Communities and Justice

27 November 2023

Our ref: GIPA23/

Dear

Formal Access Application - Notice of Decision

I refer to your Formal Access Application under the *Government Information (Public Access) Act 2009* (GIPA Act) that you lodged with the Department of Communities and Justice (the Department) on 14 September 2023. You have consented to an extended due date of 30 November 2023 to decide this application.

Scope of application

In your application, you requested access to the following information:

> *Reports, ministerial briefings, briefing notes to the Secretary, including any attachments, emails to and from the Secretary's office and emails to and from the NSW State Coroner's office relating to:*
>
> - *the number of coronial inquests that have been completed but are still awaiting findings more than 6 months later,*
> - *general delays in delivering findings on inquests and the reasons for these delays, and*
> - *general issues in preventing Coronial Inquiry decision being made*
>
> *within the date range 1 January 2022 – 14 September 2023.*

Searches for information

Under section 53 of the GIPA Act, the Department must undertake reasonable searches as may be necessary to find any of the government information applied for that was held by the Department when the application was received, using the most efficient means reasonably available to the Department.

In accordance with section 53 of the GIPA Act, I advise you that searches for records falling within the scope of your application were undertaken by the Office of the Secretary and Briefings and Correspondence Allocation Management business units.

While minimal information was identified as falling squarely within the scope of your request, I have elected to provide you with some additional information relating to coronial delays in accordance with section 76 of the GIPA Act. I have elected to provide you with

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this information as I am of the view that it is relevant to your request and may be of interest to you.

I have considered your request in view of the objectives of the GIPA Act where you have a legally enforceable right to obtain information, unless there is an overriding public interest against disclosure of the subject information. Further, I have also considered the requirements of section 74 of the GIPA Act, which provides that an agency may delete information from a record if the deleted information does not fall within the scope of the information applied for.

In deciding your application, I was required to conduct a "public interest test" where the public interest considerations favouring disclosure of government information were weighed against those factors that do not favour disclosure. On this occasion, I have not identified any public interest factors against the disclosure of the information that you have requested.

Therefore, in accordance with section 58(1)(a) of the GIPA Act, I have decided to provide you with a complete copy of the information that falls within the scope of your request.

Form of Access

Access to the information will be provided in the form of pdf copies of the relevant documents.

Further information

I note that additional information regarding the performance of the NSW coronial jurisdiction is publicly available.

The Productivity Commission's annual Report on Government Services (RoGS) measures the performance of government services and includes specific measures for courts, including coroner's courts.

The 2023 RoGS Report data on the performance of the NSW coronial jurisdiction is available here: https://www.pc.gov.au/ongoing/report-on-government-services.

Furthermore, the full 2022 report from the Select Committee Inquiry into the Coronial Jurisdiction is available here:
https://www.parliament.nsw.gov.au/lcdocs/inquiries/2809/Report%20No.%201%20-%20Select%20Committee%20on%20the%20coronial%20jurisdiction%20in%20New%20South%20Wales.pdf

The full 2021 progress report on improving the timeliness of Coronial Procedures Taskforce is available here:
https://www.parliament.nsw.gov.au/lcdocs/other/16815/Letter%20from%20Hazzard%20and%20Speakman%20to%20Chair%20of%20Select%20Committee.pdf

Review rights

If you disagree with any of the decisions in this notice that are reviewable, you may seek a review under Part 5 of the GIPA Act. Before you do so, I encourage you to contact me to discuss your concerns. My contact details are set out below.

You have three review options:

- internal review by another officer of this agency, who is no less senior than me
- external review by the Information Commissioner, or
- external review by the NSW Civil and Administrative Tribunal (NCAT).

You have 20 working days from the date of this Notice to apply for an internal review. If you would prefer to have the decision reviewed externally, you have 40 working days from the date of this Notice to apply for a review by the Information Commissioner or the NCAT.

To assist you, I have enclosed a fact sheet published by the Information and Privacy Commission (IPC), entitled Your review rights under the GIPA Act. You will also find some useful information and frequently asked questions on the IPC's website: www.ipc.nsw.gov.au

You can also contact the IPC on freecall1800 IPC NSW (1800 472 679).

Further information

If you have any questions about this Notice or would like any further information, please contact me on (02) 9716 2662.

Yours sincerely

Alicia McKenzie
Solicitor
Open Government, Information and Privacy Unit
Department of Communities and Justice

LEGISLATIVE COUNCIL

SELECT COMMITTEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

Coronial jurisdiction in New South Wales

April 2022

www.parliament.n

Chapter 2 Structural and resourcing concerns

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

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

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

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

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

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

Pressures on regional magistrates acting as coroners

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

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

87 Submission 18, NSW Government, p 24.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Submission 14, Adjunct Professor Hugh Dillon, p 23.

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

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

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

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

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

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

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

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

103 Submission 41, Mr Michael Barnes, p 5.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Independence of the State Coroner

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

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

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

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

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

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

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

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

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

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

Funding and resource issues

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

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

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

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

119 Submission 41, Mr Michael Barnes, p 5.

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

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

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

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

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

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

Caseload and clearance rates

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

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

Table 2 Caseload from 2011 to 2020

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

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

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

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

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

125 Submission 18, NSW Government, p 12.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Source: Submission 18, NSW Government, p 12.

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

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

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

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

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

132 Submission 18, NSW Government, p 12.

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

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

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

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

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

Delays in investigations and inquests

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

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

Table 4 Coroners Court of NSW time standards for matters

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

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

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

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

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

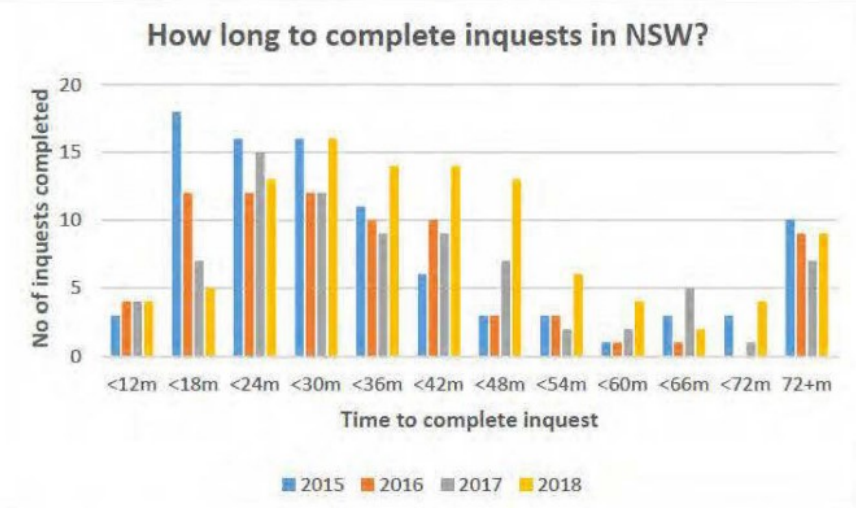
138 See, for example, Submission 8, Aboriginal Health and Medical Research Council of NSW, p 3; Submission 30, The Royal Australian and New Zealand College of Psychiatrists, p 4; Submission 31, Jumbunna Institute of Indigenous Education and Research, Research Unit, p 9; Submission 35, Australian Medical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

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

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

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

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



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

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

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

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

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

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

141 Submission 39, Gilbert + Tobin, p 26.

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

143 Submission 6, Australian Lawyers Alliance, p 7.

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

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

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

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

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

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

Initiatives to improve timeliness

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

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

145 Submission 18, NSW Government pp 12-13.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

159 Submission 18, NSW Government, p 16.

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

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

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

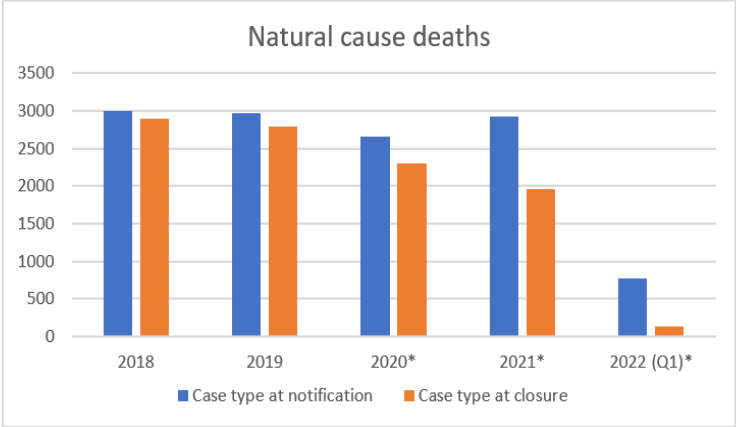
163 Correspondence from the Department of Communities and Justice, to Chair, 13 April 2022.

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

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

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

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



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

Impact of delays

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

169 Submission 39, Gilbert + Tobin, p 17.

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

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

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

173 Submission 37, Independent Bushfire Group, p 2.

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

Backlog of mandatory death in custody inquest cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expenditure on coronial services across Australian jurisdictions

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

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

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

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

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

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

190 Submission 41, Mr Michael Barnes, p 4.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Committee comment

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

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

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

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

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

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

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

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

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

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

2.100 Thirdly, recognising that regional magistrates are usually over-burdened, time-poor and under-resourced when it comes to coronial matters, the Coroners Court of NSW has evolved its practices and processes to better deliver consistent, standardised and high-quality decision-making across the state throughout the coronial process. Specialist full-time coroners now undertake all initial assessments and give coronial directions for all deaths in New South Wales, along with undertaking most inquests into regional deaths. The coronial process has become increasingly centralised, without the formal structure and funding in place to sufficiently support it.

2.101 While we consider some proposals to reform the Court's structure in the next chapter, it is clear that the coronial jurisdiction also needs to be significantly better funded and resourced to meet its death investigation and prevention objectives – regardless of what structure it takes.

2.102 In this regard, we wish to make a couple of observations. First, we would like to acknowledge that there are initiatives underway to improve timeliness in the coronial process through the work of the NSW Government's *Improving the Timeliness of Coronial Procedures Taskforce* (Timeliness Taskforce). The Timeliness Taskforce has identified aspects of the coronial process contributing to delays and has implemented initiatives to improve timeliness outcomes. While this work is undoubtedly important, the scope of the Timeliness Taskforce meant that it has not looked at processes involving inquests and the dispensing of coronial matters by a coroner.

2.103 The second point is that the committee found it difficult to fully ascertain the extent to which resourcing constraints are impacting the Court's performance, given the limitations of data provided by the Department of Communities and Justice. We were unable to get a clear picture on the average timeframe from a decision to hold an inquest to the commencement of an inquest, nor the average length of an inquest in metropolitan areas versus the regions. We also found it challenging to look at funding for the Court in a holistic way, given the figures did not take into account the judicial and staff resources undertaking coronial work at regional local court locations.

2.104 Despite this, it was still very clear to the committee that the resources the Court has at its disposal are insufficient in meeting the growing number of complex cases it has to deal with and current caseload pressures. There are lengthy delays at various parts of the coronial system, and a significant backlog in mandatory section 23 death in custody inquests. These issues are deeply affecting the families involved in the coronial process, who understandably only want timely investigations into the circumstances of their loved one's death. We therefore make two recommendations related to these issues, with the first aimed at improving data collection, management and reporting of coronial cases.

Recommendation 2

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

2.105 Second, and regardless of whether structural reforms are implemented to the coronial jurisdiction, it is vital that the NSW Government address the delays and backlogs in coronial cases by allocating additional funding, staffing and resources to the Coroners Court of NSW.

2.106 The committee recognises the skill, hard work and dedication of coroners and all staff involved in the coronial process from the Department of Communities and Justice, NSW Health Pathology Forensic Medicine, NSW Police Force and the Crown Solicitors Office, operating in the context of high workloads and limited recourses. We consider that a significant injection and maintenance of additional resources is required across different components of the coronial system. The committee considers this absolutely critical in enabling the Court to deliver quality and timely coronial services, effectively undertake its death investigation and prevention objectives and maximise its contribution to public safety outcomes.

Recommendation 3

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

Progress Report on the Improving the Timeliness of Coronial Procedures Taskforce

October 2021

NSW GOVERNMENT

4. Taskforce initiatives to improve the coronial system in NSW

4.1 Reduce over reporting of natural deaths

General Practitioners (GPs) can issue a Medical Certificate of Cause of Death if they are 'comfortably satisfied' as to the likely underlying cause of a natural death. There are limited circumstances in which a GP should not issue a Medical Certificate of Cause of Death and a death should instead be reported to the Coroner. These include violent or unnatural deaths, a sudden death the cause of which is unknown or deaths under suspicious or unusual circumstances.[1]

Despite this, natural cause deaths account for approximately 60% of deaths reported to the Coroner each year. In 2019, this equated to approximately 3,980 cases out of a total of 6,525 deaths (or 61% of cases) reported to the Coroner.

The Taskforce undertook data analysis to better understand the reasons why GPs may be reluctant to issue a Medical Certificate of Cause of Death. Commonly reported reasons included the GP:

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

Supporting GPs with tools and guidance to increase their confidence in certifying natural cause deaths will enable coronial system resources to focus on deaths that warrant the scrutiny of the Coroner. It is also expected to improve timeliness by alleviating pressure on the coronial system.

Initiatives

Coroners Act reform removing the requirement to report a death to the Coroner because the deceased person had not seen a medical practitioner in the six months before death

The *Coroners Act* was amended to remove the requirement to report a death to the Coroner if the deceased person had not seen a medical practitioner in the six months prior to their death. This reform is expected to reduce the number of natural cause death referrals to the Coroner, thereby enabling the coronial system to focus on deaths that warrant investigation. An education campaign was undertaken to ensure general practitioners were aware of this change. This included three newsletter articles published by the Royal Australian College of General Practitioners (RACGP), which is the largest professional general practice organisation in Australia and a key channel for engagement with general practitioners in NSW.

The amendment commenced on 20 January 2020 and already appears to have had a positive impact. Between December 2019 to February 2020, general practitioners reported not issuing a Medical Certificate of Cause of Death on 18 occasions because it had been over six months since they had cared for the patient. A significant reduction has occurred since the reform commenced, with this reason only being reported twice between March 2020 to June 2020.

Education and support to increase general practitioners' confidence in issuing Medical Certificates of Cause of Death

NSW Health collaborated with the RACGP to provide a webinar for general practitioners about how and when to complete a Medical Certificate of Cause of Death and which deaths should be reported to the Coroner. The webinar was held on 26 August 2020 and received a very positive response, with evaluation survey feedback indicating participants found it informative and felt it provided clarity on a topic rarely

[1] See section 6, *Coroners Act 2009* (NSW)

discussed in such a practical way. The webinar is available for medical practitioners to view online[2] and was promoted in a RACGP newsletter article to extend the reach of the webinar.

NSW Health continues to explore further opportunities to deepen general practitioners' understanding of the coronial process and how to correctly complete a Medical Certificate of Cause of Death, including additional webinars and other resources.

4.2 Reduce delays in release of deceased persons

The NSW Government recognises the concerns raised by people, particularly those from rural and regional areas, about the length of time taken for their deceased loved ones to be transferred for post-mortem examination and returned to their family.

Coronial post-mortem examinations can only be performed by highly qualified forensic pathologists who require the support of forensic mortuary technicians, radiologists and radiographers, clinical nurse consultants and forensic medicine social workers, as well as specialised equipment.

Forensic Medicine follows international best practice and makes best use of limited forensic medicine resources. The current model of dedicated facilities at Sydney, Newcastle and Wollongong ensures families and coroners receive timely, respectful answers. It also allows for essential training and supervision of forensic pathology trainees, as well as a collaborative environment for case peer review.

The model is supported by a state-wide multi-disciplinary interagency triage process in which forensic duty pathologists and clinical nurse consultants across the three Forensic Medicine sites review and discuss medical records with local doctors and, where appropriate, provide support and guidance for the issuing of a Medical Certificate of Cause of Death or Coroner's Certificate.

The triage process can help remove the need for a deceased person to be transferred to a Forensic Medicine facility, thereby reducing the number of natural deaths entering the coronial pathway. When a medical examination is required by the Coroner, the Forensic Medicine team schedules all activities in such a way as to minimise the time from admission of the deceased person to their release into the care of an appointed funeral director.

The NSW Government also recognises there are occasions when the timeframes for the release of deceased persons cause additional distress for family members. The timeframe for a post-mortem examination and subsequent release of a deceased person may be extended for a range of reasons, including:

- the case is complex and additional tests are required,
- family members raise objections,
- the case is associated with a Police investigation,
- when there has been a temporary increase in the number of admissions to Forensic Medicine, as occurred in the 2018/19 period.

Timeliness may also be affected by delays in accessing medical records, medical images and other relevant information. Forensic Medicine clinicians rely on timely access to clinical information to support decision-making, inform discussions with general practitioners regarding issuing a Medical Certificate of Cause of Death, make recommendations to the Coroner, compare and interpret radiological images, perform post-mortem examinations and finalise coronial case reports. As Forensic Medicine clinicians rely

[2] The Royal Australian College of General Practitioners (RACGP), 'To report or not to report? Understanding when and how to report a death to the Coroner', available at: www.racgp.org.au/racgp-digital-events-calendar/online-event-items/on-demand/understanding-when-and-how-to-report-a-death-to-th

on hospitals and GPs to copy and transfer medical records and images, either electronically or in hardcopy, delays in receiving these can extend timeframes.

Uncertainty about when a deceased person will be released can make it difficult for their family to plan a funeral and make associated arrangements, such as organising travel and/or leave from work to attend the funeral. For this reason, all Forensic Medicine social workers encourage families not to set a date for a funeral until the final Release Order has been received from the Coroner.

Initiatives

Coroners Act reform enabling preliminary examinations to commence earlier

An amendment to the *Coroners Act* commenced on 20 January 2020 to enable preliminary examinations of deceased persons to be carried out without the need for a coronial direction. Section 88A lists different types of preliminary examination, such as visual examination of the remains, collection and review of personal and health information and imaging of the remains. This reform enables preliminary examination to be undertaken as early as possible upon admission to a Forensic Medicine facility. This allows the coronial process to start earlier and may negate the need for an invasive procedure, enabling the deceased person to be returned to their family sooner.

Forensic Medicine has begun a phased implementation of preliminary examinations using a 'case-type' approach. This involves identifying certain types of deaths (such as suicide, where there are no suspicious circumstances or suspected infectious cases) where a particular type of preliminary examination can provide additional necessary information to improve timeframes. Staged implementation is necessary to enable the impact and practical application of each type of preliminary examination to be assessed for specific case types.

Facilitating direct access to electronic medical records and images for forensic pathologists

Forensic Medicine forensic pathologists have been given access to the NSW Health Enterprise Image Repository (EIR) and technical arrangements have been made to give them access to local health districts' electronic medical records (eMR). All forensic pathologists now have access to the eMR and further refinements are being made to optimise access. Being able to directly access the EIR and eMR, rather than having to request copies of these from hospitals, will enable Forensic Medicine clinicians to access ante-mortem records more efficiently and to expedite their advice to the Coroner, reducing overall timeframes.

Considering implementation of direct transfers for certain types of deaths

The Taskforce is considering phased implementation of direct transfers for certain types of deaths in rural and regional areas to enable deceased persons to be returned to their families sooner. While currently triage must occur and a coronial direction made before transfer can be arranged, under the proposed model police would arrange for the deceased person to be transferred to a Forensic Medicine facility as soon as possible if satisfied the death meets certain criteria. A pilot of direct transfers for certain types of deaths in the Riverina Police District will commence in November 2021, which will assess the potential benefits of this approach.

4.3 Reduce delays in finalising post-mortem reports

The lengthiest phase of the coronial process is the post-mortem investigation. Currently a Coroner or Local Court magistrate exercising coronial jurisdiction cannot make a decision to dispense with or to hold an inquest until they receive the final post-mortem report. A post-mortem examination is typically

completed within three to five days of admission; however, post-mortem reports can take several months depending on the nature of the death and tests required. The NSW Government recognises delays in finalising post-mortem reports may cause distress for grieving families.

A key reason for the lengthy timeframes for finalising post-mortem reports is the limited number of forensic pathologists, both in Australia and worldwide. There is also an extremely limited number of neuropathologists in NSW, which can impact timely completion of reports. This is because forensic pathologists rely on neuropathological interpretation of the brain to assist in determining the cause of death in a number of complex cases that undergo post-mortem examination.

Initiatives

Increasing forensic pathology resources and enhancing specialist capacity

Forensic Medicine has taken steps to enhance specialist capacity. This included recruiting two forensic pathologists after an extensive international search to ensure current capacity could be maintained. Forensic Medicine has also recruited a clinical training coordinator and currently has four forensic pathology trainees.

To reduce delays stemming from the lack of neuropathologists in NSW, Forensic Medicine is implementing a strategy to further develop the neuropathology skillsets of its forensic pathologists. This is expected to improve timeframes for final reports by ensuring neuropathology support will be available at all Forensic Medicine sites in the event a specialist neuropathologist is unavailable.

Developing a new statewide Forensic Medicine Information System

Forensic Medicine is in the process of developing the Forensic Medicine Information System (FMIS). The FMIS will capture all workflow, clinical information, case management and reporting requirements for Forensic Medicine. The FMIS will have many benefits which are expected to improve timeframes for the coronial system and improve support for families. These include facilitating the efficient receipt of information through electronic systems, improving engagement with families by forensic social workers by assigning automated tasks, eliminating manual processes and enabling real time communications with the Coroner, Local Court magistrates exercising coronial jurisdiction and other key parties. The FMIS is currently in the design phase and is expected to go live in March 2022. Many of the timeliness initiatives for Forensic Medicine identified by the Taskforce are dependent on the successful implementation of the FMIS.

Streamlining the post-mortem reporting process

Forensic Medicine has developed templates for use in the FMIS which will streamline the production of post-mortem reports by single point of data entry, auto-populating some information and reducing manual administrative input for certain causes of deaths. It is anticipated that post-mortem reports produced using these templates will be more consistent and more readily understood by families. The templates will be programmed into the FMIS. Forensic Pathologists will also be able to use voice to text dictation in the FMIS which will further increase efficiency.

Exploring the appropriateness of the Coroner basing their determination on the interim cause of death report

An audit of a subset of interim and final post-mortem reports has been undertaken to determine if there are certain types of cases where it may be appropriate for the Coroner to make a determination based on an interim report. For this to be considered, there would need to be evidence of a high rate of consistency between the cause of death identified in interim cause of death reports and final reports for the particular

case type. The audit found a high concordance between interim cause of death reports and final post-mortem reports for presumed suicide by hanging cases. Similarly, where a cause of death had been identified in the interim cause of death report for a presumed natural cause death, there was high concordance with the final post-mortem report. The State Coroner is considering the findings of the audit and the potential process changes which may be appropriate as a result. For example, the Coroner may be able to finalise such cases sooner if they were not required to wait until they receive the final post-mortem report to make a determination as to the cause of death.

Introducing timeliness standards for the coronial process

The Taskforce is developing timeliness standards for the key steps in the coronial process to support monitoring of performance, including the impact of Taskforce initiatives. Contemporary accreditation processes are based upon agreed performance standards. These agreed timeliness standards, in combination with clinical standards also being developed, will form the basis against which each agency will monitor compliance against the standard and the key performance indicators. The Coronial Services Committee, which is discussed in Chapter 6, will monitor compliance with the timeliness standards into the future.

4.4 Improve communication with families

The NSW Government recognises the importance of sensitive, timely and accurate communication with loved ones, especially where there are unavoidable delays in the coronial process.

Throughout the coronial process, families and loved ones of the deceased may have contact with a range of agencies, including NSW Police, Forensic Medicine and/or the NSW Coroners Court.

A key resource to help families and loved ones understand the coronial process is the NSW Coroners Court brochure on the initial steps after a death is reported to the Coroner.[3]

There are also support services available for the deceased person's loved ones. The Coronial Information and Support Program (CISP) provides enhanced communication between the Coroners and Local Court magistrates exercising coronial jurisdiction within NSW and bereaved individuals and families. The CISP social work team assist senior next of kin, individuals and families to access accurate and timely information about all aspects of coronial proceedings. CISP provides a supportive environment to individuals and families and provides guidance in relation to appropriate referral pathways to grief and loss services for immediate and ongoing support.

Bereaved families accessing the coronial pathway are also supported by the Forensic Medicine Social Work team, which provides care coordination and case management activities across a care continuum. Forensic Medicine social workers contribute to the timely access to information for the senior next of kin, support families to be able to express their grief in a safe environment and contribute to the commencement of the restoration of health and wellbeing following the death event.

Funeral directors are also a significant source of information and support for grieving families, and interact with all agencies in the coronial process. Family members often seek information about Forensic Medicine procedures and timeframes from funeral directors, and therefore it is important that funeral directors have a good understanding of the coronial process and reliable information about expected timeframes.

[3] NSW Government, 'Initial Steps after a Death is Reported to the Coroner', available at: https://www.coroners.nsw.gov.au/coroners-court/resources/publications.html

Initiatives

Enhancing social work services for families and loved ones

Forensic Medicine recruited two additional social workers to provide support and information for families. This equates to a 25% increase in Forensic Medicine social work resources in NSW. They have also introduced the Forensic Medicine Social Work Model of Care to ensure families receive early and consistent contact and support throughout the coronial process.

Improved engagement with funeral directors

Joint understanding of the coronial system is being achieved through extensive engagement with funeral directors, enabling them to better support families. This has included targeted newsletters, a survey seeking feedback, attending industry events, offering tours of Forensic Medicine facilities and publishing articles in industry magazines.

Engaging with Aboriginal and Torres Strait Islander communities

DCJ has established two Aboriginal Family Liaison Officer roles within its CISP social work unit that commenced in September and October 2021. These officers will assist families throughout the coronial process from initial contact through to conclusion, including assisting with the identification of Aboriginal and Torres Strait Islander status, helping families to better access information and participate in the process, and ensuring culturally appropriate practices are maintained. DCJ has also commenced a joint project between the NSW Coroners Court and the Aboriginal Services Unit to develop a culturally appropriate coronial brochure.

Forensic Medicine continues to outreach to Aboriginal and Torres Strait Islander communities and services to discuss ways to improve the experience of the coronial process for families, through shared newsletter distribution, attendance at site facilities and direct communication with Aboriginal Liaison Officers working directly in local communities.

Engaging with Culturally and Linguistically Diverse (CALD) communities

Engagement between Forensic Medicine and the Muslim community in Sydney has identified a range of concerns for bereaved families. These include a need to better understand what a post-mortem examination involves, how to lodge an objection, the timeframes of a post-mortem examination, the role of the senior next of kin and for communication materials with a specific cultural/religious focus. Engagement is continuing with funeral directors and the Australian National Imams Council about hosting information sessions in the community and providing input into culturally appropriate material.

Forensic Medicine will conduct outreach and engagement with other CALD communities in 2021 to improve the experience for bereaved families who may feel confused, distressed or excluded as a result of sensitivities related to cultural, religious or linguistic diversity.

Improving the NSW Coroners Court website

The NSW Coroners Court has updated its website to make it more user friendly, including improving navigation, search functionality and compatibility with mobile devices. A page with information about how to provide feedback, compliments and complaints has also been added to the website to make it easier for members of the public to provide feedback on their experiences with the coronial system.[4]

[4] Coroners Court, 'Feedback, complaints and compliments', available at: www.coroners.nsw.gov.au/coroners-court/how-the-coroners-court-work/feedback--complaints-and-compliments.html