.

613 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cls 7.2(c)(iii) and 10.2(c).

614 Local Court of New South Wales, *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples* (9 March 2022), cl 11.1(c).

615 Submission 17, New South Wales Bar Association, p 20.

616 Submission 14, Adjunct Professor Hugh Dillon, p 14.

617 Submission 36, Aboriginal Legal Service (NSW/ACT), p 7; Submission 46, Legal Aid Commission of New South Wales, p 7. See also See Submission 12, Justice Action, p 10; Submission 27 National

5.93 However, Jumbunna held a different view, describing the First Nations Protocol as inadequate, urging 'that First Nations deaths in custody before the Coroners Court are not treated as a special cultural group issue, but as an issue fundamental to justice for uses of fatal state power on a colonised people'. Jumbunna made a number of recommendations, including that there be 'a process of formal guidance from the Coroner to participating counsel about the dignity and social and emotional wellbeing of families, and the requirement for their conduct outside of formal proceedings to respect that dignity and wellbeing'.[618]

5.94 Ms Katie Lowe, criminology graduate and intern at the Jumbunna, highlighted key therapeutic features which exist in both the Victorian and Queensland coronial jurisdiction's policies and protocols, including the incorporation of practices related to First Nations mourning and Sorry Business, using the correct name of the deceased (verbally and in documents), the identification of traditional owner groups and lands, and sensitivity to men's and women's business.[619]

5.95 Ms Lowe also highlighted that the *Coroners Act 2003* (Qld) contains provisions that address cultural considerations for First Nations people. She also explained that in 2019 the Coroners Court of Queensland published a guide for cultural competency and engagement with First Nations people, which was created in collaboration with First Nations families with lived experience of the coronial jurisdiction. She described the guide as being multifaceted, speaking to the cultural considerations and protocols surrounding death in First Nations communities, senior next of kin responsibilities, and issues arising for First Nations people when engaging with the coronial process.[620]

Cultural competency training

5.96 Stakeholders also highlighted the need for improved cultural competency, both at the Coroners Court of NSW and within the justice system more broadly.

5.97 Professor Megan Williams, Head of Girra Maa Indigenous Health Discipline at the University of Technology Sydney, spoke during a hearing about non-Indigenous staff lacking in confidence when engaging with First Nations families within the coronial process:

> There is that simple phrase that if you get it right for Aboriginal and Torres Strait Islander people, you will get it right for everyone. But in my role, say, at the National Centre for Cultural Competence and in collaborative research, I am constantly told by non-Indigenous people, "I'm scared of saying or doing the wrong thing," and that includes my experience in the coronial process.[621]

5.98 Professor Williams went on to advocate for more cultural competency training and resources for non-Indigenous staff:

> In terms of the non-Indigenous workforce, there are guidelines in the professions associated with issues relevant to the coronial process, such as health, and any employee

Justice Project, p 8; Submission 31, p 12; Submission 38, Deadly Connections Community & Justice Service, p 2.

618 Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 19.

619 Submission 33, Katie Lowe, pp 15-16.

620 Submission 13, Coroners Court of Queensland, p 3; Submission 33, Katie Lowe, p 15.

621 Evidence, Professor Williams, 29 September 2021, p 30.

> of New South Wales Government that mean that conduct should already be informed, culturally safe, culturally responsive—whatever the phrase people choose to use—as well as informed by leadership of Aboriginal and Torres Strait Islander people and Aboriginal people's perspectives, as well as in partnership with Aboriginal and Torres Strait Islander community controlled organisations. So we already have that written in current documents.[622]

5.99 Deadly Connections Community & Justice Service (Deadly Connections) referenced its submission to the Australian Law Reform Commission's *Review of Judicial Impartiality*, suggesting that a similar approach to cultural competency training would be appropriate for the Coroners Court of NSW.[623] Essentially, it argued for mandatory cultural competency training for all judges and courtroom staff, designed and led by First Nations people, with a mandatory assessment process to ensure minimum standards of completion.[624]

5.100 In designing and delivery this training, Deadly Connections outlined a number of principles that should be followed, including:

- the training being 'trauma-aware and led by qualified and experienced Aboriginal and Torres Strait Islander controlled organisations or individuals'
- it being 'incumbent on judicial officers to do a range of activities, including on-country cultural immersion and probono work with Aboriginal organisations'
- the training also 'encompassing implicit bias training so that judicial officers can identify their own bias arising from a social/cultural standpoint'.[625]

5.101 In order to map, coordinate, monitor, and develop ongoing judicial education programs in relation to cultural competency, Deadly Connections advocated for a First Nations Advisory Committee, in collaboration with First Nations organisations who specialise in professional cultural competency training in the justice sector.[626]

5.102 As mentioned previously, the Coroners Court of Queensland have created a guide to cultural competency and engagement between the Coroners Court and First Nations people in 2019 titled 'Sorry Business'. It speaks to the cultural considerations and protocols surrounding death in First Nations communities, next of kin responsibilities, and issues arising when engaging with the Western coronial investigation and inquest process. The guide provides advice to coroners and coronial proceedings, as well as background information for engaging in a manner considerate to First Nations people. In her submission, Ms Lowe encourages a similar guide to be created for the NSW jurisdiction, to 'engage with First Nations families in reforming the death investigation process'.[627]

622 Evidence, Professor Williams, 29 September 2021, p 30.

623 Submission 38, Deadly Connections Community & Justice Service, p 7.

624 Submission 38, Deadly Connections Community & Justice Service, Appendix A, p 13.

625 Submission 38, Deadly Connections Community & Justice Service, Appendix A, p 11.

626 Submission 38 Deadly Connections Community & Justice Service, Appendix A, p 9.

627 Submission 33, Katie Lowe, p 15.

5.103 As noted in correspondence to the committee, the Department of Communities and Justice is progressing a range of strategies as part of their Aboriginal Employment Strategy, including improvements to the cultural competency of non-Indigenous staff.[628]

Adequate space and a culturally safe environment

5.104 A number of inquiry participants also discussed the importance of the physical space at the Coroners Court being adequate and culturally safe for First Nations families.

5.105 Legal Aid NSW explained that up until 2019, families attending the previous Coroners Court in Glebe had access to a small family room that included 'comfortable soft furnishings, artwork, water, and privacy … '. The room was an area that 'families were able to comfortably occupy to the exclusion of others'. Legal Aid NSW observed the value of this space in allowing families to avoid contact with other witnesses and excuse themselves from courtroom proceedings.[629]

5.106 However, despite there being a variety of meeting rooms at the State Coroners Court, Legal Aid NSW contended that there is no dedicated room for families attending inquest hearings. It supported the development of breakout 'family rooms' at the complex.[630] Ms Mackander also addressed this issue, stating:

> Although the complex at Lidcombe in new, is very tidy, and has small meeting rooms, there is no dedicated 'family room' for relatives attending inquests at the Lidcombe Coroner's Court to sit quietly away from everyone else with simply [sic] things like a fridge, microwave and water.[631]

5.107 According to Jumbunna, as cited by Ms Lowe, the space available to families and their supporters in the Coroners Court is often outnumbered by the legal representation provided by the police, corrective services, and other interested parties. In this regard, Jumbunna stated that the space for extended kinship, family and supporters at the Coroners Court is inadequate.[632]

Employment and First Nations representation

5.108 Participants to this inquiry discussed the presence of First Nations people within the coronial system as crucial for the development of a culturally safe institution, and also relevant to effectively identify and prevent deaths of First Nations people in institutional settings.

5.109 A number of stakeholders acknowledged the recent appointment of the two Aboriginal Coronial Information and Support Program Officers at the State Coroners Court.[633] The NSW

628 Correspondence from Department of Communities and Justice to Chair, 11 February 2022, p 29.

629 Submission 46, Legal Aid Commission of New South Wales, p 39.

630 Submission 46, Legal Aid Commission of New South Wales, p 40.

631 Submission 40, Tracy Mackander, p 5.

632 Submission 33 Katie Lowe, p 13, citing Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2020), p 44.

633 See, for example, Correspondence from Magistrate Teresa O'Sullivan, NSW State Coroner, to Chair, 24 March 2021; Submission 12, Justice Action, p 11; Submission 6, Australian Lawyers Alliance, p 8; Submission 18, NSW Government, p 19; Submission 46, Legal Aid Commission of New South Wales, p 52

Government explained that these officers are part of the Coronial Information and Support Program team, providing support to the families of First Nations people whose deaths have been reported to the coroner.[634]

5.110 The NSW Government said that this support extends throughout the course of the coronial process, from the reporting of the death until the result of the inquiry is known. The officers also help develop policies and procedures on how the Coroners Court of NSW can best engage with First Nations people who are involved with the coronial system.[635]

5.111 Legal Aid NSW indicated its support for these roles and for the creation of other Aboriginal-identified positions in the registry and other support positions, including in the social worker team with Forensic Medicine.[636]

5.112 The National Justice Project highlighted the importance of having First Nations representation in positions throughout the entire criminal justice system. In particular, it shared how the Dungay family were concerned about a lack of involvement of First Nations people throughout the coronial process, reinforcing their 'existing distrust in the justice system' and leading to re-traumatisation. The Dungay family advocated for greater First Nations representation across the criminal justice sector, including having a First Nations coroner and investigators.[637]

5.113 These views were echoed by Deadly Connections. It reinforced the recommendation in the Select Committee on First Nations' report that the NSW Government should implement a program to actively employ a greater number of First Nations staff across all areas of the criminal justice system. Deadly Connections also noted that it is essential for courts to retain First Nation judges:

> The increase in representation of First Nations peoples in all levels of the Commonwealth courts system, in conjunction with other recommendations outlined, is likely to assist in building the trust and confidence of First Nations peoples through increased cultural safety and competency.[638]

5.114 The appointment of First Nations persons to high-level decision-making and advisory positions was advocated by some inquiry participants. The New South Wales Aboriginal Land Council recommended that Aboriginal Coroners and Aboriginal Counsel Assisting be appointed for First Nations deaths and 'the appointment of Aboriginal Elders to sit with and assist the Coroner similar to the function that Elders currently play in Koori Court proceedings'.[639] On this point, the NSW Bar Association also called for the appointment of First Nations coroners and the appointment of a First Nations Commissioner to sit with coroners when investigating First Nations deaths.[640]

5.115 Related to the topic of improved advisory mechanisms for the Coroners Court of NSW, the NSW Bar Association and Adjunct Professor Dillon referred to the strengths of the Coroners

634 Submission 18, NSW Government, p 19.

635 Submission 18, NSW Government, p 19.

636 Submission 46, Legal Aid Commission of New South Wales, p 52.

637 Submission 27, National Justice Project, p 42.

638 Submission 38, Deadly Connections Community & Justice Service, p 14.

639 Submission 34, New South Wales Aboriginal Land Council, p 3.

640 Submission 17, New South Wales Bar Association, p 20.

Court of Queensland's Coronial Services Governance Board in providing high-level co-ordination and strategic planning of the coronial system.[641] The NSW Bar Association considered that the objectives of the current NSW Coronial Services Committee to be different to the Queensland Board:

> NSW has recently set up a Coronial Services Committee to co-ordinate the operations of the NSW coronial system. The committee meets quarterly and has representatives from the Department of Communities and Justice, NSW Health and NSW Police as well as from the Local Court. We understand that this committee is primarily involved with operational issues rather than the broader strategic questions the Queensland Board is engaging with.[642]

5.116 In recommending that a 'high-level board or committee similar to the Queensland Coronial Services Governance Board be established in NSW, the NSW Bar Association emphasised that 'a number of positions should be allocated for First Nations people'.[643]

5.117 In this regard, the committee also notes recommendation 38 of the Select Committee on First Nations inquiry report which advocated for suitably qualified and experienced First Nations persons to be appointed to the judiciary.[644]

Cultural and religious considerations for CALD communities

5.118 Throughout this inquiry the committee also sought to understand whether the needs of families from culturally and linguistically diverse communities were being met within the coronial system. The committee invited a wide group of stakeholders to contribute to the inquiry on this point, although only a handful of submissions were received. Most of the evidence received focused on the experience of Jewish and Muslim communities.[645]

Access to information and support

5.119 In terms of access to information and the availability of translators, the Ethnic Communities' Council of NSW highlighted that people engaging with the courts may require in-language resources to explain the role and functions of the court, and how to access interpretation services. Without these, it stated that culturally and linguistically diverse families may not be able to participate effectively in the coronial process.[646]

5.120 According to the Coroners Court website, families are instructed to use the free Translating and Interpreting Service during office hours Monday to Friday to receive information and updates

641 Submission 14, Adjunct Professor Hugh Dillon, pp 49-50; Submission 17, New South Wales Bar Association, pp 20, 43 and 47-48.

642 Submission 17, New South Wales Bar Association, p 13.

643 Submission 17, New South Wales Bar Association, pp 20 and 43.

644 Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Legislative Council, *High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (2021), pp 179-180.

645 See, for example, Submission 59, New South Wales Jewish Board of Deputies Ltd; Submission 61, Australian Federation of Islamic Councils.

646 Submission 62, Ethic Communities' Council of NSW, p 2.

from court staff. Interpreters may also be arranged for family members or anyone who has been asked to give evidence at an inquest.[647]

5.121 A number of other operations and practices were highlighted which support the needs of culturally and linguistically diverse families involved in the coronial system. This includes the State Coroners Court at Lidcombe having a multifaith prayer room, and consultation with Muslim and Jewish religious leaders.[648]

Post-mortem examinations

5.122 Some stakeholders highlighted cultural issues related to post-mortem examinations, explaining that invasive procedures can go against religious law.

5.123 According to the New South Wales Jewish Board of Deputies, after death a Jewish person must be protected from desecration. Due to this, Jewish families often object to invasive post-mortem examinations. Consent is regularly given by families to conduct a limited non-invasive post-mortem examination, which may include the taking of bodily fluids and samples, or a CT scan, MRI, ultrasound or x-ray.[649]

5.124 Islamic law also requires that no autopsy be performed 'unless absolutely necessary'. The Australian Federation of Islamic Council stated that in the event a body is to be autopsied, the organs should be placed carefully back into the body 'in a manner that is considerate and respectful'. This is to adhere to the Islamic practice of burying the deceased in the way they were when they died.[650]

5.125 With respect to the practices undertaken during a post-mortem examination, the Australian Federation of Islamic Councils explained that substances used for post-mortem testing must be free of alcohol and pig products as they are forbidden in Islam. It also noted that in some instances, alcohol-based sanitisers may be required, but they should only be used externally.[651]

5.126 Adjunct Professor Dillon highlighted in his submission that the Coroners Act does not make any specific reference to cultural diversity, and there is no legislative requirement that the coroner observe religious practices.[652]

5.127 However, as noted by the Department of Communities and Justice, section 88 of the *Coroners Act 2009* (NSW) requires the coroner to have regard to the dignity of the deceased person and to order the least invasive procedure to allow the determination of the cause of death.[653] The Department of Communities and Justice stated:

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647 Interpreters and translators, Coroners Court New South Wales (31 March 2020) https://coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/interpreters-and-translators.html

648 Correspondence from Department of Communities and Justice to Chair, 11 February 2022, pp 31-32.

649 Submission 59, New South Wales Jewish Board of Deputies, p 2.

650 Submission 61 Australian Federation of Islamic Councils, p 3.

651 Submission 61, Australian Federation of Islamic Councils, p 4.

652 Submission 14, Adjunct Professor Hugh Dillon, p 49.

653 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 31.

> When making the initial coronial direction the Coroner will take religious beliefs and cultural practices into account when determining whether it is "necessary or is desirable" in the public interest to conduct and examination, and if so will adhere to the requirement to order the least invasive procedure appropriate in the circumstance.[654]

5.128 The Timeliness Taskforce's Progress Report stated that a range of concerns for bereaved families from the Muslim community had been identified through consultation with Forensic Medicine. These concerns centered on post-mortem-examinations, such as what an examination involves, the process to lodge an objection, timeframes, the role of the senior next of kin and communication of materials with a religious and cultural focus. The Progress Report stated that during 2021 Forensic Medicine would 'conduct outreach and engagement with other CALD communities in 2021 to improve the experience for bereaved families who may feel confused, distressed or excluded as a result of sensitivities related to cultural, religious or linguistic diversity'.[655] It is not presently known whether this took place and, if it did, what outcomes were achieved.

5.129 Further, the Department of Communities and Justice informed the committee that the State Coroner's Office have engaged with religious leaders of Australian Imams Council and Chevra Kadish to develop a process and procedure to allow Muslim and Jewish families to object to post-mortem examination and to request priority release of the body.[656]

5.130 The NSW Government noted that engagement with Jewish and Muslim community leaders has helped to identify a range of concerns for bereaved families including:

> … a need to better understand what a post-mortem examination involves, how to lodge an objection, the timeframes of a post mortem examination, the role of the senior next of kin, and for communication materials with a specific cultural/religious focus.[657]

Retention of organs

5.131 To determine the cause of death, tissue samples are often collected as part of the post-mortem process. In rare cases organs may be retained for further examination.[658]

5.132 Section 90(5) of the *Coroners Act 2009* (NSW) stipulates that a forensic pathologist may retain human tissue and organs if they believe it will assist in determining the medical cause of death. Nevertheless, the Department of Communities and Justice acknowledged that organ retention can be in opposition to the religious practices of some faiths and cultural groups who may wish for their loved one's body to be 'intact', with all organs returned as per their religious or cultural beliefs.[659]

5.133 The retention of organs was one of the main areas of concern for stakeholders regarding cultural sensitivity. The Australian Federation of Islamic Councils explained that Muslim families will

654 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 31.

655 NSW Government, *Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce* (October 2021), p 16.

656 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 32.

657 Submission 18, NSW Government, p 20.

658 Brochure 'Initial steps after a death is reported to the Coroner', NSW Government, p 4.

659 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 31.

often object to the retention of organs based on cultural or religious grounds. In its submission it stated: 'We ask that organs be returned into the body in a manner that is considerate and respectful. When Muslims bury a body, it is best that it be buried completely intact'.[660]

5.134 Mr Michael Barnes, a former state coroner in NSW and Queensland, acknowledged the struggle coroners face when trying to balance the primary objective of improving public health and safety, in which autopsies and organ retention may be necessary, with the wishes of bereaved families who may oppose autopsies and organ retention.[661] Mr Barnes submitted that 'the legislation or procedural rules should give guidance as to how these competing interest should be ranked or resolved. Absent such guidance, inconsistent practice will continue'.[662]

Burial

5.135 Various cultural and religious communities across NSW require expedited release of bodies from forensic pathology for burial, however, it was noted by stakeholders that this may not always be feasible within the current coronial system.

5.136 The New South Wales Jewish Board of Deputies highlighted that Jewish law requires the body of the deceased be prepared for burial and that the burial take place as soon as possible after death. A Jewish person is required to sit with the body during the time between death and burial and to pray for the deceased person.[663]

5.137 The Australian Federation of Islamic Councils and Tripoli and Mena Association also highlighted the significance of a 'quick release' of the deceased for burial within the Islamic faith.[664]

5.138 One submission was received in relation to the experience of the Hindu community. According to AASHA, an organisation supporting seniors from South East Asian communities, Hindu rituals are conducted within 24 hours of death. These rituals include chanting holy mantras, applying sacred ash and flowers to the deceased's body, as well as placing rice in the mouth and coins in the hands in preparation for cremation.[665]

5.139 Although in some circumstances it may be necessary for a body to be held for longer than a day, submissions to the inquiry emphasised that in Judaism, Islam, and Hinduism, there is a cultural and religious need to minimise the length of post-mortem examinations by applying the priority request process that respects religious requirements for an expedited release of remains.[666] On this, it should be noted that the Coroners Court Registry use a 'Priority Request' process to allow families to request an expedited post-mortem report. However, as noted by the

660 Submission 61, Australian Federation of Islamic Councils, p 3.

661 Submission 41, Mr Michael Barnes, p 3.

662 Submission 41, Mr Michael Barnes, p 3.

663 Submission 59, New South Wales Jewish Board of Deputies, p 2.

664 See, for example, Submission 61, Australian Federation of Islamic Councils, p 3; Submission 65, Tripoli and Mena Association, p 2.

665 Submission 64, AASHA Australia Foundation, pp 1-2.

666 See, for example, Submission 59, New South Wales Jewish Board of Deputies, p 2; Submission 61, Australian Federation of Islamic Councils, p 3; Submission 64, AASHA Australia Foundation, p 1; Submission 65, Tripoli and Mena Association, p 2.

Department of Communities and Justice, this is subject to the NSW Health forensic pathologist capacity to accommodate these requests.[667]

5.140 The Timeliness Taskforce, as discussed in chapter 1, is implementing a range of strategies to address delays within the system, with one objective being to reduce delays in the release of deceased persons.[668]

Privacy

5.141 Stakeholders also highlighted the need for privacy in some circumstances, with many religions having rules about the privacy of the human body and who might be permitted to see and examine it. The Australian Federation of Islamic Councils emphasised that the 'right to privacy does not stop at death', and it is proper for the forensic pathologist to ensure the body is handled appropriately in a faith sensitive manner.[669] It noted:

> The body should always remain covered and not be left naked. Only parts which are necessary to be exposed should be exposed. Wherever possible, examinations of a body should be performed by a person of the same gender, in the absence of an appropriately qualified person of the same gender, any handling by the opposite gender must be monitored by a person of the same gender present in the room.[670]

5.142 In addition, according to Islamic law there are some circumstances surrounding death that are potentially very sensitive and the family may not wish to disclose publicly. The Australian Federation of Islamic Councils explained:

> We do believe that sensitivities in disclosure of information to the public may arise, especially in instances of suicide, drug, alcohol and poison related deaths. Especially if the family never saw any of this coming. Suicide and substance abuse are prohibited in Islam … We do understand that there are cases where public interest would override, however, as a general rule, we need to do our utmost to respect the family's privacy.[671]

Committee comment

5.143 We recognise that navigating an unfamiliar legal and bureaucratic system while grieving the loss of a loved one is immensely difficult for families. The level of communication and support provided to families is key to not only their satisfaction with and experience of the coronial system but also their wellbeing. The coronial process has the potential to provide answers, closure and healing for bereaved families. These positive outcomes are most likely to be achieved when families can actively participate in the process with the aid of appropriate information and supports. As such, it is absolutely critical for the Coroners Court of NSW to ensure all of its processes and practices respect the centrality of families in the coronial system.

667 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 11.
668 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 10.
669 Submission 61, Australian Federation of Islamic Councils, p 4.
670 Submission 61, Australian Federation of Islamic Councils, p 4.
671 Submission 61, Australian Federation of Islamic Councils, p 3.

Recommendation 18

That the Coroners Court of New South Wales ensure that all of its practices and processes appropriately balance on the needs and interests of families in the coronial system with other considerations.

5.144 The impact of lengthy delays are exacerbated when families feel like they are kept in the dark. It is essential that families are provided with information about the coronial process and its stages, including updates on the progress of the case and reasons for delays. While other parts of this report focus on the organisational objective of reducing delays, our comments and recommendations in this chapter seek to ensure families have access to appropriate and timely information and supports. To that end, the NSW Government should explore options to ensure information and material are provided to families in a timely manner to support their meaningful participation in investigations and inquests, either through legislative or policy changes. Specifically, unless contrary orders are sought, all materials provided to the Coroner's Court should also be provided to the family or families concerned within one month of the brief being returned to the Coroners Court from the Crown Solicitor's Office or Department of Communities and Justice Legal.

Recommendation 19

That the NSW Government develop and propose reform options, legislative or otherwise, to ensure the provision of information and material to families in a timely manner, in order to support their meaningful participation in investigations and inquests. Specifically, unless contrary orders are sought, all materials provided to the Coroners Court of New South Wales should also be provided to the family or families concerned within one month of the brief being returned to the Coroners Court from the Crown Solicitor's Office or Department of Communities and Justice Legal.

5.145 While recognising the important work of the Coronial Information and Support Program Officers and Forensic Medicine social workers in supporting families, the evidence to this inquiry suggests that the limits on the scope of these services can leave families feeling unsupported at critical points in the process. Continuity of support by way of counselling, from the initial stages through to the investigation and inquest processes, as well as post-inquest, would greatly benefit the wellbeing of families.

Recommendation 20

That the NSW Government implement options to enhance the access families have to social support and counselling in the coronial system, with the aim of ensuring continuity in services and flexibility to meet families' needs.

5.146 Evidence to the committee has highlighted that despite legal representation for inquests being incredibly valuable to navigate the process and enhance families' voices and interests, a majority of families appear at inquests unrepresented. The committee agrees with the inquiry participants who called for better resourcing for legal representation for families. For example, legal

representation provided on a basis similar to inquiries conducted by the Independent Commission Against Corruption.

5.147 We recognise that participation in the coronial process comes at more than just an emotional cost. There are also financial costs which present barriers to some families' participation, such as taking time away from paid work and travel expenses. It appears that current financial support to overcome practical barriers to participation is sparse and often families and their communities are left no choice but to wear these costs, when feasible. Bereaved families should not be placed under additional pressures during an already stressful and difficult time. There should be funding available upon application to provide financial support to families which would cover logistical costs such as travel and accommodation for inquests.

5.148 In addition, the committee was interested in looking at any issues relating to the provision of legal representations for witnesses and persons of interest in coronial investigations and inquests. To that end, the committee notes the point made by Legal Aid NSW that in other contexts, such as inquiries undertaken by the NSW Independent Commission Against Corruption and the NSW Crime Commission, witnesses who meet certain criteria can make an application for legal representation to the Attorney General. The implementation of a scheme of this kind for the coronial jurisdiction would be a significant improvement on the present situation and would be supported by the committee. However, the committee considers that the evidence on the appropriateness of this type of model for the coronial jurisdiction was limited. This issue should, however, be further examined.

Recommendation 21

That the NSW Government allocate additional funding to Legal Aid NSW and Aboriginal Legal Service (NSW/ACT) in order for these services to provide greater legal assistance and representation to families involved in coronial inquests.

Recommendation 22

That the NSW Government implement a financial assistance scheme to cover the logistical costs incurred by families participating in coronial inquests, including the costs of transport, meals and accommodation.

5.149 Turning to the specific needs of First Nations people, the committee recognises the initiatives of the Coroners Court to improve its engagement with First Nations families and enhancements to create a culturally safe and respectful process for families. At the site visit to the State Coroners Court in December 2021, we heard about the meaningful impact the Aboriginal Coronial Information and Support Programs Officers are making in terms of court practices, engaging with families and building relationships within the community and networks with services. The committee was impressed with the dedication and commitment of these Officers to their roles, and can see the value they are adding to the Court's services. The committee also commends the work of the State Coroner in the process undertaken to establish the First Nations Protocol and looks forward to seeing the positive impact its implementation will surely have on First Nations' families experience in the coronial system.

5.150 That being said, two Aboriginal Coronial Information and Support Programs Officers for the entire state is clearly insufficient, particularly in light of the number of mandatory death in custody inquests and the persistent backlog. Increasing the First Nations workforce capacity at the court should be a priority, including an expansion the resources Aboriginal Coronial Information and Support Program team as well as the creation of other identified positions in the registry and other support positions, including in the social worker team with Forensic Medicine. Further, there should be funding allocated for the delivery of cultural competency training across the various government agencies and departments involved in the coronial pathway, including Forensic Medicine and NSW Police Force.

Recommendation 23

That the NSW Government allocate funding to increase the First Nations workforce capacity at the Coroners Court of New South Wales, including expansion of the Aboriginal Coronial Information and Support Program Officer team, and the creation of other identified positions in the registry and other support positions, including in NSW Health Pathology's Forensic Medicine Social Work service.

Recommendation 24

That the NSW Government ensure government departments provide ongoing cultural competency training to all staff, especially those departments working in the coronial jurisdiction.

5.151 We now turn to the Court's capacity to meet the needs of culturally and linguistically diverse families and communities. In our view, it appears that cultural and religious practices and ceremonies relating to the body of a deceased person and their burial or otherwise can be in conflict with processes required to be undertaken by Forensic Medicine, such as post-mortem examination, and related issues like organ retention and release of the deceased's body. We are encouraged to hear that the Coroners Court has been engaging with culturally and linguistically diverse communities to improve their experience of the coronial system. We are also encouraged by the work the Court has undertaken to develop the First Nations Protocol.

5.152 We consider that this engagement should be transitioned into a more formalised consultation process to better understand the various sensitivities relating to Forensic Medicine practices for different cultural and religious communities. The objective of this consultation should be the creation of publicly available guidelines or information on the role of Forensic Medicine and its procedures in the context of the Coroners Court and how cultural and religious considerations are taken into account in coronial decisions. It should also include information and guidance on processes to object to certain procedures and how conflicting interests are resolved. This material should be made easily available in community languages.

Recommendation 25

That the Coroners Court of New South Wales and the NSW Health Pathology's Forensic Medicine unit consult with culturally and linguistically diverse communities and First Nations communities on the development of publicly available and clear guidelines that cover both the Court's practices and how cultural and religious considerations are best accommodated.

5.153 We also support the submission of the NSW Bar Association indicating that the presence of First Nations persons within the coronial system in positions of power, not only support, is important in creating a culturally safe institution and preventing future deaths of First Nations persons in institutional settings. We support its recommendation that First Nations persons be appointed to the Coroners Court of NSW as a matter of urgency. In so doing, we note recommendation 38 of the First Nations inquiry, referred to in paragraph 5.117 above.

5.154 The committee also supports the recommendation of the NSW Bar Association that a First Nations commissioner, or similar, sit with coroners dealing with First Nations' deaths.

5.155 In addition, the committee supports the suggestion of the NSW Bar Association and other stakeholders that a body similar to the Queensland Coronial Services Governance Board should be established in NSW, to support the medium to long-term co-ordination and performance of the coronial jurisdiction. This would involve all the agencies whose work bears on the performance of the coronial system. This body should also have First Nations representation on it.

Recommendation 26

That the NSW Government appoint significantly more qualified First Nations people to the judiciary, including the appointment of First Nations persons as coroners and introduction of a First Nations Commissioner to sit with coroners dealing with First Nations deaths.

Chapter 6 Intersection of the Coroners Court and other jurisdictions and proceedings

This final chapter focuses on the extent to which the coronial jurisdiction is involved in workplace death investigations, and the intersection of coronial and work health and safety proceedings. It will consider the role of the Coroners Court of New South Wales in undertaking inquests to not only investigate particular workplace deaths but to also examine systemic issues to potentially improve workplace safety standards. The chapter also considers referrals to the Office of the Director of Public Prosecutions and some evidentiary matters relevant to the coronial jurisdiction, given that a death can enliven several jurisdictions, investigations or proceedings.

Workplace deaths

6.1 Several unions participated in the inquiry, providing their perspectives on the interplay between the coronial jurisdiction and work health and safety laws and proceedings as they relate to workplace deaths. While also invited to participate in this inquiry, no employer association made a submission. This section will consider the extent to which the coronial jurisdiction does and should investigate workplace deaths and stakeholders views on the challenges raised when multiple investigatory processes are undertaken.

Workplace deaths and the coronial jurisdiction

6.2 Several submissions were received from unions noting the high levels of worker fatalities in their industries and the value of coronial inquests into these deaths.

6.3 The Mining and Energy Union noted mining is regularly in the top five occupations in Australia where fatalities are likely to occur.[672] Likewise, the Transport Workers' Union of New South Wales advised that the transport, postal, warehousing industry consistently ranks as one of the highest in terms of worker fatalities.[673] Similarly, the Construction Forestry Mining and Energy Union, Construction and General Division, NSW Divisional Branch advised that building and construction industry 'is marred by a large number of fatalities'.[674]

6.4 All of these unions emphasised that in their experience, despite the high number of deaths, inquests into workplace deaths are infrequent. For the building and construction industry, the Construction Forestry Mining and Energy Union explained that it has been more than a decade since the last inquest into a workplace fatality in the industry.[675] In terms of the transport industry, Mr Mitch Wright, Media and Political Advisor at the Transport Workers' Union of

672 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 3.

673 Submission 53, Transport Workers' Union of New South Wales, p 3.

674 Submission 52, CFMEU Construction and General Division, NSW Divisional Branch, p 1.

675 Submission 52, CFMEU Construction and General Division, NSW Divisional Branch, p 1; Evidence, Ms Rita Mallia, State President, Construction Forestry Mining and Energy Union, Construction and General Division NSW, 31 January 2022, pp 22 and 26.

New South Wales, noted that road transport industry deaths are generally seen as road fatalities, as opposed to workplace deaths, and as a consequence inquests are not regularly held.[676]

6.5 The Coroners Court of New South Wales provided the committee with data from the National Coronial Information System on work-related deaths reported to the Court between 2000 and 2022. The National Coronial Information System noted that only cases that are coded as 'work-related' in the system are included in the data, which refers to 'deaths where it is determined that exposure of the deceased to their own or another person's work environment or activities contributed to the death, with the exception of industrial disease'.[677]

6.6 With respect to the number of inquests held for work-related deaths, the data from the National Coronial Information System is congruent with the evidence from the various unions that inquests into workplace deaths occur infrequently. From January 2011 to February 2022, the Coroners Court of NSW was notified of 960 work-related deaths, with an average of 86 work-related deaths per calendar year. In that period, 36 inquests were held, with recommendations made in 23 cases.[678] From July 2000 to December 2010, the Coroners Court of NSW was notified of 1,154 work-related deaths, with an average of 110 work-related deaths per calendar year. In that period, 164 inquests were held with recommendations made in 83 cases.[679] This data is demonstrated below in Table 5.

Table 5 Work-related deaths in the Coroners Court of NSW 2000-2022

	Number of notifications[680]	Number of inquests	Number of cases in which recommendations made
2000-2010	1,154	164	83
2011-2022	9,60	36	23

Source: Correspondence from the NSW State Coroner, Magistrate O'Sullivan, to Chair, 15 February 2022; Correspondence from Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, to Chair, 4 March 2022.

6.7 Comparing the number of inquests into workplace deaths to the total number of inquests, obtained from the Annual Reviews of the Local Court between 2005 and 2020, there were 1,410 inquests held across NSW between 2011 and 2022 and 1,212 inquests between 2005 and 2010.[681]

676 Evidence, Mr Mitch Wright, Media and Political Advisor, Transport Workers' Union of New South Wales, 31 January 2022, pp 15 and 18.

677 Correspondence from the NSW State Coroner, Magistrate O'Sullivan, to Chair, 15 February 2022.

678 The National Coronial Information System advised that there may be an underestimate in the total number of cases for the 2020–2022 calendar years due to the number of cases remaining open for these years of data.

679 The National Coronial Information System advised that data is available for all Australian states and territories (except Queensland) from 1 July 2000. Queensland data is available from 1 January 2001.

680 The National Coronial Information System advised that these figures include both cases that are closed on the NCIS following coronial investigation and open cases where the coronial investigation is ongoing. It is possible cases of relevance may still be under coronial investigation and not included in this report based on coding availability at the time of data extraction.

681 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 5; Local Court of New South Wales, *Annual Review 2006*, p 24; Local Court of New South Wales, *Annual Review 2006*, p 24; Local Court of New South Wales, *Annual Review 2008*, p 28; Local Court of New South Wales, *Annual Review 2010*, p 22.

6.8 The data from the National Coronial Information System also indicated that the most common incident location and mechanism of the fatal injury for 2000 to 2022 remained consistent. The top three incident locations were transport area (public highway, freeway, street or road), industrial or construction area, and farm. The three most common mechanisms of fatal injuries were vehicle incident, crushing and fall-related.[682]

6.9 The Construction Forestry Mining and Energy Union argued that the lack of coronial inquests into construction deaths has led to SafeWork NSW being the primary investigator which 'has resulted in a complete lack of thorough exposé of the factors leading to a workplace death'.[683] It argued that a coronial process would be significantly more effective at improving safety legislation, processes and systems than an adversarial prosecution for a breach of work health and safety legislation by SafeWork NSW.[684]

6.10 In the view of the Construction Forestry Mining and Energy Union, investigations and prosecutions by SafeWork NSW are often inadequate in getting answers as to the circumstances surrounding and leading to a construction fatality. It noted that the function of SafeWork NSW is to investigate breaches for the purposes of a bringing a criminal prosecution, with the nature of this type of investigation not presenting an opportunity to explore broader safety or systemic factors potentially leading to the incident resulting in a fatality.[685] This is particularly the case where there is no robust contesting of the facts and circumstances, as when both prosecution and defence proceed by way of an agreed statement of facts.

6.11 Ms Rita Mallia, State President of the Construction Forestry Mining and Energy Union Construction and General Division NSW, emphasised that compared to a SafeWork NSW prosecution, coronial inquests for workplace deaths have greater potential to improve safety and prevent deaths and to provide closure for families:

> In years of experience of speaking to families of loved ones lost, access to the Coroners Court to allow them to ask questions about what happened to their loved ones is very important for them in understanding how the death occurred. There is no other process available to them in a formal setting. Prosecutions and breaches of the Act are not a sufficient substitute and this function in providing answers does provide important closure.[686]

6.12 The Construction Forestry Mining and Energy Union referred to the death of Mr Christopher Cassaniti in 2019 as an example that illustrates the deficiencies of a SafeWork NSW prosecution in providing answers to families about the circumstance of their loved one's death, as discussed further in the case study below.

682 Correspondence from the NSW State Coroner, Magistrate O'Sullivan, to Chair, 15 February 2022; Correspondence from Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, to Chair, 4 March 2022.

683 Submission 52, CFMEU Construction and General Division NSW Branch, p 1.

684 Submission 52, CFMEU Construction and General Division NSW Branch, p 1.

685 Submission 52, CFMEU Construction and General Division NSW Branch, p 1.

686 Evidence, Ms Mallia, 31 January 2022, p 22.

Case study: Death of Mr Christopher Cassaniti[687]

Mr Christopher Cassaniti died on 1 April 2019 in a worksite accident as a result of a scaffold collapse.

Ms Patrizia Cassaniti, Christopher's mother, informed the committee that she has made several applications to the Coroners Court of NSW for an inquest to be conducted into her son's death. She stated that these applications have been rejected on the basis that a SafeWork NSW investigation and prosecution is occurring. Ms Cassaniti disagrees with this decision and considers a coronial inquest into her son's death to be necessary for two key reasons.

First, despite the SafeWork NSW proceedings, Ms Cassaniti still feels as though there are many questions unanswered surrounding the circumstances of Christopher's death. She said that there is still a limited understanding of what occurred on the day of Christopher's death, despite the case being one of the largest SafeWork NSW investigations undertaken, spanning over two years and with over 100 investigation files relating to the case.

Ms Cassaniti advised that one prosecution in relation to Christopher's case has concluded and another is ongoing. With respect to the finalised prosecution, Ms Cassaniti noted that the building company pled guilty to the relevant breaches, meaning there was only a short sentencing hearing, and little to no examination of the circumstances of Christopher's death, despite the volume of evidence gathered by SafeWork NSW.

Second, Ms Cassaniti recognised the value an inquest into her son's death could have in terms of preventing future deaths. Ms Cassaniti believes an inquest will bring to light any unsafe work practices or systemic issues, enabling recommendations to be made to potentially prevent future fatal incidents.

According to Ms Cassaniti, a coronial inquest must be held for deaths that occur at a workplace before any SafeWork NSW or criminal prosecution occurs.

Like Ms Cassaniti, the Construction Forestry Mining and Energy Union also commented that the prosecution related to Mr Cassaniti's death provided 'no opportunity at all to delve into the full range of causes and culpability, leaving many unanswered questions for the family' and the union. In calling for the Coroners Court of NSW to be adequately resourced and empowered to hold inquests for workplace deaths, the Construction Forestry Mining and Energy Union highlighted the benefits that would come from a coronial inquest in Mr Cassaniti's case:

> A full coronial inquiry would have more effectively revealed the true cause of the fatality, answered the many questions the family and the CFMEU still have about this matter and possibly led to others, including individuals to be prosecuted for breaches of Safety laws and more meaningful and extensive recommendations for reform in a public setting. The adage justice needs to be seen to be done is not unimportant in these cases that cause families such permanent damage.[688]

687 Evidence, Ms Patrizia Cassaniti, Mother of Christopher Cassaniti, 31 January 2022, pp 2-7.

688 Submission 52, CFMEU Construction and General Division NSW Branch, p 2.

6.13 Reflecting on the importance of coronial inquests for deaths in their industry, the Mining and Energy Union noted that previous inquests and recommendations have led to improved safety standards in their respective industries.[689] The Mining and Energy Union considered that even with a robust regulator, coronial inquests continue to have an important role to play in the mining industry, given the independence of the Coroners Court of NSW:

> Even though the investigation into any fatality is carried out by the NSW Resource Regulator we see it as important that a body, not directly engaged in the management, supervision and regulation of the industry has an opportunity to review the investigation and where necessary hold an inquiry. We see this as the role of the Coroner's Court.[690]

6.14 Moreover, Mr Grahame Kelly, General Secretary of the Mining and Energy Union, observed that the role of coronial investigations and inquests is particularly important for industries that do not have a well-resourced regulator with a death prevention and safety focus like exists in the mining industry.[691]

6.15 The Construction Forestry Mining and Energy Union agreed, advocating for a greater number of inquests to be held into workplace constructions deaths to examine how they occur with the objective of preventing future death and provide families a platform to have their questions answered.[692]

Overlap between the coronial, criminal and workplace health and safety jurisdictions

6.16 The investigatory functions of the criminal, coronial and workplace health and safety jurisdictions with respect to workplace deaths were noted by some inquiry participants to result in duplication of work, blurred lines of responsibility and delays.

6.17 As explained by the Transport Workers' Union of New South Wales, a workplace death may enliven three jurisdictions, including investigatory processes by the Coroners Court of NSW, SafeWork NSW and police.[693] Additionally, as noted by Australian Rail, Tram and Bus Industry Union (NSW Branch) and the NSW Nurses and Midwives' Association, there is the possibility that disciplinary proceedings, internal reviews or other regulatory investigations could be on foot at the same time as a coronial investigation.[694]

6.18 Investigations may occur consecutively. A regulator may wait for the finalisation of any coronial investigation or inquest before deciding whether to bring any prosecution. For example, Mr Stuart Barnett, State Practice Group Leader at Slater and Gordon Lawyers, noted that in his experience with workplace deaths in the mining industry, most commonly a coronial inquest is

689 Evidence, Mr Grahame Kelly, General Secretary, Mining and Energy Union, 31 January 2022, p 22.

690 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 3.

691 Evidence, Mr Kelly, 31 January 2022, pp 23-24.

692 Evidence, Ms Mallia, 31 January 2022, pp 22-23 and 26.

693 Submission 53, Transport Workers' Union of New South Wales, pp 5-6.

694 Evidence, Mr Alex Claassens, Branch Secretary, Rail, Tram & Bus Union (NSW Branch), 21 January 2022, p 18; Submission 55, Australian Rail, Tram and Bus Industry Union (NSW Branch), p 2; Evidence, Ms Laura Toose, Legal Officer, NSW Nurses and Midwives' Association, 31 January 2022, pp 8-9; Submission 51, New South Wales Nurses and Midwives' Association, p 7.

finalised prior to the regulator's decision on whether to prosecute.[695] Similarly, Mr Wright commented that SafeWork NSW often wait until the completion of a coronial inquest into transport industry deaths before deciding whether to prosecute.[696]

6.19 Conversely, the Transport Workers' Union of New South Wales noted that a coronial investigation may wait for a SafeWork NSW matter to be completed before any investigation or inquest occurs.[697] In circumstances where a prosecution for an indictable offence has commenced, the coroner may, and usually does, suspend the coronial investigation or inquest.[698] Similarly, the Mining and Energy Union explained that any fatality in the industry is investigated by the NSW Resource Regulator which can delay any coronial investigation taking place.[699]

6.20 Two stakeholders reported that in their experience, investigative bodies did not see a need for dual investigations to take place into the same death. As noted above, Ms Cassaniti's evidence to the inquiry was that despite making several requests for an inquest into the death of Mr Cassaniti she was informed that 'because there has been a prosecution there will be no need' for an inquest.[700] By contrast, the New South Wales Nurses and Midwives' Association was concerned that for two deaths on duty which occurred in 2019 and 2020, SafeWork NSW declined to undertake a full investigation because the matters were being investigated by the Coroners Court of NSW.[701] In its view, this approach 'fails to appreciate the distinct purposes of each investigation as well as the importance of a SafeWork investigation in the early identification and management of WHS risks … '. To address this, the New South Wales Nurses and Midwives' Association considered that there is a need for improved multi-agency approaches to investigations of workplace deaths.[702]

6.21 Stakeholders also raised a concern about the absence of an information sharing framework between the Coroners Court of NSW and SafeWork NSW when both investigatory functions are enlivened by a workplace death. The Transport Workers' Union of New South Wales noted that there are established investigative agreed principles between SafeWork NSW and NSW Police. The agencies have agreed principles aiming to assist in determining which agency will lead the investigation and which kind of offence a particular investigation is focusing on:

> According to the SafeWork NSW Prosecution Guidelines, SafeWork NSW and the NSW Police Force "have agreed on certain investigative principles aimed at maximising the expertise and resources of each agency to ensure that the most appropriate charges are laid in the circumstances" when determining whether to pursue a charge of manslaughter under the Crimes Act or charge(s) under the WHS Act, with this decision being made at the commencement of the process to assist in deciding which agency will lead the investigation.[703]

695 Evidence, Mr Stuart Barnett, State Practice Group Leader, Slater and Gordon Lawyers, 31 January 2022, p 28.

696 Evidence, Mr Wright, 31 January 2022, p 19.

697 Submission 53, Transport Workers' Union of New South Wales, p 7.

698 Submission 53, Transport Workers' Union of New South Wales, p 8.

699 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 3.

700 Evidence, Ms Cassaniti, 31 January 2022, p 2.

701 Submission 51, New South Wales Nurses and Midwives' Association, p 8.

702 Submission 51, New South Wales Nurses and Midwives' Association, p 8.

703 Submission 53, Transport Workers' Union of New South Wales, p 5.

6.22 However, the Transport Workers' Union of New South Wales stated that there is currently no mechanism setting out cooperation or coordination between the Coroners Court of NSW and SafeWork NSW in conducting their respective investigations.[704]

6.23 In addition, if a coronial matter is paused due to a prosecution for an indictable offence, the Coroners Court of NSW is required to provide the Office of the Director of Public Prosecutions with the depositions taken but there is no similar requirement that they be provided to SafeWork NSW.[705] Mr Wright explained the importance of having such a requirement in the context of workplace deaths:

> … the Coroners Act refers to obligations for the coroner to share certain information and statements collected with the DPP and specifically names the DPP. But, in the event of a workplace fatality, the DPP is seldom the one bringing the prosecution. You would like to hope that, in practice, that information is being shared between the coroner and SafeWork in instances where SafeWork are bringing the prosecution. But, if that framework does not exist, it should.[706]

6.24 There were also some concerns expressed about the use and gathering of evidence in the context of overlapping jurisdictions and live investigations. Some unions explained that their members may be required to provide multiple statements for different investigations. This was seen as an inefficient use of resources, unnecessarily causing distress to witnesses who are required to recount the events several times to different investigators.[707] Mr Alex Claassens, Branch Secretary of the Rail, Tram & Bus Union (NSW Branch), stated that 'it is really disappointing for us that somebody who has already been involved in a traumatic experience is having to relive that experience several times over because of a bureaucratic nightmare'.[708]

6.25 In addition, improving the communication of coronial findings and recommendations to SafeWork NSW was considered desirable by the Transport Workers' Union of New South Wales. In its view, when the recipient of recommendations is a person conducing a business or undertaking, in addition to the recommendations being sent to any relevant minister and published online, the Coroners Court of NSW should also provide to SafeWork NSW any findings or recommendations relating to work health and safety practices, to assist in 'enforcement and compliance purposes'. To this end, it suggested that the *Coroners Act 2009* (NSW) (Coroners Act) be amended to require the Coroners Court of NSW to provide to SafeWork NSW a copy of any findings and recommendations directed to a person conducting a business or undertaking.[709]

704 Submission 53, Transport Workers' Union of New South Wales, p 6.

705 Submission 53, Transport Workers' Union of New South Wales, p 5.

706 Evidence, Mr Wright, 31 January 2022, p 19.

707 See, for example, Submission 55, Australian Rail, Tram and Bus Industry Union (NSW Branch), p 2; Submission 53, Transport Workers' Union of New South Wales, pp 5-6.

708 Evidence, Mr Claassens, 31 January 2022, p 17.

709 Submission 53, Transport Workers' Union of New South Wales, pp 8-9; Evidence, Mr Wright, 31 January 2022, p 21.

Industrial and regulatory expertise

6.26 Suggestions were made about how to enhance the resources available to the Coroners Court of NSW to support its function in investigating workplace deaths, such as the involvement of peak bodies and unions at inquests and the ability to draw on investigators with industrial and regulatory expertise.

6.27 One issue raised by the Mining and Energy Union was the right of unions to appear at inquests. Pursuant to the section 57(1) of the *Coroners Act 2009* (NSW), a coroner may grant 'a person with sufficient interest in the subject matter' leave to appear at an inquest.[710]

6.28 Although the Mining and Energy Union acknowledged that an application to appear is generally granted when representing families at an inquest, it contended that section 57(1) 'falls short of guaranteeing a right of appearance'. It suggested that section 57 could be amended to state:

> A Coroner holding an inquest or inquiry concerning a death, suspected death, fire or explosion at or in a Coal Mine must grant leave under section (1) to an Organisation whose members are employed by or at the mine in which the fatality, accident, fire or explosion occurred.[711]

6.29 The Mining and Energy Union contended that the Coroners Act should also enable organisations representing members to appear at an inquest, due to the impact of any fatality any recommendations stemming from the inquest on the broader workforce.[712] With respect to this point, Mr Barnett from Slater and Gordon Lawyers, argued:

> It is important in the mining industry that findings are relayed across the industry and, of course, the people with the most interest in the safety are the members and mine workers. Their interests need to be represented.[713]

6.30 Mr Timothy Bowen, Manager at Advocacy and Legal, Medical Insurance Group Australia, also supported the early involvement of representative bodies and peak organisations in inquests, like the Royal Australian and New Zealand College of Psychiatrists or the Royal Australian College of General Practitioners, to respond to and comment on matters relevant to their members' interests.[714]

6.31 Some inquiry stakeholders noted that investigations of workplace deaths can be complex in nature due to the various regulatory apparatus and rules in play.[715] Mr Wright acknowledged the added value that could be brought to investigations if coroners had the capacity and authority to draw on the expertise of regulatory bodies. For example, for certain workplace deaths, the coronial investigation could benefit from the involvement and assistance of SafeWork NSW

710 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 4.

711 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 4.

712 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 4.

713 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 4; Evidence, Mr Barnett, 31 January 2022, pp 25-26.

714 Evidence, Mr Timothy Bowen, Manager, Advocacy and Legal, Medical Insurance Group Australia, 30 November 2021, p 30.

715 See, for example, Submission 55, Australian Rail, Tram and Bus Industry Union (NSW Branch), p 2; Evidence, Mr Claassens, 31 January 2021, p 18; Evidence, Mr Wright, 31 January 2022, p 19.

investigators with relevant expertise or experience.[716] Additionally, Mr Claassens commented that for transport deaths investigated by the coroner, the NSW Office of Transport Safety Investigators could be well suited and resourced to assist in the investigation.[717]

Referrals to the Office of the Director of Public Prosecutions

6.32 Section 78 of the *Coroners Act 2009* (NSW) sets out the process for referral of matters to the Office of the Director of Public Prosecutions where the coroner forms an opinion that there is a reasonable prospect that the person could be convicted of an indictable offence which caused a death or fire.[718] The Legal Aid Commission of New South Wales (Legal Aid NSW) explained that if this test is met, the coroner suspends the matter and makes the referral, providing the coronial brief of evidence.[719]

6.33 The Department of Communities and Justice, among other inquiry participants, highlighted that referrals to the Office of the Director of Public Prosecutions are relatively infrequent.[720] The Department of Communities and Justice provided data on the number of referrals to the Office of the Director of Public Prosecutions over the last few years. Essentially, there were three referrals in 2013, two in 2014, three in 2015, none in 2016, one in 2017, two in 2018, one in 2019, five in 2020 and one in 2021.[721] In the National Justice Project's view, coroners have demonstrated reluctance to make these referrals.[722]

6.34 Concerns were also raised about the appropriateness of the current threshold for these referrals. On this, the NSW Bar Association drew the committee's attention to changes which were made under the *Criminal Procedure Act 1986* (NSW) to the committal process to ensure magistrates would not be making decisions about the sufficiency of evidence. The NSW Bar Association contended that a similar shift in policy and legislation should occur with the threshold for coroners to refer matters to the Office of the Director of Public Prosecutions, such that the test should be a 'prima facie' test instead. This would mean that the coroner would then only have to 'determine whether there was admissible evidence capable at law, if accepted, or proving that a "known person" had committed an indictable offence causing the death or fire under investigation'.[723] The NSW Bar Association explained the rationale for this proposal:

> It can be difficult for coroners (and Counsel Assisting) to assess the sufficiency of admissible evidence to give rise to a reasonable prospect of conviction when they have heard a mixture of admissible and inadmissible material. That requires judgments to be made about witness credibility, whether evidence will be excluded and other matters.

716 Evidence, Mr Wright, 31 January 2022, p 19.

717 Evidence, Mr Claassens, 31 January 2021, p 18.

718 *Coroners Act 2009* (NSW), s 78.

719 Submission 46, Legal Aid Commission of New South Wales, p 43.

720 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 19. See also Submission 33, Katie Lowe, p 8.

721 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 19.

722 Submission 27, National Justice Project, pp 14 and 16.

723 Submission 17, New South Wales Bar Association, p 26.

> The prima fade test is clearer for coroners, Counsel Assisting and others. Judging the prospects of conviction is a task for which the OPP is better suited than coroners.[724]

6.35 The National Justice Project also supported legislative amendments to lower the threshold for referral of a matter to the Office of the Director of Public Prosecutions, as well as to SafeWork NSW or any other relevant disciplinary or complaint body, if the coroner 'has reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to the death'.[725] The National Justice Projected highlighted that the current threshold in NSW is higher than in other Australian jurisdictions and its proposed amendment would closer align NSW with those thresholds for referral.[726]

6.36 Stakeholders were also concerned about time taken between a referral being made to the Office of the Director of Public Prosecutions and the decision on whether or not to prosecute.

6.37 Highlighting some specific cases to the committee, the Legal Aid NSW noted that 'the wait for justice is agonising' for families of the deceased. In its view, delay in prosecutions after a referral 'diminishes public confidence in the justice system'.[727] Similarly, Gilbert + Tobin highlighted its experience which was that proceedings in the Coroners Court of NSW can be significantly delayed while awaiting for a decision by the Office of the Director of Public Prosecutions whether or not to prosecute a person of interest. It noted a case where a client had been waiting for over three years for a decision from the coroner as to whether there would be an inquest due to a delay in decision making by the Office of the Director of Public Prosecutions as to whether or not there will be a prosecution.[728]

6.38 Legal Aid NSW made three proposals to address these issues:

- to amend the Coroners Act to introduce a statutory timeframe with respect to referrals to the Office of the Director of Public Prosecutions
- that the Office of the Director of Public Prosecutions develop guidelines in relation to referrals to minimise delay in deciding whether to prosecute
- that the State Coroner consider issuing a practice note for referrals to the Office of the Director of Public Prosecutions and timely decisions relating to those referrals.[729]

6.39 Similarly, Gilbert + Tobin recommended that a protocol between the Coroners Court of NSW and the Office of the Director of Public Prosecutions be established to facilitate faster decision making on prosecutions and 'more transparent, frequent and useful communication with the family of the deceased about the investigation, the decision to prosecute and timing'.[730]

6.40 In Mr Michael Barnes' submission to the statutory review of the Coroners Act, attached to the NSW Bar Associations submission to this inquiry, Mr Barnes contended that referrals to the Office of the Director of Public Prosecutions could be made independently of a coroner's duty

724 Submission 17, New South Wales Bar Association, p 26.

725 Submission 27, National Justice Project, p 16.

726 Submission 27, National Justice Project, p 35.

727 Submission 46, Legal Aid Commission of New South Wales, p 44.

728 Submission 39, Gilbert + Tobin, pp 20 and 27.

729 Submission 46, Legal Aid Commission of New South Wales, p 45.

730 Submission 39, Gilbert + Tobin, p 20.

to make findings, with or without an inquest. In his view, taking into account the prohibition on a coroner to make findings suggesting that an offence has been committed, 'there is little basis for concern that an inquest will undermine a person's right to a fair trial'.[731]

Evidence in coronial investigations and inquests

6.41 There were particular issues raised in relation to evidentiary matters in the coronial jurisdiction. One issue related to the use of witness certificates in coronial proceedings where a person raises an objection to giving evidence on the basis of self-incrimination. There was also the matter of the use of privileged communications and non-publication orders in coronial proceedings. A further issue related to the admissibility of internal investigation reports to the Coroners Court of NSW for deaths in a health setting.

Protection against self-incrimination

6.42 Under section 61 of the *Coroners Act 2009* (NSW) a witness at an inquest may object to giving evidence 'on the ground that the evidence may tend to prove that the witness has committed an offence against or arising under an Australian law or a law of a foreign country or is liable to a civil penalty'.[732] In response to an objection, a coroner can compel the witness to give evidence if the coroner considers it is in the interest of justice. In this circumstance, the coroner grants the witness a certificate under section 61 which means that their evidence in the coronial matter cannot be used against them in any proceedings in a New South Wales court or other body.[733]

6.43 Stakeholders noted some concerns with this provision and its impact, including the difficulties associated with obtaining written witness statements during an investigation and the inconsistencies occurring in relation to the granting of certificates by coroners under section 61.

6.44 The NSW Bar Association expressed a concern about the lack of protection under the legislation for witness statements. It noted that the effect of section 61 means that witnesses may only gain protection against self-incrimination when they participate in a coronial proceeding and object to answering a question.[734]

6.45 The NSW Bar Association contended that there is a gap in the statutory protections for witnesses which is resulting in a 'strong disincentive' for witnesses to provide statements.[735] Mr Kelly noted that witnesses may not provide statements that are 'full and frank' as part of the coronial investigation because only their evidence at the inquest, not their written statement, may be protected against self-incrimination.[736]

731 Submission 17, New South Wales Bar Association, Appendix D, pp 72-73.

732 *Coroners Act 2009* (NSW), s 61.

733 See, for example, Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 5; Submission 57, Public Service Association of New South Wales, pp 5-6.

734 Submission 17, New South Wales Bar Association, p 25.

735 Submission 17, New South Wales Bar Association, p 25.

736 Evidence, Mr Kelly, 31 January 2022, p 26. See also Submission 17, New South Wales Bar Association, p 25.

6.46 Ms Kirsten Edwards, Member of the New South Wales Bar Association Inquests and Inquiries Committee, highlighted this issue to the committee, stating:

> The first is that significant delay is being caused in inquests because there is no facility within the Act to allow people to give evidence in written form by way of statement with protection of a certificate. That means that coroners can wait months and years to get an account from critical people involved in a matter because they are seeking protection when they give evidence under oath.[737]

6.47 Ms Edwards added that this area needs significant reform, given it 'can lead fairly to a lot of speculation and unhappiness as to why it is that person is not giving that account, and sometimes that is based on cautious legal advice and does not necessarily disclose the true issue'.[738]

6.48 With respect to the impact of this provision on witnesses' wellbeing, the NSW Bar Association highlighted that the limits of the current protection often cause distress for witnesses in medical inquests:

> … the issue of protection for witnesses giving statements arises regularly in medical inquests. It is constant source of anxiety and frustration for health practitioners and their legal representatives. Our experience is that health practitioners are usually keen to cooperate with investigations but are extremely conscious of placing themselves at potential risk of disciplinary action. Anecdotal evidence suggests that some health practitioners are more anxious about inquests than about being sued.[739]

6.49 With a view to addressing this issue, several inquiry participants, including Mining and Energy Union and Australian Rail, Tram and Bus Industry Union (NSW Branch), recommended that the protection against self-incrimination be extended to written statements, for example, when provided prior to an inquest or in an investigation when no inquest is held.[740] The importance of addressing these issues was described by Ms Edwards:

> … it is an area where the Bar Association considers there needs to be urgent reform. It is the section which is probably singled out by most participants as the most dysfunctional system because it is not fit for purpose within the coronial jurisdiction.[741]

6.50 In the view of MIGA, a medical defence organisation and professional indemnity insurer, the protection should also extend to criminal, civil, disciplinary and administrative contexts. It argued that an amendment of this type would 'provide significant comfort to interested parties, particularly healthcare and other professionals, in providing statements at an early stage'. It concluded that there exists 'no compelling reason' for the difference in approach for the protection applying to evidence obtained during an investigation and evidence obtained at an inquest.[742]

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737 Evidence, Ms Kirsten Edwards, Member, New South Wales Bar Association Inquests and Inquiries Committee, 29 September 2021, p 22.

738 Evidence, Ms Edwards, 29 September 2021, p 22.

739 Submission 17, New South Wales Bar Association, p 25. See also Submission 5, MIGA, p 2.

740 See, for example, Submission 5, MIGA, p 2; Submission 17, New South Wales Bar Association, pp 25-26; Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 5; Submission 55, Australian Rail, Tram and Bus Industry Union (NSW Branch), p 2.

741 Evidence, Ms Edwards, 29 September 2021, p 22.

742 Submission 5, MIGA, p 2.

6.51 Noting that this type of protection is available in regulatory proceedings, the Mining and Energy Union and the Australian Rail, Tram and Bus Industry Union (NSW Branch) highlighted that written statements given to their respective regulatory bodies are covered by a protection against self-incrimination.[743]

6.52 Stakeholders also raised concerns with coroners not having the power to compel witness statements. In evidence provided to the committee by Adjunct Professor Dillon, expressed in Mr Barnes' submission to the statutory review of the Coroners Act, it was noted that a coroner can require a person to produce a document or thing relevant to an investigation but not information by way of a statement.[744]

6.53 By comparison, the NSW Bar Association highlighted that coroners in Queensland and Victoria have this power and statements are afforded protection. In Queensland, coroners can require people to give information or a document unless they have a reasonable excuse, and in Victoria coroners can demand statements unless the person has a reasonable excuse not to comply. In both jurisdictions, a reasonable or lawful excuse includes giving self-incriminating information.[745] However, in both Queensland and Victoria a coroner can then compel the giving of the evidence in the form of a witness statement and in so doing also confer on the person giving that evidence protection against that same evidence being used against them in criminal or other proceedings, including disciplinary proceedings.[746]

6.54 Legal Aid NSW also raised a concern with timeliness, noting that in practice statements are often prepared with the assistance of lawyers usually well after a death occurs. Considering this can affect the quality of evidence, it called for the Coroners Act to be amended to provide coroners with the power to compel anyone acting in a professional capacity to provide a written statement during an investigation unless there is a lawful excuse not to, which includes the common law privilege against self-incrimination.[747]

6.55 In the view of Mr Barnes, expressed in his submission to the statutory review of the Coroners Act, is it important for the investigative powers of coroners to be 'reviewed and rationalised' so that 'coroners can access the information they need to discharge their role while the interests of those who may be compelled to provide it are appropriately protected'.[748]

6.56 A further concern raised during the inquiry was that there are inconsistent approaches being adopted by coroners at inquests in relation to the granting of certificates when witnesses have objected to giving evidence for reasons of self-incrimination.

6.57 The Mining and Energy Union stated that in its experience, there has been varied responses to witnesses' objections, including the coroner excusing the witness from giving evidence, the granting of a 'global' protection to the witness that covers all of their evidence, or determination

743 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 5; Submission 55, Australian Rail, Tram and Bus Industry Union (NSW Branch), p 2.

744 Submission 14, Adjunct Professor Hugh Dillon, Appendix D, p 96.

745 Submission 17, New South Wales Bar Association, p 25.

746 See *Coroners Act 2008* (Vic), s 50(2); *Coroners Act 2003* (Qld), s 17A.

747 Submission 46, Legal Aid Commission of New South Wales, p 30.

748 Submission 14, Adjunct Professor Hugh Dillon, Appendix D, p 96.

of the protection on a question by question basis.[749] The Union noted that uncertainty about how objections would be dealt with by a coroner can cause distress for witnesses.[750]

6.58 The Mining and Energy Union, among other coronial practitioners who gave evidence to the inquiry, highlighted the distress this can cause families in observing the proceedings, interpreting objections from witnesses as being somewhat obstructive.[751] Ms Edwards noted the confusion and distress that can be caused for families when the decision is made to not compel someone to give evidence, which is particularly relevant when there is the prospect of potential criminal proceedings:

> The practice at the Coroners Court at the moment is that if there is any prospect of a criminal proceeding, like a trial or a referral, a person will not be compelled to give evidence because that could eventually prejudice any steps that were taken to prosecute that particular person. The coroners are required to make an assessment of how likely a referral is. It is really, really important that families have access to legal representation or people that can explain to them … They may not understand that that step is being taken to preserve the ability to hold someone accountable in a different forum, and it can feel like a whitewash or a cover-up.[752]

6.59 The Public Service Association of New South Wales contended that the current wording of section 61 of *Coroners Act 2009* (NSW) does not contemplate global objections which apply to all evidence from the witness. As such, it called for the provision to be amended to make clear that a certificate can be issued in respect to evidence under a global objection.[753]

Privilege and suppression and non-publication orders

6.60 The NSW Bar Association also raised concerns in relation to the protection of privileged communications in coronial proceedings. The NSW Bar Association submitted that it was unclear whether communications which generally attract legal protection, like sexual assault communications privilege and client legal privilege, would be protected in the coronial jurisdiction, given that the rules of evidence under the *Evidence Act 1995* (NSW) do not apply to inquests. In its view, the public policy basis for protection of these types of communications should 'apply just as much in coronial investigations and inquests as in other proceedings'. The NSW Bar Association therefore called for the Coroners Act to be amended to expressly provide that the provisions in Part 3.10 of the *Evidence Act 1995* (NSW), relating to privileges, apply in inquests.[754]

6.61 The NSW Bar Association also submitted that the powers of a coroner with respect to non-publication and suppression orders needs to be clarified. Referring to the case of *Commissioner of Police v Deputy State Coroner for NSW* [2021] NSWSC 398, the NSW Bar Association noted that

749 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 5.

750 Submission 54, CFMEU Mining and Energy Union Division, NSW Branch, p 5.

751 Evidence, Mr Barnett, 31 January 2022, p 27. See also See also Evidence, Craig D Longman, Head, Legal Strategies and Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit, 29 September 2021, p 33.

752 Evidence, Ms Edwards, 29 September 2021, p 22.

753 Submission 57, Public Service Association of New South Wales, p 6.

754 Submission 17, New South Wales Bar Association, p 28.

the Coroners Court is not a 'court' for the purposes of the *Court Suppression and Non-Publication Orders Act 2010* (NSW), meaning that it lacks statutory power to make a suppression order, 'making it necessary for coroners to rely on an implied incidental power' to make such order.[755]

Use of internal reports in coronial investigations

6.62 A specific issue discussed by the Australian Medical Association (NSW) and NSW Nurses and Midwives' Association was the extent to which internal investigations and reports can be used in coronial proceedings, particularly reports these stakeholders referred to as 'root cause analysis' reviews.[756]

6.63 The Australian Medical Association (NSW) noted that deaths that occur in public hospital settings and are reported to the Coroners Court of NSW are almost always investigated via a root cause analysis review by an internal team at the health service in which the person died. It stated that the purpose of this process is 'to review/analyse incidents by identifying the root causes and factors that contributed to an incident' and potentially make recommendations.[757]

6.64 The Australian Medical Association (NSW) further explained that this process is established under division 6C of the *Health Administration Act 1982* (NSW), with some reports provided to NSW Health within 60 days of the incident notification, depending on the severity of the incident.[758] According to evidence from the Association, the advice on conducting a root cause analysis review is that 'care should be taken when reporting so that it does not prejudice police or coronial investigation'.[759]

6.65 The Department of Communities and Justice advised the committee that coroners can only request, not compel, the production of a root cause analysis report.[760] The Department noted that under section 23 of the *Health Administration Act 1982* (NSW) a root cause analysis report cannot be used as evidence in any proceeding, including coronial proceedings. It explained that if a root cause analysis report is produced to the coroner, it cannot be referred to in any coronial findings or recommendations.[761]

6.66 The Department of Communities and Justice highlighted that there may be value in the coroner having access to a root cause analysis report as it is 'useful in indicating whether relevant systemic failures were identified by a hospital, and whether recommendations were made and if so implemented'.[762] Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to

755 Submission 17, New South Wales Bar Association, p 28.

756 Submission 35, Australian Medical Association (NSW), pp 2-3; Evidence, Dr Danielle McMullen, President, Australian Medical Association (NSW), 30 November 2021, pp 31 and 34; Evidence, Ms Toose, 31 January 2022, p 8.

757 Submission 35, Australian Medical Association (NSW), p 2.

758 Submission 35, Australian Medical Association (NSW), p 2.

759 Submission 35, Australian Medical Association (NSW), p 3.

760 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 35.

761 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 35.

762 Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 35. See also Evidence, Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Deprtment of Justice NSW, 30 November 2021, p 51.

the NSW State Coroner, explained that the inadmissibility of a root cause analysis report is a relatively recent change and prior to that root cause analysis reports 'were regularly called for and referred to in proceedings'.[763]

6.67 The Australian Medical Association expressed concern about the duplication of work involved in a root cause analysis report and coronial inquest. In this regard, Dr Danielle McMullen, President of Australian Medical Association (NSW), highlighted that similar to the death prevention function of the coronial system, the aim of the root cause analysis report process is ' … to investigate that event and to implement systemic change to prevent a similar event from occurring in future'.[764] In her experience, there is a risk for the duplication of work which unnecessarily impacts on coronial resources:

> Often we find that the outcomes and the recommendations made by the Coroner either mirror or very closely align with those that have already been made at the local level and have, in fact, often already been implemented.[765]

6.68 However, there were some concerns about these reports being used in the coronial context. Ms Laura Toose, a legal officer at the NSW Nurses and Midwives' Association, contended that it is important for a root cause analysis report to remain inadmissible because witnesses do not usually have access to legal representation nor access to support services prior to being interviewed as part of the root cause analysis review.[766]

6.69 Dr McMullen recognised the balance to be struck between the critical role of the coroner as an independent and unbiased 'fresh set of eyes' on the death and limiting the unnecessary duplication occurring in terms of the review of systemic issues. To this end, Dr McMullen suggested that improvements could be made to information sharing between the Coroners Court of NSW and the public hospital system.[767] Dr McMullen also suggested that there could be improvements in communication between health facilities and the Coroners Court of NSW about the instances in which a root cause analysis report is being conducted and when the report has been completed and may be available to the coroner.[768]

Committee comment

6.70 The committee is grateful to Ms Cassaniti for her participation in this inquiry. In sharing her personal experience and providing insights regarding investigations into her son's death, the committee has heard firsthand the potential benefits a coronial inquest could offer the Cassaniti family.

6.71 Families can come to better understand what happened to their loved one through a coronial inquest into the circumstances of a workplace death. The point has been made many times throughout this report that inquests are an opportunity to identify broader systemic issues and to make recommendations for measures to prevent future deaths. Some deaths that occur in

763 Evidence, Mr McLennan, 30 November 2021, p 51.

764 Evidence, Dr McMullen, 30 November 2021, p 31.

765 Evidence, Dr McMullen, 30 November 2021, p 31.

766 Evidence, Ms Toose, 31 January 2022, p 8.

767 Evidence, Dr McMullen, 30 November 2021, pp 31 and 34.

768 Evidence, Dr McMullen, 30 November 2021, p 34.

the workplace would benefit from this type of investigation to identify safety or system failures and prevent similar incidents from occurring in the future.

6.72 We do not see SafeWork NSW prosecutions offering the same outcomes because, as demonstrated by the case of Ms Cassaniti's son, they serve a different purpose of attributing culpability, and there is limited fact-finding, let alone review of systemic issues, especially when a defendant pleads guilty.

6.73 As such, the committee believes that there are clear benefits to be gained from holding inquests into some workplace fatalities. Unfortunately through, relatively few, if any, workplace deaths are examined by the coroner. Looking at the data from the National Coronial Information System, it shows that a limited number of inquests are held into workplace deaths when compared with the number of workplace deaths reported to the Coroners Court of NSW. Additionally, workplace inquests appear to be a small proportion of all inquests held between 2005 and 2020, with a noticeable collapse in the number of workplace inquests in the past decade. While a number of factors likely contribute to this, the committee believes the Coroners Act should be explicitly amended to require a coronial inquest be held into all workplace deaths, excluding deaths from natural causes.

Recommendation 27

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to mandate that a coronial inquest be held for workplace deaths, excluding deaths from natural causes.

6.74 Further, it was highlighted to us that there are some provisions in the *Coroners Act 2009* (NSW) for information sharing between the Court and the Office of the Director of Public Prosecutions, such as the Court providing all depositions to the Office of the Director of Public Prosecutions Court when a referral for an indictable offence is made. In the instance of workplace deaths, it can be SafeWork NSW rather than the police who is the prosecuting entity. It should be ensured that information and evidence sharing requirements that exist between the Court and the Office of the Director of Public Prosecutions are replicated as between the Court and SafeWork NSW.

6.75 Further, when undertaking inquests into workplace deaths, we consider it appropriate for the Coroners Court of New South Wales to have at its disposal the appropriate resources and expertise in industrial law and work health and safety law, regulation and practice. To this end, the Coroners Court of NSW could have ability to, when appropriate, draw on experts from relevant regulatory bodies to assist in investigations.

6.76 We also consider it important for unions and peak bodies to be part of the coronial process. They can provide insights and specialised knowledge about industry practices and issues and comment on matters relevant to their members' interests.

Recommendation 28

That the NSW Government Coroners Court of New South Wales and SafeWork NSW establish a framework for sharing information, expertise and outcomes of investigations and inquests, including:

- the ability of the Coroners Court of NSW to engage, when appropriate, experts from relevant regulatory bodies to assist in an investigation
- the timely provision of coronial findings and recommendations to SafeWork NSW
- similar information and evidence sharing requirements as that that exists between the Coroners Court of NSW and the Office of the Director of Public Prosecutions.

Recommendation 29

That the NSW Government propose an amendment to the *Coroners Act 2009* (NSW) to ensure unions, employer bodies and other industry organisations be granted standing to appear at inquests.

6.77 We now turn to the coronial jurisdiction's intersection with criminal proceedings. The committee notes stakeholder comments about the threshold in section 78 of the *Coroners Act 2009* (NSW) which enables coroners to refer matters to the Office of the Director of Public Prosecutions when there is a reasonable prospect that the person could be convicted of an indictable offence. We recognise that the test and process for committal proceedings in New South Wales underwent reform in 2018, with magistrates no longer required to make a decision about the sufficiency of the evidence before committal. We suggest that the NSW Government investigate whether the test in section 78 of the *Coroners Act 2009* (NSW) remains suitable in light of those changes.

Recommendation 30

That the NSW Government consider the appropriateness of amending section 78 of the *Coroners Act 2009* (NSW) to change the threshold for referrals of matters to the Office of the Director of Public Prosecutions to the 'prima facie' test.

6.78 Separate to the legislative test for referrals, there is also the issue of delays when matters are referred to the Office of the Director of Public Prosecutions. Bereaved families already experience significant delay in the coronial process which is prolonged even further when a referral is made. The committee understands families endure much angst awaiting the decision as to whether a prosecution will be brought. The inquest process is often paused during that time, with families' questions about the death remaining unanswered.

6.79 In the event that a decision is finally made that a prosecution not proceed, the inquest may resume, however often many years have passed since the death, meaning it takes some time for coronial recommendations and findings to be eventually delivered. We agree with stakeholders that measures should be implemented to improve delays and to regularly inform families about the progress of the matter. There should also be improved record keeping of when referrals are made under section 78 of the *Coroners Act 2009* (NSW) and the reasons for referral.

Recommendation 31

That the Coroners Court of New South Wales and the Office of the Director of Public Prosecutions implement a protocol relating to referrals under section 78 of the *Coroners Act 2009* (NSW) to minimise delays, ensure the timely provision of information to families and improve record keeping.

6.80 The committee also supports Legal Aid NSW's calls for the introduction of a statutory timeframe with respect to referrals from the Coroners Court to the Office of the Director of Public Prosecutions, and for other supporting procedures, practice notes or guidelines to be developed on referrals between the two organisations, all of which could help to minimise delays and ensure the timely provision of information to families.

Recommendation 32

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a statutory timeframe with respect to referrals to the Office of the Director of Public Prosecutions.

Recommendation 33

That the State Coroner consider issuing a practice note relating to referrals to the Office of the Director of Public Prosecutions, focusing on the need for timely decisions and information to be provided to families.

Recommendation 34

That the Office of the Director of Public Prosecutions develop guidelines in relation to referrals under section 78 of the *Coroners Act 2009* (NSW) to minimise delay in deciding whether to prosecute.

6.81 With respect to the evidence regarding witness statements, we acknowledge that the effective collection of evidence as soon as possible after the death is important for the timely progress of an investigation and quality of proceedings. To this end, the committee believes that the powers and associated protections relating to witness statements in Queensland and Victoria should be introduced in this state as they appear to better balance the interests of the investigation with those of witnesses.

6.82 As such, coroners in NSW should have the power to compel the giving of evidence, including in the form of witness statements, without risking witness self-incrimination. In the context of our recommendation in chapter 4 that coroners be empowered to make findings without inquest, the power to compel witness statements is critical to coroners having ready access to all the information they need to discharge their role. Without this power and the associated

protection for witnesses contained in section 61(7) of the *Coroners Act 2009* (NSW), coroners face the current challenges with statements not being provided, or statements not being as complete as they should be, resulting in a less than full account of the causes and circumstances of a death, which is clearly contrary to the public interest.

Recommendation 35

That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to extend the protection against self-incrimination in section 61 of the *Coroners Act 2009* (NSW) to the giving of written statements, for example, when provided prior to an inquest or in an investigation when no inquest is held.

6.83 Regarding access to and use of internal investigation reports in coronial proceedings, including root cause analysis reports, we agree that access to a root cause analysis may be useful for coroners. However, the evidence was limited on this issue, and we would prefer the matter had broader consultation and consideration before making any recommendations in changing the status quo.

Appendix 1 Submissions

No.	Author
1	Magistrates Court of Tasmania
2	Mr Robert Knight
3	Mr Terry Flanders
4	Ms Jennifer Saunders
5	MIGA
6	Australian Lawyers Alliance
7	Associate Professor Laura Grenfell, Associate Professor Julie Debeljak, and Dr Anita Mackay
8	Aboriginal Health and Medical Research Council of NSW
9	The Law Society of New South Wales
10	Mr Robert Wade
10a	Mr Robert Wade
10b	Mr Robert Wade
10c	Mr Robert Wade
11	Mrs Leesa Topic
12	Justice Action
13	Coroners Court of Queensland
14	Adjunct Professor Hugh Dillon
14a	Adjunct Professor Hugh Dillon
15	Mr Mark Leveson
16	Mary Jerram AM
17	New South Wales Bar Association
18	NSW Government
19	Police Association of NSW
20	Confidential
21	Confidential
21a	Confidential
22	Lynda Newnam
23	Public Interest Advocacy Centre
24	Name suppressed
25	Associate Professor Megan Williams
26	Confidential
27	National Justice Project

No.	Author
28	Adjunct Professor George Newhouse
29	Support After Murder Inc.
30	The Royal Australian and New Zealand College of Psychiatrists (RANZCP)
31	Jumbunna Institute of Indigenous Education and Research, Research Unit
32	Elizabeh Jarrett
33	Katie Lowe
34	New South Wales Aboriginal Land Council
35	Australian Medical Association (NSW) Limited
36	Aboriginal Legal Service (NSW/ACT)
37	Independent Bushfire Group
38	Deadly Connections Community & Justice Services Inc
39	Gilbert and Tobin
40	Tracy Mackander
41	Mr Michael Barnes
42	Confidential
43	Name suppressed
44	Susan Slatcher
45	Mark McKenzie
46	Legal Aid Commission of New South Wales
47	Confidential
48	Lindsay McCabe
49	Anglican Community Services (trading as Anglicare)
50	Confidential
51	New South Wales Nurses and Midwives' Association
52	CFMEU Construction and General Division NSW Branch
53	Transport Workers' Union of NSW
54	CFMEU Mining & Energy Union Division, NSW Branch
55	Australian Rail, Tram and Bus Industry Union (NSW Branch)
56	Noeline Bridge
57	Public Service Association of New South Wales
58	Jacci Quinlivan
59	New South Wales Jewish Board of Deputies Ltd
60	Domestic Violence NSW
61	Australian Federation of Islamic Councils
62	Ethnic Communities' Council of NSW

No.	Author
63	Confidential
64	AASHA Australia Foundation
65	Tripoli and Mena Association
66	Dr Rebecca Scott Bray

Appendix 2 Witnesses at hearings

Date	Name	Position and Organisation
Wednesday 29 September 2021 Virtual hearing via videoconference	Ms Mary Jerram AM	Previous NSW State Coroner from 2007 to 2013
	Adjunct Professor Hugh Dillon	Previous Deputy State Coroner from 2008 to 2016 and researcher in relation to coronial systems at the Law Faculty, University of New South Wales
	Mr Michael Barnes	Previous Queensland State Coroner from 2003 to 2013 and previous NSW State Coroner from 2014 to 2018
	Mr David Evenden	Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW
	Dr Kristina Stern SC	Chair, NSW Bar Association Inquests and Inquiries Committee
	Ms Kirsten Edwards	Member, NSW Bar Association Inquests and Inquiries Committee
	Dr Louis Schetzer	Policy & Advocacy Manager, Australian Lawyers Alliance
	Ms Catherine Henry	Principal, Catherine Henry Lawyers
	Mr Craig D. Longman	Head, Legal Strategies and Senior Researcher, Jumbunna Institute of Indigenous Education and Research (JIER), Research Unit
	Ms Alison Whittaker	Senior Researcher, Jumbunna Institute of Indigenous Education and Research (JIER), Research Unit
	Dr Rebecca Scott Bray	Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney
	Professor Megan Williams	Head of Girra Maa Indigenous Health Discipline, School of Public Health, Faculty of Health, University of Technology Sydney

Date	Name	Position and Organisation
Tuesday 30 November 2021 Macquarie Room, Parliament House, Sydney	Mrs Leesa Topic	Mother of Miss Courtney Jayde Topic
	Mr Ron Topic	Father of Miss Courtney Jayde Topic
	Ms Sarah Crellin	Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT)
	Mr Jonathon Hunyor	Chief Executive Officer, Public Interest Advocacy Centre
	Mr Ian Brown	Secretary, Independent Bushfire Group
	Mr Dave Darlington	Committee Member, Independent Bushfire Group (via WebEx)
	Mr Geoffrey Luscombe	Convenor, Independent Bushfire Group (via WebEx)
	Dr Christina Matthews	Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
	Dr Andrew Ellis	Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
	Dr Danielle McMullen	President, Australian Medical Association (NSW)
	Mr Timothy Bowen	Manager – Advocacy and Legal, MIGA
	Mr Mark Follett	Executive Director, Policy, Reform and Legislation Branch, Department of Communities and Justice
	Mr Don McLennan	Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW
	Mr Carlo Scasserra	Assistant Commissioner Governance and Continuous Improvement, Corrective Services NSW (via WebEx)

Date	Name	Position and Organisation
	Mr Danny Doherty APM	Detective Superintendent, NSW Police Force
	Dr Isabel Brouwer	Chief Forensic Pathologist and Clinical Director Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service
	Ms Rebecca Gigli	Chief Operating Officer Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service
Monday 31 January 2022 Jubilee Room, Parliament House, Sydney	Ms Patrizia Cassaniti	Mother of Christopher Cassaniti
	Ms Laura Toose	Legal Officer, NSW Nurses and Midwives' Association
	Mr Mitch Wright	Media and Political Advisor, Transport Workers Union
	Mr Alex Claassens	Branch Secretary, Rail, Tram & Bus Union (NSW Branch)
	Ms Helen Bellette	Branch Organiser, Rail, Tram & Bus Union (NSW Branch)
	Ms Rita Mallia	State President, CFMEU Construction and General Division NSW
	Mr Ivan Simic	Senior Partner, Taylor & Scott Solicitors
	Mr Grahame Kelly	General Secretary, Mining and Energy Union
	Mr Stuart Barnett	State Practice Group Leader, Slater & Gordon Lawyers

Appendix 3 Minutes

Minutes no. 1
Thursday 13 May 2021
Select Committee on the coronial jurisdiction in New South Wales
Room 1254, Parliament House, Sydney, 2.31 pm

1. Members present
Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair (from 2.32 pm)*
Mr Khan
Mr Roberts
Ms Sharpe

2. Apologies
Mrs Ward

3. Tabling of resolution establishing the committee
The Chair tabled the resolution of the House establishing the committee, which reads as follows:

(1) That a select committee be established to inquire into and report on the coronial jurisdiction in New South Wales, and in particular:

(a) the law, practice and operation of the Coroner's Court of NSW, including:
(i) the scope and limits of its jurisdiction,
(ii) the adequacy of its resources,
(iii) the timeliness of its decisions,
(iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
(v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,
(vi) the operational arrangements in support of the Coroner's court with the NSW Police Force and the Ministry of Health,

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

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

(d) any other related matter.

(2) That, notwithstanding anything to the contrary in the standing orders, the committee have the same membership as the Select Committee on the High Level of First Nations people in custody and oversight and review of deaths in custody, comprising:

(a) two government members, being the Honourable Trevor Khan MLC and the Honourable Natalie Ward MLC,

(b) two opposition members, being the Honourable Adam Searle MLC and the Honourable Penny Sharpe MLC, and

(c) two crossbench members, one from the Greens and one from another cross bench party, being Mr David Shoebridge and the Honourable Rod Roberts.

(3) That the Chair of the committee be the Honourable Adam Searle MLC and the Deputy Chair be Mr David Shoebridge MLC.

(4) That, unless the committee decides otherwise:

(a) submissions to inquiries are to be published, subject to the Committee Clerk checking for confidentiality and adverse mention and, where those issues arise, bringing them to the attention of the committee for consideration,

(b) the Chair's proposed witness list is to be circulated to provide members with an opportunity to amend the list, with the witness list agreed to by email, unless a member requests the Chair to convene a meeting to resolve any disagreement,

(c) the sequence of questions to be asked at hearings alternate between Opposition, Cross-bench and Government members, in that order, with equal time allocated to each,

(d) transcripts of evidence taken at public hearings are to be published,

(e) supplementary questions are to be lodged with the Committee Clerk within two days (excluding Saturday and Sunday) following the receipt of the hearing transcript, with witnesses requested to return answers to questions on notice and supplementary questions within 21 calendar days of the date on which questions are forwarded to the witness, and

(f) answers to questions on notice and supplementary questions are to be published, subject to the Committee Clerk checking for confidentiality and adverse mention and, where those issues arise, bringing them to the attention of the committee for consideration.

(5) That the committee report by the end of December 2021.

4. Conduct of committee proceedings – media

Resolved, on the motion of Ms Sharpe: That unless the committee decides otherwise, the following procedures are to apply for the life of the committee:

- the committee authorise the filming, broadcasting, webcasting and still photography of its public proceedings, in accordance with the resolution of the Legislative Council of 18 October 2007
- the committee webcast its public proceedings via the Parliament's website, where technically possible
- the committee adopt the interim guidelines on the use of social media and electronic devices for committee proceedings, as developed by the Chair's Committee in May 2013 (attached)
- media statements on behalf of the committee be made only by the Chair.

5. Conduct of the inquiry into the coronial jurisdiction of New South Wales

5.1 Advertising

The committee noted that all inquiries are advertised via Twitter, Facebook, stakeholder letters and a media release distributed to all media outlets in New South Wales. It is no longer standard practice to advertise in the print media.

5.2 Closing date for submissions

Resolved, on the motion of Mr Roberts: That the closing date for submissions be 27 June 2021.

5.3 Stakeholder list

Resolved, on the motion of Mr Khan: That the secretariat email members with a list of stakeholders to be invited to make written submissions, and that members have two days from the email being circulated to amend the list or nominate additional stakeholders.

Resolved, on the motion of Mr Khan:

- that the standard stakeholder invitation email be slightly modified for those First Nation organisations who previously made a submission to the inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody, to acknowledge their contribution to the previous inquiry and explain how this new inquiry will examine the coronial jurisdiction in more detail
- a formal letter be emailed to the NSW Coroners Court to invite them to make a submission
- formal letters be emailed to Coroners Courts in other jurisdictions to encourage their contribution to the inquiry.

5.4 Proposed site visits

Resolved, on the motion of Mr Roberts: That the Chair:

- write to the President of the NSW Legislative Council to seek the approval of the President to visit the Victorian Coroners Court, and if approval is given, seek authority from the House
- write to the Coroners Court NSW to seek their assistance in facilitating a site visit to the court complex at Lidcombe and to encourage their participation in giving evidence at a hearing
- write to the Coroners Court in Victoria to seek their assistance in facilitating a proposed site visit to the Victorian Coroners Court.

5.5 Proposed timeline and hearings

Resolved, on the motion of Ms Sharpe: That the committee adopt the following timeline for the administration of the inquiry:

- Site visit to the NSW Coroners Court – July 2021
- Site visit to the Victorian Coroners Court – July 2021
- Two public hearings – one in July 2021 and one in September 2021, subject to member availability.

6. Adjournment

The committee adjourned at 2.33 pm, *sine die.*

Sarah Dunn
Committee Clerk

Minutes no. 2
Wednesday 29 September 2021
Select Committee on the coronial jurisdiction in New South Wales
Via WebEx at 9.13 am

1. Members present

Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair*
Ms Cusack *(from 11.45 am to 12.30pm, from 1.53 pm to 2.21 pm)*
Mr Khan *(until 2.00 pm)*
Mr Roberts
Ms Sharpe

2. Committee membership

The committee noted that the Hon Catherine Cusack replaced the Hon Natalie Ward on the committee from the 16 June 2021.

3. Draft minutes

Resolved, on the motion of Mr Roberts: That draft minutes no. 1 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received:

- 20 May 2021 – Email from Ms Jackie Fitzgerald, Executive Director, NSW Bureau of Crime Staistics and Research, to committee, declining the invitation to make a submission to the inquiry
- 24 May 2021 – Email from Ms Cassandra Kang, Strategic Development Manager, Community Restorative Centre, to committee, declining the invitation to make a submission to the inquiry
- 24 May 2021 – Email from Mr Chris D'Aeth, Executive Director and Principal Registrar, Supreme Court of New South Wales, to Chair, advising that the Supreme Court will not be making a submission
- 17 June 2021 – Memorandum from the Hon Mathew Mason-Cox MLC, President of the Legislative Council, to Chair, approving the committee's interstate site visit to the Victorian Coroner's Court
- 21 June 2021 – Email from Ms Suellen Simpson, to secretariat, requesting that the submission deadline be extended to provide the opportunity of family members of crime to participate in the inquiry
- 7 July 2021 – Email from Ms Donna Austin, Research Officer, Health Services Union, to Chair, advising that they will not be making a submission to the inquiry
- 12 July 2021 – Email from Ms Brooke Delbridge, Policy officer, Chief Magistrate's Office, to secretariat, advising that the Chief Magistrate will not be making a submission to the inquiry, but is happy to answer any specific questions the members may have in writing
- 15 July 2021 – Email from Ms Christina Hey-Nguyen, NSW Co-Convenor, Australian Lawyers for Human Rights, to secretariat, advising that they will not be making a submission to the inquiry
- 1 September 2021 – Email from the legal representative of authors of confidential submission no. 42, to secretariat, advising that the submission be kept confidential, until the inquest of their family member has concluded, at which time the submission can be made public
- 9 September 2021 – Email from Ms Vicky Kuek, Principal Policy Lawyer, The Law Society of NSW, to secretariat, declining the invitation to appear at the hearing on 29 September 2021
- 9 September 2021 – Email from Ms Brooke Delbridge, Policy Officer, Chief Magistrate's Office, to secretariat, declining the invitation to appear at the hearing on 29 September 2021 and offering to provide answers to any specific questions in writing
- 13 September 2021 – Email from Ms Teresa O'Sullivan, NSW State Coroner, to secretariat, requesting that the committee provide her with questions in writing at least two weeks in advance of the hearing.

Sent:

- 13 May 2021 – Letter from Chair, to the State Coroner in New South Wales, regarding an invitation to make a submission and a proposal to visit the Coroners Court
- 13 May 2021 – Letter from Chair, to the State Coroner in Victoria, including an invitation to make a submission to the inquiry
- 13 May 2021 – Letter from Chair, to the State Coroner in Queensland, including an invitation to make a submission to the inquiry
- 13 May 2021 – Letter from Chair, to the State Coroner in South Australia, including an invitation to make a submission to the inquiry
- 13 May 2021 – Letter from Chair, to the State Coroner in Tasmania, including an invitation to make a submission to the inquiry
- 13 May 2021 – Letter from Chair, to the State Coroner in the Northern Territory, including an invitation to make a submission to the inquiry

- 13 May 2021 – Letter from Chair, to the State Coroner in the Australian Capital Territory, including an invitation to make a submission to the inquiry
- 13 May 2021 – Letter from Chair, to the State Coroner in Western Australia, including an invitation to make a submission to the inquiry
- 10 June 2021 – Memorandum from Chair, to the Hon Matthew Mason-Cox MLC, President of the Legislative Council, seeking approval for the committee to undertake a site visit to the Victorian Coroners Court
- 17 June 2021 – Letter from Chair, to State Coroner, Coroners Court of Victoria, advising that the committee would like to visit the Court and seeking their assistance in facilitating the visit
- 21 June 2021 – Email from secretariat, to Ms Suellen Simpson, explaining the committee's process for inviting submissions and advising that she can request an extension to make a submission
- 23 June 2021 – Letter from Chair, to Mr Christopher J Blanden QC, President, The Victorian Bar, advising that the committee would like to meet with them when they visit Victoria in July
- 23 June 2021 – Letter from Chair, to Ms Tania Wolff President, Law Institute Victoria, advising that the committee would like to meet with them when they visit Victoria in July
- 31 August 2021 – Email from secretariat, to Multicultural NSW, requesting a distribution list to get in contact with culturally and linguistically diverse communities, particularly those organisations that may assist culturally and linguistically diverse families through the coronial inquest process
- 20 September 2021 – Email from secretariat, to Multicultural NSW, distributing the letter from the Chair inviting organisations to make a submission
- 20 September 2021 – Letter from Chair, to organisations representing culturally and linguistically diverse communities inviting them to make a submission by Sunday 24 October 2021.

Resolved, on the motion of Mr Shoebridge: That the committee keep the following correspondence confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information:

- 1 September 2021 – Email from the legal representative of authors of confidential submission no. 42, to secretariat, advising that the submission be kept confidential, until the inquest of their family member has concluded, at which time the submission can be made public.

5. Submission deadline extended

The committee noted that the deadline for providing a submission to the inquiry was extended to Sunday 11 July 2021, and that the Chair continued to approve requests for extensions beyond this date for the following stakeholders:

- Gilbert and Tobin Lawyers, extension granted to 8 August 2021
- Legal Aid NSW, extension granted to 17 September 2021
- Dr Rebecca Scott Bray, University of Sydney, *TBC*
- Ms Tracey Mackander, extension granted to 31 August 2021
- Ms Belinda Lockwood, extension granted to 31 August 2021
- Ms Gabrielle Gawthorne, extension granted to 31 August 2021.

6. Public submissions

The committee noted that the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 10a, 10b, 10c, 11, 12, 13, 14, 14a, 15, 16, 17, 18, 19, 22, 23, 25, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 44, 45, and 46.

7. Name suppressed submissions

The committee noted that the following submissions were partially published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 24 and 43.

Resolved, on the motion of Mr Shoebridge: That the committee keep submission author names confidential, as per the request of the author, in submissions nos. 24 and 43.

8. Confidential submissions

Resolved, on the motion of Mr Shoebridge: That the committee keep submission nos. 20, 21, 26 and 47 confidential, subject to further review by members, as per the recommendation of the secretariat, and agreed to by the submission author, as they contain identifying and/or sensitive information.

9. Submission no. 42

The committee noted the correspondence from the legal representative of authors of confidential submission number 42, to secretariat, dated 1 September 2021, asking that the submission be processed as confidential until the inquest of their family member has concluded and the submission can then be published online. The committee noted that the submission author has also indicated that they do not have any objection to evidence from their submission being included in the committee's report.

Resolved, on the motion of Mr Shoebridge: That the committee keep submission no. 42 confidential, as per the request of the author, until the inquest of their family member has concluded at which time the committee authorise the publication of submission no. 42.

10. Work, health and safety unions and employer associations

Resolved, on the motion of Mr Shoebridge: That the committee invite unions and employer associations to make a submission to the inquiry by Monday 13 December 2021 on the intersection between the coronial jurisdiction and work, health and safety laws, particularly in terms of work-related fatalities, and the final list of unions and employer associations be circulated to the committee.

11. Culturally and linguistically diverse communities

The committee noted that it invited organisations that assists culturally and linguistically diverse communities through the coronial process to make a submission by 24 October 2021, through Multicultural NSW's network distribution list.

12. Law and Justice Foundation NSW report

The committee noted that it published on the inquiry webpage the Law and Justice Foundation of NSW report on *Aboriginal and Torres Strait Islander Families in Australian Coroners Courts.*

13. Upcoming inquiry activity

The committee noted that it will be holding inquiry activity on the following dates:

- Wednesday 29 September – virtual public hearing
- Thursday 4 November – site visit to Lidcombe
- Friday 26 November – public hearing
- Tuesday 30 November – public hearing (originally the site visit to Victoria, and subject to change if restrictions ease)
- Tuesday 14 December – public hearing (State Coroner)
- potentially a further hearing date in February 2022.

14. Questions to the Chief Magistrate

The committee noted the correspondence from the Chief Magistrate of the Local Court's office declining the invitation to appear at the hearing on 29 September 2021, however offering to provide answers to any specific questions the committee may have in writing.

15. Pre-hearing questions to the NSW State Coroner

The committee noted the correspondence from Ms Teresa O'Sullivan, NSW State Coroner, requesting that the committee provide her with questions in writing at least two weeks in advance of the hearing to ensure

that she is well prepared and avoid her having to take questions on notice. The committee decided to postpone discussion of this matter.

16. Extending the report tabling

Resolved, on the motion of Mr Khan: That the Chair seeks agreement from the House to extend the report tabling date to the 29 April 2022, noting that the committee intends to report by the end of March 2022.

17. Allocation of questioning

The committee noted that the resolution appointing the committee provides that 'the sequence of questions to be asked at hearings alternate between Opposition, Crossbench and Government members, in that order, with equal time allocated to each'.

Resolved, on the motion of Ms Sharpe: That the sequence of questions at the virtual public hearing on 29 September 2021 be left in the hands of the Chair.

18. Photo of committee for social media

Resolved, on the motion of Ms Sharpe: That the secretariat take a screenshot of the committee during its deliberative for the purposes of publishing on social media for all future hearings for this inquiry.

19. Virtual public hearing

The committee proceeded to take evidence in public.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings, virtual hearing etiquette and other matters.

The following witnesses were admitted via video link, sworn and examined:

- Ms Mary Jerram AM, previous NSW State Coroner from 2007 to 2013
- Adjunct Professor Hugh Dillon, previous Deputy State Coroner from 2008 to 2016 and researcher in relation to coronial systems at the Law Faculty, University of New South Wales
- Mr Michael Barnes, previous Queensland State Coroner from 2003 to 2013 and previous NSW State Coroner from 2014 to 2018.

The evidence concluded and the witnesses withdrew.

The following witness was admitted via video link, sworn and examined:

- Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW.

Mr Evenden tendered the following documents:

- 'Sad news sorry business, Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Health, December 2015
- 'State Coroner's Guidelines 2013, Chapter 2, The rights and interests of family members', Coroners Court of Queensland
- 'Inquest into the death of Master Carr and Jaylen', Coroners Court of Queensland, 27 August 2020.

The evidence concluded and the witness withdrew.

The following witnesses were admitted via video link, sworn and examined:

- Ms Kristina Stern SC, Chair, NSW Bar Association Inquests and Inquiries Committee
- Ms Kirsten Edwards, Member, NSW Bar Association Inquests and Inquiries Committee
- Dr Louis Schetzer, Policy & Advocacy Manager, Australian Lawyers Alliance
- Ms Catherine Henry, Principal, Catherine Henry Lawyers.

The evidence concluded and the witnesses withdrew.

The following witnesses were admitted via video link, sworn and examined:

- Mr Craig D. Longman, Head, Legal Strategies and Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit
- Ms Alison Whittaker, Senior Researcher, Jumbunna Institute of Indigenous Education and Research, Research Unit
- Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, The University of Sydney
- Professor Megan Williams, Head of Girra Maa Indigenous Health Discipline, School of Public Health, Faculty of Health, University of Technology Sydney.

The evidence concluded and the witnesses withdrew.

The public hearing concluded at 2.18 pm.

20. Draft 2017 Statutory Review

Resolved, on the motion of Ms Sharpe: That the committee write to the Attorney General requesting a copy of the draft 2017 Statutory Review of the *Coroners Act 2009*.

21. Tendered documents

Resolved, on the motion of Mr Shoebridge: That the committee accept and publish the following document(s) tendered during the public hearing by Mr David Evenden, Solicitor Advocate, Coronial Inquest Unit, Legal Aid NSW:

- 'Sad news sorry business, Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying', Queensland Health, December 2015
- 'State Coroner's Guidelines 2013, Chapter 2, The rights and interests of family members', Coroners Court of Queensland
- 'Inquest into the death of Master Carr and Jaylen', Coroners Court of Queensland, 27 August 2020.

22. Adjournment

The committee adjourned at 2.21 pm, until Thursday 4 November (site visit to Lidcombe Coroners Court).

Sarah Dunn
Committee Clerk

Minutes no. 3
Wednesday 10 November 2021
Select Committee on the coronial jurisdiction in New South Wales
Via WebEx at 1.48 pm

1. Members present

Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair*
Ms Cusack *(from 1.52 pm)*
Mr Khan
Mr Roberts
Ms Sharpe

2. Draft minutes

Resolved, on the motion of Ms Sharpe: That draft minutes no. 2 be confirmed.

3. Correspondence

The committee noted the following items of correspondence:

Received:

- 5 October 2021 – Email from Ms Teresa O'Sullivan, NSW State Coroner, to Secretariat, advising that she will only be able to give evidence to questions provided in advance of the hearing, otherwise questions will be take on notice.

Sent:

- 18 October 2021 – Letter from Chair, to Hon Mark Speakman MP, Attorney General, and Minister for Prevention of Domestic and Sexual Violence, requesting a copy of the draft 2017 Statutory Review report by 8 November 2021.

4. Work, health and safety unions and employer associations

The committee noted that letters have now been sent inviting unions and employer associations to make a submission by Monday 20 December 2021, regarding the intersection between the coronial jurisdiction and work, health and safety laws.

5. Culturally and linguistically diverse communities

The committee noted that a request for organisations that assist culturally and linguistically diverse communities through the coronial jurisdiction to make a submission was sent through Multicultural NSW with a deadline of Sunday 24 October 2021. To date no submission has been received from these organisations.

6. Public submission

The committee noted that Submission no. 48 was published by the committee clerk under the authorisation of the resolution appointing the committee.

7. Upcoming inquiry activity

The committee noted the updated dates for future inquiry activity, as agreed via email:

- Tuesday 30 November 2021 – Public hearing
- Tuesday 14 December 2021 – Site visit to Lidcombe Coroners Court and public hearing with State Coroner
- Monday 31 January 2022 – Public hearing
- Friday 4 February 2022 – Site visit to Victoria

8. Publication of hearing recording

The committee noted the recording from the hearing on 29 September 2021 was placed on the Parliament's YouTube channel.

9. Answers to questions on notice

The committee noted the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- Answers to questions on notice from Jumbunna Institute of Indigenous Education and Research (JIER), Research Unit received 28 October 2021.

10. Pre-hearing questions to the NSW State Coroner

The committee noted the correspondence from Ms Teresa O'Sullivan, NSW State Coroner, advising that she will only be able to give answers at the hearing if the questions are provided two weeks in advance, otherwise questions will be taken on notice.

Resolved, on the motion of Mr Shoebridge: That the committee provide the NSW State Coroner with written questions two weeks in advance of her appearing at the hearing on 14 December 2021, noting that

it is within the committees power to ask questions that flow from the answers that are provided at the hearing.

Resolved, on the motion of Mr Roberts: That the secretariat prepare draft questions for the NSW State Coroner in relation to the issues raised in submissions and that these be circulated to the committee for consideration/agreement.

Resolved, on the motion of Mr Shoebridge: That on Tuesday 14 December 2021 the committee visit the Lidcombe Coroners Court between 9.30 am and 1.00 pm, with a public hearing to then be held at Parliament House, Sydney, from 2.30 pm to 4.30 pm.

11. Corrective Services NSW submission and appearance at a hearing

Resolved, on the motion of Mr Shoebridge: That the committee invite Corrective Services NSW to make a submission on what work they are doing in relation to the deaths of First Nations people in custody and the intersection between the coronial jurisdiction, and that they be invited to appear and give evidence at an upcoming hearing.

12. Adjournment

The committee adjourned at 1.55 pm, until Tuesday 30 November 2021, public hearing.

Sarah Dunn
Committee Clerk

Minutes no. 4
Tuesday 30 November 2021
Select Committee on the Coronial Jurisdiction in New South Wales
Macquarie Room, Parliament House, Sydney, at 9.07 am

1. Members present

Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair* (from 9.18 am until 11.51 am and from 2.00 pm)
Ms Cusack (until 11.51 am and from 1.41 pm)
Mr Khan (until 10.30 am and from 11.00 am)
Mr Roberts
Ms Sharpe

2. Apologies

3. Previous minutes

Resolved, on the motion of Mr Roberts: That draft minutes no. 3 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 1 November 2021 – Email from Hon Adam Searle MLC, to secretariat, attaching a research response from the NSW Parliamentary Research Service on the Coroner's Courts around Australia.
- 9 November 2021 – Email from Ms Chanelle McEnallay, Company Secretary, Ramsay Health Care, declining the invitation to make a submission to the inquiry on the intersection between the coronial jurisdiction and work, health and safety laws.
- 9 November 2021 – Email from the Office of Mark Speakman, Attorney General, to secretariat, advising that they had only received advice on 8 November 2021 in response to the letter from the Chair

requesting a copy of the draft 2017 Statutory Review report and will be reviewing this as a matter of urgency.

- 11 November 2021 – Email from Witness B, to secretariat, providing the reasons why they would like to give evidence to the committee confidentially.
- 18 November 2021 – Letter from Hon Mark Speakman, Attorney General, to Chair, providing a response in relation to obtaining a copy of the draft 2017 Statutory Review report.
- 23 November 2021 – Email from Ms Kate Aubrey-Poiner, Strategy and Policy Manager, NSW Aboriginal Land Council, declining the invitation to appear at the hearing on 30 November 2021.
- 26 November 2021 – Letter from Minister for Health and Medical Research, Hon Brad Hazzard MP, and Attorney General, to Chair, Hon Mark Speakman, attaching the Timeliness of Coronial Procedures Taskforce's progress report (October 2021).
- 29 November 2021 – Email from Margaret Cashman, Director of Health Policy and Programs, Aboriginal Health and Medical Research Council of NSW, to secretariat, notification of appearance withdrawn for public hearing.
- 29 November 2021 – Email from Rani Young, Principal Policy Manager, Corrections Strategy and Executive Services, Corrective Service NSW, Department of Communities and Justice, to secretariat, response to letter, dated 12 November 2021, with invitation to provide written submission.

Sent:

- 9 November 2021 – Email from secretariat, to the Office of Mark Speakman, Attorney General, following up a response to the letter from the Chair requesting a copy of the draft 2017 Statutory Review report.
- 12 November 2021 – Letter from Chair, to Mr Kevin Corcoran, Acting Commissioner, Corrective Services NSW, inviting them to make a written submission to the inquiry and appear at the hearing on 30 November 2021.
- 18 November 2021 – Email from secretariat, to the Office of Mark Speakman, Attorney General, following up again the response to the letter from the Chair requesting a copy of the draft 2017 Statutory Review report.

Resolved, on the motion of Mr Khan: That the committee keep the following item of correspondence confidential, as per the recommendation of the secretariat, as it contains identifying information:

- 11 November 2021 – Email from Witness B, to secretariat, providing the reasons why they would like to give evidence to the committee confidentially.

5. Response from the Attorney General

The committee noted and deferred consideration of the response from Hon Mark Speakman, Attorney General, in relation to the request for a copy of the draft 2017 Statutory Review report.

6. *In camera* evidence

The committee noted the request from Witness A and Witness B to give evidence *in camera* at the hearing today.

Resolved, on the motion of Mr Khan: That the committee take evidence in camera from Witness A and Witness B at the hearing on 30 November 2021.

7. Confidential supplementary submission no. 21

Resolved, on the motion of Mr Khan: That the committee keep supplementary submission no. 21 confidential, as per the request of the author as it contains identifying and/or sensitive information.

8. Answers to questions on notice – 29 September hearing

The committee noted the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from the NSW Bar Association, received 11 November 2021.

9. 14 December site visit and hearing schedule

The committee noted the confirmed itinerary for the site visit to the Forensic Medicine and Coroners Court complex in Lidcombe and the hearing schedule for 14 December 2021 with the NSW State Coroner and court officials. The secretariat will publish the hearing schedule on the inquiry webpage shortly.

The committee noted the COVIDsafe plan for the site visit.

Resolved, on the motion of Mr Roberts: That the committee adopt the COVIDsafe plan for the site visit to the Forensic Medicine and Coroners Court complex on 14 December 2021.

10. Recording of hearing

Resolved, on the motion of Mr Roberts: That the committee agree to placing all video footage of the hearings (except in camera sessions) on the Parliament's YouTube channel as soon as practicable after each hearing

11. *In camera* hearing

The committee proceeded to take *in camera* evidence.

Persons present other than the committee: Ms Tina Higgins, Ms Emily Treeby, Ms Jessie Halligan, Ms Irene Penfold, Ms Arizona Hart and Hansard reporters.

The following witnesses were sworn and examined:

- Witness A
- Witness B

The evidence concluded and the witnesses withdrew.

12. Public hearing

Witnesses were admitted.

The Chair made an opening statement regarding the broadcasting of proceedings and other matters.

The following witnesses were sworn and examined:

- Mrs Leesa Topic
- Mr Ron Topic

The evidence concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Sarah Crellin, Acting Principal Legal Officer, Aboriginal Legal Service (NSW/ACT).

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Ian Brown, Secretary, Independent Bushfire Group
- Mr Dave Darlington, Committee Member, Independent Bushfire Group *(via WebEx)*
- Mr Geoffrey Luscombe, Convenor, Independent Bushfire Group *(via WebEx)*

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Dr Christina Matthews, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
- Dr Andrew Ellis, Consultant Forensic Psychiatrist, Royal Australian and New Zealand College of Psychiatrists
- Dr Danielle McMullen, President, Australian Medical Association NSW
- Mr Timothy Bowen, Manager – Advocacy and Legal, MIGA.

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Mark Follett, Executive Director, Policy, Reform and Legislation Branch, Department of Communities and Justice
- Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW
- Mr Carlo Scasserra, Assistant Commissioner Governance and Continuous Improvement, Corrective Services NSW *(via WebEx)*
- Mr Danny Doherty APM, Detective Superintendent, NSW Police Force
- Dr Isabel Brouwer, Chief Forensic Pathologist and Clinical Director Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service
- Ms Rebecca Gigli, Chief Operating Officer Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service

The evidence concluded and the witnesses withdrew.

The hearing concluded at 4.47 pm.

13. Other business

14. Adjournment

The committee adjourned at 4.51 pm until Tuesday 14 December 2021, site visit to Lidcombe Coroners Court and public hearing.

Emily Treeby
Committee Clerk

Minutes no. 5
Tuesday 14 December 2021
Select Committee on the coronial jurisdiction in New South Wales
Macquarie Street, Parliament House, Sydney at 1.10 pm

1. Members present

Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair*
Ms Cusack
Mr Roberts
Ms Sharpe (via teleconference)

2. Apologies

Mr Khan

3. Site visit to the Forensic Medicine and Coroners Court complex in Lidcombe

The committee travelled to the Forensic Medicine and Coroners Court complex and met with:

- Magistrate Teresa O'Sullivan, NSW State Coroner
- Judge Peter Johnstone, Chief Magistrate of the Local Court
- Mr Michael Symonds, Director Forensic & Analytical Science Service
- Dr Isabel Brouwer, Chief Forensic Pathologist, Clinical Director Forensic Medicine
- Ms Rebecca Gigli, Chief Operating Officer Forensic Medicine, NSW Health Pathology Forensic and Analytical Science Service
- Mr Don McLennan, Coronial Manager of NSW
- Ms Holly Smith, Acting Registrar Lidcombe Coroner Court
- Ms Kazeline Dawson, Deputy Registrar Lidcombe Coroner Court
- Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support, Courts Tribunals and Service Delivery Department of Communities and Justice
- Ms Grace Romeo, Regional Director, Court Services, Metro Region, Department of Communities and Justice
- Ms Alison Passe-de Silva, Senior Policy Officer, Court Services, Department of Communities and Justice.

4. Previous minutes

Resolved, on the motion of Mr Roberts: That draft minutes no. 4 be confirmed.

5. Correspondence

The committee noted the following items of correspondence:

Received

- 1 December 2021 – Email from Alison Passé-de Silva, Senior Policy Officer, Programs, Specialist Courts & Judicial Support, Courts, Tribunals & Service Delivery, to secretariat, NSW State Coroner's appearance at public hearing on 14 December 2021.
- 1 December 2021 – Email from Stacy Harmer, Executive Assistant to the Executive Director, Office of the Commissioner, NSW Police Force, to secretariat, contact for post-hearing responses for hearing held on 30 November 2021.
- 3 December 2021 – Letter from Ms Teresa O'Sullivan, NSW State Coroner, to Chair, declining witness invitation to public hearing on 14 December 2021.
- 7 December 2021 – Letter from Ms Suzanne Jenner, Executive Director, Court Services, Courts, Tribunals and Service Delivery, Department of Communities and Justice, declining witness invitation to public hearing on 14 December 2021.
- 7 December 2021 – Email from Mr Mitch Wright, Transport Workers Union, to secretariat, response to letter from Chair confirming intent to lodge submission.
- 7 December 2021 – Email from Mr Leigh Shears, Secretary, Newcastle Trades Hall, to secretariat, response to letter from Chair confirming intent to lodge submission.
- 7 December 2021 – Email from Ms Rita Mallia, President, Construction & General Division, NSW Branch, to secretariat, response to letter from Chair confirming intent to lodge Submission.
- 7 December 2021 – Email from Mr Bernie Smith, Shop, Distributive and Allied Employees Association NSW, to secretariat, response to letter from Chair declining invitation to make Submission.
- 7 December 2021 – Email from Mr Paul Murphy, Media Entertainment and Arts Alliance, to secretariat, response to letter from Chair declining invitation to make submission.
- 7 December 2021 – Email from Mr David Babineau, Divisional Secretary, NSW Tram and Bus Division, to secretariat, response to letter from Chair declining invitation to make Submission.
- 7 December 2021 – Email from Mr Theo Samartzopoulos, NSW State Secretary, NSW Plumbing Trades Employee's Union, to secretariat, response to letter from Chair declining invitation to make submission.

- 8 December 2021 – Email from Mr Arthur Rorris, Secretary, President, South Coast Labour Council, to secretariat, response to letter from Chair confirming intent to lodge submission.
- 8 December 2021 – Email from Ms Laura Toose, Legal Officer, Professional Services, New South Wales Nurses and Midwives' Association, to secretariat, response to letter from Chair confirming intent to lodge submission.
- 8 December 2021 – Email from Mr Gerard Hayes, Health Services Union of Australia, to secretariat, response to letter from Chair declining invitation to make submission.
- 8 December 2021 – Email from Ms Carol Matthews, Acting Secretary of the IEU NSW/ACT, to secretariat, attaching letter in response to letter from Chair declining invitation to make submission.
- 9 December 2021 – Email from Ms Joanne Nava, Acting NSW/ACT Local Executive Secretary, to secretariat, response to letter from Chair declining invitation to make submission.
- 9 December 2021 – Email from Mr Daniel Walton, Australian Workers' Union, to secretariat, response to letter from Chair declining invitation to make submission.
- 9 December 2021 – Email from Mr Mark Morey, Secretary, Unions NSW, to secretariat, response to letter from Chair declining invitation to make submission.
- 9 December 2021 – Letter from Ms Teresa O'Sullivan, NSW State Coroner, to Chair, response to Chair's letter dated 8 December 2021 about witness invitation to NSW State Coroner and other nominated representatives at the public hearing on 14 December 2021.
- 9 December 2021 – Email from Witness B, to secretariat, attaching requested document from appearance at public hearing.
- 9 December 2021 – Email from Witness B, to secretariat, further information about requested document from appearance at public hearing.

Sent

- 2 December 2021 – Email to Alison Passé-de Silva, Senior Policy Officer, Programs, Specialist Courts & Judicial Support, Courts, Tribunals & Service Delivery, to secretariat, NSW State Coroner's appearance at public hearing on 14 December 2021.
- 8 December 2021 – Letter to Ms Teresa O'Sullivan, NSW State Coroner, from Chair, witness invitation to NSW State Coroner and other nominated representatives at the public hearing on 14 December 2021.

Resolved, on the motion of Mr Shoebridge: That the committee publish the following items of correspondence:

- 3 December 2021 – Letter from Ms Teresa O'Sullivan, NSW State Coroner, to Chair, declining witness invitation to public hearing on 14 December 2021.
- 9 December 2021 – Letter from Ms Teresa O'Sullivan, NSW State Coroner, to Chair, response to Chair's letter dated 8 December 2021 about witness invitation to NSW State Coroner and other nominated representatives at the public hearing on 14 December 2021.

Resolved, on the motion of Mr Shoebridge: That the committee keep the following items of correspondence confidential, as per the recommendation of the secretariat, as it contains identifying information:

- 9 December 2021 – Email from Witness B, to secretariat, attaching requested document from appearance at public hearing.
- 9 December 2021 – Email from Witness B, to secretariat, further information about requested document from appearance at public hearing.

6. Draft 2017 *Coroners Act 2009* Statutory Review report - Order for papers

Mr Shoebridge moved: That the Chair of the Select Committee on the coronial jurisdiction in New South Wales, Hon Adam Searle MLC, move in the House a motion under Standing Order 52 that the following

document in the possession, custody or power of the Hon Mark Speakman, Attorney General be laid upon the table of the House:

- the draft 2017 *Coroners Act 2009* Statutory Review report.

Question put.

The committee divided.

Ayes: Mr Searle, Ms Sharpe, Mr Roberts.

Noes: Ms Cusack

Question resolved in the affirmative.

7. Public submission
The committee noted submission no. 49 was published by the committee clerk under the authorisation of the resolution appointing the committee.

8. Members' roundtable discussion
Resolved, on the motion of Mr Roberts: That the committee agree:

- to hold a roundtable discussion on a date to be canvassed by the secretariat.
- that the secretariat record the roundtable discussion for the purposes of incorporating members discussion in the final report, and that the recording be destroyed once the report is drafted.

9. Public hearing originally scheduled for 14 December
The committee noted that as agreed via email, the public hearing scheduled with the State Coroner for 14 December 2021 did not proceed, for reasons detailed in the correspondence between the NSW State Coroner and the Chair on 3, 8 and 9 December 2021.

10. Adjournment
The committee adjourned at 1.15 pm, until Monday 31 January 2022, public hearing.

Jessie Halligan
Committee Clerk

Minutes no. 6
Monday 31 January 2022
Select Committee on the Coronial Jurisdiction in New South Wales
Jubilee Room, Parliament House, Sydney at 10.00 am

1. Members present
Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair* (via videoconference) (from 10.11 am)
Ms Cusack (via videoconference)
Mr Roberts (via videoconference)
Ms Sharpe (via videoconference)

2. Apologies
Mr Poulos

3. Previous minutes
Resolved, on the motion of Mr Roberts: That draft minutes no. 5 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received

- 9 December 2021 – Email from Mr Timothy Bowen, Manager, Advocacy & Legal Services, MIGA, to secretariat, regarding transcript of public hearing 30 November 2021
- 9 December 2021 – Email from Witness B 01 with attachments
- 9 December 2021 – Email from Witness B 02
- 10 December 2021 – Email from Witness B 01
- 10 December 2021 – Email from Witness B 02
- 10 December 2021 – Email from Mr Carlo Scasserra, Assistant Commissioner – Governance and Continuous Improvement Corrective Services NSW, Department of Communities and Justice, to secretariat, regarding transcript of public hearing 30 November 2021
- 13 December 2021 – Email from Witness B with attachments
- 13 December 2021 – Email from Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support, Courts Tribunals and Service Delivery Department of Communities and Justice, to secretariat, regarding public hearing 14 December 2021 to not proceed
- 16 December 2021 – Email from Witness B
- 16 December 2021 – Email from Magistrate Teresa O'Sullivan, NSW State Coroner, to secretariat, regarding site visit on 14 December 2021
- 17 December 2021 – Email from Witness A
- 17 December 2021 – Email from Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre, to secretariat, regarding transcript of public hearing 30 November 2021
- 18 December 2021 – Email from Witness B
- 20 December 2021 – Email from Ms Grace Di Giorgio, Senior Policy Officer, Courts, Access to Justice, and Regulatory Team, Policy, Reform, and Legislation Branch, Department of Communities and Justice, to secretariat, seeking extension for providing answers to questions on notice
- 23 December 2021 – Email from Ms Dominika Rajewski, Senior Business Partner, Parliament and Cabinet, Executive and Ministerial Services, NSW Health, to secretariat, seeking extension for providing answers to questions on notice
- 29 December 2021 – Email from Independent Bushfire Group to secretariat, providing additional information titled 'Further information to the Select Committee Inquiry into Coronial Jurisdiction in NSW'
- 4 January 2022 – Email from Ms Helen Bellette, Brand Organiser, Rail, Tram & Bus Union (NSW Branch), to secretariat, requesting extension to lodge submission
- 10 January 2022 – Email from Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support, Courts Tribunals and Service Delivery Department of Communities and Justice, to secretariat seeking extension to provide answers to pre-hearing questions for the NSW State Coroner
- 10 January 2022 – Email from Dr Mary Fogarty, Research/Industrial Officer, New South Wales Teachers Federation, to secretariat, requesting submission be kept confidential
- 12 January 2022 – Email from Dr Mary Fogarty, Research/Industrial Officer, New South Wales Teachers Federation, to secretariat, providing reasons for request for submission to be kept confidential
- 12 January 2022 – Email from Ms Jane Parkin, Paralegal, Law Institute of Victoria, to secretariat regarding site visit arrangements for 4 February 2022
- 19 January 2022 – Email from Dr Rebekah Farrell, Head of Legal Policy, Law Institute of Victoria, to secretariat, regarding site visit scheduled for 4 February 2022 to Law Institute of Victoria
- 21 January 2022 – Email from Ms Sophie Friggens, Head of Legal Policy, Law Institute of Victoria, to secretariat, regarding site visit scheduled for 4 February 2022 to Coroner's Court of Victoria
- 24 January 2022 – Email from Ms Debra Pascall, to secretariat, regarding decline to appear as a witness at public hearing on 31 January 2022

- 25 January 2022 – Email from Dr Mary Fogarty, Research/Industrial Officer, New South Wales Teachers Federation, to secretariat, regarding decline to appear as a witness at public hearing on 31 January 2022.

Sent

- 13 December 2021 – Email from secretariat to Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support, Courts Tribunals and Service Delivery Department of Communities and Justice, advising public hearing 14 December 2021 will not proceed
- 16 December 2021 – Letter from Chair to Magistrate Teresa O'Sullivan, NSW State Coroner, regarding site visit on 14 December 2021
- 16 December 2021 – Letter from Chair to Mr Ron Topic and Ms Leesa Topic, regarding public hearing 30 November 2021
- 16 December 2021 – Letter from Chair to Witness A and Witness B
- 22 December 2021 – Email from secretariat to Ms Grace Di Giorgio, Senior Policy Officer, Courts, Access to Justice, and Regulatory Team, Policy, Reform, and Legislation Branch, Department of Communities and Justice, providing approval of extension of time to provide answers to questions on notice
- 23 December 2021 – Email from secretariat to Ms Dominika Rajewski, Senior Business Partner, Parliament and Cabinet, Executive and Ministerial Services, NSW Health, responding to extension request for providing answers to questions on notice
- 10 January 2022 – Email from secretariat to Ms Helen Bellette, Brand Organiser, Rail, Tram & Bus Union (NSW Branch), providing acknowledgement of extension request to lodge submission
- 18 January 2022 – Letter from Chair to Mrs Patrizia Cassaniti, forwarding invitation to make submission to inquiry and witness invitation for public hearing on 31 January 2022
- 18 January 2022 – Letter from Chair to Ms Debra Pascall, forwarding invitation to make submission to inquiry and witness invitation for public hearing on 31 January 2022
- 20 January 2022 – Email from secretariat to Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support, Courts Tribunals and Service Delivery Department of Communities and Justice, approving extension to provide answers to pre-hearing questions for the NSW State Coroner
- 24 January 2022 – Email from secretariat to Dr Rebekah Farrell, Head of Legal Policy, Law Institute of Victoria, to secretariat, regarding decision to reschedule site visit to Law Institute of Victoria.

Resolved on the motion of Ms Cusack: That the committee keep the following correspondence confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information:

- 9 December 2021 – Email from Witness B 01 with attachments
- 9 December 2021 – Email from Witness B 02
- 10 December 2021 – Email from Witness B 01
- 10 December 2021 – Email from Witness B 02
- 13 December 2021 – Email from Witness B with attachments
- 16 December 2021 – Letter to Witness A and Witness B
- 17 December 2021 – Email from Witness A
- 18 December 2021 – Email from Witness B
- 16 December 2021 – Letter from Chair to Witness A and Witness B
- 10 January 2022 – Email from Dr Mary Fogarty, Research/Industrial Officer, New South Wales Teachers Federation, to secretariat, requesting submission be kept confidential
- 12 January 2022 – Email from Dr Mary Fogarty, Research/Industrial Officer, New South Wales Teachers Federation, Reasons for request for submission to be kept confidential.

The committee noted the publication of correspondence from Independent Bushfire Group titled 'Further information to the Select Committee Inquiry into Coronial Jurisdiction in NSW', dated 29 December 2021.

5. Public Submissions

The committee noted that submission nos. 51-54 were published by the committee clerk under the resolution appointing the committee.

6. Confidential submissions

The committee noted that consideration to keep submission no. 50 confidential would be deferred until a later time.

7. Answers to questions on notice

The committee noted that the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from Mr Jonathon Hunyor, Chief Executive Officer, Public Interest Advocacy Centre, received on 17 December 2021.
- answers to questions on notice from NSW Police Force, received on 17 December 2021.
- answers to questions on notice from NSW Health, received on 10 January 2021.

Resolved, on the motion of Mr Roberts: That the committee keep the attachment to answers to questions on notice from NSW Police Force, titled 'NSW Police Force Handbook for Deceased Persons' confidential, as per the request of the author, as it contains sensitive information.

8. Public hearing

8.1 Allocation of questioning

Resolved, on the motion of Ms Sharpe: The allocation of the questions to be asked at the hearing on 31 January 2022 be determined by the Chair.

8.2 Public hearing

The committee proceeded to take evidence in public at 10.15 am.

Witnesses were admitted via video link.

The Chair made an opening statement regarding the broadcasting of proceedings, virtual hearing etiquette and other matters.

The following witness was sworn and examined:

- Ms Patrizia Cassaniti

The evidence concluded and the witness withdrew.

The following witness was sworn and examined:

- Ms Laura Toose, NSW Nurses and Midwives' Association

The evidence concluded and the witness withdrew.

The following witnesses were sworn and examined:

- Mr Mitch Wright, Transport Workers Union
- Mr Alex Claassens, Rail, Tram & Bus Union (NSW Branch)
- Ms Helen Bellette, Rail, Tram & Bus Union (NSW Branch)

The evidence concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Rita Mallia, CFMEU Construction and General Division NSW
- Mr Ivan Simic, Taylor & Scott Solicitors
- Mr Grahame Kelly, Mining and Energy Union
- Mr Stuart Barnett, Slater & Gordon Lawyers

The evidence concluded and the witnesses withdrew.

The hearing concluded at 1.27 pm.

9. Site visit to Coroners Court of Victoria on 4 February 2022
The committee noted that Ms Cusack, Ms Sharpe, and Mr Poulos will be apologies for the upcoming site visit to the Coroners Court of Victoria on 4 February 2022.

10. Other business
The Chair noted Mr Poulos replaced Mr Khan as a substantive member of the committee from 25 January 2022.

11. Adjournment
The committee adjourned at 1.28 pm until Friday 4 February, site visit to Coroners Court of Victoria.

Emily Treeby and Jessie Halligan
Committee Clerk

Minutes no. 7
Friday 4 February 2022
Select Committee on the Coronial Jurisdiction in New South Wales
Coroners Court of Victoria, 65 Kavanagh St, Southbank at 12.16 pm

1. Members present
Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair*
Mr Roberts

2. Apologies
Ms Cusack
Mr Poulos
Ms Sharpe

3. Change of membership
Committee noted Mr Peter Poulos replaced Mr Trevor Khan as a substantive member of the committee from 25 January 2022.

4. Correspondence
Committee noted the following items of correspondence:

Received:

- 25 January 2022 – Letter from the Hon Damien Tudehope MLC, Leader of the Government in the Legislative Council, to Clerk of the Parliament and Clerk of the Legislative Council, regarding changes to Government representation of membership on Legislative Council committees
- 27 January 2022 – Email from Mr Mitch Wright, Transport Workers Union, to secretariat, regarding placing Mr Olsen as witness at public hearing on 31 January 2022
- 27 January 2022 – Email from Ms Sophie Friggens, Coroners Court of Victoria, to secretariat, regarding confirmation of site visit itinerary and staff members.

5. Site visit to Coroners Court of Victoria
Committee conduced a site visit of the Coroners Court of Victoria and was met by:

- Judge John Cain, Victorian State Coroner
- Alex Cottrell, Acting Chief Executive Officer

- Noel Woodford, Director - Victorian Institute of Forensic Medicine
- Kathy Gilbert, Family Liaison Manager
- Troy Williamson, Koori Engagement Unit Manager
- Josephine McGuinness, Director - Coroners Prevention Unit
- Ciara Millar, Database Manager - Coroners Prevention Unit.

6. Other business

Committee members discussed:

- holding a virtual meeting with the Law Institute of Victoria
- holding a committee round table discussion
- writing to the NSW State Coroner about the number of inquests held into work-place deaths in New South Wales.
- holding a virtual meeting with the Queensland State Coroner.

Resolved, on the motion of Mr Shoebridge: That the committee write to the NSW State Coroner to obtain information on the number of workplace deaths that are reported to the NSW Coroners Court and the number of inquests held for workplace deaths in NSW.

Resolved, on the motion of Mr Shoebridge: That the committee conduct a virtual meeting with the Queensland State Coroner.

7. Adjournment

The committee adjourned at 12.23 pm, *Sine die.*

Emily Treeby and Jessie Halligan
Committee Clerk

Minutes no. 8
Wednesday 23 February 2022
Select Committee on the Coronial Jurisdiction in New South Wales
Room 814/815, Parliament House, Sydney at 1.47 pm

1. Members present

Mr Searle, *Chair*
Mr Shoebridge, *Deputy Chair* (via videoconference from 1.50 pm)
Ms Cusack (via videoconference)
Mr Roberts (via videoconference)
Ms Sharpe (from 1.53 pm until 2.20 pm)

2. Apologies

Mr Poulos

3. Draft minutes

Resolved, on the motion of Ms Cusack: That draft minutes nos. 6 and 7 be confirmed.

4. Correspondence

Committee noted the following items of correspondence:

Received:

- 31 January 2022 – Email from Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, University of Sydney, to secretariat, providing update on lodging submission to the inquiry

- 4 February 2022 – Email from Ms Georga Kemp, Acting Manager, Ministerial and Parliamentary Services, Law Reform and Legal Services, Department of Communities and Justice, to secretariat, regarding extension to providing answers to questions on notice and pre-hearing questions to the NSW State Coroner
- 8 February 20222 – Email from Witness B, to secretariat
- 11 February 2022 – Email from Ms Georga Kemp, Acting Manager, Ministerial and Parliamentary Services, Law Reform and Legal Services, Department of Communities and Justice, to secretariat, regarding answers to questions on notice and pre-hearing questions to the NSW State Coroner
- 15 February 2022 – Email from Ms Donna Schriever, Senior Case Co-ordinator to NSW State Coroner, Department of Justice, to secretariat, regarding Workplace deaths in New South Wales and statistics obtained by the Court via the National Coronial Information System

Sent:

- 7 February 2022 – Email from the secretariat to Ms Georga Kemp, Acting Manager, Ministerial and Parliamentary Services, Law Reform and Legal Services, Department of Communities and Justice, from secretariat, regarding approval of extension to providing answers to questions on notice and pre-hearing questions to the NSW State Coroner
- 8 February 2022 – Email from the secretariat to Magistrate Terry Ryan, Queensland State Coroner, , regarding virtual discussion with committee
- 9 February 2022 – Letter from the Chair to Magistrate O'Sullivan, NSW State Coroner, seeking advice on workplace deaths and the coronial jurisdiction
- 14 February 2022 – Letter from the Chair to Judge John Cain, Victorian State Coroner, regarding site visit to Victorian Coroners Court on 4 February 2022
- 14 February 2022 – Letter from the Chair to Dr Rebekah Farrell, Head of Legal Policy, Law Institute of Victoria, regarding invitation to attend virtual meeting on 23 February 2022
- 15 February 2022 – Email from the secretariat to Nickie Flambouras, Manager Community Engagement, Multicultural NSW, regarding request to invite Culturally and Linguistically Diverse organisations to make a submission to the inquiry
- 16 February 2022 – Email from the secretariat to Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, University of Sydney, regarding update on submission to the inquiry

Resolved, on the motion of Ms Cusack: That the committee keep the following correspondence confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information:

- Email from witness B, to secretariat, dated 8 February 2022.

5. Virtual meeting with the Coroners Court of Queensland

Committee virtually met with the following representatives from the Coroners Court of Queensland:

- Queensland State Coroner, Magistrate Terry Ryan
- Director of Coroners Court of Queensland, Ms Raelene Speers

Resolved, on the motion of Mr Roberts: That the committee agree to the secretariat recording the virtual meeting for the purposes of assisting the secretariat's note taking, and that the recording be destroyed once the report is drafted.

6. Public submissions

Committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 56, 57, 58.

7. Answers to questions on notice

Committee noted the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from the Aboriginal Legal Service (NSW/ACT), received 27 January 2022
- answers to questions on notice from Department of Communities and Justice, received 11 February 2022

8. Correspondence from the Department of Communities and Justice

Committee noted the Department of Communities and Justice responses to pre-hearing questions prepared for the NSW State Coroner in December 2021 were published by the committee clerk.

The committee previously noted on 30 November 2021 correspondence received from the Department of Communities and Justice regarding the Timeliness of Coronial Procedures Taskforce's progress report (October 2021).

Resolved, on the motion of Ms Cusack: That the committee authorise the publication of correspondence and the Timeliness of Coronial Procedures Taskforce's progress report from the Department of Communities and Justice, dated 26 November 2021, on the committee's webpage.

9. Other business

Resolved, on the motion of Ms Cusack: That the committee invite the following organisations to make a submission to the inquiry, and committee members notify the secretariat of any further stakeholders they wish to invite to make a submission:

- Child deaths review committee
- Victims of Domestic and Family Violence

10. Adjournment

The committee adjourned at 2.40 pm, until Friday 25 February 2022, 9.15 am, Room 814/815 (virtual meeting with Law Institute of Victoria and committee roundtable).

Emily Treeby and Jessie Halligan
Committee Clerk

Minutes no. 9
Friday 25 February 2022
Select Committee on the Coronial Jurisdiction in New South Wales
Room 814/815, Parliament House, Sydney at 9.29 am

1. Members present

Mr Searle, *Chair*
Ms Cusack
Mr Poulos (via videoconference)
Mr Roberts (via videoconference)
Ms Sharpe (via videoconference until 12 pm)

2. Apologies

Mr Shoebridge, *Deputy Chair*

3. Correspondence

Committee noted the following items of correspondence:

Sent:

- 21 February 2022 – Letter from Chair, to Mr Samier Dandan, President, Lebanese Muslim Association, invitation to make submission to the inquiry into the coronial jurisdiction in New South Wales.
- 21 February 2022 – Letter from Chair, to Mr Darren Bark, Chief Executive Officer, NSW Jewish Board of Deputies, invitation to make submission to the inquiry into the coronial jurisdiction in New South Wales.

4. Virtual meeting with Law Institute of Victoria

Committee noted the program

Committee virtually met with the following representatives:

- Stephen Taffe, Chair, LIVE Health Law Committee
- Emily Hart, Member, LIV Health Law Committee
- Paula Chatfield, Member, LIV Elder Law Committee
- Sharon Keeling, Victorian Bar Member, Joint LIV/AMA/VicBar Medico Legal Standing Committee
- Naty Guerrero-Diaz, Member, LIV Public Liability & Medical Negligence Committee
- Richard Moloney, Member, LIV Transport Accident Committee (TAC)
- Jessica O'Reilly, Section Lead DEHL, Succession and Workplace
- Sinead O'Brien Butler, Section Lead and Lawyer, Criminal Law
- Irene Chrisafis, Section Lead and Senior Lawyer Litigation, Cost and Privacy Officer

Resolved, on the motion of Ms Cusack: That the committee agree to the secretariat recording the virtual meeting for the purposes of assisting the secretariat's note taking, and that the recording be destroyed once the report is drafted.

5. Roundtable discussion

Committee noted the 'Discussion points' for the roundtable discussion.

6. Other business

7. Adjournment

The committee adjourned at 12.16 pm, sine die.

Emily Treeby and Jessie Halligan
Committee Clerk

Draft minutes no. 10
Wednesday 27 April 2022
Select Committee on the Coronial Jurisdiction in New South Wales
Room 814/815, Parliament House, Sydney at 10.05 am

1. Members present

Mr Searle, *Chair*
Ms Faehrmann, *Deputy Chair*
Ms Cusack
Mr Rath (substituting for Mr Poulos, from 10.15am)
Mr Roberts
Ms Sharpe

2. Apologies

3. Previous minutes

Resolved, on the motion of Ms Sharpe: That draft minutes nos. 8 and 9 be confirmed.

4. Correspondence

The committee noted the following items of correspondence:

Received:

- 15 February 2022 – Letter from NSW State Coroner, Magistrate O'Sullivan to Chair, data relating to workplace deaths and coronial jurisdiction with requested statistics attached
- 24 February 2022 – Correspondence from Mr David D. Knoll AM, NSW Jewish Board of Deputies and the Sydney Chevra Kadisha, to Chair, seeking extension to provide submission to the inquiry into the coronial jurisdiction 28 February 2022 – Correspondence from Donna Schriever, Senior Case Co-ordinator to NSW State Coroner, Department of Justice, relating to publication of data on workplace deaths and coronial jurisdiction with requested statistics attached
- 28 February 2022 – Correspondence from Magistrate Terry Ryan, Coroners Court of Queensland, to secretariat, relating to virtual meeting with the committee and documents attached
- 2 March 2022 – Correspondence from Ms Helen Wodak, Acting Deputy Ombudsman, Projects and Systemic Reviews, to Chair, NSW Ombudsman, to Chair, regarding invitation to make submission to the inquiry into the coronial jurisdiction
- 3 March 2022 – Correspondence from NSW State Coroner Magistrate O'Sullivan, to secretariat, relating to obtaining additional data on workplace deaths in NSW data from 2000 to 2010
- 3 March 2022 – Correspondence from Liz Snell, Law Reform and Policy Coordinator, Women's Legal Service NSW, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 3 March 2022 – Correspondence from Joumana Menzalji El Jamal, Director/Chairperson, Sydney Community Connect, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 3 March 2022 – Correspondence from Mary Karras, Chief Executive Officer, Ethnic Communities' Council of NSW, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 4 March 2022 – Correspondence from Ms Laura Henschke, Legal and Policy Officer, Full Stop Australia, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 4 March 2022 – Correspondence from Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, data relating to workplace deaths and coronial jurisdiction with requested statistics attached
- 7 March 2022 – Correspondence from Ghada Daher-Elmowy, Director, Andalus Arabic Choir Inc., to secretariat, declining invitation to make submission
- 11 March 2022 – Correspondence from Alia Sarfraz, Legal Support Officer, Australian Federation of Islamic Councils, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 15 March 2022 – Correspondence from Chris Lacey, Chief Executive Officer & Co. Secretary, MCCI, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 15 March 2022 – Correspondence from Jonathan David, President of Dayenu – Sydney's Jewish LGBTQ+ Group, to secretariat, decline invitation to make submission to the inquiry into the coronial jurisdiction
- 15 March 2022 – Correspondence from Benjamin Chow, Australian Chinese Charity Foundation of NSW, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 15 March 2022 – Correspondence from Fiaese Leulua'iali'i PESA, Project Manager, Pacific Isalands (Samoa) Language School, Multicare Australia Pacific, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction

- 15 March 2022 – Correspondence from Bijinder Dugal, Director, AASHA Australia Foundation, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 17 March 2022 – Correspondence from Paul Miller, NSW Ombudsman to Chair, NSW Child Death Review Team declining invitation to make a submission to the inquiry into the coronial jurisdiction
- 18 March 2022 – Correspondence from Marisa Previtera, Secretary, Maltese Community Council of NSW, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 18 March 2022 – Correspondence between Ms Helen Wodak, Acting Deputy Ombudsman, Projects and Systemic Reviews, NSW Ombudsman, and secretariat, regarding invitation to make submission to the inquiry into the coronial jurisdiction
- 18 March 2022 – Correspondence from Verica Sajdovska JP, Manager, Macedonian Welfare Association of NSW, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 18 March 2022 – Correspondence from Dr Yadu Singh, Federation of Indian Associations of NSW Inc, to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 19 March 2022 – Correspondence from Eziz Bawermend, President, Kurdish Lobby Australia, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 19 March 2022 – Letter from Isaac K. Acquah, President of the Ghana Association of NSW, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 19 March 2022 – Correspondence from Isaac K. Acquah, President of the Ghana Association of NSW, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 20 March 2022 – Correspondence from Tauke Kalua, Admin Assistant, NSW Council for Pacific Communities to secretariat, accepting invitation to make submission to the inquiry into the coronial jurisdiction
- 21 March 2022 – Correspondence from Keshav Gautam, Public Officer, Nepalese Community in Sydney, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
  21 March 2022 – Correspondence from Lucy Wang, Secretary, Australian Chinese Painting Society Inc, to secretariat, declining invitation to make submission to the inquiry into the coronial jurisdiction
- 24 March 2022 – Correspondence from NSW State Coroner, Magistrate O'Sullivan to Chair, enclosing a copy of the First Nations Protocol and Coronial Practice Note 3
- 5 April 2022 – Letter from NSW State Coroner, Magistrate O'Sullivan to Chair, relating to introduction of First Nations Protocol
- 13 April 2022 – Correspondence from Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support Courts Tribunals and Service Delivery, Department of Communities and Justice, to secretariat, relating to answer to question on notice and data on natural cause deaths reported to NSW Coroners Court
- 14 April 2022 – Correspondence between Dr Rebecca Scott Bray, Associate Professor of Criminology and Socio-Legal Studies, University of Sydney and secretariat between 1 March 2022 and 14 April 2022, submission to the inquiry into the coronial jurisdiction.

Sent:

- 25 February 2022 – Correspondence from Chair, to Mr David D. Knoll AM, NSW Jewish Board of Deputies and the Sydney Chevra Kadisha, approving extension to provide submission
- 25 February 2022 – Letter from Chair, to Magistrate Terry Ryan, Coroners Court of Queensland, thanking them for meeting with the committee
- 1 March 2022 – Correspondence from Chair, to Renata Field, Policy, Advocacy and Research Manager, Domestic Violence NSW, invitation to make a submission to the inquiry into the coronial jurisdiction
- 1 March 2022 – Correspondence from Chair, to Hayley Foster Chief Executive Officer, Full Stop Australia, invitation to make a submission to the inquiry into the coronial jurisdiction
- 1 March 2022 – Correspondence from Chair, to Mr Paul Miller, Convenor NSW Child Death Review Team, invitation to make a submission to the inquiry into the coronial jurisdiction
- 1 March 2022 – Correspondence from Chair, to Liz Snell, Law Reform and Policy Coordinator, Women's Legal Service NSW, invitation to make a submission to the inquiry into the coronial jurisdiction

- 2 March 2022 – Letter from Chair, to NSW State Coroner Magistrate O'Sullivan, seeking additional data on workplace deaths in NSW data from 2000 to 2010.

Resolved, on the motion of Ms Sharpe: That the committee keep the correspondence between Ms Helen Wodak, Acting Deputy Ombudsman, Projects and Systemic Reviews, NSW Ombudsman, and secretariat, regarding invitation to make submission, dated 18 March 2022, correspondence confidential, as per the recommendation of the secretariat, as it contains identifying and/or sensitive information.

Resolved, on the motion of Mr Roberts: That the committee authorise the publication of:

- correspondence from Ms Louise Blazejowska, Director, Programs Specialist Courts and Judicial Support Courts Tribunals and Service Delivery, Department of Communities and Justice, to secretariat, dated 13 April 2022, including on the committee's webpage.
- letter from NSW State Coroner, Magistrate Teresa O'Sullivan, to Chair, dated 5 April 2022, including on the committee's webpage.

5. Draft statutory review report

Resolved, on the motion of Mr Roberts: That the committee authorise the publication of correspondence from the Hon Mark Speakman, Attorney General, dated 18 November 2021, including on the committee's webpage.

6. NSW Death Child Review Team correspondence

The committee noted that as agreed via email, the secretariat published the correspondence from Mr Paul Miller, Convenor of the NSW Child Death Review Team, dated 1 March 2022, on the committee's webpage, with the exception of the agreed redaction.

7. Submissions

7.1 Public submissions

The committee noted the following submissions were published by the committee clerk under the authorisation of the resolution appointing the committee: submission nos. 59, 60, 61, 62, 64, 65 and 66.

7.2 Confidential submissions

Resolved, on the motion of Ms Cusack: That the committee keep submission nos. 50 and 63 confidential, as per the request of the author.

8. Answers to questions on notice

The committee noted the following answers to questions on notice were published by the committee clerk under the authorisation of the resolution appointing the committee:

- answers to questions on notice from Mr Mitch Wright, Media and Political Advisor, Transport Workers Union of NSW, received 3 March 2022

9. Consideration of Chair's draft report

Consideration of Chair's draft report, entitled *'Inquiry into the Coronial Jurisdiction in New South Wales'*.

Resolved, on the motion of Ms Cusack: That paragraph 1.22 be amended by omitting 'as well as' and inserting instead 'and was part way through hearing the inquest into the twenty five deaths that occurred during the Black Summer Bushfires of 2019-2020. The State Coroner will also soon commence'.

Resolved, on the motion of Ms Sharpe: That paragraph 1.26 be amended by inserting 'and from time to time as required' after 'rotation program'.

Resolved, on the motion of Ms Sharpe: That paragraph 1.27 be amended by omitting 'Newcastle and Wollongong'.

Resolved, on the motion of Ms Sharpe: That paragraph 1.27 be amended by inserting at the end: 'A full-time magistrate in Newcastle also undertakes coronial work on a regular, part-time basis'.

Resolved, on the motion of Ms Sharpe: That paragraph 1.67 be amended by omitting 'All coroners' by inserting instead 'While the State Coroner is a County Court judge, all other coroners'.

Resolved, on the motion of Ms Sharpe: That paragraph 2.13 be amended by inserting at the end: 'The committee understand this practice has now been abandoned in favour of a two day induction course for new magistrates.'

Resolved, on the motion of Ms Sharpe: That the following new paragraph be inserted after paragraph 3.20:

'The inquiry received evidence of a variety of institutional arrangements concerning Coroners in the different jurisdictions, and other specialist tribunals. The Coroner in Victoria is a County Court judge, equivalent to the NSW District Court. The Coroner in Western Australia is apparently equivalent to a Supreme Court judge.[1] The NSW Civil and Administrative Tribunal, which hears a wide spectrum of matters from anti-discrimination, freedom of information, building and other commercial cases as well occupational licensing and regulatory matters, is also headed by a NSW Supreme Court judge. The NSW Drug Court is composed of District Court judges. A District Court judge is President of the NSW Personal Injury Commission, which hears workers' compensation and motor accident cases. The committee heard evidence that the work of the Coroners Court of NSW was no less important than each of those bodies.[2]'

[FOOTNOTE: [1] Evidence, Mr Michael Barnes, Queensland State Coroner from 2003 to 2013, and NSW State Coroner from 2014 to 2017, 29 September 2021, p 12. [2] Evidence, Ms Mary Jerram AM, NSW State Coroner from 2007 to 2013, 29 September 2021, p 12; Evidence, Adjunct Professor Hugh Dillon, Deputy NSW State Coroner from 2008 to 2016, and researcher in relation to coronial systems at the Law Faculty, University of New South Wales, 29 September 2021, p 12; Evidence, Mr Michael Barnes, Queensland State Coroner from 2003 to 2013, and NSW State Coroner from 2014 to 2017, 29 September 2021, p 12.]

Resolved, on the motion of Ms Cusack: That paragraph 3.51 be amended by omitting 'legal counsel' and inserting instead 'solicitors'.

Resolved, on the motion of Ms Cusack: That paragraph 3.52 be amended by omitting 'Legal counsel' inserting instead 'Solicitors'.

Resolved, on the motion of Ms Cusack: That paragraph 3.52 be amended by inserting 'also' after 'the Crown Solicitor's Office will'.

Resolved, on the motion of Ms Cusack: That paragraph 3.52 be amended by inserting 'more' after 'proceedings raise'.

Resolved, on the motion of Ms Cusack: That paragraph 3.52 be amended by omitting 'legal counsel from' after 'Further to this, Mr Evenden noted that'.

Resolved, on the motion of Ms Cusack: That paragraph 3.53 be amended by omitting 'legal counsel' inserting instead 'solicitors'.

Resolved, on the motion of Ms Cusack: That paragraph 3.53 be amended by inserting 'as Counsel Assisting' after 'inquest hearing'.

Resolved, on the motion of Ms Cusack: That paragraph 3.53 be amended by inserting at the end: 'In matters of any complexity or which raise issues of public importance, barristers from the private bar are engaged through the Crown Solicitor's Office or DCJ Legal to act as Counsel Assisting in matters. This will occur on the decision of the presiding coroner. Where the barrister is a Senior Counsel, the approval of the Attorney General must be sought and granted. The practice is to submit a short list of names to the Attorney, with a recommendation. Where the barrister to be engaged as Counsel Assisting is not a Senior Counsel, they will almost always be a senior junior barrister. In such cases, the choice is left to the Coroner and the Crown Solicitor's office.'

Resolved, on the motion of Ms Faehrmann: That paragraph 3.66 be amended by inserting 'part time' after '200'.

Resolved, on the motion of Ms Faehrmann: That paragraph 3.66 be amended by inserting 'who fulfil this function in addition to their role as Local Court registrars' after 'across the state,'

Resolved, on the motion of Ms Sharpe: That paragraph 3.97 be amended by omitting 'but with a clear focus on the work of the coronial jurisdiction,' and inserting instead 'with consultation occurring between the Attorney General and the head of jurisdiction (in this case, the State Coroner) but with a clear focus on the work of the coronial jurisdiction. The committee considers there should be no term limit on holding the office of coroner. Further, that persons appointed as coroners who are not already magistrates should also be appointed to the Local Court. This would retain the nexus between the two courts and there could be a sharing of resources, or transfers between the courts, with the concurrence of the State Coroner and Chief Magistrate. Of course, there would also need to be consultation with the Chief Magistrate in relation to any such appointment'

Resolved, on the motion of Ms Sharpe: That recommendation 4 be amended by inserting ', following consultation with both the State Coroner and the Chief Magistrate,' after 'Local Court magistrates'.

Resolved, on the motion of Ms Sharpe: That recommendation 4 be amended by inserting 'any transfers from the Coroners Court to the magistracy to occur only with the agreement of both the State Coroner and the Chief Magistrate' after 'in consultation with the Chief Magistrate'.

Resolved, on the motion of Mr Roberts: That paragraph 3.101 be amended by inserting at the end: 'The matters raised in the NSW Bar Association submission concerning providing more guidance to coroners through a Bench Book or State Coroner's guidelines should be more thoroughly assessed in that process.'

Resolved, on the motion of Ms Cusack: That paragraph 3.108 be amended by omitting 'in the regions (as recommended above)' after 'the work of specialist coroners'.

Resolved, on the motion of Ms Cusack: That paragraph 3.109 be amended by:

- omitting 'legal officers would assume the functions performed by Counsel Assisting the coroner and'
- omitting 'counsel' and inserting instead 'support'.

Resolved, on the motion of Ms Cusack: That the following new paragraph be inserted after paragraph 4.112:

> 'The committee also notes the evidence of Domestic Violence NSW not only as to the importance of the Domestic Violence Death Review Team and the work it does, but also for the need to strengthen the accountability measures in the system and, specifically, improving the oversight of responses to coronial findings. This point is dealt with below in several recommendation, particularly recommendation 13.' [FOOTNOTE: Submission 60, Domestic Violence NSW, p 2.]

Resolved, on the motion of Ms Cusack: That the following new committee comment be inserted after recommendation 16:

> 'The committee also considered whether domestic violence deaths should be included as mandatory for inquests, given the continued high incidence of deaths connected to domestic relationships; mainly of women at the hands of their current or former spouse or domestic partner. After some reflection, the committee formed the view that the work of the Domestic Violence Death Review Team fulfils substantially the same public policy objective and in many ways is more comprehensive than an inquest.
>
> However, the committee also notes the observation of Domestic Violence NSW that only two members of the DVDRT are from non-government providers. The committee does consider that the membership of the team should be expanded to include more non-government front line service providers, who would have a wealth of knowledge and experience to being to bear on the work of the team.'

Resolved, on the motion of Ms Cusack: That the following new recommendation be inserted after paragraph 4.134:

Recommendation x
That the membership of the Domestic Violence Death Review Team be expanded to include more non-government service providers.

Resolved, on the motion of Mr Roberts: That recommendation 12 be amended by:

- omitting 'First Nations'
- inserting at the end: 'in custody'.

Resolved, on the motion of Ms Cusack: That the following new paragraph be inserted after paragraph 5.30:

'The committee understands that after materials are filed with the Coroners Court they are then supplied to the Crown Solicitor's Office or DCJ Legal to determine if there are any omissions requiring additional information, reports or statements, or any sensitive matters requiring protective orders. The brief is then returned to the Coroners Court when finalised.'

Resolved, on the motion of Ms Cusack: That paragraph 5.143 be amended by inserting at the end: 'of the brief being returned to the Coroners Court from the Crown Solicitor's Office or DCJ Legal.'

Resolved, on the motion of Ms Cusack: That recommendation 18 be amended by inserting at the end: 'of the brief being returned to the Coroners Court from the Crown Solicitor's Office or DCJ Legal'.

Resolved, on the motion of Ms Sharpe: That Recommendation 24 be amended by inserting 'unit' after 'Medicine', 'both' after 'cover' and omitting 'can be' and inserting instead 'are best'.

Resolved, on the motion of Ms Sharpe: That Recommendation 24 be amended by inserting 'both' after 'cover'

Resolved, on the motion of Ms Sharpe: That Recommendation 24 be amended by after omitting 'can be' and inserting instead 'are best'

Ms Roberts moved: That the following recommendation 25 be omitted: 'That the NSW Government consider appointing significantly more suitably experienced and qualified First Nations people to the judiciary, including the appointment of First Nations persons as coroners and introduction of a First Nations Commissioner to sit with coroners dealing with First Nations deaths.'

Question put.

The committee divided.

Ayes: Mr Roberts

Noes: Mr Searle, Ms Faehrmann, Ms Cusack, Mr Rath, Ms Sharpe

Question resolved in the negative.

Ms Faehrmann moved: That recommendation 25 be amended by:

- omitting 'consider appointing' and inserting instead 'appoint'
- omitting 'suitably experienced and'.

Question put.

The committee divided.

Ayes: Mr Searle, Ms Faehrmann, Ms Cusack, Mr Rath, Ms Sharpe

Noes: Mr Roberts

Question resolved in the affirmative.

- Resolved, on the motion of Ms Cusack: That the following paragraphs be inserted after paragraph 6.4:

- 'The Coroners Court of New South Wales provided the committee with data from the National Coronial Information System on work-related deaths reported to the Court between 2000 and 2022. The National Coronial Information System noted that only cases that are coded as 'work-related' in the NCIS are included in the data, which refers to 'deaths where it is determined that exposure of the deceased to their own or another person's work environment or activities contributed to the death, with the exception of industrial disease'. [FOOTNOTE: Correspondence from the NSW State Coroner, Magistrate O'Sullivan, to Chair, 15 February 2022].

- 'With respect to the number of inquests held for work-related deaths, the data from the National Coronial Information System is congruent with the evidence from the various unions that inquests into workplace deaths occur infrequently. From January 2011 to February 2022, the Coroners Court of NSW was notified of 960 work-related deaths, with an average of 86 work-related deaths per calendar year. In that period, 36 inquests were held, with recommendations made in 23 cases.[1] From July 2000 to December 2010, the Coroners Court of NSW was notified of 1,154 work-related deaths, with an average of 110 work-related deaths per calendar year. In that period, 164 inquests were held with recommendations made in 83 cases.[2] This data is demonstrated below in Table X.'

- [FOOTNOTES: [1] The National Coronial Information System advised that there may be an underestimate in the total number of cases for the 2020–2022 calendar years due to the number of cases remaining open for these years of data. [2] The National Coronial Information System advised that data is available for all Australian states and territories (except Queensland) from 1 July 2000. Queensland data is available from 1 January 2001.]

Table 5Work-related deaths in the Coroners Court of NSW 2000-2022

	Number of notifications[678]	Number of inquests	Number of cases in which recommendations made
2000-2010	1154	164	83
2011-2022	960	36	23

Source: Correspondence from the NSW State Coroner, Magistrate O'Sullivan, to Chair, 15 February 2022; Correspondence from Mr Don McLennan, Manager Coronial Services NSW, Executive Officer to the NSW State Coroner, Department of Justice NSW, to Chair, 4 March 2022.]

- 'Comparing the number of inquests into workplace deaths to the total number of inquests, obtained from the Annual Reviews of the Local Court between 2005 and 2020, there were 1,410 inquests held across NSW between 2011 and 2022 and 1,212 inquests between 2005 and 2010.' [FOOTNOTE: Correspondence from Department of Communities and Justice, to Chair, 11 February 2022, p 5].

Resolved, on the motion of Mr Roberts: That paragraph 6.49 be amended by inserting at the end: 'However, in both Queensland and Victoria a coroner can then compel the giving of the evidence in the form of a witness statement and in so doing also confer on the person giving that evidence protection against that same evidence being used against them in criminal or other proceedings, including disciplinary proceedings.' [FOOTNOTE: See *Coroners Act 2008* (Vic), s 50(2); *Coroners Act 2003* (Qld), s 17A.]

Resolved, on the motion of Ms Cusack: That paragraph 6.69 be amended by inserting 'Looking at the data from the National Coronial Information System, it shows that a limited number of inquests have been held into workplace deaths when compared with the number of workplace deaths reported to the Coroners Court of NSW. Additionally, workplace inquests appear to be a small proportion of all inquests held between 2005 and 2020, with a noticeable collapse in the number of workplace inquests in the past decade.' after 'Unfortunately through, relatively few, if any, workplace deaths are examined by the coroner.'

Resolved, on the motion of Mr Roberts: That paragraph 6.78 be amended by omitting 'could' and inserting instead 'should' after 'Queensland and Victoria'

Resolved, on the motion of Mr Roberts: That paragraph 6.79 be amended by omitting 'witness statements except in circumstances where the person has a reasonable or lawful excuse, which includes giving self-incriminating evidence' and inserting instead 'the giving of evidence, including in the form of witness statements, without risking witness self-incrimination'.

Resolved, on the motion of Mr Roberts: That paragraph 6.79 be amended by omitting 'unless they give self-incriminating evidence would be critical to coroners having ready access to the information' and inserting instead 'is critical to coroners having ready access to all the information'

Resolved, on the motion of Mr Roberts: That paragraph 6.79 be amended by omitting 'Without this power and associated protection for witnesses, coroners could face the current challenges with statements not being provided, or statements not being fulsome, with no opportunity to obtain this information at inquest' and inserting instead 'Without this power and the associated protection for witnesses contained in section 61(7) of the *Coroners Act 2009* (NSW), coroners face the current challenges with statements not being provided, or statements not being as complete as they should be, resulting in a less than full account of the causes and circumstances of a death, which is clearly contrary to the public interest'

Resolved, on the motion of Mr Roberts: That recommendation 34 be amended by omitting 'give coroners a power similar to that which exists in Victoria and Queensland to compel witness statements except in circumstances where the person has a reasonable or lawful excuse, which includes giving self-incriminating evidence' and inserting instead 'extend the protection against self-incrimination in section 61 of the *Coroners Act 2009* (NSW) to the giving of written statements, for example, when provided prior to an inquest or in an investigation when no inquest is held.

Resolved, on the motion of Ms Cusack: That:

- The draft report as amended be the report of the committee and that the committee present the report to the House;
- The transcripts of evidence, submissions, tabled documents, answers to questions on notice and correspondence relating to the inquiry be tabled in the House with the report;
- Upon tabling, all unpublished attachments to submissions be kept confidential by the committee;
- Upon tabling, all unpublished transcripts of evidence, submissions, tabled documents, answers to questions on notice and supplementary questions, and correspondence relating to the inquiry, be published by the committee, except for those documents kept confidential by resolution of the committee;
- The committee secretariat correct any typographical, grammatical and formatting errors prior to tabling;
- The committee secretariat be authorised to update any committee comments where necessary to reflect changes to recommendations or new recommendations resolved by the committee;
- Dissenting statements be provided to the secretariat by 10.00am on Thursday 28 April 2022;
- The secretariat table the report at 11.00 am, Friday 29 April 2022;

10. Other business

The committee formally acknowledged the contribution of previous committee members to the inquiry – Mr Shoebridge, Mr Khan and Ms Ward.

11. Adjournment

The committee adjourned at 10.45 am.

Emily Treeby
Committee Clerk

Appendix 4 Dissenting statement

The Honourable Rod Roberts MLC, Pauline Hanson's One Nation.

This is a good report. One that is detailed and long overdue. Overall, I strongly support the report and all bar one of the recommendations.

However, the inclusion of the following recommendation caused me concern. I moved to have the recommendation omitted but my motion was not supported by the committee.

RECOMMENDATION 25.

One Nation and I as an individual, do not support identity politics. We believe in meritocracy. Nowhere is this more important than in the administration of justice to ensure that only the most qualified and suitable appointments are made.

Trust and faith in the judicial system is based on the maxim justice is blind. In other words, impartial and independent. There are current and former members of the judiciary that identify as First Nations people, they have been appointed on merit.

To suggest that individuals should be appointed to the judiciary because of their race does nothing but erode confidence in the integrity and independence of the justice system.

At no stage during this inquiry did we receive any evidence either definitive or perceived of any racial or cultural bias displayed by our current or previous Coroners. Nor was there any suggestion of cultural insensitivity by the Coroners, in fact we received evidence of the complete opposite.

I suggest that this recommendation is purely symbolic.

NSW Government response: Legislative Council Select Committee on the coronial jurisdiction in New South Wales

The NSW Government welcomes the Select Committee's *Report into the coronial jurisdiction in New South Wales*. The Government acknowledges the contribution by individuals and organisations that participated in the inquiry, particularly families who have experienced the coronial system for sharing their views on how the coronial system can be improved.

The Government recognises the trauma and grief experienced by families and communities affected by an unexpected or unexplained death and that the coronial jurisdiction must not add to this burden. It is critical that these important services are delivered in a professional, therapeutic and timely manner, which upholds the dignity of the deceased person and ensures respect for their family and friends.

The Government also acknowledges the importance of coronial processes being culturally safe and responsive to First Nations families, and effective in preventing the future loss of life for First Nations people. Within this context, the Government notes the commencement in April 2022 of the *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples*, which sets out arrangements for the case management of mandated inquests in respect of First Nations people.

Initially commencing ahead of and later running in parallel with the work of the Select Committee, the Government established the *Timeliness of Coronial Procedures Taskforce* (**Taskforce**), whose aim was to reduce delays in the coronial system and improve the experiences of families. The Taskforce's work has since resulted in the implementation of a range of initiatives to improve the timeliness of the coronial process, especially in relation to post-mortem investigations, and streamline early case management processes.

The Government has also boosted investment in the coronial jurisdiction to strengthen outcomes for families, reduce the number of preventable deaths, improve timeliness and support culturally safe and responsive processes. Following an investment of in the 2021-22 State Budget, an additional magistrate was assigned exclusively to the coronial jurisdiction, and additional resourcing was provided to the Coronial Case Management Unit to reduce delays and improve information and support for families. Two Aboriginal Coronial Information and Support Officer positions have also been established to improve support for First Nations families.

The Government has carefully considered the report and is pleased to support or support in principle 15 recommendations and to note 20 recommendations.

Recommendation	Government Response
1 – That the NSW Government finalise and publish the statutory review of the *Coroners Act 2009* (NSW) by the end of 2022.	**Noted**
2 – That the NSW Department of Communities and Justice undertake a review into the collection, management and reporting of data in relation to coronial cases, with a view to identifying system improvements that would enable greater monitoring of the coronial jurisdiction's performance.	**Supported**
3 – That the NSW Government allocate additional resources to the Coroners Court of New South Wales, including adequate funding and staffing, to ensure it can address current caseload pressures, delays and backlogs.	**Supported** The 2021-22 State Government Budget included funding for eight additional magistrates, including a magistrate assigned exclusively to the coronial jurisdiction. Additional resourcing was also provided to the Coronial Case Management Unit to reduce delays and improve information and support for families.
4 – That the NSW Government restructure the Coroners Court of NSW to be an autonomous and specialist court within the Local Court framework, similar to the Children's Court of NSW, with these 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.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families, including those in regional locations, and support the jurisdiction's efforts to reduce preventable deaths and to enhance public safety.
5 – That the NSW Government ensure the Judicial Commission of New South Wales is sufficiently funded to design, develop and deliver a bespoke and comprehensive	**Supported**

training and professional development program for coroners, with input from the current State and Deputy State Coroners and former coroners.	
6 – That the NSW Government provide in-house legal officers and registrars to each coroner or alternatively establish a pool of legal officers and registrars to assist all coroners.	**Noted**
7 – That the NSW Government provide a greater level of case management, family liaison and administrative support for coroners, particularly for the triaging and management of natural cause deaths reported to the Coroners Court of New South Wales.	**Supported** In the 2021-22 State Budget, the NSW Government provided funding for an additional magistrate assigned exclusively to the coronial jurisdiction, and to enhance the Coronial Case Management Unit to reduce delays and improve information and support for families.
8 – That the NSW Police Force improve its training of police officers on coronial processes, including: • regular, comprehensive and specialist training for investigative police • specific training for officers in the preparation of high quality and timely coronial briefs of evidence.	**Supported** The NSWPF Specialist Advocacy Unit and the CCMU are implementing and facilitating comprehensive and specialist training for investigative police on coronial processes. The NSWPF is also currently developing online modules and resources for probationary constables and plan to hold conferences on the coronial jurisdiction for investigators and regional police prosecutors.
9 – That the NSW Government, to attract, recruit and retain more forensic pathologists: • work with relevant professional bodies and educational institutions, including universities, to ensure there are sufficient opportunities for the training and qualification of forensic pathologists • enhance financial and professional incentives for forensic pathologists in New South Wales.	**Supported in principle** There is a national and international shortage of forensic pathologists, with both professional training and accreditation, and market, factors impacting the supply of such pathologists. The Ministry of Health will continue to progress opportunities to increase the availability of forensic pathologists in NSW, including through engagement with university medical programs, students and the Royal College of Pathologists Australia. In addition, the Ministry of Health will continue to review and benchmark the remuneration and allowances for the profession. The NSW Health Workforce Strategy 2022-2032 prioritises equipping the health workforce with the skills and capabilities necessary to be an agile, responsive workforce (Priority 4); and establishing partnerships with education providers to develop health career pipelines (Outcome 4.4).
10 – That the NSW Government review and propose amendments to the objects of the *Coroners Act 2009* (NSW) 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.	**Supported**
11 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a power for coroners to make findings without inquest.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
12 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to require coroners to examine whether systemic issues played a role leading to any death, including: • an explicit power to make such recommendations as the coroner considers necessary or desirable, including in relation to any systemic issues connected with a death, suspected death, fire or explosion • a requirement to consider and report on whether the implementation of any recommendation of the Royal Commission into Aboriginal Deaths in Custody report could have reduced the risk of death in all cases where a person died in custody.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
13 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to improve the accountability of responses to recommendations, including: • 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	**Noted** The NSW Government notes that part of this recommendation reflects recommendation 32 of the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody. The NSW Government supports in principle creating a statutory requirement to strengthen accountability relating to, and transparency around the progress of, acquitting coronial recommendations made to government and non-government entities. The NSW Government does not consider it consistent with the function of the judiciary for it to have a monitoring and reporting function in relation to coronial recommendations, or coercive information to gather powers for that purpose. The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.

• 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.	
14 – That the Coroners Court of New South Wales, in consultation with key stakeholders, enhance its website to ensure coronial findings, recommendations and responses to recommendations are published in an accessible manner.	**Supported**
15 – That the Parliament of New South Wales widen the remit of the joint parliamentary committee on the Law Enforcement Conduct Commission, the Ombudsman and Crime Commission so that it regularly reviews the adequacy of responses to coronial recommendations.	**Noted**
16 – That the NSW Government establish and fund a specialist preventive death review unit in the Coroners Court of New South Wales which: • is modelled on the goals and functions of the Coroners Prevention Unit in the Coroners Court of Victoria • expands on the processes of the NSW Domestic Violence Death Review Team to undertake in-depth qualitative analysis of a broad range of reported deaths, including but not limited to First Nations deaths, domestic violence deaths, suicide deaths and drug related deaths.	**Noted** The NSW Government notes DCJ is considering opportunities to strengthen the preventative capacity of the NSW coronial system to support reductions in preventable deaths. This includes considering, in conjunction with the State Coroner: • the scale, governance and purpose of a preventative death review function • how the function would contribute to reducing preventable deaths • its relationship to the Domestic Violence Death Review Team (**DVDRT**) established under Chapter 9A of the *Coroners Act 2009* (NSW) and Suicide Monitoring System.
17 – That the NSW Government ensure the membership of the Domestic Violence Death Review Team is expanded to include more non-government service providers.	**Noted**
18 – That the Coroners Court of New South Wales ensure that all of its practices and processes appropriately balance on the needs and interests of families in the coronial system with other considerations.	**Supported**
19 – That the NSW Government develop and propose reform options, legislative or otherwise, to ensure the provision of information and material to families in a timely manner, in order to support their meaningful participation in investigations and inquests. Specifically, unless contrary orders are sought, all materials provided to the Coroners Court of New South Wales should also be provided to the family or families concerned within one month of the brief being returned to the Coroners Court from the Crown Solicitor's Office or Department of Communities and Justice Legal.	**Supported in principle** The NSW Government invested in 2021 to support families involved in the coronial processes and to improve timeliness. This includes investments for an additional coroner, Aboriginal Coronial Information Support Officers and staff for the Coronial Case Management Unit and registry.
20 – That the NSW Government implement options to enhance the access families have to social support and counselling in the coronial system, with the aim of ensuring continuity in services and flexibility to meet families' needs.	**Supported in principle** The NSW Government invested in 2021 to support families involved in the coronial processes and to improve timeliness. The 'Digitising the Coronial Pathway to Improve the Family Experience' project is an example of an initiative that will support the handover of case-specific information between the Coronial Information and Support Program and forensic social workers to improve service continuity for families.
21 – That the NSW Government allocate additional funding to Legal Aid NSW and Aboriginal Legal Service (NSW/ACT) in order for these services to provide greater legal assistance and representation to families involved in coronial inquests.	**Noted**
22 – That the NSW Government implement a financial assistance scheme to cover the logistical costs incurred by families participating in coronial inquests, including the costs of transport, meals and accommodation.	**Noted** Assistance is already facilitated to families on a case-by-case basis to help meet the costs of transport and accommodation costs.
23 – That the NSW Government allocate funding to increase the First Nations workforce capacity at the Coroners Court of New South Wales, including expansion of the Aboriginal Coronial Information and Support Program Officer team, and the creation of other identified positions in the registry and other support positions, including in NSW Health Pathology's Forensic Medicine Social Work service.	**Noted** In 2021, the NSW Government allocated additional funding to support families involved in the coronial process. This included funding for additional Aboriginal Coronial Information Support Officers. Work is underway as part of DCJ's Aboriginal Employment Strategy to increase the number of Aboriginal people employed in courts, including in the coronial jurisdiction. In addition, the Ministry of Health is considering opportunities to enhance the continuity of care for First Nations families through the inclusion of First Nations forensic social workers in the Forensic Medicine Team.
24 – That the NSW Government ensure government departments provide ongoing cultural competency training to all staff, especially those departments working in the coronial jurisdiction.	**Supported** The NSW Government is committed to First Nations people involved in the coronial process being supported in a culturally safe and responsive manner. This work has included:

	• The NSW Public Service Commission has developed *Everyone's Business*, a cultural capability training package for the NSW public sector workforce. Through this training, NSW public sector employees learn how to support and build culturally safe workplaces and services across NSW. • A DCJ-wide *Cultural Development and Learning Framework* is currently in development to build Aboriginal cultural capability across DCJ, and will include a mandatory induction, cultural awareness training and ongoing development opportunities for all DCJ staff. • NSWPF, in addition to the current Aboriginal Cultural Awareness Training that is delivered, is also currently developing further Aboriginal cultural competency training for its senior leaders. • NSW Health run *Respecting the Difference*, an Aboriginal cultural training framework that is mandatory for all staff. This training program has recently been updated, and a roll-out of the revised training for all staff will commence in 2022. DCJ and the Ministry of Health are considering opportunities to strengthen the delivery and regularity of cultural competence training to staff working in the coronial jurisdiction. This includes, for example, NSW Health Pathology's forensic medicine staff being provided with cultural competency training, as emphasised through its Reconciliation Action Plan.
25 – That the Coroners Court of New South Wales and the NSW Health Pathology's Forensic Medicine unit consult with culturally and linguistically diverse communities and First Nations communities on the development of publicly available and clear guidelines that cover both the Court's practices and how cultural and religious considerations are best accommodated.	**Supported in principle** The NSW Government considers that the Coronial Services Committee is the appropriate forum for continuing to implement initiatives to address recommendation 25. Consultation has already occurred with culturally and linguistically diverse communities and First Nations communities. This consultation will continue to inform the nature and content of publicly available material regarding court practices and the accommodation of cultural and religious considerations.
26 – That the NSW Government appoint significantly more qualified First Nations people to the judiciary, including the appointment of First Nations persons as coroners and introduction of a First Nations Commissioner to sit with coroners dealing with First Nations deaths.	**Noted** The NSW Government notes the importance of NSW courts, including the coronial jurisdiction, reflecting the diversity of its population, including First Nations people. Applications for judicial appointments are encouraged from qualified Aboriginal and Torres Strait Islander lawyers. The Government notes that the State Coroner has initiatives underway to support culturally safe processes for First Nations peoples involved in the coronial process, including the First Nations Protocol launched in May 2022 and developing healing mechanisms as part of the coronial process.
27 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to mandate that a coronial inquest be held for workplace deaths, excluding deaths from natural causes.	**Note**d The NSW Government considers that current class of deaths that give risk to a mandatory inquest to be appropriate. However, the NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
28 – That the NSW Government, Coroners Court of New South Wales, and SafeWork NSW establish a framework for sharing information, expertise and outcomes of investigations and inquests, including: • the ability of the Coroners Court of NSW to engage, when appropriate, experts from relevant regulatory bodies to assist in an investigation • the timely provision of coronial findings and recommendations to SafeWork NSW • similar information and evidence sharing requirements as that that exists between the Coroners Court of NSW and the Office of the Director of Public Prosecutions.	**Supported in principle**
29 – That the NSW Government propose an amendment to the *Coroners Act 2009* (NSW) to ensure unions, employer bodies and other industry organisations be granted standing to appear at inquests.	**Noted**
30 – That the NSW Government consider the appropriateness of amending section 78 of the *Coroners Act 2009* (NSW) to change the threshold for referrals of matters to the Office of the Director of Public Prosecutions to the 'prima facie' test.	**Noted**
31 – That the Coroners Court of New South Wales and the Office of the Director of Public Prosecutions implement a protocol relating to referrals under section 78 of the Coroners Act 2009 (NSW) to minimise delays, ensure the timely provision of information to families and improve record keeping.	**Noted**
32 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a statutory timeframe with respect to referrals to the Office of the Director of Public Prosecutions.	**Noted**
33 – That the State Coroner consider issuing a practice note relating to referrals to the Office of the Director of Public Prosecutions, focusing on the need for timely decisions and information to be provided to families.	**Noted**
34 – That the Office of the Director of Public Prosecutions develop guidelines in relation to referrals under section 78 of the Coroners Act 2009 (NSW) to minimise delay in deciding whether to prosecute.	**Noted**

35 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to extend the protection against self-incrimination in section 61 of the *Coroners Act 2009* (NSW) to the giving of written statements, for example, when provided prior to an inquest or in an investigation when no inquest is held.	**Supported in principle**

NJP POSITION STATEMENT:

First Nations Over-incarceration and Deaths in Custody

Version dated 12-Jul-2022

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The National Justice Project

The National Justice Project ('**NJP**') is a not-for-profit human rights legal and civil rights service. Our mission is to fight for justice, fairness and inclusivity by eradicating systemic discrimination. Together with our clients and partners, we work to create systemic change and amplify the voices of communities harmed by government inaction, harm and discrimination.

The NJP creates positive change through strategic legal action, supporting grassroots advocacy, collaborative projects, research and policy work and practice-inspired and catalytic social justice education. Our focus areas include health justice, specifically for persons with disability and First Nations communities; racial justice, challenging misconduct in policing, prisons, judicial and youth services; and seeking justice for refugees and people seeking asylum. We receive no government funding and intentionally remain independent in order to do our work. We therefore rely on grassroots community, philanthropic and business support.

Acknowledgement of First Nations Peoples' Custodianship

The National Justice Project pays its respects to First Nations Elders, past and present, and extends that respect to all First Nations Peoples across the country. We acknowledge the diversity of First Nations cultures and communities and recognise First Nations Peoples as the traditional and ongoing custodians of the lands and waters on which we work and live.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The National Justice Project recognises that throughout history the Australian health and legal systems have been used as an instrument of oppression against First Nations Peoples. The National Justice Project seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

CONTENTS

EXECUTIVE SUMMARY

National Justice Project position on First Nations Overincarceration and Deaths in Custody[I]

The National Justice Project ('**NJP**') believes that everyone has the right to substantive equality and protection before the law, including safe and equitable access to justice, health care, education and other services free of racism and discrimination.

When race, gender, sexuality, health, disability and age intersect, First Nations people are put at unacceptable risk of coming into contact with the criminal justice system. These risks are compounded by the multiple levels of discrimination First Nations people encounter in the provision of health care, family and child services, housing, employment, education and other services.

We recognise that throughout history the Australian criminal justice system has been an instrument of oppression against First Nations people, with harmful, and at times fatal consequences. The deeply entrenched racism across our Federal, State and Territory justice, law enforcement, health and social systems continues to deny First Nations people access to equitable outcomes and fails to protect their rights by applying the rule of law in an unfair and unjust manner.

Many First Nations people who come into contact with the criminal justice system have experiences of intergenerational and interpersonal trauma. These traumas directly stem from colonisation, and are often compounded by poverty, social and economic inequality, a lack of access to adequate, appropriate and equitable standards of health care, and inequitable access to justice and equality before the law – often as a result of racism. Comprehensive structural reform is urgently needed to address the inequalities and traumas perpetuated in the criminal justice system. Critically, the system needs to be redesigned to prioritise rehabilitation, care and humanity, and First Nations people must also be involved in the design of the systems that directly affect them.

In the more than 30 years since 1991 Royal Commission into Aboriginal Deaths in Custody ('**Royal Commission**')[1] there have been numerous reports and inquiries by human rights bodies, First Nations organisations and successive Federal, State and Territory governments,[2] as well as countless advocacy efforts and national campaigns,[II,3] without meaningful action or improved circumstances. The NJP denounces the lack of commitment by governments to eradicate the pervasive and entrenched racial violence toward First Nations people by its various agencies and institutions. This ongoing failure to challenge systemic racism and hold governments, institutions and individuals accountable for their actions (and inaction) is not due to a lack of practical solutions but an absence of political will and is a crisis that needs to be remedied with urgency.

[I] The NJP Position Statement on First Nations Over-incarceration and Deaths in Custody is part of a series of position statements. Please also see: NJP Position Statement on Health Justice; NJP Position Statement on Discriminatory Policing; NJP Position Statement on Immigration Detention.

[II] For example, the Black Lives Matter and Raise the Age campaigns driven by Change the Record.

National Justice Project approach to First Nations Overincarceration and Deaths in Custody

The NJP's Health Justice, Racial Justice and Just Systems programmes challenge systemic discrimination by defending and extending the rights of First Nations Peoples experiencing racism and discrimination in law enforcement, the courts, and custodial settings as well as in health care, child 'protection', education and other services.

The NJP supports clients in their pursuit of justice through legal processes including litigation, conciliation and complaints. We also pursue justice through education programmes, advocacy and collaborative projects. We contribute to public debate, awareness and make powerful submissions to public inquiries to draw the attention of decision-makers to the systemic injustices affecting First Nations communities and pressure governments to implement the recommendations of coronial inquests and parliamentary inquiries through petitions and open letters. We support our clients to tell their stories, helping to educate and raise awareness in the wider community and inspire others to fight for justice.

Our Copwatch programme promotes police accountability, provides critical community rights education and challenges systemic issues in policing, in particular police violence and over-reach. Our Tech4Justice programme is in development and aims to create technological solutions to enable users to make complaints, navigate the complex complaint pathways and access support, as well as gathering evidence to inform advocacy strategies driven by communities affected by discrimination to drive systemic change.

We collaborate with stakeholders to amplify our collective impact. Together with the Jumbunna Institute for Education and Research, we have developed *Call it Out*, an online register to record instances of personal or systemic racism towards First Nations people and promote anti-racist policy and practices.

We work with a range of community organisations to address individual, institutional and systemic racism in the criminal justice, health and social systems. We are an active member of the Partnership for Justice in Health; we work closely with the Queensland University of Technology Indigenist Health Humanities project; we have developed an Aboriginal Patient Advocacy Training programme with the Aboriginal Health Council of Western Australia (ACHWA) and the Health Consumers' Council of WA (HCCWA); and we work closely with Deadly Connections to deliver the Bugmy Justice Project.

In partnership with Larissa Behrendt AO, we have created a number of digital roundtables with a range of expert panellists on the topic of Health Justice for First Nations people, including: Fighting for the Rights of First Nations People with Disabilities in the Justice System; Spotlight on the NSW report into First Nations deaths in custody; and Exploring health justice beyond the courtroom.

Working with a range of stakeholders from the legal, community and advocacy sectors, and with support from our partners, donors and sponsors, we delivered our inaugural *Law Hack 2021: Disability Justice* in a unique event where participants worked in teams to solve some of the most challenging problems and injustices facing people living with disability, including in relation to criminal justice and policing. A panel of judges selected a new emergency services branch to support people with disability (and others requiring specialist support) and divert them from police and the criminal justice system as the winning pitch.

Many of our clients have been directly impacted by injustice, often as a result of discrimination. We represent individuals and families of loved ones who have been harmed or have died because of poor or discriminatory attitudes in our justice and health systems. We facilitate legal action and complaints against government, health and custodial institutions that have failed in their duty to eradicate systemic bias and to ensure First Nations people receive substantive equality before the law. We are motivated and informed by the strength and experiences of our clients and their communities and it is from this perspective that we present the NJP's Position Statement on First Nations Overincarceration and Deaths in Custody.

PRIORITIES & RECOMMENDATIONS

Overarching priorities and recommendations

1. Governments have a responsibility to assess, acknowledge and address the systemic racism within Australia's criminal justice system, including the profound and direct impact on First Nations people's right to equality before the law. Significant reforms are urgently needed to identify and eradicate the pervasive and entrenched racism in law enforcement, the courts, and custodial settings as well as in healthcare, child 'protection', education and other services.
2. Eradicate racist and discriminatory policing and ensure police accountability by ending the practice of police investigating the actions of police and prison guards and legislating genuinely independent investigations of deaths in custody.
3. Law and policy reform to decriminalise poverty, addiction, mental ill-health and disability.
4. Monitor, record and report on police and court statistics specific to First Nations arrests, bail determinations, convictions and incarceration.
5. Reforms to increase police accountability and oversight, including the development of key performance indicators for police to divert First Nations people away from the criminal justice system.
6. Police should not be first responders to critical situations involving people with disability, mental ill-health and/or addiction. Alternative response pathways that prioritise de-escalation, compassion and safety, and promote ongoing recovery oriented, trauma informed support and treatment over a police response are urgently needed.
7. Systemic reform to ensure appropriate, trauma-informed and culturally safe health care is delivered in custodial settings and delivered by culturally appropriate services with such care to include holistic health care, mental health care, disability support and rehabilitation.
8. Increased resourcing for diversion and justice reinvestment programmes that promote culturally safe and trauma-informed rehabilitation and healing.
9. Enhanced complaint and redress mechanisms, ensuring these are person-centred, trauma-informed and better attend to the intersectional nature of discrimination.

10. Urgently implement the recommendations from the Royal Commission[4] and all relevant subsequent reports and inquiries into First Nations over-incarceration and deaths in custody,[5] and

11. Ensure that all future inquiries include investment for the meaningful implementation of recommendations, with First Nations groups leading the design, implementation, monitoring and evaluation processes.

12. Build and maintain robust nationally consistent data based on First Nations-defined, objective and meaningful measurements of institutional racism and implicit bias in the criminal justice system with the results published annually and utilised to implement evidence-based reforms.

First Nations over-incarceration

13. First Nations-led reforms to outdated policy and laws are urgently needed to address the criminalisation and over-incarceration of First Nations people and implement policing and sentencing measures that are appropriate, proportionate and measured. Key reforms include:
    a. Decriminalising minor offences, mental illness and addiction;
    b. Improved bail, remand, community-based sentencing and parole options;
    c. Alternatives to fines and fine-default penalties, abolishing mandatory sentencing and short term sentences for minor offences; and
    d. Funding and supports to expand justice reinvestment programmes, specialised courts and culturally safe and trauma-informed rehabilitative and healing supports and programmes.

14. Governments should mandate imprisonment as a last resort and instead prioritise and fund community-controlled early intervention, diversion and rehabilitation pathways.

15. In order to prioritise reintegration over recidivism, governments must properly fund education programmes inside youth and adult prisons and provide culturally safe multi-disciplinary services and supports to First Nations people upon release from custody. At a minimum, such services and supports should include family reunification, housing, education, training and employment.

16. Children deserve special protection and do not belong in prisons. Nationally, the minimum age of criminal responsibility should be raised from 10 years (an age that disproportionately impacts First Nations children) to at least 14 years for all offences, consistent with medical and scientific evidence pertaining to child and adolescent neurodevelopment and in line with international standards.[6]

17. First Nations children under 18 years of age should be supported through culturally appropriate community-based responses, with a focus on prevention, diversion and support rather than punishment.

18. The minimum age of criminal responsibility should be raised to at least 14 years for all offences. Establishing 14 years as the minimum age of criminal responsibility is consistent with medical and scientific evidence pertaining to child and adolescent neurodevelopment and is in line with international standards.[7]

19. First Nations-led anti-racism and cultural competency education and training should be resourced and embedded,[8] updated regularly and delivered on an ongoing basis to police, corrections, the courts, corruption and complaints bodies, child 'protection', healthcare, and social and other services.

Custodial health and safety

20. People in custody have the right to receive adequate health care without discrimination at a standard equitable to that available in the community and proportionate to the needs of the individuals and communities it serves.[9]

21. Governments must urgently mandate equitable access to adequate medical staff and facilities within the community and for the closure of all remaining prison hospitals, including Long Bay Prison Hospital in New South Wales (NSW).

22. First Nations people in custody have the right to receive health care that is culturally safe, anti-racist, non-discriminatory and trauma-informed. Mainstream health care services must be made responsive, appropriate, trauma-informed and culturally safe, and increased resourcing and support is urgently needed for Aboriginal Community Controlled Health Organisations (ACCHOs) to ensure continuity of care is provided both in custody and upon release.

23. People in custody are entitled to receive access to health care benefits at a standard equivalent to that provided in the community, including full access to the Medicare Benefits Scheme (**Medicare**), Pharmaceutical Benefits Scheme (**PBS**) and National Disability and Insurance Scheme (**NDIS**).

24. Expand the scope of coronial inquests and mandate that coroners examine and make recommendations relevant to systemic issues including the quality of care, treatment and supervision of people in custody, and for these to be applied consistently across all Australian States and Territories.

25. Urgently implement the recommendations of the Royal Commission that relate to health care[10] and subsequent coronial inquests into First Nations deaths in custody that relate to health care.[11]

Investigating First Nations deaths in custody

26. Expand the scope of the coronial jurisdiction to require that coroners consider and comment on broad systemic factors, including discrimination and bias by police, corrective services and health services, with a view to prioritising the protection of lives and the prevention of death and injury, and for these to be applied consistently across all Australian States and Territories.

27. Expand the scope of the coronial jurisdiction to require coroners to investigate the conduct of police officers, corrections officers and other officials (including investigating systemic or structural discrimination), make appropriate recommendations, and refer for prosecution or discipline where their acts or omissions may have in any way contributed to the death of a First Nations person.

28. Establish and properly fund a culturally appropriate, First Nations-led and staffed independent oversight and investigative body into deaths in custody. The body should have a statutory focus on transparency, accountability and systemic reform of the justice system, and with powers to examine the death of a First Nations person in all custodial settings including in prisons, police cells, remand

centres, detention centres, custodial transportation, and healthcare. The body should have real powers to identify misconduct and systemic racism and to make appropriate recommendations, including to refer for prosecution and to undertake regular inspections of prisons, remand centres and youth detention facilities.

29. Encourage the substantive participation of families in the coronial process by developing and implementing trauma-informed and culturally safe practices and policies. The wishes and rights of the family of the deceased must be respected and prioritised at all times throughout the process.
30. Significant resources should be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.

THE JUSTIFICATION

Legislative, policy and service issues

Racism is an endemic problem in Australia and these attitudes permeate into our criminal justice system. The disproportionate contact First Nations people have with the criminal justice system is directly attributable to the systemic prejudice and bias in the way our laws are enforced by police and the courts. Successive governments have repeatedly failed to take immediate, specific and meaningful action to achieve First Nations healing, equality, justice and self-determination and ultimately end the hyper-incarceration and the senseless and avoidable custodial deaths of First Nations people in this country.

Current legislation and policy instruments are inadequate to ensure First Nations people receive safe and equitable access to justice free of racism and discrimination. Rather, these laws, policies and practices continue to systematically discriminate based on race and function to perpetuate the disparity between First Nations people and the general population in criminal justice, youth justice, health justice, child 'protection', education, employment, life expectancy and other indicators.

Throughout history, the Australian justice system has been an instrument of oppression against First Nations people. The traumatic effects of First Nations over-incarceration and deaths in custody are felt across every community and every generation, shattering First Nation families and communities who are left to deal with legal processes which only re-traumatise them.

More than 30 years since the Royal Commission, successive Federal, State and Territory governments have failed to substantively implement the recommendations and deliver justice and self-determination to First Nations Peoples. Government inquiries, reports and promises persist, without meaningful action or improvement of circumstances. Rather, the normalised and damaging patterns of racism against First Nations individuals, families and communities by police, the courts, and a range of government agencies, institutions and oversight bodies have become further entrenched.

The Royal Commission into Aboriginal Deaths in Custody

The Royal Commission was established in 1987 to investigate 99 of the 105 First Nations deaths that occurred in custody between 1 January 1980 and 31 May 1989, and made 339 recommendations for change at all levels of government.[12] Of these, 107 recommendations relate to First Nations deaths in custody, 106 to First Nations over-representation in the criminal justice system, and 126 to social justice.[13] Notably, these recommendations include developing pathways to achieving First Nations self-determination, and the critical need to progress meaningful reconciliation to achieve the systemic changes recommended in the report.

Since the Royal Commission, there have been at least 495 First Nations deaths in custody[14] and the number of First Nations people in prisons has more than doubled.[15] Data from the NSW Bureau of Crime Statistics and Research (**BOCSAR**) has revealed that between 1990-1995, First Nations people were 14.7 times more likely to die in police custody and 17.4 times more likely to die in prison than the general population.[16] Despite this, the Royal Commission and successive Australian governments continue to erroneously maintain that First Nations people in custody do not die at a higher rate than their non-Indigenous counterparts.[17]

The inadequacies of current legislation and policy instruments to ensure First Nations people receive safe and equitable access to justice free of racism and discrimination is particularly evident in the Deloitte Access Economics ('**Deloitte**') review of progress (or lack thereof) made by Federal, State and Territory Governments to implement the Royal Commission's recommendations.[18]

Deloitte's review, commissioned by the then Minister for Indigenous Affairs, Nigel Scullion, reported that of the 339 recommendations made by the Royal Commission, 64 per cent had been fully implemented, 14 per cent had been mostly implemented and 16 per cent had been partially implemented.[19] However, their report has been widely criticised by academics and experts, particularly the rating scale used to determine the implementation status of the recommendations.[20] Deloitte's rating scale assessed each recommendation in terms of 'actions taken towards implementing the recommendation' – such as through the introduction of or amendments to policies and programmes. However, their assessment process failed to examine 'how effective these actions have been'. Specifically, the review does not assess and determine whether a policy or programme has been successful in achieving its intended outcomes for First Nations people in its practical application.[21] The review has also been criticised for relying heavily on data and reports provided by governments and their agencies without critical assessment of the information provided and for failing to consult with First Nations experts and communities at any stage of the review process.[22] Unsurprisingly, the limited parameters of Deloitte's review produces a misleadingly favourable assessment of the progress governments have made in their implementation of the recommendations.

Policy and laws that fail to respect principles of self-determination remain inextricably linked to the continuance of destructive practices that intensify and perpetuate the violence and injustice perpetrated by governments against First Nations people.[III, 23] Significant investment in First Nations-led policies, practices and supports are urgently needed to reduce this violence, including through self-determined

[III] For instance, the Federal Government's suspension of the Racial Discrimination Act in 2007 in order to execute the Northern Territory Emergency Response.

strategies and initiatives that give First Nations individuals, families and communities the right to influence policy development and implementation to protect themselves from the violence and discrimination of the state. [IV, 24]

The Royal Commission recognised the importance of self-determination in reducing First Nations over-incarceration and deaths in custody more than 30 years ago.[25] Despite decades of persistent advocacy, First Nations people are still fighting for a Voice to Parliament to be enshrined in the Constitution,[26] despite substantial public support.[27] In the absence of substantive Constitutional change and structural reform, First Nations people continue to be denied their inalienable right to self-determination by a political system created to perpetuate their oppression.

The over-incarceration of First Nations people[28]

The impacts of racism and discrimination in the criminal justice system

Far too often in Australia, First Nations people are denied access to substantive equality before the law, often as a result of prejudice and bias. First Nations people encounter racism and discrimination at every stage of the criminal justice process. This prejudicial system is demonstrated in well-known statistics, most notably in the disturbing reality that Australia's First Nations Peoples are the most incarcerated people on the planet.[29]

For decades, numerous commissions and inquiries have repeatedly recommended that the arrest, detention or imprisonment of a person should be used only as a measure of last resort and for the shortest possible time. However, despite the repeat warnings and recommendations, successive governments have continued to ignore how existing law and policy, and their implementation by police and the courts, plays a key role in the disproportionately high rate of contact First Nations people have with the criminal justice system[30] – all too often as a result of arrest, detention and imprisonment being applied as a *first resort*.[V]

The majority of First Nations people have never been incarcerated; however, First Nations people have disproportionately higher rates of contact with the criminal justice system, as both offenders and victims, than non-Indigenous Australians.[31]

The Australian Law Reform Commission's *Pathways to Justice* report (2017) found that, compared with the wider population, First Nations people are seven times more likely to be prosecuted and appear in court, and 12.5 times more likely to receive a prison sentence. First Nations people are more likely to have been in prison previously (76 per cent) compared with non-Indigenous offenders (49 per cent) and are less likely to receive a community-based sentence.[32] First Nations people are also more likely to receive a short prison sentence of less than six months (45 per cent) when compared with their non-Indigenous counterparts (27 per cent);[33] most commonly for offensive language, public intoxication, non-payment of fines and other

[IV] For instance, exercised through a constitutionally enshrined First Nations Voice to Parliament and Makarrata Commission to oversee treaty-making processes between Australian governments and First Nations people towards truth telling, justice and self-determination.

[V] For more information on the role of discriminatory policing in the criminalisation and over-representation of First Nations people, please see the NJP Position Statement on Discriminatory Policing.

minor non-violent offences as well as breach of custodial or community-based orders, breach of protection orders and failure to appear in court.[34]

Despite First Nations people accounting for 3.3 per cent of the Australian population,[35] First Nations men, women and children continue to be grossly over-represented in both adult and youth prisons at rates of 30 per cent, 39 per cent[36] and 54 per cent,[VI,37] respectively.[38] Incarceration rates for First Nations women and children have escalated sharply in recent years.

First Nations women's experiences of the criminal justice system[VII]

The vast majority of First Nations women will never enter the criminal justice system as offenders or be incarcerated.[39] However, First Nations women are vastly overrepresented in the criminal justice system and are the fastest growing demographic in Australian prisons.[40] First Nations women in Australia are also imprisoned at more than 20 times the rate of non-Indigenous women.[41] Between 2013 and 2020, there was a 49 per cent increase in the sentencing of First Nations women (compared with just 6 per cent for the general female population). Prior to sentencing, First Nations women are also less likely to be granted bail by police[42] and are more likely to be held longer on remand.[43]

The rising and disproportionate incarceration rates of First Nations women is interwoven with experiences of violence and trauma, as well as the pervasive and systemic racism and discrimination in our law enforcement, health and justice systems. First Nations women's interactions with these systems and the grossly inadequate, inequitable and culturally unsafe treatment they receive further compounds existing traumas and perpetuates long lasting disparities in health, mental health, poverty, homelessness, domestic, family and sexual violence, as well as a range of other social and economic indicators.[44]

The harmful impacts of disconnecting women from family were recognised by the NSW Supreme Court in 2015.[45] Despite this recognition, in cases where suitable accommodation is limited or unavailable, First Nations women are increasingly being placed on so-called 'therapeutic remand', further exacerbating the cycle of trauma, injustice and disadvantage for First Nations women, their families and communities. [46]

First Nations children and young peoples' experiences of the criminal justice system[VIII]

Systemic racism, including racial profiling and other discriminatory police and court practices directly contributes to the criminalisation and over-incarceration of First Nations children and young people.[47] First Nations children and young people are more likely to be targeted and subject to racially biased and illegitimate police surveillance, monitoring[48] and strip searches.[49] First Nations children and young people are also more likely to be charged, refused bail, convicted and sentenced[50] and are 187 per cent more likely to reappear in court.[51]

[VI] This figure represents First Nations children aged 10-17 years, the rate for First Nations children aged 10-13 is staggeringly higher at a rate of 65 per cent.

[VII] For more information on the role of discriminatory policing in the criminalisation and over-representation of First Nations women experiencing domestic, family and sexual violence, please see the NJP Position Statement on Discriminatory Policing.

[VIII] For more information on the role of discriminatory policing in the criminalisation of First Nations children and young people, please see the NJP Position Statement on Discriminatory Policing.

First Nations children and young people are imprisoned at 22 times the rate of their non-Indigenous counterparts.[52] Despite comprising 6 per cent of the total population of children aged 10-17 years, First Nations children account for 54 per cent of all children in youth prisons.[53]

Actual criminal offending by children is predominantly non-violent[54] with more than 50 per cent of crimes relating to theft, burglary or property related offences.[55] A snapshot of children in youth prisons reveals that, at any one time, over 50 per cent are on remand without having been convicted or sentenced.[56]

Children are entitled to special protection due to their age.[57] Despite this fact, across all Australian jurisdictions the minimum age of criminal responsibility is set at 10 years of age[58] – an age that disproportionately impacts First Nations children. In 2019-2020 alone, 499 children aged between 10 and 13 were imprisoned, and of these 65 per cent are First Nations children.[59]

In 2019, the UN Committee on the Rights of the Child specifically recommended that Australia raise the minimum age of criminal responsibility from 10 to 14 years,[60] a call reiterated by the Universal Periodic Review in 2021.[61] However, as at May 2022, the Australian Capital Territory[62] and Tasmania[63] are the only governments committed to raising the age of criminal responsibility to 14 years as remaining States and Territories continue to lag defiantly behind.[IX, 64]

The over-representation of First Nations children in out-of-home care

The strong link between contact with child 'protection' services and experiences of long-term socio-economic disadvantage, adverse health outcomes and subsequent contact with juvenile and adult criminal justice systems is well established.[65] Despite this, First Nations children continue to be disproportionately over-represented in the out-of-home care (OOHC) system in every jurisdiction in Australia. The increasing rates of First Nations children being removed from their families and cultures and placed in OOHC presents profoundly troubling parallels to the Stolen Generations.[66] As at 30 June 2020, there were a staggering 21,523 First Nations children in OOHC across Australia,[67] accounting for almost half (47 per cent, or 21,523/45,996) of all children in OOHC.[68] New South Wales alone accounts for one-third of First Nations children in OOHC.[69] Failing significant reforms, the number of First Nations children in OOHC nationally is projected to increase by 54 per cent by 2030.[70]

Ongoing connection to community, culture, Country and kin has been proven critical to the social and emotional wellbeing of First Nations children.[71] Despite this, First Nations children spend longer periods in OOHC[72] and are less likely to be reunified with their families when compared with their non-Indigenous counterparts.[73] The rate of permanent care and adoption orders for First Nations children is high and escalating, with a significant majority being place with non-Indigenous adoptive parents.[74] The rate of First

[IX] For example, In December 2019, the Meeting of Attorneys-General (MAG) called for submissions on whether to raise the minimum age of criminal responsibility and what an alternative system would look like. While the 88 submissions received by the MAG have not been published, a communiqué was released on 15 November indicating a potential move towards raising the age of criminal responsibility from 10 to 12 years. This response not only ignores the consistent evidence and recommendations in the majority of submissions (48 of which are self-published on the 'Raise the Age' campaign website), it also ensures the least impact: In 2019-2020, just 43 of the 499 children aged 10-13 years in prison were under the age of 12.

Nations children placed with kin rather than non-Indigenous family has also been steadily declining since 2006.[75]

The intersection of these and other factors, including inadequate, discriminatory and culturally unsafe health care, education and other services, puts First Nations children and young people at unacceptable risk of coming into contact with police and the criminal justice system at a young age.

The criminalisation of disability, mental ill-health and addiction

The criminalisation and over-incarceration of First Nations people living with disability

People with disability are disproportionately represented in Australia's criminal justice system as a result of an institutionalised process whereby certain acts and behaviours are criminalised and consequently policed and punished.[76] People with disability account for roughly 18 per cent of the Australian population while comprising about 29 per cent of the prison population.[77]

More than one in five First Nations children and almost one in two (48 per cent) First Nations adults live with disability and it is accepted that these figures are under-representative.[78] First Nations people with a disability are 14 times more likely to be imprisoned than the general population.[79] Since 1991, over 40 per cent of deaths in custody have involved First Nations people living with disability.[80]

Incarceration also disproportionately impacts First Nations children and young people living with disability. When race and disability intersect, First Nations young people face a double disadvantage. First Nations children living with cognitive and/or psychosocial disability are more likely to be criminalised[81] and have substantially higher rates of contact with police than their non-indigenous counterparts. First Nations children who have been imprisoned also face higher rates of violence and abuse by prison staff and police.[82]

Within the criminal justice system, people with disability are at grave risk of verbal, physical and sexual violence as well as bullying and harassment.[83] Due to a lack of adequate and appropriate health services and trained staff, prison staff responses are often punitive, resorting to the use of physical restraints and prolonged solitary confinement and isolation.[84]

People living with disability, and children in particular should be supported through culturally appropriate community-based responses, with a focus on prevention, diversion and support rather than punishment. Children and young people with disability and complex needs, and their families, are particularly vulnerable to inadequate, discriminatory and culturally unsafe health care, education and other services provided in custodial settings. Such measures are cruel, inhumane and degrading and violate international laws and obligations.[85]

The criminalisation and over-incarceration of First Nations people experiencing mental ill-health

The prevalence of people with mental illness in prisons is almost double that of the general population.[86] Across Australia, the demand for mental health care in custodial settings far exceeds service capacity, with patients being held in environments unsuitable for their needs.[87]

Nationally, over 75 per cent of imprisoned children and young people are living with one or more mental illnesses. The causal link between incarceration and poor mental health is well established, with some

studies showing that one third of incarcerated youth diagnosed with depression experienced its onset following incarceration.[88] For First Nations children and young people in particular, the additional trauma from exposure to institutional violence, abuse and neglect coupled with removal from family, kin and Country has been found to further exacerbate these risks.[89]

People in prisons are 10 times more likely to report a history of suicidal ideation and suicide attempts.[90] The suicide rate is also five times higher for men and twelve times higher for women in prisons when compared with the general population.[91] People in prisons commonly suffer from depression, anxiety, drug and alcohol dependence, and post-traumatic stress disorder.[92] Prison staff do not have the skills and training to manage the specialised physical and mental health care demands of people in prison experiencing mental ill-health and/or living with disability.[93] In many cases, these inadequacies result in prison staff using solitary confinement as a strategy to cope with 'difficult' behaviours rather than providing essential and compassionate medical care and supports.[94]

The Royal Commission recognised that solitary confinement causes 'extreme anxiety' and has a particularly detrimental impact on First Nations people in prisons, many of whom are already separated from family, kin, culture and Country.[95] Since then, Corrective Services Australia has been repeatedly found to have failed to properly address the poor conditions in their prisons, including the deteriorating conditions of confinement, inadequate access to culturally safe and trauma informed mental health services and supports, and the overuse of solitary confinement and resulting harms. Human Rights Watch remarked that the fundamental approach to the issue of mental health and self-harm in prisons relies heavily on confiscating items that can be used to self-harm and applying strict isolation and observation strategies for the most at-risk.[96]

People in prison commonly suffer from depression, anxiety, drug and alcohol dependence, and post-traumatic stress disorder.[97] Prison staff do not have the skills and training to manage the specialised health care demands of people in prison living with cognitive and psychosocial disability or experiencing mental ill-health.[98] In many cases, this inadequacy results in prison staff inappropriately applying strict observation, solitary confinement and confiscation practices to cope with behaviours of people with complex health needs rather than providing essential supports or treatments.[99]

First Nations people with complex needs, and their families, are particularly vulnerable to the inadequate, discriminatory and culturally unsafe health care, education and other services provided in custodial settings. Such measures are cruel, inhumane and degrading; and violate international laws and obligations.[100]

Abuse of remand systems and failure to divert First Nations people away from the criminal justice system

Bail determinations

Bail determinations and conditions act as significant drivers for the over-representation of First Nations people on remand, with devastating consequences. In 2019, 34 per cent (or 4,128/12,195) of all First Nations people in prisons were unsentenced.[101] Guardian Australia's Deaths Inside project found that,

nationally, more than half (54 per cent) of all Aboriginal people who died in custody between 2008 and 2021 were on remand.[102]

A recent NSW BOCSAR study (2021) reviewed more than 500,000 bail decisions made by police and courts in NSW between 2015 and 2019.[103] It found that factors, including the number and seriousness of offences and previous criminal history of a defendant, impacts the likelihood that the courts will overturn police bail decisions. This suggests that police are setting a lower threshold than the courts to refuse bail. The study also found that police are 20.4 per cent more likely to refuse bail to First Nations defendants based on 'extra-legal factors', including Indigeneity.[104] Alternatives to the current bail laws are urgently needed to address the imbalance created by extra-legal factors impacting bail decisions made by police and the courts. For instance, section 3A of the *Bail Act 1977* (Vic) includes a provision *requiring* (rather than *permitting*, as is the case in Queensland*)* a court to consider issues relating to a person's Indigeneity, including cultural background, ties to extended family or place and other relevant cultural issues or obligations.[105]

Diversion from custody

First Nations children and young people are also less likely to be diverted away from the criminal justice system by police[106] despite being are roughly 13 times more likely to be placed under youth justice supervision orders.[107] Across Australia, legislation aimed at diverting children, and First Nations children in particular, away from the criminal justice system is failing. For example, the *Young Offenders Act 1997* (NSW) (YOA) specifically provides for the use of warnings, cautions and conferences instead of court proceedings for certain non-violent offences.[108] It was enacted specifically to address the over representation of First Nations children in the criminal justice system. Despite its legislated intentions, First Nations children do not enjoy equal access to diversion under this policy.[109]

Another example is the Bail Assistance Line (BAL), a service designed to reduce the number of young people held in detention on short-term remand. It is mandated to target vulnerable young people and over-represented groups, including First Nations people.[110] The BAL partners with non-government organisations to assist with short-term accommodation and other supports and is intended to work with police to ensure remand is used as a last resort.[111] Despite the fact that the BAL is intended to specifically target First Nations children and young people, a recent BOCSAR study found that the programme mostly benefits non-Indigenous female defendants with shorter criminal histories, and that First Nations young people comprise a significantly smaller proportion of BAL placements (24 per cent) when compared with the general youth bail population (38 per cent).[112]

Custodial Health and safety[X]

First Nations people are put at an unacceptable risk of death or harm in custody due to a lack of cultural safety, inadequate supervision and inadequate healthcare. The sub-standard health care provided in prisons, and the lack of culturally safe and trauma informed care afforded to First Nations individuals within

[X] Please refer to the NJP Position Statement on Health Justice for a detailed overview of issues relating to the provision of health care in custodial settings.

the healthcare and justice systems, is one of many contributing factors to the unacceptably high rate of First Nations deaths in custody.[113]

Australian State and Territory legislation provides that people in prison have the right to timely access to health care of equitable standard to that which is provided in the community,[114] also known as the 'equivalence of care' principle.[115] However, prisons and youth detention facilities are not adequately equipped to provide health services and supports to people with complex and multiple physical health, mental health, disability and rehabilitation needs. Instead, they often function as warehouses, particularly for people from lower socio-economic circumstances, people with a history of trauma, people with addiction, people experiencing mental ill-health and people living with disability.[116] To achieve the goal of equitable health care for people in custody, governments must urgently address the inadequate and inferior health care services available in adult and youth prisons and the long waiting times for accessing what limited services are available.[117]

The specialised needs of people in prisons, and First Nations people in particular, are well established.[118] Despite this fact, the quality of health care provided by governments and private contractors in custodial settings remains wholly inadequate to meet the complex and multiple health, mental health, disability and rehabilitation needs of people in prisons.[119]

Specialised, equitable and culturally safe health services must be made available to all in carceral environments whether privatised or publicly operated. Achieving this goal requires legislation mandating a) the closure of all remaining prison hospitals, including Long Bay Prison Hospital in NSW;[120] b) equitable access to proper medical staff and facilities within the community; c) full access to Medicare, PBS, and the NDIS; and d) increased funding and supports for the expansion of Aboriginal Community Controlled Health Organisations, Aboriginal Health Liaison Officer programmes and programmes to enhance the employment and retention of First Nations healthcare professionals.

Alternatives to incarceration

Alternatives to incarceration, delivered by specialist courts and community-led justice reinvestment programmes, provide inclusive and culturally appropriate alternatives to police and traditional court orientated justice. These courts and programmes reduce First Nations incarceration and recidivism rates while improving individual, family and community outcomes in health and well-being, education, employment and other indicators. These courts and programmes are vital as they promote healing, equality, justice and self-determination; all of which are necessary to effectively combat the over-incarceration of First Nations people.

Despite having legislation and programmes that aim to divert First Nations people away from the criminal justice system, including the YOA and BAL, First Nations people do not enjoy equal access to, and benefit from, these initiatives. Their exclusion is often as a result of racism. Meaningful diversion and justice reinvestment is urgently needed to address these disparities, with significant input from First Nations communities in the drafting, monitoring and application of these programmes.

Justice reinvestment

Justice reinvestment is an emerging approach to tackle the high incarceration rates of First Nations people by diverting funds currently being spent on policing and prisons and reinvesting in community programmes. The recent international 'Black Lives Matter' protests following the death of George Floyd, and the similar protests here in Australia following the death of Mr David Dungay Jr and other First Nations people, have drawn increased attention to justice reinvestment as an alternative to police and court orientated 'justice'.[121]

Case study: Justice Reinvestment

The Maranguka Justice Reinvestment Project in Bourke, NSW exemplifies the effectiveness of justice reinvestment. The project effectively reduced the overall crime rates in the Bourke area while providing substantial economic savings by diverting people away from custodial and criminal justice settings.[XI,122] The project saw a clear increase in the number of people gaining licences, while the number of driving offences decreased.[123] Its effectiveness can be attributed to its focus on targeting the underlying factors which may cause driving offences, such as lack of access to vehicles and supervisors, identification documents, and language and literacy issues which may be obstacles for written tests.[124]

As the first major justice reinvestment project in Australia, the Maranguka Justice Reinvestment Project works in coordination with government and non-government agencies to create targeted methods of crime prevention, diversion and community development.[125] The Maranguka project effectively implemented the Royal Commission's recommendation to identify and address the relevant factors or causes of motor vehicle offences and to design community projects to address those factors.[126]

The Yiriman Project is a successful youth project in the Kimberley, and is currently based in Fitzroy Crossing, Western Australia. Originally conceived and developed in 2000 by Elders from four Kimberley language groups – Nyikina, Mangala, Karajarri and Walmajarri – the project focuses on supporting and reconnecting young Aboriginal people to culture and Country to address issues affecting young people in the community, including self-harm and substance use. [127]

Justice reinvestment is the leading recommendation in the *Pathways to Justice Report.*[128] The Special Rapporteur on the rights of Indigenous peoples has also highlighted the urgent need to 'move away from detention and punishment towards rehabilitation and reintegration' in her country report from her visit to Australia.[129] Consequently, what is now required is a commitment from the Government to implement programmes suitable for, and in partnership with, community. However, the onus cannot simply be on First Nations communities to reduce contact with the criminal justice system.

Specialist courts

Specialist courts provide inclusive and culturally appropriate alternatives to traditional courts, by focusing on principles of validation, respect and self-determination. Specialist courts seek to directly engage with

[XI] Key findings of the 2018 KPMG Impact Assessment the project included: 23% reduction in police recorded incidence in domestic violence and comparable drops in rates of reoffending; 31% increase in year 12 retention rates; 38% reduction in charges across the top five juvenile offence categories; 14% reduction in bail breaches; and 42% reduction in days spent in custody.

the person appearing before them, provide individualised case management and address key challenges in culturally appropriate ways, including through participation of Elders in sentencing discussions and minimising the use of legalese during proceedings.

The first Aboriginal Community Court was established in South Australia in 1999, following the Royal Commission.[130] Since then, several other jurisdictions have adopted comparable models, including Victoria,[XII,131] NSW,[XIII,132] Queensland[XIV,133] and Western Australia.[XV,134] Victoria is the only Australian jurisdiction to have enacted specific legislation to recognise and give effect to its Aboriginal courts (*Magistrates' Court (Koori Court) Act 2002*).[135] The Victorian Aboriginal Justice Agreement, developed in response to recommendations from the Royal Commission and subsequent Summit,[136] contains strategies and opportunities that are designed to strengthen First Nations oversight and focus on the important roles of family and therapeutic, cultural healing to tackle offending.[137] The Agreement aims to improve Aboriginal justice outcomes, family and community safety, and reduce over-representation in the Victorian criminal justice system.

Case study: Koori Courts

The Koori Youth Justice Program (KYJP) in Victoria[138] was developed in 1992, in response to recommendations from the Royal Commission. The KYJP is operated in the community, mainly by Aboriginal Community Controlled Organisations. The KYJP aims to prevent offending or re-offending behaviour by ensuring that young Aboriginal people are connected to their families and communities and provided with access to the supports and services they require.[139] An evaluation of the KYJP found it to be 'more engaging, inclusive and less intimidating than the mainstream court'.[140]

The Youth Koori Court (YKC) in NSW[141] commenced as a pilot programme at the Parramatta Children's Court in 2015. The YKC is a modified process within the usual Children's Court process. It has the same powers as the Children's Court but uses a different process to better involve First Nations young people, their families and the broader First Nations community in the court process.[142] An evaluation of the pilot programme found it significantly reduce the average number of days spent in detention from 57 days down to 25 days on average. The evaluation concluded that it is 'an effective and culturally appropriate means of addressing the underlying issues that lead many Aboriginal and Torres Strait Islander young people to appear before the criminal justice system'.[143] The YKC was expanded to the Surry Hills Children's Court in 2019.[144]

A public health approach over criminalisation

Substance use, misuse, and dependence should not be considered in isolation from experiences of trauma, poverty, mental ill-health and cognitive and/or psychosocial disability. The co-existence of these factors is

[XII] There are a number of Victorian Koori Courts, these are located in Bairnsdale, Broadmeadows, Latrobe, Valley (Morwell), Mildura, Shepparton and Warrnambool.

[XIII] The Youth Koori Court in NSW, commenced as a pilot programme at the Parramatta Children's Court in 2015 and was expanded to the Surry Hills Children's Court in 2019.

[XIV] For example, the Murri Court in Queensland.

[XV] For example, the Aboriginal Community Court in Western Australia.

the norm rather than the exception for people, and First Nations people in particular, coming into contact with the criminal justice system. Community-based services that can adequately meet complex health needs are urgently needed alongside reforms to policies and laws that criminalise so-called 'problematic' behaviours related to trauma, mental ill-health, disability, poverty and addiction. Such reforms must prioritise recovery oriented, trauma-informed support and treatment over a police response.[145]

Case Study: Alternative response pathways

The Denver STAR (Support Team Assisted Response)[146] program, based in Denver, Colorado, launched mid-2020 in partnership with local health, mental health and police departments. It is closely modelled on the CAHOOTS (Crisis Assistance Helping out on the Streets) program[XVI,147] and responds to calls that have a mental health or substance use component. Staff are trained to de-escalate situations and connect individuals in distress with appropriate services. It In its inaugural year, the pilot program (including a single vehicle and operating between 10 a.m. and 6 p.m., five days per week) responded to 1,400 emergency calls. Of these, no calls required the assistance of the Denver Police Department, no individuals were arrested, and no injuries were recorded. The programme has been welcomed by the Denver Police Department and its officers, with police accounting for 34.8 per cent of calls.[148] The programme has since been expanded with the purchase of five additional vans and 13 additional staff to respond to calls city-wide between the hours of 6 a.m. and 10 p.m. seven days per week.[149]

First Nations deaths in custody

Investigating First Nations deaths in custody

First Nations deaths in custody occur against a backdrop of over-incarceration, dispossession, intergenerational trauma, and continued oppressive systemic discrimination. Australia's public systems were created and operated as an instrument of colonial control against First Nations people and have resulted in extreme poverty, disadvantage and over-representation in the criminal justice system.

The right to life is a fundamental human right and yet many avoidable deaths pass through the coronial system each year. An avoidable loss of life causes irreversible effects to families, communities and is a stain on society as whole. When a death occurs at the hands of state institutions, purportedly designed to serve and protect the community, additional scrutiny is required to promote accountability and prevent future deaths from occurring.

[XVI] CAHOOTS, based in Eugene, Oregon, launched in 2014. CAHOOTS is funded through the Eugene Police Department and is staffed and operated by the White Bird Clinic. The programme has multiple vans that operate 24 hours a day, seven days a week, 365 days a year, with an equivalent of 60 service hours per day. More than 60 per cent of CAHOOTS clients are homeless, and 30 per cent live with severe and persistent mental illness. The programme is equipped to provide a range of interventions and services including de-escalation; crisis counselling; suicide prevention; conflict mediation; grief and loss support; welfare checks; substance use support; housing crisis; harm reduction; information and referral; transportation to services; first aid and non-emergency medical care. In 2019, CAHOOTS diverted 5-8 per cent of calls from police. Of the estimated 24,000 calls CAHOOTS responded to in 2019, only 250 required police backup. CAHOOTS has reported estimated annual savings of 14 million on emergency/ambulance treatment and 8 million on public safety.

The coronial jurisdiction has a unique role in investigating the circumstances that lead to a death. This can be the ultimate opportunity to provide truth, healing, closure and justice to families. However, the adversarial nature of the coronial process contributes to the sense of disempowerment experienced by First Nations families. While coronial proceedings are 'ostensibly inquisitorial', they are increasingly conducted in an adversarial manner.[150] One consequence of this is that First Nations families feel 'as if they are on trial and that the process is more about suppressing their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice'.[151]

Police and corrections officers retain a significant role in coronial inquests and are generally responsible for the initial fact-finding investigation.[152] This lack of independence not only further entrenches the existing mistrust First Nations people have in the legal system but also denies First Nations individuals, families and communities a sense of justice following the death of a loved one in custody.[153]

The critical lack of fairness and independence of investigators, the courts and integrity agencies throughout all levels of investigation and complaints processes, further reinforces existing mistrust of government systems by First Nations people seeking justice and redress for the violence they experience.[XVII]

More than 30 years ago, the Royal Commission recommended that a Coroner inquiring into a death in custody should make broad recommendations with the view to prevent further custodial deaths.[154] In the Australian Capital Territory, the Northern Territory, Western Australia and Tasmania, where there is a death in custody, coroners are mandated to make recommendations pertaining to the quality of care, supervision and treatment of the deceased to prevent similar deaths occurring.[155] In NSW, making such findings remains at the Coroner's discretion.[156] However, Newhouse, Ghezelbash and Whittaker (2020) found that even in jurisdictions where such recommendations are mandated, it is the general practice of coroners to deliberately confine their investigations to avoid addressing systemic issues relating to First Nations deaths in custody.[157] For example, they note that the inquest into the death of Jayden Stafford Bennell in Western Australia, where Coroner Linton ruled that the:

> *questioning of witnesses, other than the lead police investigators, was generally to be limited to other relevant issues … [and] questioning directed towards any potential systemic issues and preventative comments/recommendations must relate to the particular circumstances of Jayden's death rather than extending into a broad-reaching inquiry into prison systems as a whole.*[158]

Many foreign jurisdictions have also managed to establish coronial inquest processes with investigations that are independently conducted. For example, New Zealand's Independent Police Conduct Authority (a statutory body) provides independent oversight of police conduct, including monitoring places where police detention occurs. The Authority is itself empowered to investigate complaints and has a statutory mandate to operate with complete independence from both the police force and other parts of the state.[159] A similar degree of independence in the oversight of police and prison guard conduct across all Australian States and Territories is crucial to creating a system of accountability that First Nations people can trust to operate impartially and in the interests of justice.

[XVII] For more information and specific case study examples, please see NJP's Submission to the NSW Select Committee on the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Oversight and Review of Deaths in Custody (2020), 17-18.

Genuine accountability for wrongdoing is critical for deterring future misconduct, and for providing justice for the families and communities of First Nations people who have died at the hands of police and prison staff. Despite coroners having the power to refer for prosecution or disciplinary review, this rarely occurs.[160] To those who are the victims of state violence, the existing investigative procedure lacks fairness and independence. An independent investigation requires that those conducting it have no interest in the outcome to ensure unconscious bias does not influence the investigation. First Nations people can have no faith in a coronial inquest process that appears from the outset to be biased against the interests of the victim and in favour of the state.

Establishing an independent review body

Existing oversight bodies tasked with investigating First Nations deaths in custody, including the Coroner's Court, police investigators and oversight bodies, have failed to implement the recommendations made by numerous commissions, inquests and inquiries and are not meeting the needs of First Nations people. In particular, the lack of First Nations involvement in these systems and a general lack of oversight and accountability, threatens the integrity of the investigative process, the prospect of accountability for perpetrators and a sense of justice for families.

The Royal Commission recognised that an institution 'which has rules, practices, habits which systematically discriminate against or in some way disadvantage Aboriginal people, is clearly engaging in institutional discrimination or racism'[161] and envisaged that post death investigations could lead to systemic change.[162] At present, coronial jurisdictions across all Australian States and Territories fail to implement those recommendations by generally avoiding addressing systemic issues relating to First Nations deaths in custody.[163]

Fundamental changes are required to re-establish the coronial jurisdiction as a vehicle capable of delivering justice through truth, accountability and prevention. However, to date no Australian jurisdiction has established a system for a completely independent investigation into deaths in police and prison custody[164] and this lack of independence has led to mistrust in the system by First Nations families seeking justice.[165] It is unsurprising that the criminal justice system is perceived as a tool for perpetuating the suffering, impoverishment and punishment of First Nations families, while police, under the sanction of the state, operate with impunity for the violence and suffering they inflict.

It is therefore imperative that all State and Territory Governments urgently establish and properly fund a culturally appropriate, First Nations staffed and led, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. Such a body must have real powers to make recommendations, compel responses to recommendations, refer matters for prosecution or disciplinary action and to undertake regular prison and youth detention inspections.

Promoting a culturally responsive coronial system

Cultural safety is borne of shared respect, shared meaning, shared knowledge and experience, and involves learning, living and working together with dignity and truly listening.[166] It encompasses self-reflection by officials on individual cultural identity and a recognition of the impact of another individual's culture on their professional practices.[167]

The experience of many First Nations people is that the Australian legal system is fundamentally structured against their interests. A key issue is the failure to accommodate cultural and religious concerns about the treatment of bodies of the deceased or other expressions of culture throughout the inquest.

In Victoria, for example, there is a culturally specific unit within the Coroner's Court. The Coroner's Court has recruited a Koori Registrar and a Koori List Engagement Registrar to manage Aboriginal coronial cases to ensure that coronial practices are culturally sensitive and appropriate.[168] Victoria is also in the process of engaging Aboriginal Elders in the Coroners Court to provide cultural advice to ensure that coronial practices are culturally appropriate and safe.[169]

In Tasmania, the engagement of a First Nations organisation is mandatory where the coroner suspects that a death involves human remains of a First Nations person.[170] This direction ensures the treatment of a First Nations person's body post-death can be conducted respectfully and that cultural protocols are adhered to.

In contrast, in NSW, as the current coronial system stands, First Nations cultural practices and values are not accommodated for *at all*. Without the appearance of independence and integrity, the coronial inquest process will only serve to further validate this perception, alienating First Nations people from institutions which are intended to protect *all* Australians in a manner that is just and equitable. In almost all cases, these processes function to re-traumatise First Nations people who have spent lifetimes contending with institutions and officials who systematically fail to protect their most basic interests.

Human Rights Framework

Australia's obligations under international law

The right to substantive equality before the law, including safe and equitable access to justice, health care, education and other services free of racism and discrimination and discrimination is enshrined in international law.

The rights of First Nations Peoples

The United Nations Declaration on the Rights of Indigenous Peoples (**UNDRIP**)[171] is the most comprehensive international instrument on the rights of First Nations Peoples. The UNDRIP establishes a universal framework of minimum standards for the survival, dignity and well-being of First Nations Peoples globally and elaborates on existing human rights standards and fundamental freedoms as they apply to the specific situations and circumstances of First Nations Peoples.[172] The UNDRIP specifically provides for the right to self-determination[173] and a life free of discrimination,[174] as well as the right to liberty and security of person,[175] the right to the highest attainable standard of health[176] and the right to effective remedy.[177]

While not binding, the *United Nations 2030 Agenda for Sustainable Development* includes 17 Sustainable Development Goals (**SDG**) for the realisation of human rights for all, including economic, social and environmental rights.[178] Goal 10 of the SDG aims to 'reduce inequality within and among countries', and specifically provides for the right to equal opportunity through the elimination of 'discriminatory laws, policies and practices' and the promotion of 'appropriate legislation, policies and action'.[179] Goal 16 of the

SDG specifically provides for the right to 'equal access to justice for all';[180] 'effective, accountable and transparent institutions at all levels';[181] 'responsive, inclusive, participatory and representative decision-making at all levels';[182] and 'public access to information and [protection of] fundamental freedoms'.[183]

The right to life, liberty and security

Articles 6 and 9 of the *International Covenant on Civil and Political Rights* (**ICCPR**)[184] and article 3 of the *Universal Declaration of Human Rights* (**UDHR**)[185] recognise the universal right to life, liberty and security of person. The right to be free from arbitrary arrest or detention is also protected in article 9 of the ICCPR[186] and affirmed in article 9 of the UDHR.[187]

Article 1 of the UDHR affirms that '[a]ll human beings are born free and equal in dignity and rights', and article 10 of the ICCPR recognises the rights of all persons deprived of their liberty to be treated with humanity and with respect for their inherent dignity.

The Committee on the Elimination of Racial Discrimination ('**CERD Committee**') makes it clear that de facto and de jure racial profiling is a violation of international human rights law, a position supported by other treaty monitoring bodies including the Human Rights Committee[188] and the Committee against Torture.[189] Racial profiling can lead to infringements of other rights, such as the right to liberty and security of person, the right to the highest attainable standard of health and the right to an effective remedy. First Nations people have been identified as particularly vulnerable to racial profiling.[190] In this context, racial profiling is understood as described in the Durban Programme of Action, that is, 'the practice of police and other law enforcement relying, to any degree, on race, colour, descent or national or ethnic origin as the basis for subjecting persons to investigatory activities or for determining whether an individual is engaged in criminal activity'.[191] The Human Rights Committee identifies the link between racial profiling and stereotypes and biases – including conscious, unconscious, individual, institutional and systemic (or structural) – and identifies stereotyping as a violation of international human rights law when these assumptions are put into practice to undermine the enjoyment of human rights.[192]

The rights of people in custody

Article 7 of the ICCPR affirms that '[n]o one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'.[193] This right is further protected in the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**)[194] whereby state parties agree to meet international standards which aim to prevent cruel, inhuman and degrading treatment or punishment within closed environments.[195] The OPCAT also requires that state parties establish a system of regular visits, to be undertaken by independent international and national bodies, to all places of detention including police cells, adult and youth prisons and forensic hospitals.[196]

The Human Rights Committee[197] makes it clear that state obligations relating to the rights of prisoners extend to privately run institutions and has previously expressed concerns regarding the impact of the privatisation of prisons and related services on states in meeting their human rights obligations.[198]

Article 7 of the UDHR affirms that '[a]ll are equal before the law and are entitled without any discrimination to equal protection of the law'.[199] Similar protections against discrimination can be found in article 2 of the

Basic Principles for the Treatment of Prisoners which prohibits discrimination on the basis of 'race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'.[200]

Article 37 of the *Convention on the Rights of the Child* (**CRC**)[201] details the obligations of state parties to ensure that '[n]o child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment'[202] and that '[n]o child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time'.[203] The Committee on the Rights of the Child ('**CRC Committee**') has repeatedly urged Australia to urgently raise the minimum age of criminal responsibility to an 'internationally acceptable level' of a minimum of 14 years.[204]

The right to equitable health care free of discrimination

The United Nations' *Standard Minimum Rules for the Treatment of Prisoners* ('**Nelson Mandela Rules**'), establishes the minimum requirements for the treatment of all persons in prisons, youth detention, and remanded in custody.[205] The Nelson Mandela Rules are based on the overarching principle that 'all prisoners shall be treated with the respect due to their inherent dignity'[206] and recognises that states are responsible for guaranteeing this right, including by ensuring people in custody receive a standard of health care equitable to that which is available in the community, without discrimination; a right emulated in the Royal Commission recommendations.[207]

The Committee on Economic, Social and Cultural Rights ('**CESCR Committee**') also details the obligations of state parties to respect the right to healthcare, particularly for prisoners, detainees and minorities and to abstain from enforcing discriminatory practices in the delivery of health services.[208] The CESCR Committee is clear that this right is violated by denying 'access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination'.[209] Similar rights are also found in Article 9 of the *Basic Principles for the Treatment of Prisoners* which affirms that people in prison have the right to access 'health services available in the country without discrimination on the grounds of their legal situation'.[210]

Obligations under Australian law

Australia has agreed to be bound by a series of international human rights treaties, optional protocols and reporting and communications obligations,[211] which set out in clear terms Australia's international human rights obligations. Under international law, Australia is bound to comply with their provisions and to implement them domestically.[XVIII, 212] However, they do not form part of Australia's domestic law unless the treaties have been specifically incorporated into Australian law through legislation.[213]

[XVIII] Section 51(xxix) of the Australian Constitution, the 'external affairs' power, gives the Commonwealth Parliament the power to enact legislation that implements the terms of those international agreements to which Australia is a party.

Australia has ratified all the international human rights treaties mentioned above,[XIX] meaning that it has agreed to be bound by their provisions. Several rights have made it into Australian law at the Federal level, including the *Racial Discrimination Act 1975* (Cth), the *Sex Discrimination Act 1984* (Cth), the *Australian Human Rights Commission Act 1986* (Cth), the *Disability Discrimination Act 1992* (Cth), and the *Age Discrimination Act 2004* (Cth), and at State and Territory levels, including the *Human Rights Act 2004* (ACT), *Charter of Human Rights and Responsibilities Act 2006* (Vic) and the *Human Rights Act 2019* (Qld). The principles can also be found in common law.

Significantly, Australian does not have a Bill of Rights in our Constitution. In the absence of Constitutional protections, the safeguards against human right violations provided in domestic legislation remain susceptible to override by the legislature and the courts continue to be denied power to deprive legal validity to legislation that contravene their terms.

CONCLUDING COMMENTS

Successive Governments have repeatedly failed to take immediate, specific and meaningful action to achieve First Nations healing, equality, justice and self-determination and ultimately end the over-incarceration and the senseless and preventable custodial deaths of First Nations people.

At the National Justice Project, we continue to fight for justice alongside our clients who have been discriminated against in prisons, youth detention, health care and other institutional settings. We continue to work tirelessly to hold Governments to account for the harms caused by their actions (and inaction) and represent families who've lost loved ones because of discrimination in policing and places of detention.

Time and time again there has been a lack of genuine and lasting political commitment to implementing the recommendations that have been made in numerous inquests, inquiries and Royal Commissions. This lack of accountability and reform is at the heart of the problem. Continued advocacy is needed to ensure the priorities and recommendations made in this Position Statement are implemented in a manner that is meaningful and proportionate to the deeply disturbing entrenched racial bias within existing systems.

[XIX] Australia is also a party to the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, the *Convention on the Elimination of All Forms of Discrimination against Women*, the *Convention on the Rights of Persons with Disabilities*, the *1967 Convention relating to the Status of Refugees* and the *1967 Protocol relating to the Status of Refugees*.

ADDITIONAL RESOURCES

- Igniting Change interview - George Newhouse with Dan Mori (2022).*
- Submission to the Special Rapporteur on violence against women, its causes and consequences (2022).
- Submission to the Australian Human Rights Commission National Anti-Racism Framework (2022).*
- Submission to the Queensland Parliament Community Support and Services Committee - Criminal Law (Raising the Age of Responsibility) Amendment Bill 2021 (2021).
- Submission to NSW Select Committee's Inquiry into the Coronial Jurisdiction in New South Wales (2021).
- Submission to the Australian Law Reform Commission: Judicial Impartiality Inquiry (2021).
- Submission to the NSW Law Reform Commission - Open Justice Review (2021)
- Health Inquiry into Health Outcomes and Access to Health and Hospital Services in rural, regional, and remote New South Wales (2021)
- Law Hack 2021: Disability Justice Final Report (2021).
- Law Hack 2021: Disability Justice Kick-Off Event (2021).
- Law Hack 2021: Disability Justice Pitch Event (2021).
- Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability Submission on laws, policies and practice affecting migrants, refugees and citizens from culturally and linguistically diverse backgrounds (2021)
- Submission to the NSW Select Committee on the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Oversight and Review of Deaths in Custody (2020)
- Submission to the NSW Civil and Administrative Tribunal Statutory Review (2019).

* Publication pending.

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