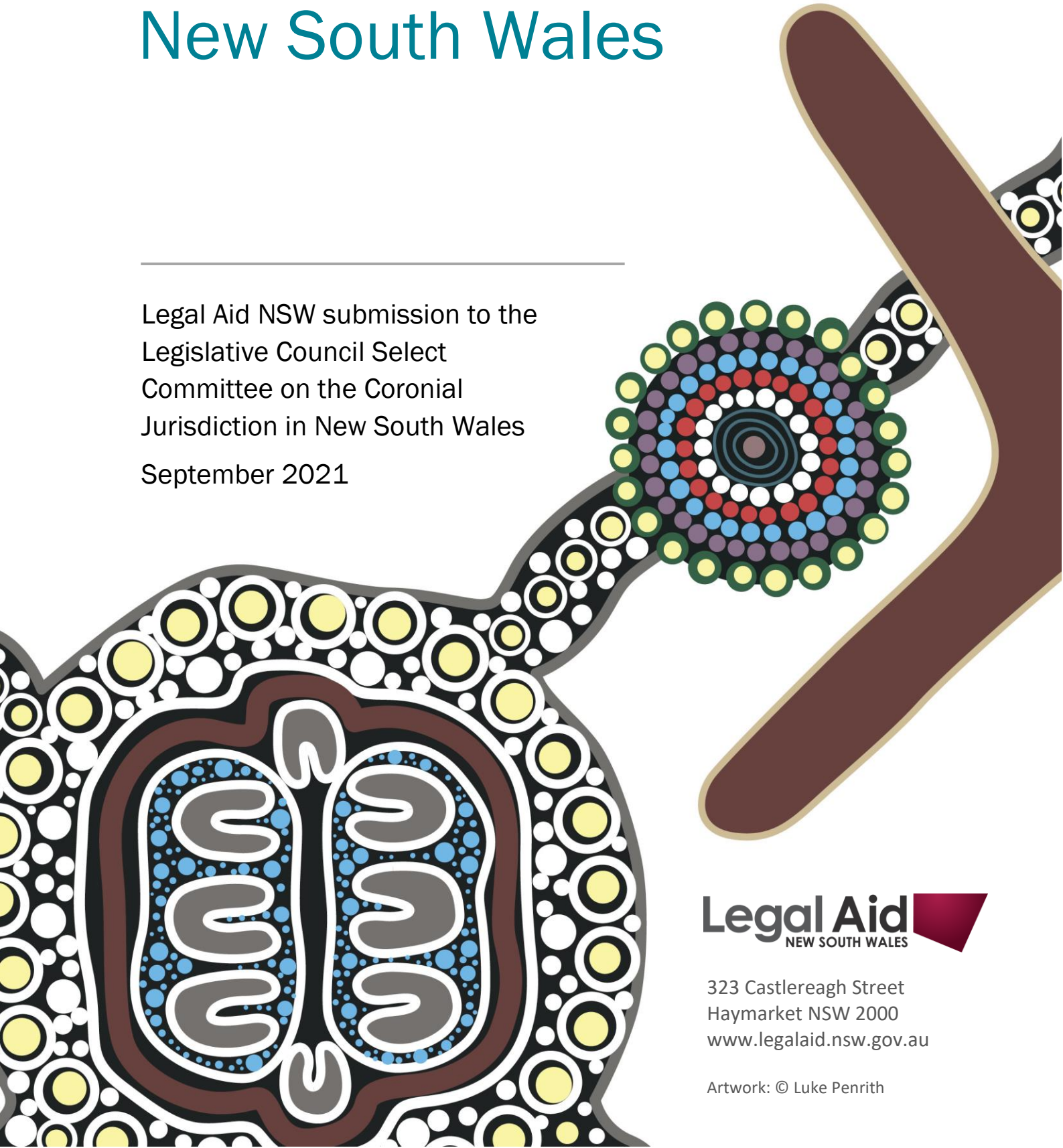
Inquiry into the coronial jurisdiction in New South Wales

Legal Aid NSW submission to the Legislative Council Select Committee on the Coronial Jurisdiction in New South Wales

September 2021



Legal Aid NEW SOUTH WALES

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Acknowledgement

We acknowledge the traditional owners of the land we live and work on within New South Wales. We recognise continuing connection to land, water and community.

We pay our respects to Elders both past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

Legal Aid NSW is committed to working in partnership with community and providing culturally competent services to Aboriginal and Torres Strait Islander people.

1. About Legal Aid NSW

The Legal Aid Commission of New South Wales (**Legal Aid NSW**) is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW). We provide legal services across New South Wales through a state-wide network of 25 offices and 243 regular outreach locations, with a particular focus on the needs of people who are socially and economically disadvantaged. We offer telephone advice through our free legal helpline LawAccess NSW.

We assist with legal problems through a comprehensive suite of services across criminal, family and civil law. Our services range from legal information, education, advice, minor assistance, dispute resolution and duty services, through to an extensive litigation practice. We work in partnership with private lawyers who receive funding from Legal Aid NSW to represent legally aided clients.

We also work in close partnership with community legal centres, the Aboriginal Legal Service (NSW/ACT) Limited and pro bono legal services. Our community partnerships include 27 Women's Domestic Violence Court Advocacy Services, and health services with a range of Health Justice Partnerships.

The Civil Law Division focuses on legal problems that impact on the everyday lives of disadvantaged clients and communities in areas such as housing, social security, financial hardship, consumer protection, employment, immigration, mental health, discrimination and fines. The Civil Law practice includes dedicated services for Aboriginal communities, children, refugees, prisoners and older people experiencing elder abuse.

The Legal Aid NSW Family Law Division provides services in Commonwealth family law and state child protection law. Specialist services focus on the provision of Family Dispute Resolution Services, family violence services and the early triaging of clients with legal problems through the Family Law Early Intervention Unit.

The Criminal Law Division assists people charged with criminal offences appearing before the Local Court, Children's Court, District Court, Supreme Court, Court of Criminal Appeal and the High Court. The Criminal Law Division also provides advice and representation in specialist jurisdictions including the State Parole Authority and Drug Court.

Legal Aid NSW's Coronial Inquest Unit is a state-wide specialist service that provides free legal advice and assistance in coronial matters and represents people at coronial inquests where legal aid has been granted.

It was established in 2006 in the Legal Aid NSW Civil Law Division, which provides advice, minor assistance, duty and casework services from the Central Sydney office and 20 regional offices.

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2. Executive Summary

Legal Aid NSW welcomes the opportunity to make a submission to the Select Committee inquiry into the coronial jurisdiction in New South Wales. Our submission is informed by the legal services we provide to families and individuals involved in the coronial system, including Aboriginal and Torres Strait Islander families.

The NSW coronial system is under strain from a lack of resources, and there are significant delays in the hearing of inquests. The system lacks effectiveness in preventing future deaths and creating systemic change. There are major issues with the way in which the coronial system serves families of deceased and missing persons, and particularly the special needs of Aboriginal and Torres Strait Islander families.

Legal Aid NSW considers that there is an urgent need for improvements to the NSW coronial system in relation to resourcing issues and delays, the provision of information to families, and cultural competency. To function effectively, the coronial system - inquisitorial by nature - must conduct investigations and inquests in a timely manner, to determine the circumstances surrounding a reportable death, including the manner and cause of death. The knowledge gained from these investigations must translate into systemic improvements, to prevent future deaths, through ameliorative and remedial actions by relevant agencies and interested parties.

Where a person or institution has caused a death, or contributed to it, appropriate referrals must occur in a timely fashion. Conversely, the rights and reputations of individuals brought before the Coroners Court as persons of interest, must be secured, together with their ability to access legal advice and representation.

Finally, the system must serve the needs of the families of deceased and missing persons, providing them with information, support, hope, therapeutic jurisprudence, and accountability, all delivered in a culturally competent way.

We appreciate there is much goodwill within the coronial system. We recognise and support the recent initiatives taken by the NSW State Coroner, and the outgoing Chief Magistrate, to improve court processes through the introduction of Practice Note 3 of 2021 and a First Nations Protocol. Further, we support the initiatives proposed by the individuals and organisations to this inquiry, in particular Adjunct Professor Hugh Dillon and the NSW Bar Association. However, without significant changes to resourcing and processes, together with a new or highly modified legislative framework, any improvements to the coronial system will remain limited.

Our responses to the Terms of Reference aim to improve the experience and outcomes for families involved in coronial proceedings. Our recommendations are formulated based on our involvement in numerous coronial inquests, together with our work as the only specialist advice and legal assistance service available in NSW for coronial matters. We provide more detailed recommendations in response to the relevant terms of reference below.

Recommendations

Recommendation 1

That the NSW Government ensure there are ongoing and increased levels of funding to ensure that families can access legal representation through the whole coronial inquest process.

Recommendation 2

That the NSW Government introduce a new Coroners Act which establishes a standalone Coroners Court and creates the framework for a modern coronial system centred on death prevention and the needs of bereaved families.

Recommendation 3

Amend the Coroners Act to include a provision advancing the preventative objective of the jurisdiction, similar to the preventative objectives of the *Coroners Act 2008* (Vic).

Recommendation 4

Amend the Coroners Act to include a provision identifying factors to be considered in relation to functions exercised under the Act, in order to advance the needs of the family of the deceased, similar to the factors identified in section 8 of the *Coroners Act 2008* (Vic).

Recommendation 5

Amend the Coroners Act, or introduce a new Act, that:

- consolidates all categories of deaths into one section, and contains a definition of 'reportable death' that covers all deaths within the coroner's jurisdiction
- defines 'death' to included 'suspected death'
- clarifies that the jurisdiction under section 23 of the Act extends to deaths in mental health facilities arising from involuntary admission or detention, and deaths in custody or as the result of police operations involving Commonwealth agencies
- establishes that the standard of 'reasonableness' in relation to a health-related reportable death be determined by an appropriately qualified independent person, in order to more accurately identify deaths arising from medical misadventure.

Recommendation 6

Amend the Coroners Act to mandate that the quality of care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

Recommendation 7

All reportable deaths in NSW should be centralised to a senior coroner at the Lidcombe Coroners Court on a permanent and ongoing basis.

Recommendation 8

That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court can effectively undertake its role in investigating all deaths reported to it in a timely manner.

Recommendation 9

That the NSW Government ensure the Coroner's Court is adequately resourced to produce annual reports that track the efficiency of the jurisdiction and report on performance measures.

Recommendation 10

(a) The State Coroner develop a protocol to ensure that coronial investigations proceed in a timely manner and are not delayed due to any delay in the provision of a final post-mortem report, and

(b) NSW Health Pathology Forensic Medicine provide interim post-mortem reports in order to facilitate the timely investigation of coronial matters.

Recommendation 11

Amend the Coroners Act to provide coroners with the power to compel anyone acting in a professional capacity to provide a written statement during the investigation phase unless there is a lawful excuse not to (including the common law privilege against self-incrimination).

Recommendation 12

That the Department of Communities and Justice and the Coroners Court establish a broad-based working group or court-users forum to address ongoing operational issues, including delay and other processes within the coronial jurisdiction.

Recommendation 13

(a) Amend the Coroners Act to place an onus on the Coroner to provide relevant material to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.
(b) Alternatively, that the State Coroner issue a Practice Note to require that relevant material be provided to relatives of the deceased as soon as it is available, unless there are compelling reasons to delay or not provide the information.

Recommendation 14

That the Coroners Court review its processes to ensure that families of the deceased are provided with information and brief material in a timely manner, and that the State

Coroner consider issuing guidelines (similar to the Queensland State Coroners Guidelines 2013) in relation to the rights and interests of family members.

Recommendation 15

That the NSW Government ensure that resources and facilities are provided to support families attending inquests, including a coronial counselling service, family break-out rooms at court and grants to family members for childcare, travel and accommodation expenses.

Recommendation 16

That the NSW Government provide additional funding to ensure that persons of interest can be provided with legal representation at inquests, where certain criteria are met.

Recommendation 17

Amend the Coroners Act to establish a statutory timeframe in relation to referrals under section 78 of the Act.

Recommendation 18

(a) That the Office of the Director of Public Prosecutions develop a guideline in relation to referrals under section 78 Coroners Act in order to minimise the delay in charging a person or advising that no proceedings will be taken, and

(b) That the State Coroner consider issuing a practice note for referrals under section 78 of the Coroners Act and timely decisions by the Office of the Director of Public Prosecutions regarding those referrals.

Recommendation 19

That Aboriginal identified positions be established within the NSW Coroners Court (including positions in the court registry and other support positions), and within NSW Health Pathology Forensic Medicine, particularly social worker positions, in order to improve cultural competency of the services that they provide.

Recommendation 20

Amend the Coroners Act in order that:

- definitions of ‘relative’ and ‘senior next of kin’ will recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures)
- persons other than the default senior next of kin may be appointed by the Coroners Court in exceptional circumstances, including where there are competing claims.

Recommendation 21

That NSW Health Pathology's 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.

Recommendation 22

Amend the Coroners Act to introduce a mandatory response regime to coronial recommendations, with responses being tabled in Parliament. Responses should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations. A response should be provided within three months of the Coroner's findings.

Recommendation 23

Amend the Coroners Act to empower the State Coroner "to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations" in relation to all coronial recommendations under section 82 of the Act.

Recommendation 24

That the NSW Government provide funding to establish a Coroners Prevention Unit at the State Coroners Court to provide sufficient resources and expertise to follow up on coronial recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

Recommendation 25

That the NSW Government establish an independent Coronial Council to advise and provide recommendations to government on the coronial system.

3. Importance of legal representation for families

The Coronial Inquest Unit (**CIU**) at Legal Aid NSW was established in 2006, to advise and represent family members of the deceased in coronial inquests. Over 15 years the CIU has provided representation to many families as they navigate the complex and emotionally draining experience of inquest proceedings.

Our lawyers have appeared and instructed in many high-profile inquests involving public interest issues, including the Lindt Café inquest, the Courtney Topic inquest, the David Dungay inquest, and the Rebecca Maher inquest. Additionally, we have provided thousands of advice and minor assistance services to family members in relation to coronial investigations. This includes advising family members shortly after a death has occurred in relation to post-mortem decisions and the coronial process, together with assistance through all stages of the coronial investigation in obtaining information, raising concerns with the Coroner, or arguing for an inquest to be held.[1]

Access to legal aid

A pre-requisite to a family member being granted legal aid for representation at an inquest is that a public interest test be satisfied. The public interest is something of common concern to the public at large, or a significant section of the public, such as a disadvantaged or marginalised group. This test applies in all matters except in Aboriginal and Torres Strait Islander deaths in custody, where the test is not applied, consistent with Recommendation 23 of the Royal Commission into Aboriginal Deaths in Custody.

Where legal aid is unavailable, we endeavour to refer applicants to alternative pro bono legal services. There is no other network in NSW that guarantees free legal representation to families of the deceased. The cost of private legal representation is often prohibitive.

Our lawyers have first-hand experience of the anguish and despair felt by many families following their attempts to engage with the coronial process. Often, they are unable to obtain information and answers about the death of a loved one from the coronial system; specifically, investigating police, coroners and assistant coroners in regional areas, registry staff and senior coroners at the State Coroners Court and elsewhere, police advocates at the State Coroners Court, and solicitors assisting the Coroner from the

[1] Noting that of the roughly 6000 deaths reported to the NSW Coroner each year, almost 99% of those matters (amounting to about 5900) will not result in an inquest because the Coroner has determined to dispense with an inquest: see Local Court of New South Wales, *Annual Review 2020* (2020) <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

Crown Solicitors Office and the Department of Communities and Justice Inquests, Inquires and Representation, Legal **(DCJ Legal)**.

We see both the tangible and intangible benefits that come from supporting families throughout this process. The importance of legal representation for families at complex inquest proceedings cannot be under-estimated. Legal Aid NSW and Aboriginal Legal Service (NSW/ACT) (**ALS**) representation of families spearheads their efforts to seek answers, and together we are able to take inquiries to levels that are unlikely to be reached where there is no family representative appearing as an interested party.

Of the inquests completed in 2018 and 2019, families were represented in just a third of the 220 deaths investigated. Of these families, about 40% were represented by the Coronial Inquest Unit, or their legal representation was funded by Legal Aid NSW.[2] There were similar levels of private representation of families at inquests.

The impact of legal representation is two-fold. First, the therapeutic impact on families of being able to voice their concerns through legal representation, and participate fully in the inquest process, are well-recognised.[3] Second, it improves the potential for the coronial system to prevent deaths, through a rigorous process of fact-finding and the formulation of coronial recommendations targeted at preventing future deaths and systemic failures.

Legal Aid NSW considers that families having legal representation from an early stage of the coronial process is crucial to their experience of the process and the outcome. In our experience, having a family representative involved in proceedings adds rigour to the level of inquiry and is vital to ensuring that issues are properly reviewed.

Unfortunately, the strong demand for representation of families at inquest outstrips the capacity of both Legal Aid NSW and the ALS. The ALS has no dedicated coronial unit and restricts its representation to mandatory section 23 inquests.

Recommendation 1

That the NSW Government ensure there are ongoing and increased levels of funding to ensure that families can access legal representation through the whole coronial inquest process.

[2] Based on a review of inquest findings, which record the interested parties (including family members) and their representatives.

[3] 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 *Frontiers in Psychology* 2322, 5.

4. Previous reviews of the coronial system in NSW

Legal Aid NSW welcomed the Report of the Select Committee on the high level of First Nations People in custody and oversight and review of deaths in custody (**First Nations Select Committee**) and 39 recommendations, which were directed primarily at the NSW Government, together with other NSW government entities. Chapter 6 of the report dealt with the coronial system, addressing a wealth of evidence about resourcing and timeliness, cultural considerations, accountability mechanisms, and the need for a review.

In our submission to the First Nations Select Committee, we stated:

> Legal Aid NSW considers that there is a need for a broader independent review or audit of how the coronial inquest system operates in NSW with the aim of ensuring that the NSW model has a greater focus on preventing deaths. The review should consider the adequacy of funding of the coronial system, including legal services for families, delays and other inadequacies in relation to the provision of information and support to families.[4]

In addition to the recommendation that has given rise to the present inquiry,[5] the Committee also recommended:

> Recommendation 31: That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroners Court 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.[6]

Whilst both these recommendations were directed at the investigation of deaths in custody, the evidence heard by the Committee concerning underlying issues such as resourcing and timeliness provide an excellent starting point for the current inquiry.

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[4] Legal Aid NSW, Submission No 117 to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *Legal Aid NSW Submission to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (11 September 2020) 89.

[5] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) Recommendation 30.

[6] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv.

Other than the First Nations Select Committee, Legal Aid NSW is not aware of any other publicly available reports or reviews into the NSW coronial system, to assess its efficacy and areas for improvement and reform.

In other jurisdictions, comprehensive reviews have been conducted resulting in deficiencies being clearly identified, and steps being taken to reform and modernise coronial systems, including through the introduction of new legislation. For example, in Victoria, in 2004 a Parliamentary Law Reform Committee reviewed the *Coroner's Act 1985* (Vic) with a view to modernising the coronial jurisdiction to better meet community need.[7] A report published in 2006 made 136 recommendations, and as a result a new Act established Victoria's first inquisitorial court with a key focus on reducing preventable deaths.[8]

In Queensland, an audit was conducted of the coronial system in 2018, which found significant systemic issues that affected the ability of the Queensland State Coroner to effectively fulfil its responsibility for the efficiency of the Queensland coronial system.[9] The State Coroner's lack of functional control had resulted in a system that was under-resourced to meet existing and future demand. The audit found excessive delays and a declining clearance rate were leading to a growing backlog of coronial investigations, indicating a system under stress.

Legal Aid NSW strongly supports the scope of the present inquiry and we hope that the Committee makes targeted recommendations aimed at ensuring that the NSW model has a greater focus on preventing deaths, as well as increased funding of the coronial system to address delays, including legal services for families, and other inadequacies in relation to the provision of information and support to families. We acknowledge the breadth of such an Inquiry and consider that there may be scope for further and ongoing independent reviews of the NSW coronial system, to ensure that it continues to achieve its stated aims.

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[7] *Coroners Act 2008* (Vic).

[8] Coroner's Court of Victoria, *Practice Handbook* (2011) <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/practice%2Bhandbook%2B%28web%2Bversion%29%2B-%2Bmarch2012.pdf>.

[9] In October 2018, the Queensland Audit Office delivered its report entitled 'Delivering Coronial Services', which assessed whether relevant government agencies were effective and efficient in supporting the Queensland State Coroner in investigating and helping to prevent deaths. The audit found that under Queensland Coroners Act 2003, whilst the State Coroner is legally accountable for the efficiency of the Queensland coronial system, the role has little functional control over the resources needed to effectively fulfil this responsibility.

4.1 Statutory Review of the *Coroners Act 2009*

The *Coroners Act 2009* (NSW) (**Coroners Act**) commenced in June 2009, and whilst it repealed the former *Coroners Act 1980* (NSW), it also re-enacted a number of the provisions of that Act, with modifications to improve the efficiency and effectiveness of the coronial jurisdiction. A statutory review mechanism was built into the new Coroners Act at section 109 of the Act, which required the Attorney General, as the responsible Minister, to review the Act to determine whether the policy objectives of the Act remained valid and whether the terms of the Act remained appropriate for securing those objectives.

Under section 109 of the Coroners Act, the review is to be undertaken after five years from the date of assent to the Act, and a report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the five-year period. The NSW Department of Communities and Justice commenced a review process in 2014. However, as this Committee has heard, to date, no report has been tabled in Parliament, and the statutory review has not been finalised.

We strongly support the NSW Department of Communities and Justice sharing a copy of the draft 2017 Statutory Review with the Committee, to inform the present inquiry. Its strength lies in the level of consultation that was undertaken, and the fact that it so comprehensively identifies the deficiencies with the current legislation, and the best solutions by way of statutory amendment.

5. A stand-alone court and new Act

A fundamental question for coronial reform in NSW is whether a new Coroners Act should be introduced, and whether there should be a stand-alone Coroners Court, as exists throughout most Australian jurisdictions.

At present, the Coroners Act does not establish a Coroners Court. It simply confers coronial jurisdiction on certain magistrates and other persons, and the operation of the legal part of the coronial system falls under the realm of the NSW Local Court.

Legal Aid NSW recognises that a significant component of the coronial system involves the work of NSW Health Pathology's Forensic Medicine service, which is established under NSW Health. For example, the State Coroners Court at Lidcombe is a joint facility containing a facility operated by the Forensic Medicine service, which employs Health staff and contains a morgue, together with a court complex, accommodating judicial officers, employing NSW Justice employees, and containing a court registry and four courts. The work of the State Coroners Court co-exists with the operation of facilities which fall beyond the realm of justice and the courts.

It is critically apparent that NSW must modernise processes and enact legislation that supports and enhances the ability of the Court to provide a therapeutic and restorative environment for family members, and to properly serve the culturally and linguistically diverse members of our society. In particular, there is a need for a system that can better serve the needs of First Nations people, who are likely to be disproportionately represented in deaths reported to the Coroner and inquests held.

In the context of First Nations deaths in custody, the First Nations Select Committee report (Chapter 6) provided evidence of the following issues:

1. lack of funding and resources for the Coroners Court
2. its impact on the effectiveness and timeliness of inquests
3. structural issues that impact on the coronial system (such as its use of regional magistrates to undertake coronial work in circumstances where they have competing workloads and lack specialist training)
4. timeliness and the provision of information to families, and the impact of these timeframes on families
5. accountability for coronial recommendations, and

6. the ability of the coronial system to address systemic failures and prevent further deaths.[10]

The report highlighted a recommendation by Adjunct Professor Dillon that "the NSW Government recognise the need for a specialist coronial system and design it accordingly, including a specialist Coroners Court of NSW." It referred to concerns raised by Legal Aid NSW with the Coroners Court being part of the NSW Local Court structure, indicating:

> [Legal Aid NSW] said that this 'has proven to be a major limitation on the functions of the court, and its capacity to adapt and reform so as to provide an effective death prevention function, and to cater adequately for families of the deceased'. Legal Aid NSW also recommended that 'serious consideration ought to be given to establishing the NSW Coroners Court as a separate court, as has occurred in Victoria, Queensland, South Australia and Western Australia.[11]

Our position remains that the existence of the Coroners Court within the NSW Local Court creates major limitations on the functions of the Coroners Court, its capacity to provide an effective death prevention function, and to cater adequately for families of the deceased.

Legal Aid NSW supports consideration of a new Act as the most appropriate step forward. Whilst additional resources and discrete legislative amendments may provide a solution to some problems in the coronial system in the short term, consideration should be given to introducing a new Act which establishes a separate court and creates the framework for a modern coronial system, centred on death prevention and the needs of bereaved families. There would undoubtedly be benefits in establishing an independent, stand-alone court under a new Act, enhancing the jurisdiction's capacity to grow and to advocate for its own advancement.

Recommendation 2

That the NSW Government introduce a new Coroners Act which establishes a standalone Coroners Court and creates the framework for a modern coronial system centred on death prevention and the needs of bereaved families.

[10] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021).

[11] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 131 [6.26].

6. The jurisdiction of the Coroners Court

6.1 Objects of the Act and factors to consider

Before considering the scope and limits of coronial jurisdiction, it is appropriate to reflect on the coronial jurisdiction generally, and some of the key deficiencies. As we have stated, the NSW coronial system lacks effectiveness in preventing future deaths and creating systemic change, and there are major issues with how it serves families of deceased and missing persons. Importantly, the legislation that underpins our coronial system barely refers to these issues, let alone providing a framework or guiding principles to address them.

6.1.1 Preventative function

The objects to the Coroners Act do not include a preventative function, other than identifying that an object of the Act is 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).[12]

Legal Aid NSW supports adopting the preventative objectives of the Victorian *Coroners Act 2008*,[13] which invests the Victorian Coroners Court with a key focus on reducing preventable deaths.[14] The preamble to the Act provides:

> The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purposes of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice. This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations.[15]

The *Coroners Act 2008* (Vic) also contains purposes which include contributing "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."[16]

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

[13] *Coroners Act 2008* (Vic).

[14] Coroner's Court of Victoria, *Practice Handbook* (2011) <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/practice%2Bhandbook%2B%28web%2Bversion%29%2B-%2Bmarch2012.pdf>.

[15] *Coroners Act 2008* (Vic), Preamble.

[16] *Coroners Act 2009* (NSW) s 1 (c).

Recommendation 3

Amend the Coroners Act to include a provision advancing the preventative objective of the jurisdiction, similar to the preventative objectives of the *Coroners Act 2008* (Vic).

6.1.2 Focus on needs and centrality of deceased's family

There are no provisions in the Coroners Act that cement the importance of families of deceased and missing persons within the coronial process, other than a provision dealing with representation at coronial proceedings (which requires that a Coroner must grant leave to appear to a relative of a deceased person unless satisfied there are exceptional circumstances to refuse leave).[17]

In contrast, the *Coroners Act 2008* (Vic) contains the following six factors to be considered in relation to functions exercised under the Act, which are primarily directed at the needs of family:[18]

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

Recommendation 4

Amend the Coroners Act to include a provision identifying factors to be considered in relation to functions exercised under the Act, in order to advance the needs of the family of the deceased, similar to the factors identified in section 8 of the *Coroners Act 2008* (Vic).

[17] *Coroners Act 2009* (NSW) s 57 (3).

[18] *Coroners Act 2008* (Vic) s 8.

6.2 The scope and limits of jurisdiction

Legal Aid NSW supports a new Coroners Act, or amendments to the existing Act, which would achieve the following outcomes:

1. Consolidate the jurisdiction over deaths into a single place in the Act – presently, the definition of "reportable death" in s.6 only lists some of the deaths over which coroners have jurisdiction, whilst jurisdiction over other deaths is found in other parts of the Act (e.g., ss.23, 24 and 27).
2. A definition of 'death' to include 'suspected death' – the jurisdiction of coroners extends to 'suspected deaths', yet that term is found in an ad hoc and inconsistent way through the Act. Including a definition of 'death' which includes 'suspected death' would promote clarity and consistency.
3. Section 23 of the Coroners Act requires clarification in several respects, due to uncertainty over its scope:
    a. clarification that deaths in mental health facilities arising from involuntary admission or detention are deaths "in other lawful custody" for the purposes of section 23, and are therefore subject to a mandatory inquest; and
    b. clarification that deaths in custody or as the result of police operations involving Commonwealth agencies are included within the scope of section 23.

6.2.1 Health-related reportable deaths

In relation to health-related reportable deaths,[19] we hold concerns that there is likely to be an under-reporting of such matters to the Coroner. These concerns are based on cases where family members have sought assistance to submit that the Coroner should assume jurisdiction over a hospital-related death, in circumstances where the family member alleges inadequate care, but the death has not been reported to the Coroner.[20]

The difficulty with the current system is that medical practitioners involved in the person's care may also be involved in making the decision as to whether a death is reported to the Coroner.[21] There is arguably a disincentive for a practitioner to report a death when they know this will result in a coronial investigation. There is a fundamental flaw in this

[19] *Coroners Act 2009* (NSW) s 6 (1)(e) provides that a person's death is a reportable death if "the person died in circumstances where the person's death was not the reasonably expected outcome of a health-related procedure carried out in relation to the person."

[20] Usually because it has not been assessed as a reportable death, and a death certificate has then been issued by a medical practitioner: *Coroners Act 2009* (NSW) ss 6, 21.

[21] In assessing whether a death was not the reasonably expected outcome of a health-related procedure, NSW Health Guidelines require the doctors to use their own professional judgment to assess whether a death is reportable. In particular, doctors are asked to assess was "the health-related procedure performed in a manner, which at the time of the death, would be considered by your peers as competent professional practice?": NSW Health Department, *Coronial Checklist* (IB2010_058, 30 November 2010), 4.

process, as it requires the practitioner to recognise deficiencies in their own professional practice, or that of their colleagues. A solution is to require the standard of reasonableness as to the expected outcome to be assessed by an appropriately qualified independent person.[22]

Recommendation 5

Amend the Coroners Act, or introduce a new Act, that:

- consolidates all categories of deaths into one section, and contains a definition of 'reportable death' that covers all deaths within the coroner's jurisdiction
- defines 'death' to included 'suspected death'
- clarifies that the jurisdiction under s.23 of the Act extends to deaths in mental health facilities arising from involuntary admission or detention, and deaths in custody or as the result of police operations involving Commonwealth agencies
- establishes that the standard of 'reasonableness' in relation to a health-related reportable death be determined by an appropriately qualified independent person, in order to more accurately identify deaths arising from medical misadventure.

6.3 Deaths in custody

Legal Aid NSW supports expanding the court's jurisdiction in relation to inquests into deaths in custody consistent with recommendation 12 of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), which is not reflected in the Act:

> "a coroner enquiring 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."[23]

Whilst care is normally taken to review matters that may be causally linked to a death, there is no general obligation on a coroner to review the quality of care, treatment and supervision of a person who dies in custody.[24] In certain circumstances, this may result in both an investigation and inquest that fails to address matters important to family

[22] Adjunct Professor Hugh Dillon, Submission No 14 to the Select Committee on the coronial jurisdiction in NSW, *Inquiry into the coronial jurisdiction in New South Wales* (5 July 2021) Appendix C.

[23] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 12.

[24] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 96.

members, such as the provision of health care to the deceased and conditions whilst in custody.

We anticipate that the State Coroner's First Nations Protocol will include directions to investigate and consider the quality of care, treatment and supervision of First Nations deceased during the period leading up to their death. However, at present the Act itself, and in particular the findings required by s.81 (as to identity, date and place of death, and manner and cause) do not extend to "the quality of the care, treatment and supervision of the deceased."

Recommendations 35 and 36 by the RCIADIC were directed at police investigations, and sought that investigations extend to the general care, treatment and supervision of the deceased prior to death, including a particular focus on whether custodial officers observed all relevant policies and instructions concerning care, treatment and supervision. In our experience, often the extent of police investigation of these matters is relatively cursory or left to legal professionals assisting the Coroner. Some police investigators reach conclusions that indicate there were 'no suspicious circumstances' and fail to identify issues such as adequacy of medical or other care.

Legal Aid NSW notes recommendations 33 and 34 made by the First Nations Select Committee seeking legislative amendments to require a coroner to examine systemic issues in relation to a death in custody, and to make findings on whether the implementation of RCIADIC recommendations could have reduced the risk of death.[25]

Legal Aid NSW considers that the Coroners Act should be amended to provide consistency with Recommendation 12 of the RCIADIC, at the very least for Aboriginal and Torres Strait Islander deceased persons, if not all deaths in custody. It should mandate that the quality of the care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

Recommendation 6

Amend the Coroners Act to mandate that the quality of care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

[25] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv and 6.129-6.131.

6.4 Regional deaths

Legal Aid NSW supports the ongoing centralisation of reportable deaths to coroners operating at Lidcombe Coroner's Court. The Coroners Act permits a system whereby regional magistrates may exercise jurisdiction for reportable deaths (excluding deaths under section 23 or 24) occurring outside Sydney metropolitan region which in 2020 numbered 2,834 against 3,540 to Lidcombe.[26]

Legal Aid NSW understands a significant change adopted during the pandemic was centralised reporting of all NSW deaths to a senior coroner at Lidcombe. This ensures post-mortem directions are determined by experienced coroners, rather than dealt with by regional magistrates. According to the Local Court Annual Review, the benefits achieved by a single decision maker have been far reaching and have also seen a reduction in the number of post-mortem examinations conducted.

This reporting has proved to be successful, and we understand the intention is for it to remain as a permanent change. Legal Aid NSW strongly supports this initiative continuing on an ongoing basis. Under the regional system, our casework informs us that a lack of guidance to regional magistrates exercising coronial functions may be causing missed opportunities to review reportable deaths, such as preventable deaths involving substandard levels of health and hospital services. In Legal Aid NSW's experience, significant coronial inquests into issues of public health and safety in regional NSW were borne out of coronial cases that had been previously dispensed with by regional magistrates.[27]

Recommendation 7

All reportable deaths in NSW should be centralised to a senior coroner at the Lidcombe Coroners Court on a permanent and ongoing basis.

[26] Local Court of New South Wales, *Annual Review 2020* (2020), 24 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[27] *Inquest into the Death of Sandra Cree* (2016/118575, 22 October 2018), NSW State Coroner's Court, Glebe.

7. Resourcing

Inadequate resourcing within the NSW coronial system has a significant impact on families. Legal Aid NSW supports increased funding to the NSW Coroners Court, consistent with recent findings by the First Nations Select Committee:

> "Firstly, it is unquestionable that the funding and resourcing of the NSW Coroners Court needs to be improved. As we have heard, it is having a significant impact on the length of time to complete an inquest, which in turn is causing undue stress on the families involved."[28]

Whilst the First Nations Select Committee recommendation[29] was limited to deaths in custody, inadequate resourcing has an impact on all coronial investigations, and is most clearly demonstrated through the lengthy delays in completing inquests.

7.1 Numbers of coroners

A comparison with other jurisdictions on a range of indicators (budget, judicial positions, support services) is likely to highlight funding inadequacies which exist in NSW. One key indicator is the number of coroners. In 2020 there were an equivalent of 4 deputy state coroners at Lidcombe, together with the State Coroner, and 3 other regional magistrates also exercising jurisdiction as deputy state coroners.[30] These regional magistrates also carry a heavy criminal workload. By comparison, the Victorian Coroner's Court comprises one Senior State Coroner, one Deputy State Coroner and 11 Coroners.[31] In Queensland, there are 7 specialist full-time coroners located through the state.[32] Queensland's population is 63% of that in NSW, and Victoria's population is 82%.

7.2 Outstanding mandatory inquests

Legal Aid NSW is concerned about clearance rates, particularly for deaths in custody

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[28] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 150.

[29] The Select Committee recommended at xiv::Recommendation 31: That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroners Court can effectively undertake its role in investigating deaths in custody in a timely manner.

[30] Local Court of New South Wales, *Annual Review 2020* (2020), 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[31] Local Court of New South Wales, *Annual Review 2020* (2020), 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[32] Queensland Courts website: <https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/coroners-list>.

cases. At the end of 2020, only 45 death in custody inquests had been finalised.[33] At the same time, there were 96 death in custody inquests that had not been completed. Some of these unresolved inquests are dated five years prior to the 2020 report – at least two are from 2015, one from 2016, nine from 2017, and 15 from 2018.[34] The NSW State Coroner's report from 2019 also indicates a similar trend with only 23 death in custody inquests being completed, and 94 inquests pending an outcome.[35] These trends demonstrate that, given current resourcing, it is unlikely that the legacy caseload of 96 outstanding death in custody inquests that existed at the end of 2020 will be finalised in a timely way.

Recommendation 8

That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court can effectively undertake its role in investigating all deaths reported to it in a timely manner.

7.3 Annual reporting

Lack of comprehensive annual reporting in relation to the NSW coronial system makes it difficult to monitor its efficacy and is a further product of inadequate funding. The work of the Coroners Court is recorded annually in the NSW Local Court Annual Review. A handful of statistics are presented (reported deaths, investigations finalised, inquests held) with no assessment of clearance rates or other performance data.

In comparison, the Queensland State Coroner report is comprehensive.[36] It sets out a framework for action and performance review, established after a report into the court's efficiency by the Queensland Audit Office in 2018-19. For example, the 2019-20 report outlines a 'triaging trial' undertaken by the court to reduce demand pressures, better support families and ensure coroners have increased capacity to focus on complex investigations. The Queensland State Coroner reports on coronial performance according to clearance rates and provides state-wide figures and comparisons to other

[33] NSW State Coroner, Parliament of New South Wales, *Report by the NSW State Coroner into Deaths in Custody/Police Operations* (Report, December 2020) 510.

[34] Ibid.

[35] NSW State Coroner, Parliament of New South Wales, *Report by the NSW State Coroner into Death in Custody/Police Operations* (Report, April 2019) 577.

[36] Coroners Court of Queensland, *2019-20 Annual Report* (17 November 2020) <(https://www.courts.qld.gov.au/__data/assets/pdf_file/0020/670421/osc-ar-2019-2020.pdf>.

annual reporting years. The report also monitors autopsy expenditure and the number of examinations ordered in the year.

Similarly, the Victorian State Coroner's annual report provides a snapshot of investigations, caseload, timelines, and inquest clearance rates.[37] The performance measures are tracked according to the objectives of the jurisdiction: investigations into deaths and fires, reducing preventable deaths, promoting public health and safety and corporate governance and support.

Legal Aid NSW considers that the Victorian Coroner's capacity to report and track the deliverables of their jurisdiction is a major strength in both death prevention and efficiency. In Legal Aid NSW's experience, the capacity to influence death prevention is a major factor in why families participate in inquests, and their motivation to ensure the tragic death of their loved one will create a positive legacy for others in the community.

Unlike its interstate counterparts, the State Coroner's Court does not produce its own comprehensive annual report. There is a lack of information about the full scope of the coroner's work, and common themes or systemic issues identified by coroners in NSW. There is no annual reporting on recommendations, or responses to recommendations. Legal Aid NSW supports additional resources for the Coroner's Court to undertake robust annual reporting.

Recommendation 9

That the NSW Government ensure the Coroner's Court is adequately resourced to produce annual reports that track the efficiency of the jurisdiction and report on performance measures.

[37] Coroners Court of Victoria, *Annual Report 2019-20* (December 2020) <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019 20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf>.

8. Timeliness and delays

The State Coroners Court website states under "Overview of the Coronial Process":

> Unfortunately, a number of popular television shows perpetuate the myth that a cause of death can be established quickly and that the Coroner can pinpoint the time of death precisely. Neither of these things is true. The reality is that a coronial investigation is both complex and lengthy. Whilst some cases may be resolved within a few months, the majority of cases take considerably longer. An investigation often takes up to 12 months and in rare instances, even longer.

In Legal Aid NSW's experience, it is common for the delay between a death and inquest to be between three and five years. Legal Aid NSW has represented families where the inquest was held up to seven years after the death, without any clear explanation for the delay. Our experience in representing family members is that delays cause unacceptable levels of prolonged grief and suffering. This observation is well-supported by the literature. Reviews conducted in Victoria and Western Australia demonstrated that:

> "delays in coronial proceedings were a significant source of distress for families, particularly due to attrition in evidence, financial strain, and prolonged grieving for families recounting information many years after a death." [38]

Lengthy delays exist not only for inquests, but also for matters that do not proceed to an inquest, whilst coroners investigate and consider whether or not to dispense with an inquest. For those families, the uncertainty of not knowing whether they will have an opportunity to ventilate issues surrounding their loved one's death is a compounding factor.

Case study: MH

MH took his own life by hanging himself at Goulburn Correctional Centre on 23 June 2017. He was 21 years old and had a diagnosis of schizophrenia. He had been an involuntary patient in the community immediately before placed in custody in May 2017. On reception at Goulburn, he advised correctional authorities of an earlier attempted suicide, and his mental health diagnosis.

Shortly after his death, his mother contacted Legal Aid NSW. She wanted answers about his death and saw the potential for meaningful reforms to the management of mental health both in prison and the general community.

[38] 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 *Frontiers in Psychology* 2322, 2.

On her behalf, requests for documentation were made to the Coroners Court in January and February 2018. There were significant delays in the most basic documentation being prepared. The autopsy report was not completed until 1 August 2018. The statement of the Officer in Charge from NSW Police was not finalised until 14 August 2018. It was only provided to the family in March 2019.

Two years after MH died, a referral was made by the Coroners Court to the Crown Solicitors Office in June 2019, seeking its assistance. Crown Solicitors accepted that referral in August 2019. Delays in the provision of information continued throughout the coronial process, with large amounts of material provided to MH's mother's and her legal representatives in the week before inquest.

The inquest was heard in March 2021. The findings were delivered in July 2021, more than 4 years after MH's death.

To address delays in the coronial system, The Improving Timeliness of Coronial Procedures Taskforce was established as a joint agency initiative between NSW Health and the Department of Communities and Justice.[39] The Taskforce was to examine the 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. One of its key tasks was to address the issue of delay in the timely provision of post-mortem reports. Despite an indication that the Taskforce was expected to complete its work in mid-2021, there has been no publicly available report released. Delays associated with post-mortem reports remain.

8.1 Specific delays through the coronial process

8.1.1 Delay in post-mortem reports & investigation until post-mortem report complete

In our experience, post-mortem reports are routinely not provided until six to nine months after death, and often after far longer periods. This delay creates a hurdle in the investigation, delaying any decision-making on the cause of death, and delaying the start of any proceedings. We understand it is common practice for a coronial investigation to not be allocated and for coroners to take no further steps until a final post-mortem has been provided. In Legal Aid NSW's experience, families are often told they must wait until the post-mortem report is received until they can access other evidentiary material, such as CCTV or witness reports (even though this material has often already been

[39] Local Court of New South Wales, *Annual Review 2020* (2020) 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

compiled by the police).

The provision of interim post-mortem reports, and a change to procedures (such that investigations proceed regardless of the provision of final post-mortem reports) is necessary to reduce delays.

Recommendation 10

(a) The State Coroner develop a protocol to ensure that coronial investigations proceed in a timely manner and are not delayed due to any delay in the provision of a final post-mortem report; and

(b) NSW Health Pathology Forensic Medicine provide interim post-mortem reports in order to facilitate the timely investigation of coronial matters.

8.1.2 Delay in obtaining statements from health professionals

Potential witnesses in a coronial investigation are entitled to rely on the privilege against self-incrimination and seek legal advice prior to providing a statement to the Coroner. However, a practice has developed in NSW whereby statements from doctors and nurses (including NSW Health and Justice Health employees) are not taken by NSW Police at an early stage of the investigation. As a result, statements are often prepared with the assistance of lawyers, usually well after a death occurs. Often this occurs after a number of years. This results in poor quality evidence with little detail. In contrast, in the experience of our solicitors, recorded interviews with police shortly after a death possess vastly greater evidential value. There is a need to address these delays, which would greatly improve the quality of evidence at inquest, and the time needed to prepare a final brief of evidence.

Recommendation 11

Amend the Coroners Act to provide coroners with the power to compel anyone acting in a professional capacity to provide a written statement during the investigation phase unless there is a lawful excuse not to (including the common law privilege against self-incrimination).

8.1.3 Delay in preparation and service of a brief of evidence

In Legal Aid NSW's experience, there are lengthy delays before a brief of evidence is prepared, and then further lengthy delays before it is served on the deceased's family. Often the delay is not due to police investigators, but other inefficiencies and issues. Sometimes it can take years before a proper brief is compiled. In some cases, the family and/or its representatives do not receive a brief of evidence until four to six weeks before

the inquest, and this may comprise many volumes of material. This provides insufficient time to discuss the evidence with the family and impacts on their capacity to meaningfully engage with the process, for example, by identifying issues and witnesses.

Families and their legal representatives provide an important level of scrutiny and oversight, in addition to the work of Counsel Assisting and the solicitors assisting the Coroner. Our solicitors routinely identify gaps in the evidence that result in requests for further material, and key lines of enquiry which later form the basis of recommendations.

Delays in preparing and serving briefs could be addressed through better resourcing of agencies which provide legal support to coroners in their investigations and preparation for inquest. For example, the level of resourcing provided to the Crown Solicitor's Office should be reviewed to ensure it is adequate, given the significant workload of its Inquiries Practice Group, and their centrality to the effectiveness of the coronial process in complex matters. Greater resourcing would enable faster preparation of briefs and earlier commencement of inquests.

Case Study: The death of David Dungay

David Dungay, a proud Dunghutti man, died on 29 December 2015 while being restrained by prison guards at Long Bay Hospital. He was an involuntary mental health patient. Because of the practice in NSW of keeping scheduled inmates in a prison hospital, he was housed at Long Bay Hospital.

His inquest did not commence until 16 July 2018. The first thing the Coroner did was acknowledge the delay:

Firstly, let me acknowledge the time it's taken to get here today. It is probably an unusual thing for anybody who is not a lawyer to experience the time that it has taken to get here today; that is, it's taken now two and a half years from an event until the Court proceeding. Anybody who is not a lawyer probably correctly thinks of that as being a long time. No doubt, in that period of time, your patience has been tested on many occasions and it's given rise to frustration on many occasions.

Family members of David Dungay had been adamantly protesting his death since it occurred. After two weeks of evidence in July 2018, the inquest was not finished. The matter was adjourned for nine months until 4 March 2019, as the Coroner had no available time.

Findings were delivered on 22 November 2019, almost four years after David's death.

8.1.4 Court listings and Coroner's availability

In our solicitor's experience, when a matter is ready to be listed for hearing, most coroners do not have availability for six to twelve months or more. This is a product of there being insufficient numbers of coroners in comparison to the number of inquest matters to be held.

8.1.5 Claims for non-publication and other protective orders

Given the sensitivity of some material obtained during a coronial investigation, parties such as the NSW Commissioner of Police or Corrective Services NSW may seek to obtain protective orders from the Coroner as to disclosure and non-publication. In Legal Aid NSW's experience, this often causes significant delays in having a matter listed or the family being provided with the brief of evidence. There have been a number of recent cases where inquest hearings have been vacated because protective orders sought by the NSW Commissioner of Police have resulted in the brief of evidence not being served, or not being served until just before an inquest. This creates significant prejudice to families appearing at inquest, who require time to read material and properly prepare.

Case Study: AA

AA was shot dead by police in July 2019. He suffered from long-term chronic schizophrenia. Critical incident investigators from NSW Police compiled a brief of evidence, with most statements and other evidence collected by January 2020.

The brief was provided to Crown Solicitors in early 2020, and served on the Commissioner of Police in June 2020, in order for his legal representatives to identify material of a confidential nature. Despite 15 months elapsing, and repeated attempts by the Coroner to hear and finalise an application for protective orders by the Commissioner of Police, the application has still not been resolved.

Repeated requests over 12 months by AA's family for access to the brief were unsuccessful, until limited documents were provided in March 2021. AA's family has still not seen critical evidence relevant to his death.

Due to the delays arising from the Commissioner's application for protective orders, the 3 week inquest, listed to start in late September 2021, was recently vacated. It is now unlikely the matter will be heard before early to mid 2022.

8.2 Working Group or Court Users Forum

We consider that a broad-based working group or court-users forum should be established to address ongoing operational issues, including delay. Key stakeholders could include the NSW Coroners Court, NSW Police, Corrective Services NSW, Justice Health, NSW Health, Crown Solicitors Office, DCJ Legal, the Aboriginal Legal Service NSW/ACT, and others who can speak on behalf of bereaved family members.

Recommendation 12

That the Department of Communities and Justice and the Coroners Court establish a broad-based working group or court-users forum to address ongoing operational issues, including delay and other processes within the coronial jurisdiction.

9. Provision of information to families

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. 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.

The impact on families of the coronial process has been described in various studies:

> 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.[40]

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.

We can provide many examples of delay and the late provision of materials. In more than one instance, the late provision of material has resulted in inquests being vacated, or additional issues being identified by the family, resulting in further investigations being required and the matter being adjourned part-heard.

Legal Aid NSW is aware that material that could be provided to a family is not provided for up to a year or more after it has been made available 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 (e.g., medical records, witness statements, electronic materials, and once available, expert reports), and it is unlikely to attract an application for protective orders.

[40] Dartnall, Goodman-Delahunty and Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 Frontiers in Psychology 2322: 3.

Legal Aid NSW considers the need to keep family members informed of key developments and the detail of any investigation as paramount to the success of the coronial system. It is vital that the family of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a culturally appropriate, timely and proper manner.

We consider it essential that strict requirements be placed on the provision of information to family members. The experience of our solicitors is that family members want detailed information from an early stage about the death of a loved one, including documents and electronic materials.

9.1 Access to documents under the Coroners Act

Access to coronial documents in NSW is governed by section 65 of the Coroners Act. Coronial Practice Note 1 of 2018 commenced in November 2018 and sought primarily to address time standards and case management of inquest matters. Whilst recognising the nature and impact of coronial proceedings on all persons involved, especially the families of deceased persons (at 2.2), it included no requirements to provide brief materials to family.

The only relevant provision of the practice note stated:

> **Part 6: The provision of the brief of evidence to interested parties**
>
> 6.1 A person seeking leave to appear or an unrepresented relative of the deceased may be supplied a copy of the brief of evidence at the discretion of the Coroner.

A second practice note in 2018 in relation to mandatory inquests involving Critical Incident Investigations contained no reference to providing the brief to family. It is only now, with the introduction of Coronial Practice Note 3 of 2021, which commenced on 24 September 2021, that the Court has recognised the importance of providing families with information and updates.[41] The objects of the Practice Note (which applies only to deaths under section 23 of the Coroners Act) include:

> 4.2 b. The families of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a timely and proper manner, including advice in relation to delay and the reason(s) for the delay.

Despite this object, and a requirement later in the Practice Note that "throughout the coronial investigation the Officer in Charge, or if instructed, the solicitor assisting must ensure that the senior next of kin (and any other family member as appropriate in the

[41] Local Court of New South Wales, *Coronial Practice Note No 3: Case management of mandatory inquests involving section 23 deaths*, 24 September 2021,<https://www.coroners.nsw.gov.au/content/dam/dcj/ctsd/coronerscourt/documents/practice-notes/Final_PN_3_of_2021_signed_230821.doc.pdf>.

circumstances) or if applicable their legal representative are kept informed of the progress of the coronial investigation", there remains no requirement to provide comprehensive information and brief materials at an early stage.

We consider it essential that strict requirements be placed on the provision of information to family members. The experience of our solicitors is that family members want detailed information from an early stage about the death of a loved one, including documents and electronic materials.

9.2 Provision of information to families in other jurisdictions

In Queensland, the State Coroners Guidelines 2013 state:[42]

> **Communicating with the family**
>
> The family must be given adequate and timely information about their loved one's death in order for them to participate meaningfully in the coroner's decision making about how to respond to the death. 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 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.
>
> **Cause of death information and autopsy reports**
>
> The family is entitled to be given as much information as possible about the cause of death and the various steps in the coronial system. They should not be required to wait until the coroner has received the final autopsy report to be informed of the pathologist's opinion as to the cause of death and other inquiries the coroner intends to undertake.
>
> **Access to brief of evidence**
>
> The family is entitled to a copy of the brief of evidence regardless of whether they are legally represented or intend to seek leave to appear at the inquest. Access to this information prior to the inquest helps the family better understand the evidence and the issues to be explored with various witnesses.

Numerous parts of the Queensland Guidelines deal with providing information to families, such as:

- 2.4 Communicating with the family
- 2.7 Case management and keeping families apprised
- 2.9 Access to coronial information
- 2.11 Involvement in inquests - particularly "access to brief of evidence."

[42] Coroners Court Queensland, *State Coroner's Guidelines 2013*, chapter 2 <https://www.courts.qld.gov.au/__data/assets/pdf_file/0012/206121/osc-state-coroners-guidelines-chapter-2.pdf>.

In Victoria, Part 2 – Objectives of the *Coroners Act 2008* (Vic) contains six factors to be considered in relation to functions exercised under the Act. 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.

Section 115 of the *Coroners Act 2008* (Vic) governs access to documents, and Practice Note 2 of 2011 provides that the registrar must provide the senior next of kin with any post-mortem reports, and any interested party with an inquest brief.

Legal Aid NSW considers that the arrangements in Victoria and Queensland, and in particular the Queensland guidelines, provide a strong example of the care and attention that is required to ensure family members are kept properly informed, and describe practices that are not, in the main part, taking place within the NSW coronial system.

Legal Aid NSW supports an onus placed on the Coroner (and those that assist the Coroner) to provide relevant material to relatives of the deceased as soon as it is available, unless there are compelling reasons to delay or not provide the information. This should be enacted either by way of legislative amendments (including the addition of objects or guiding principles similar to Victoria), and/or by incorporating these requirements into one or more of the Practice Notes issued by the State Coroner.

9.3 Who can access information?

Our lawyers have observed a common practice, both at the State Coroners Court and at regional courts dealing with coronial matters, of family members being refused information when they are not the senior next of kin.

The Coroners Court website under “Access to coronial documents” states:

> The senior next-of-kin can receive documents on an open file free of charge by sending in a written request to the Court. If the senior next-of-kin wants any of the documents not to be sent out to anyone else, they must indicate this in writing to the Coroner as soon as possible.
>
> Other family members (who are not the senior next-of-kin), may be considered to have an appropriate interest to receive documents from a coronial file.

Legal Aid NSW is of the view that information and brief materials ought to be available to any relative of the deceased person, where appropriate, not just the senior next of kin. In our experience, there are many inquests where the senior next of kin does not play a role, but other family members do. Restricting access to information to senior next of kin does not account for family divisions, the possibility that different members of the family may have different interests, or are separately represented. It is also not consistent with section 57 of the Coroners Act, which envisages that any relative of the deceased may seek leave to appear.

Similarly, the provision of information and brief materials should not be limited to family members that seek leave to appear and be represented at the inquest. Lack of legal

representation at an inquest, or the failure of a family member to take concrete steps to seek leave, may result from a variety of reasons. It should not prejudice the right of family members to access information in a timely way.

Recommendation 13

(a) Amend the Coroners Act to place an onus on the Coroner to provide relevant material to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.

(b) Alternatively, that the State Coroner issue a Practice Note Act to require that relevant material be provided to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.

Recommendation 14

That the Coroners Court review its processes to ensure that families of the deceased are provided with information and brief material in a timely manner, and that the State Coroner consider issuing guidelines (similar to the Queensland State Coroners Guidelines 2013) in relation to the rights and interests of family members.

10. Support for families

10.1 Counselling services

The limited availability of counselling and support for families involved in the coronial system is a gap in services often raised by our clients. For families experiencing a sudden or unexpected death, social workers at NSW Health Pathology's Forensic Medicine Service provide intervention at an early stage, when the deceased's body has been received.[43] The purpose of this intervention is limited, and is primarily directed towards confirming the family's wishes in relation to post-mortem procedures and initial grief support. Once post-mortem procedures are complete, there is no handover to any ongoing counselling or support service for families.

The Coronial Information and Support Program (**CISP**) is limited to providing practical information about the inquest process, court familiarisation and access to viewing sensitive evidentiary material.[44] We understand that CISP does not have the capacity to undertake individual counselling or to provide ongoing support services. Further, in the absence of any counselling, our solicitors report a lack of available brochures or information available to families, including referral services. In the ACT, a Coronial Counselling Service run by Relationships Australia is available at no cost during the coronial processes and up to three months after an inquest has concluded.[45] Research has identified a finding of death can be profound and distressing for some families, and highlights the need for post-inquest debriefing and support.[46] Legal Aid NSW would strongly support the funding and provision of counselling and support for all families Throughout NSW involved in the inquest process.

10.2 Court facilities

Until 2019, families attending Glebe Coroner's Court complex had a small but dedicated 'family room' available within the court complex. This room had comfortable soft furnishings, artwork, water, and privacy, and was an area that families were able to comfortably occupy to the exclusion of others. During our representation of families at inquest, our solicitors have observed the benefits of allowing families to avoid close contact with other witnesses, where such contact would exacerbate trauma. This room was also used for therapeutic jurisprudence, for example where witnesses and families

[43] Kerryn Butler, 'Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences' (Review, Law and Justice Foundation of New South Wales, April 2021),13.

[44] Ibid.

[45] Ibid 14.

[46] Ibid 25.

came together to provide apologies and seek forgiveness. Such spaces enable families to excuse themselves from the court room during traumatic evidence but remain nearby so they can re-enter the court room once the evidence has finished. Unlike other parties to an inquest, families can experience strong emotions of grief during the course of an inquest, and allowing families to express their emotions away from the view of other legal representatives or witnesses is paramount. Unfortunately, despite containing a number of publicly available meeting rooms, with tables, the State Coroner's Court at Lidcombe provides no dedicated rooms for families attending inquest hearings and our clients.

Legal Aid NSW supports the development of breakout 'family rooms' at Lidcombe Coroner's Court, as suggested by a participant survey into improving family engagement:

> Making families feel welcome at the Coroners Court is a vital part of improving the overall process. This could be as simple as providing tea and coffee for family members during inquests, or having a comfortable room for families and their representatives to go that is hidden from the gaze of the media and attending police. Many participants suggested that these simple things could go a really long way in proving families' experiences of the coronial system, and is certainly something that is almost immediately achievable.[47]

10.3 Financial assistance

A further area of concern is the lack of financial assistance for families attending inquests at the State Coroner's Court or other locations in NSW. In many death in custody inquests, Corrective Services NSW will offer to reimburse accommodation costs. In all other inquest matters, unless a family member is subpoenaed to give evidence, they will usually not be provided with any reimbursement of associated travel or accommodation expenses. Financially disadvantaged clients have significant difficulty in securing accommodation in advance due to a lack of available funds. Other associated expenses which act as barriers to families attending inquests include childcare, food and transport. Often inquests last for one week of more, and these costs are an unfair burden on families when other witnesses are paid witness expenses, and most other interested parties are in attendance as a result of their employment, with their expenses being reimbursed.

[47] Lindsay McCabe, 'The Coronial System in New South Wales and Indigenous Australians' (LLM Thesis, The University of Sydney, 2019). See also generally Lindsay McCabe, Allen George 'Improving Indigenous family engagement with the coronial system in New South Wales; (2021) 46(3) *Alternative Law Journal* 212-218.

Recommendation 15

That the NSW Government ensure that resources and facilities are provided to support families attending inquests, including a coronial counselling service, family break-out rooms at court and grants to family members for childcare, travel and accommodation expenses.

11. Persons of Interest

Legal Aid NSW is concerned there is a gap in legal protection for persons of interest called to give evidence in coronial inquests. Unlike organisations or state parties, private individuals identified as 'persons of interest' (**POI**) have no avenue to paid legal representation. Persons of interest are at significant risk of loss of reputation, adverse publicity and the potential for criminal proceedings as a result of lack of proper legal protections.

Legal Aid NSW understands that in tribunals such as the NSW Independent Commission Against Corruption and the NSW Crime Commission, witnesses will be provided with a lawyer funded by the state, on the application to the Attorney General, if certain criteria are met.[48] The grant of assistance may be contingent upon factors including hardship, the relevance of the evidence and public interest considerations. Those applications are dealt with by DCJ Legal and generally, their solicitors will provide that legal representation or, in the alternative, arrange legal representation from a panel.

Legal Aid NSW is frequently asked to provide advice and legal assistance to witnesses and POI's at inquest proceedings. The requests come from the witness or POI directly, or often from solicitors at the Crown Solicitors, or solicitors from DCJ Inquiries or directly from Counsel Assisting the Coroner. POI are often vulnerable persons, who without proper advice and assistance, would not be able to protect their interests at the inquest.

The risks faced by POI and witnesses at inquests include referral to the DPP for potential charges; the giving of evidence without securing appropriate protections; or without being properly advised of their right to object on the basis of self-incrimination; and adverse publicity, which can often be mitigated by the making of a non-publication order.

Deaths under suspicious or unusual circumstances, or where the person died a violent or unnatural death, must be reported to the Coroner.[49] An inquest is required to be held where it appears the death may be a result of homicide.[50] At a coronial inquest, the evidence has not yet been capable of establishing that the person has committed an indictable offence beyond a reasonable doubt, otherwise criminal charges would normally have been laid. Yet, the individual POI, if subpoenaed to give evidence, is obliged to attend court, and may be subjected to rigorous cross examination. Section 61 of the Coroners Act permits a Coroner to grant a certificate against self-incrimination, however the exercise of the discretion depends on the individual raising an objection at

[48] See for example, *Independent Commission Against Corruption Act 1988* (NSW) s 52; *Crime Commission Act 2012* (NSW) s 42); *Law Enforcement Conduct Commission Act 2016* (NSW) s 77.

[49] *Coroners Act 2009* (NSW) s6, 35.

[50] *Coroners Act 2009* (NSW) s27.

the right time and seeking the protection. Without legal advice or representation, the person is at a significant disadvantage in knowing how to exercise their rights, how to seek protective orders, question other witnesses, or make submissions.

Case study: Inquest into the disappearance of William Tyrell

In 2019, DCJ Inquiries contacted Legal Aid NSW requesting that we facilitate legal advice to multiple persons of interest who were subpoenaed to appear at the inquest into William's disappearance.

Legal Aid NSW policy guidelines do not allow the assignment of POI matters to private lawyers for representation. Legal Aid NSW solicitors were limited to providing minor assistance services to those individuals, despite the risk of jeopardy and reputational damage being significant.

Recommendation 16

That the NSW Government provide additional funding to ensure that persons of interest can be provided with legal representation at inquests, where certain criteria are met.

11.1 Referrals to the Office of the Director of Public Prosecutions and delay

Legal Aid NSW provides assistance to individuals who are put at enormous stress when a Coroner forms an opinion that there is a reasonable prospect the person could be convicted of an offence which caused a death or fire. When a Coroner suspends an inquest, or otherwise forms this opinion pursuant to section 78(2) of the Coroners Act, a copy of the Coronial brief of evidence is sent to the Office of the Director of Public Prosecutions (**ODPP**).

In our experience, there can be a delay of one year or more in the ODPP reaching a decision and often this does not result in a prosecution. In that scenario, the matter is returned to the coronial jurisdiction for resumption of the inquest, or formal findings. Legal Aid NSW is concerned about the impact of the delay of the ODPPs decision on whether to prosecute on the individual concerned, and the family of the deceased.

Case study: delay in charging family members

In November 2018, Legal Aid NSW advised three members of a deceased's family, each of whom had been identified as persons of interest in relation to the

death of a 21 year old. The inquest proceedings that month were suspended, and a referral made under s.78 to the ODPP. The death had occurred in early 2015.

It was not until February 2020, 15 months after the referral, that two members of the family were charged with manslaughter by gross criminal negligence. Another year went by before the DPP discontinued the prosecution, some 7 years after the death occurred.

For families of the deceased, the wait for justice is agonising. From late 2015, Legal Aid NSW assisted an Aboriginal family living in regional NSW in relation to the violent death of a family member in 2013 after an altercation. Despite an immediate criminal investigation, it took almost two years before the ODPP decided to not prosecute. The family then argued for an inquest to be held, which eventually resulted in the referral of a known person to the ODPP in August 2019. Over a year later, the ODPP had not reached a decision, nor engaged meaningfully with the family in relation to the matter.

Homicide matters are serious offences of great public concern. The ODPP's delay in making a decision after a Coroner's referral diminishes public confidence in the justice system. To our knowledge, there is no timetable that sets an expectation of when the ODPP will reach a decision following a s 78 referral. This issue is further illustrated by the below case study.

Case study: Abraham[51]

Abraham was a refugee aged in his 20s with a permanent residency visa, living in Sydney. Abraham had mental health issues and was homeless at the time he was arrested on suspicion of a death that occurred in 2009. Abraham was arrested and imprisoned for other offences, but not charged with murder until October 2015 when he was due for release.

In July 2017 the ODPP discontinued a prosecution for murder due to a lack of evidence. Abraham was in custody and had been bail refused since he was

[51] Not his real name.

charged. The charges were dropped a year after his lawyers had made submissions that there be no further proceedings.

Abraham was then taken from Corrective Services custody to immigration detention, and as a suspicious death, the matter came before the Coroners Court. Abraham's revocation of detention application with the Department of Home Affairs was put on hold awaiting the Coroner's Findings.

The Coroner held an inquest in December 2017. At the conclusion of the inquest Counsel Assisting recommended a referral back to the ODPP. The Coroner made the referral in December 2017, but it was not until February 2018 that the brief was sent to the ODPP.

Abraham continued to be held in immigration detention throughout 2018, and by September 2018 had been in custody for 9 years. In November 2018, the ODPP reached a decision to not prosecute Abraham. The case was returned to the Coroner's office for a decision to resume or dispense with the inquest. By 2019 no decision had been made, and Abraham's immigration case continued to be on hold.

At the end of January 2019, Abraham completed suicide.

Recommendation 17

Amend the Coroners Act to establish a statutory timeframe in relation to referrals under section 78 of the Act.

Recommendation 18

(a) That the Office of the Director of Public Prosecutions develop a guideline in relation to referrals under section 78 Coroners Act in order to minimise the delay in charging a person or advising that no proceedings will be taken, and

(b) That the State Coroner consider issuing a practice note for referrals under section 78 of the Coroners Act and timely decisions by the Office of the Director of Public Prosecutions regarding those referrals.

12. Cultural competence

12.1 Distrust of the coronial system

Our lawyers have been aware for many years of the lack of trust that many Aboriginal and Torres Strait Islander families have in relation to the coronial system, leading to speculation and outrage as to the circumstances surrounding a loved one's death. Usually, these reactions are at their most extreme in mandatory inquests involving deaths in custody or as the result of police operations.

The recurring client experience we observe at Legal Aid NSW was described by the RCADIC Commissioner in his findings in relation to foul play:

> The suspicion on the part of relatives and friends that there had been foul play was very strong indeed in some cases. One of the great weaknesses in those responsible for notifying relatives of deaths or for conducting investigations into deaths has often been the failure to realise that such suspicion was likely to occur and was not unreasonable in the minds of relatives. From the point of view of relatives a live brother, father, husband or son goes into custody and a dead body is returned. It must never be forgotten that a very important and legitimate part of the 'racial memory' or 'cultural heritage' of Aboriginals in this country is the deliberate hunting down and killing of their ancestors and the deliberate destruction of their families by the forcible movement of groups and individuals and the taking away of children. With these memories police are very strongly associated. Today police continue to arrest Aboriginals at many times the rate at which they arrest other people. One simply cannot expect many Aboriginals to share the benign view of the police function that is held by many non-Aboriginals.
>
> Death often takes place under circumstances where the only witnesses of the immediately surrounding events are custodial officers, in whose interest it is that the deceased should be found to have died by his or her own hand, or by natural causes without fault on their part. Any investigation which is to convince outsiders must critically examine such hypotheses and investigate the alternative hypotheses of death by foul play or negligence.[52]

12.2 Advocating for change

Since 2018 we have advocated for reforms to address our concerns, including a practice note to introduce changes such as the immediate briefing of the Crown Solicitors in all Aboriginal and Torres Strait Islander death in custody matters, an early directions hearing, and the early provision of information to family. We have been greatly encouraged by the State Coroner's early support for these proposals, and the significant

[52] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) 61-62.

changes in practice that have been implemented recently in specific death in custody cases. Subsequently, the circulation of a draft First Nations protocol earlier this year has resulted in improvements to processes, with earlier and greater engagement with family taking place, and reduced delays in the listing of inquests. This has been demonstrated in our recent casework, which is impacting positively on our Aboriginal and Torres Strait Islander clients.

Case study: Jonathan Hogan

Jonathan Hogan died at Junee Correctional Centre on 3 February 2018, a much-loved son of Matthew Hogan and his large extended family from Canberra. Jono was 23 years old and a proud Indigenous man of the Wiradjuri, Ngiyampaa and the Murrawarri people.

By late 2018, despite having the dedicated support of the ACT's Winnunga Nimmityjah Aboriginal Health Service, Jono's father Matt – based in Canberra - had struggled to access information about his death and was without legal representation.

Listening to Winnunga's CEO Julie Tongs describe Matt's struggles at a presentation in Canberra in November 2018, Legal Aid NSW was alerted to his predicament. We promptly sought and received instructions to act for Matt. Deputy State Coroner Grahame acted swiftly to list a directions hearing and engage the assistance of the Crown Solicitors Office. A directions hearing was held shortly before Christmas 2018, and orders made for service of the brief by late January 2019.

The inquest was held over 5 days in December 2019 at the State Coroners Court in Lidcombe. From the outset, Jono's indigenous heritage was recognised by Coroner Grahame, and permission granted to display in the courtroom a photograph of Jono, a painting by him, and a didgeridoo made by his father Matt and painted by Jono.

Five days of evidence included a detailed analysis of the lack of mental health care provided to Jono, who ultimately took his own life.

Speaking to the court by way of a family statement at the end of the proceedings, Jono's father praised the efforts of the NSW Police officer in charge of the investigation, whilst recounting his futile efforts to get information (or even a return phone call) from Junee Correctional Centre. Later, he said:

I think I would've felt better if I had been able to see Jono and look at his cell and go to the smoking ceremony and memorials. I know that my wife and daughter were not called and asked to be involved in anything.

At the end he said:

It's not just about Jonathon passing away in custody. I'm trying to get an answer so it doesn't happen to another family again. That's one of the main things too, so it doesn't happen to somebody else and they don't go through the heartache we've gone through.

Despite these steps, Legal Aid NSW believes that further improvements can be achieved, including to bring the NSW coronial system into line with practices observed in other Australian jurisdictions. Inquest delays in NSW are still significant, causing undue distress to family members. This is exacerbated by a lack of timely access to information and brief materials, depriving many families of an adequate understanding of what took place in relation to the death of their loved ones. The problem extends to all coronial investigations, not just those few matters that go to inquest, and impacts on families from a wide range of backgrounds, whether they be Aboriginal, from other culturally or linguistically diverse communities, or from elsewhere.

In our experience, there is a need for better communication with Aboriginal and Torres Strait Islander families in all coronial matters, not just section 23 deaths. For example, Aboriginal and Torres Strait Islander persons are proportionally over-represented in suicide deaths, many of which occur in regional areas.[53] We receive many requests for assistance from Aboriginal and Torres Strait Islander families in regional areas, where families hold significant distrust in the local police conducting coronial investigations. Often, they are not getting any information about the death of a family member reported to the coroner.

The history of trauma and poor relations between police and the Aboriginal and Torres Strait Islander community exacerbates the problem. In regional areas, the local police

[53] *NSW Government Health Statistics* (Website) <http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_Aboriginality_age>.

officer in charge is often the primary point of contact for families involved in the coronial system. The fact that police investigate on behalf of the coroner creates significant distrust.

12.3 The ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities

Legal Aid NSW recognises that families from a wide range of culturally and linguistically diverse backgrounds become involved with the coronial system. We support improved coronial processes to better support all families that interact with the system. Specifically, there is an opportunity to provide better information and support for families, more timely and better legal representation, and culturally appropriate services. In particular, we support improved processes for Aboriginal and Torres Strait Islander families, both in general and following a death in custody, and our submission is focused on their needs.

A recent publication by the Law and Justice Foundation of New South Wales entitled "Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences" provides an Australia-wide overview of culturally specific services within coronial jurisdictions. The research was undertaken for Legal Aid NSW in order to support coroners courts and legal assistance services seeking to develop culturally appropriate services and practices. It found that culturally specific services range from very minimal or ad-hoc services in some states, to specialised in-house services in others.[54]

Three broad themes emerged concerning the impact on families of the coronial system, being: coronial communication and information-seeking, respect of culture, and voice and jurisprudence.[55] Implications for practice identified by the research included cultural training for investigating police officers, and the establishment of culturally specific units employing Aboriginal and Torres Strait Islander staff within each coroners court.[56] A copy of this report has been provided as an appendix to this submission.

12.3.1 Better information and support for families

We understand that Coronial Practice Note 3 of 2021 will commence shortly, to cover case management issues in relation to all section 23 deaths in custody and as a result of police operations. Further, the imminent introduction of a First Nations Protocol to cover First Nations deaths under section 23 provides a unique opportunity to address

[54] Kerryn Butler, 'Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences' (Review, Law and Justice Foundation of New South Wales, April 2021), 10

[55] Ibid 22

[56] Ibid 24

concerns about access to information and brief materials, which continue to be experienced by family members in existing matters.[57]

12.3.2 More timely and better legal representation

The court's capacity to respond to the needs of culturally and linguistically diverse families and communities is enhanced when family members are legally represented. Legal Aid NSW is encouraged by the intent of the First Nations Protocol, which in part seeks to facilitate legal advice and representation for Aboriginal and Torres Strait Islander families, as we consider it vital to the coronial process that families have their own legal representatives.

Our casework representing the families of David Dungay, Rebecca Maher, Jono Hogan, Danny Whitton, Bailey Mackander and others has informed our views as to the needs of Aboriginal and Torres Strait Islander families during the inquest process, including at the early stages after a death occurs. Since 2015 there have been about five to six deaths each year of Aboriginal and Torres Strait Islander people in NSW under section 23 of the Coroners Act. Each of these deaths is reported to the Aboriginal Legal Service, and it is likely that in many cases, the family will be represented at the inquest by Legal Aid NSW or the Aboriginal Legal Service. Whilst the Coronial Inquest Unit appear in other inquests, representation by the Aboriginal Legal Service is restricted to mandatory inquests of Aboriginal persons under section 23.

Representation for families at inquest is crucial to the integrity of the process and the therapeutic benefits for family. Further resources are needed to ensure that more timely and better legal representation can be provided to all families, and in particular, to Aboriginal families.

12.3.3 Culturally appropriate services

Legal Aid NSW is encouraged by the recent funding of two identified positions within the NSW Coroner's Court, having previously identified the need for culturally specific services to accommodate the large number of Aboriginal and Torres Strait Islander people who interact with the NSW coronial system.

[57] See *9.Provision of information to families* above, and recommendations 13 and 14.

Aboriginal and Torres Strait Islander employment at Legal Aid NSW[58]

At Legal Aid NSW, over 100 of our staff identify as Aboriginal, which is 6.9 % of our workforce. We have 51 Aboriginal Identified roles, of which 76% are occupied by an Aboriginal person. We employ 31 Aboriginal solicitors, of which 13 are in identified roles.

Legal Aid NSW's Aboriginal Services Branch works across all policy, program and practice areas to ensure that Legal Aid NSW responds to the legal needs of Aboriginal people in a culturally appropriate and comprehensive manner, while also placing Legal Aid NSW as an employer of choice with Aboriginal people to ensure our workforce is reflective of our client base.

Legal Aid NSW has also developed Best Practice Standards for Representing Aboriginal Clients, which provide an insight into the issues that all practitioners need to understand in order to provide effective legal representation to Aboriginal clients no matter what the jurisdiction, as well as issues specific to crime, family and civil law.

At Legal Aid NSW, we work in partnership with Aboriginal people and communities to identify and provide services for their legal needs. Our lawyers provide targeted community legal education and coordinate Outreach services across all practice areas, and Aboriginal Cultural Awareness Training is available to all staff and key partners.

Legal Aid NSW is committed to increasing the percentage of Aboriginal people who work at Legal Aid to 11% of the total workforce by 2023 while providing meaningful career development opportunities.

Historically, the CISP within the Coroners Court has never had any Aboriginal or Torres Strait Islander staff, prior to the recently funded positions. Likewise, we are not aware of any Aboriginal or Torres Strait Islander staff filling positions within the counselling services provided by NSW Health Pathology's Forensic Medicine. These are the two services that provide specialist support to families of the deceased, first at the initial stage where a body has been received, and second, when a coronial matter is received by the Coroners Court.

[58] As at 10 September 2021.

In contrast, Victoria has a Koori Family Engagement Unit which provides guidance to the Coroners Court of Victoria, to ensure its service provision is and remains culturally informed and appropriate.

Koori Family Engagement Unit - Victoria

In March 2019, a Koori Family Engagement Coordinator was appointed at the Coroners Court in Victoria to better serve Aboriginal and Torres Strait Islander families involved in coronial investigations. The role was developed in consultation with the Aboriginal Justice Caucus and Aboriginal and Torres Strait Islander community groups. It provides services to support families and ensure culturally safe practices are embedded within Court processes. It includes incorporating Sorry Business practices throughout coronial investigations and coordinating smoking ceremonies and Welcomes to Country during inquests.

A second position of Koori Family Engagement Officer was advertised in 2020, to provide culturally safe support to family, friends, and the community throughout the coronial process, while offering culturally focused advice and support to Coroners on aspects of their coronial investigations.

Two Aboriginal-identified roles have been funded to appropriately resource the team to support both Men's Business and Women's Business.

Legal Aid NSW supports the recent creation of similar positions at the NSW Coroners Court. We also support the creation of Aboriginal-identified positions in other support roles and registry positions at the Coroners Court, together with NSW Health Pathology's Forensic Medicine, particularly social worker positions.

Recommendation 19

That Aboriginal identified positions be established within the Coroners Court (including positions in the court registry and other support positions), and within NSW Health Pathology Forensic Medicine, particularly social worker positions in order to improve cultural competency of the services that they provide.

12.4 Legislative reform to reflect cultural considerations

There is the need for the Coroners Act and coronial processes to specifically accommodate cultural needs and considerations. There are no specific provisions in the Coroners Act that make provision for cultural considerations, particularly in relation to Aboriginal and Torres Strait Islander people. NSW is the only Australian jurisdiction that has a Coroners Act which does not make specific provision for Aboriginal and Torres Strait Islander peoples, other than South Australia.

Other jurisdictions make provisions in relation to the determination of senior next of kin and family members, thereby allowing consideration of the customs and traditions of the community or group to which the person belongs. Other provisions encourage the coronial system to engage with families in ways that respect cultural diversity, whilst in Western Australia, the Act allows regulations to be made that would give effect to the recommendations of the RCADIC.

Case study: cultural engagement

AL was born in 1987 in New South Wales to New Zealand born Māori parents and was the youngest of three siblings. He was 30 years old when he died from a heart condition after being tasered and held down by police during a mental health crisis outside Royal Prince Alfred Hospital in February 2018. An inquest was held into his death in 2020 and findings delivered in 2021.

AL's family felt it was vital that at the conclusion of the inquest they send him home to New Zealand and settle his spirit. After seeking permission from the Coroner, the family performed a Haka in honour of AL and as a demonstration of respect to the court.

Three males from the family (one of them AL's brother), led the Haka, facing the police and their lawyers. The opening words "Ka mate, ka mate! ka ora! ka ora!" roughly translate as "it is death, it is death, it is life, it is life…"

In the silence that followed, AL's mother "sang AL home" to allow his spirit to pass over, with the family joining in. The ceremony had a powerful impact on all present. The family was very grateful to the court for its willingness to support this traditional ceremony and they were in great spirits on the day the findings were delivered.

Provisions in the NSW Coroners Act dealing with investigation directions and exhumations, and objections to the exercise of post-mortem investigative functions, contain no requirement to take account of cultural considerations, particularly those of Aboriginal and Torres Strait Islander people.[59] Likewise, the definition of 'relative' and

[59] *Coroners Act 2009* (NSW) Pt 8.1 and 8.2.

'senior next of kin' make no reference to cultural considerations, and no allowance for the potential departure of Aboriginal family relationships from those definitions.[60]

Legal Aid NSW supports legislative reform of the Coroners Act to amend the definition of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure in diverse cultures (including Aboriginal and Torres Strait Islander cultures). We would also support amendments to allow the appointment of persons other than the default senior next of kin, including where there are competing claims, but only in exceptional circumstances.

Recommendation 20

Amend the Coroners Act in order that:

- definitions of 'relative' and 'senior next of kin' will recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures).
- persons other than the default senior next of kin may be appointed by the Coroners Court in exceptional circumstances, including where there are competing claims.

12.5 Protocol for post-mortem investigations

In our experience, many of the suspicions and grievances experienced by Aboriginal and Torres Strait Islander families relate to contact with NSW Health Pathology Forensic Medicine shortly after a death. In particular, the viewing of deceased relatives by family members has resulted in observations that continue to disproportionately and incorrectly inform a family's views as to what may have taken place.

It is noteworthy that almost 30 years ago, the RCADIC recommended that the State Coroner or their representative:

> … should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rights and that relatives of a deceased aboriginal person be spared further grief.[61]

[60] Ibid ss 5 and 6A.

[61] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 38.

We are not aware of any Forensic Medicine publication or guideline that deals with all post-mortem issues that arise, including cultural considerations. Nor are we aware of any publication by the State Coroners Court. We support the development of such a publication to guide dealings with Aboriginal families after a death has taken place.

Recommendation 21

That NSW Health Pathology's 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.

13. Coronial recommendations and oversighting their implementation

Legal Aid NSW is concerned about the framework which governs responses to coronial recommendations. At present, there is no legislative requirement under the Coroners Act for any interested party, including government agencies, to respond to coronial recommendations. If the coronial system is to fulfil its role in promoting death prevention, an essential component of the coronial system must involve a rigorous system for response to coronial recommendations, and accountability of those to whom the recommendations are directed.

We support the Recommendation 32 of the First Nations Select Committee, directed at deaths in custody, for the reasons outlined in our submission to that Inquiry:

> 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.[62]

Families would find the process more therapeutic if they had greater confidence that Coroner's recommendations would be followed up. The comfort that families derive from hoping that no other family will suffer in the same way they did can be eroded by a sense that recommendations are empty rhetoric. This is compounded where systemic failures are the main contributors to the death: processes have failed but, despite this being acknowledged, there is no confidence those processes will change.

13.1 Outcomes of recommendations made

Legal Aid NSW is concerned by poor response to coronial recommendations by both government agencies and private sector organisations. In 2019, Legal Aid NSW appeared in 10 inquests which resulted in coroners making a total of 59 recommendations during that year. In most cases government departments responded, but about 18% of responses remain outstanding. In 2020, Legal Aid NSW appeared in five inquests involving recommendations, resulting in 35 recommendations, of which 94% of responses remain outstanding.

There is a lack of accountability where no response is received. This includes non-government agencies, who are not required to report to the Attorney General. Such

[62] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv.

organisations include private health services, such as aged care facilities or private hospitals.

Below is a table of inquests where recommendations remain outstanding, according to the Attorney-General's website which lists responses to recommendations:[63]

Inquest	Recommendations	Implementation
Inquest into the death of Jonathon Hogan (First Nations death in custody) 6 May 2020	5 made to GEO Group Australia Pty Ltd, 1 made to Corrective Services NSW.	Response received by CSNSW 4 Responses awaited from GEO Group Australia Pty Ltd.
Inquest into the death of Mahmoud Allam (death in custody) 25 March 2020	4 made to Justice and Forensic Mental Health Network. 2 made to the CEO of Therapeutic Guidelines Limited.	No response received
Inquest into the death of AP (child) 1 June 2020	2 made to the Department of Communities and Justice. 4 made to NSW Ministry of Health and Local Area Health District.	No response received
Inquest into the death of Hazel Brockett 3 March 2020	11 made to Southern Cross Care NSW and ACT	No response received
Inquest into the death of Epenesa Pahiva 27 September 2019	4 made to Castellorizon Aged Care Services	No response received

[63] NSW Communities and Justice, *Government Reponses to Coronial Recommendations* (23 August 2021) <https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx>.

The issues are further illustrated by the following case study.

Case study: Jonathan Hogan

On 6 May 2020, Deputy State Coroner Grahame made findings that Jonathon died on 3 February 2018 in his cell at Junee Correctional Centre ("Junee CC").

Jonathon died from suicide while he was alone in his cell. Jonathon's deteriorating mental health, in the context of a breakdown in his de-facto relationship and inadequate mental health care provided to him in custody, were contributory factors to his death.

Coroner Grahame made six recommendations, four of which were to the Chief Executive Officer, GEO Group, which operates Junee CC.

The Coroner recommended that GEO review Junee CC's procedures for inmates with known diagnoses for serious mental illnesses, to ensure they are assessed by a suitably qualitied mental health clinician on intake. The Coroner also recommended that GEO review mental health staff to patient ratios to ensure inmates suffering serious mental illnesses are reviewed by a psychiatrist.

Of importance to Jono's father Matt, the Coroner recommended GEO consider creating at least three full-time Aboriginal Health Worker positions at Junee CC.

So far, no response from GEO Group Pty Ltd has been published on the Attorney-General's website which provides NSW Government Responses to Recommendations.

13.2 The mechanisms for oversighting whether recommendations are implemented

The Premier's Memorandum M2009-12[64] provides that, within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney General outlining any action being taken to implement the coronial recommendation. If it is not proposed to implement a recommendation, reasons should

[64] Premier's Memorandum M2009-12 sets out the process for responding to coronial recommendations directed at Ministers and NSW government agencies. The purpose of the Memorandum is to ensure that there is a consistent process across government for responding to coronial recommendations, and that there is increased accountability and transparency in responding to such recommendations.

be given. We hope that the NSW Government supports and adopts Recommendation 32 of the First Nations Select Committee, to address the declining levels of adherence to Premier's Memorandum M2009-12 over recent years.

In Victoria, the *Coroners Act 2008* requires that a public statutory authority or entity which is the subject of a coronial recommendation must provide a written response within three months after receiving a recommendation, and that response must specify a statement of action (if any) that has, is or will be taken in relation to the recommendation.[65]

Similarly, the

RCIADIC recommended a three-month response period following findings.[66] Further to our submission above, Legal Aid NSW also supports this approach, rather than a timeframe of six months, as responsive to the need to act quickly as a matter of public health and safety to remedy systemic failings, assuming that further follow up is possible.

The written response should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations and should be provided within either three or six months of receipt of the Coroner's findings. We support a requirement that government agency responses to recommendations are tabled in a report to Parliament so that there is an increased level of parliamentary oversight.

Case Study: Inquest into the deaths of RP and DJ

Both RP and DJ were inmates at Metropolitan Remand and Reception Centre. Both men were killed by their cellmates, who were suffering from an active schizophrenic illness in 2010 and 2012. A coronial inquest into the deaths did not commence until August 2018, following criminal proceedings in 2014 where both perpetrators were found not guilty by reason of mental illness. The hearing was completed in March 2019 and findings delivered on 4 July 2019, over 9 years after RP's death, and almost 5 years after BB's criminal proceedings were finalised.

The Coroner found that given their psychotic states, neither MA or BB should have been placed in a cell with another person. Expert evidence identified that any acutely mentally ill prisoner should never be managed within the general prison population. The Court received evidence of huge pressures on beds in

[65] *Coroners Act 2008* (Vic) s 72. Similar legislative provisions exist in the ACT (*Coroners Act 1997* (ACT) s 76), and the Northern Territory (*Coroners Act 1993* (NT) ss 27, 35, 46A and 46B).

[66] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 15.

MRRC's Mental Health Screening Unit and other MRRC pods housing mentally ill inmates, together with the limited capacity of Long Bay Hospital to treat inmates requiring mental health services.

One recommendation was *"that consideration be given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in New South Wales in a secure health facility rather than in the general prison population."*

Corrective Services NSW and Justice Health support this recommendation, noting: *"although the proposition of creating a secure health facility has merit, this requires decision from the Government due to several reasons, including funding allocation for establishing such a secure facility for acutely mentally ill inmates."* Legal Aid NSW is not aware of any commitment to establish such a facility.

During the inquest, Justice Health's Clinical Director of Custodial Mental Health, Dr Sarah-Jane Spencer, gave evidence that:

Unless there is a massive overhaul, people are going to keep dying either at the hands of their cell mate, or because they take their own life.

In the year following that evidence, two more deaths occurred at MRRC in 2019 where inmates suffering acute mental illnesses killed their cellmates. Delays in our coronial system, and a corresponding failure to act on coronial recommendations, demonstrate how a failed system will continue to result in avoidable deaths.

We also recommend that the State Coroner should be empowered "to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations",[67] which is consistent with the recommendations of the RCADIC, but which has never been implemented in NSW.

We understand that 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. The establishment and funding of a Coroners Prevention Unit (**CPU)** at the

[67] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 16.

Coroners Court (addressed below) would provide the resources and expertise to follow up on recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

The implementation of a mandatory response regime embedded into the legislation and containing parliamentary oversight would 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 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.

Recommendation 22

Amend the Coroners Act to introduce a mandatory response regime to coronial recommendations, with responses being tabled in Parliament. Responses should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations. A response should be provided within three months of the Coroner's findings.

Recommendation 23

Amend the Coroners Act to empower the State Coroner "to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations" in relation to all coronial recommendations under section 82 of the Act.

13.3 The need for a Coroners Prevention Unit

Legal Aid NSW supports the creation of a CPU embedded within the Coroners Court. The coronial system could be further improved if the collective findings and recommendations of similar inquests were analysed and reviewed to identify common themes and systemic issues, and to inform NSW Government policy responses to enhance death prevention.

In NSW, aside from child deaths and deaths from domestic violence, none of the inquest findings and recommendations are the subject of further systematic review or analysis, with a view to preventing or reducing the likelihood of further deaths. 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.

The proposed solution to this crucial gap in the NSW coronial system is to establish a CPU, similar to the model in Victoria, as a specialist service for coroners to strengthen their prevention role and provide them with expert assistance. In Victoria the CPU does this by reviewing a range of reportable and reviewable deaths, collecting and analysing data relating to those deaths, and assisting coroners with the development of prevention-focused coronial recommendations.

Coroners Prevention Unit – Victoria

The central goals of the Victorian CPU are to improve the quality and applicability of coronial recommendations, increase their uptake and implementation, and contribute to the reduction of preventable deaths in Victoria. Amongst other things, the CPU undertakes both individual and collaborative research projects to support coronial investigations to generate a better understanding of preventable deaths in Victoria and identify intervention options. Since its inception, it has published reports which include understanding and preventing drug-related harms, gambling-related suicides, overdose deaths, and suicides of Aboriginal and Torres Strait Islander people.[68]

Referrals for assistance by coroners cover deaths where non-clinical advice is required, together with expert streams where clinical advice on healthcare or mental health are required. In 2019 – 20 Victorian coroners made 636 referrals to the CPU to seek input into:

- factors which may have contributed to the death,
- frequency of previous and subsequent similar deaths,
- previous interventions that have been proved or suspected to reduce the incidence of death,
- relevant regulations, standards and codes of practice, and
- previous coronial recommendations and other feasible evidence-based recommendations to reduce similar deaths.[69]

In NSW, the only systematic review or analysis of reportable deaths being undertaken is in relation to child deaths, deaths of people with disability in residential care, and

[68] Coroners Court of Victoria <https://www.coronerscourt.vic.gov.au/>.

[69] Coroners Court of Victoria, *Annual Report 2020*,.26 <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019-20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf>.

domestic violence deaths. The latest reports, all of which are required to be tabled in Parliament, are:

- Biennial report of the deaths of children in New South Wales: 2016 and 2017 (published June 2019 by the NSW Ombudsman, NSW Child Death Review Team).
- Report of reviewable deaths of people in 2014 and 2015 & 2016 and 2017: Deaths of people with disability in residential care (published August 2018 by the NSW Ombudsman).
- NSW Domestic Violence Death Review Team Report 2017-2019 (published 2020).

These reports provide factual findings, analysis and recommendations that can result in lives being saved. For example, the latest report of the Domestic Violence Death Review Team (**DVDRT**) contained 34 recommendations directed at the NSW Government and a broad range of government agencies, together with detailed quantitative and qualitative findings. This important work was undertaken by the DVDRT, which comprises two employees with expertise in data collection and qualitative review.

Legal Aid NSW notes that until this year, no State Coroner's report into First Nations deaths in custody has ever been produced to enable tracking of systemic issues and recommendations.

Domestic Violence Death Review Team

Domestic violence deaths are the subject of review by the DVDRT, constituted under Chapter 9A of the Coroners Act. The object of the legislation is to "provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to reduce the incidence of domestic violence deaths and facilitate improvements in systems and services."[70]

The DVDRT is made up of a Secretariat, and includes statutory members from relevant NSW Government agencies, non-government organisations and other experts. The DVDRT reviews closed cases of domestic violence deaths, analyses data to identify patterns and trends relating to such deaths, and makes 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.

[70] *Coroners Act 2009* (NSW) s 101A.

Importantly, the DVDRT multi-agency reviews provide a broader understanding of domestic and family violence related deaths than may be provided by investigations of discrete deaths and are therefore able to inform policy and systemic change in a way that other review processes cannot.

The DVDRT also assists Coroners on open cases and provides specialist expertise in respect of domestic and family violence in coronial matters. The DVDRT has established and maintains a database and undertakes research that aims to help prevent or reduce the likelihood of domestic violence deaths. An annual report is tabled in Parliament every second year, and the NSW Government has provided a published response to these reports.[71] The DVDRT demonstrates the significant outcomes achievable by a cost-effective operation.

The NSW coronial system requires more capacity than currently exists to achieve a death prevention role. For the system to have a meaningful impact, Legal Aid NSW supports the establishment of a CPU, to provide expert assistance to coroners, including with the development of prevention-focused coronial recommendations.

Recommendation 24

That the NSW Government provide funding to establish a Coroners Prevention Unit at the State Coroners Court to provide sufficient resources and expertise to follow up on coronial recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

[71] The latest NSW Domestic Violence Death Review Team *Report 2017-2019* reviewed 53 domestic violence related deaths in July 2014 to June 2016. Individual case reviews sought to identify common themes, issues and areas for recommendation. The report presented 34 recommendations to the NSW government and a wide variety of government agencies, together with detailed quantitative and qualitative review findings.

13.4 An independent Coronial Council

In Victoria, there is also a Coronial Council which was established under the *Coroners Act 2008* (Vic) and is the first body of its kind in Australia. It is independent from the Victorian Government and the Coroners Court.

Coronial Council – Victoria

Under the *Coroners Act 2008* (Vic), the Council's role is to advise and make recommendations to the Attorney-General on issues of importance to Victoria's coronial system; matters relating to the preventative role played by the Coroners Court, the way in which the coronial system engages with families and respects their cultural diversity, and any other matters relating to the coronial system that are referred to the Council by the Attorney-General.[72]

The Victorian Coronial Council acts in a way that does not impinge on the independence of coroners' professional tasks or the jurisdiction of the State Coroner; delivers strategic advice reflecting the changing physical and social environment with the aim of promoting a modern and responsive coronial system; strengthens collaboration between agencies across the service system; focuses on advice to enhance services to families; promotes the prevention role of the coroner; ensures that the views of bereaved families are reflected in the development of advice; complements existing governance structures in the State coronial system; and promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The Victorian Coronial Council and the Coroners Prevention Unit in Victoria are just two examples of how other jurisdictions have taken steps to enhance their coronial systems and promote their death prevention functions.

Recommendation 25

That the NSW Government establish an independent Coronial Council to advise and provide recommendations to government on the coronial system.

[72] *Coroners Act 2008* (Vic) s 110.