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Submission to New South Wales Parliament Select Committee Inquiry on the NSW coronial jurisdiction

Hugh Dillon

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UNSW Law
UNSW Sydney NSW 2052 Australia

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Submission to New South Wales Parliament Select Committee Inquiry on the NSW coronial jurisdiction

Hugh Dillon
Adjunct Professor
Faculty of Law
University of New South Wales, Sydney, Australia

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Abstract

Modern theorising of on coronial practice has identified four main purposes of coronial systems: (i) fact-finding concerning the causes and circumstances of reportable deaths; (ii) prevention of death and injury; (iii) providing therapeutic and restorative processes for the benefit of bereaved relatives and others; (iv) the protection of human rights, especially where state agencies are implicated in reported deaths. Because the purposes and structure of the NSW coronial system have not been subjected to thorough review since 1975, it has not fully adapted to modern conditions and thinking. As a result, compared with other Australian and international jurisdictions, it labours with the disadvantages of an obsolete, inefficient and badly designed Act and administrative structure. An outmoded and narrow conception of the role and functions of the coronial system have retarded the development of a modern coronial system in this state. This submission to the NSW Legislative Council Select Committee inquiry on the Coronial Jurisdiction argues for root-and-branch reform including the establishment of a stand-alone Coroners Court of NSW, separated from the NSW magistracy.

Keywords

Coroners – Death investigation – Coronial practice – Role of coroners – Purposes of coroners – Deaths in custody – Death prevention – Comparison of NSW and other coroners – Human rights – Therapeutic jurisprudence – Law reform

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SUBMISSION

Executive summary

The Coroners Act and structure of the NSW coronial system is obsolete and in need of reform.

Modern thinking on coronial practice has identified four main purposes of coronial systems:

- Fact-finding concerning the causes and circumstances of reportable deaths
- Prevention of death and injury
- Therapeutic and restorative processes for the benefit of bereaved relatives and others
- Accountability of state agencies involved in reportable deaths.

These purposes require suitably designed and resourced coronial systems.

The NSW system has a number of significant strengths:

- Deaths are investigated
- Good people in the system
- Judicial independence and impartiality
- High quality legal assistance for coroners
- Specialist forensic medical investigators
- Recognition of families and a culture of empathy and kindness for them
- Excellent facilities at Lidcombe
- Recent improvements in co-ordination of coronial services

The strengths of the system and its potential to contribute significantly are undermined by an obsolete Act and inappropriate administrative framework. It has a hybrid structure – specialist coroners based in Sydney but non-specialist general bench magistrates covering 45% of reported in the country and regional areas. NSW is the last major jurisdiction in Australia to rely on such a structure.

Country and regional magistrates do not have the expertise or capacity to provide specialist coronial services. They are able to make little significant contribution to preventing deaths and injury by holding inquests and making recommendations. They are not resourced for this purpose. They hold few inquests and rarely make recommendations.

The specialist coroners are over-stretched and under-resourced as they cover the metropolitan area, all deaths in custody and police operations cases, and much of the regional load. As a consequence, delay, and therefore distress for families, is endemic in the system.

The Coroners Act itself is poorly drafted and in urgent need of reform.

The system of coronial recommendations and responses is poorly designed. Coronial recommendations could be improved but the response regime needs a complete overhaul.

Significant efforts are being made to improve coronial services for Aboriginal families and communities. This is commendable but more resources are needed.

Other jurisdictions provide a variety of free lessons for NSW. The statutes of Queensland, New Zealand and Victoria, in particular, are superior to that of NSW in their objects and structure.

Victoria's centralised model provides efficiencies that the NSW hybrid structure and the decentralised systems of England, New Zealand, Ontario and Queensland cannot match. It is also world's best practice in terms of death and injury prevention and probably also engagement with First Nations people.

Since the 1990s, both Ontario and Victoria have placed much greater emphasis on death prevention and public health and safety than has NSW. In this aspect of coronial practice, they are the leading the institutions in the world. Ontario emphasises non-adversarial processes more than Australian coronial systems. They potentially quicker, more restorative and less costly than inquests.

NSW needs a specialist coroners court. Two options appear strongest: (a) a specialist court attached to the Local Court (like the Children's Court) or (b) a stand-alone court like the Victorian Coroners Court. Although there are reasonable arguments for both options, the preferable model is the Victorian model.

A stand-alone court potentially offers the following advantages:

- A clear, modernised philosophy or concept of coronial services could be enunciated as in Ontario, New Zealand and Victoria;
- That philosophy could be expressed in contemporary statutory objects;
- A specialist court would be seen as the hub of a multi-disciplinary death investigation system rather than as minor and relatively unimportant adjunct jurisdiction of a large criminal court;
- Strategic planning and oversight would focus on the objectives of the coronial system rather than being subject to the imperatives of a much larger organisation with different objectives;
- A stand-alone court would potentially be much more flexible and responsive to changing needs or situations than the Local Court or even a court attached to the Local Court;
- A more appropriate set of performance measures and standards could be developed;
- This would result in greater transparency and accountability of the coronial jurisdiction and would, in turn, promote higher performance standards;
- Training and professional development of coroners would be enhanced;
- A significantly greater contribution to public health and safety, especially in regional and country areas, could be expected;

- A stand-alone court could more easily make connections with external public health and safety bodies and organisations than a court that would have to make these connections through, or in with permission of, the Local Court;
- A stand-alone court could develop and manage its own processes more efficiently than having to adapt those of the Local Court to its own purposes;
- Development of its own more flexible, therapeutic and restorative processes could proceed more efficiently and expeditiously than having to be approved by the Local Court;
- Detaching coroners from the Local Court and the criminal justice system would be a symbolic step towards improving relations with Aboriginal families and communities, enhancing trust and confidence of Aboriginal people in the coronial system;
- Breaking the nexus with the Local Court would broaden the pool from which coroners could be recruited, adding range and depth to the expertise available within the coronial system;
- Breaking the connection with the Local Court may also make recruitment of Aboriginal lawyers as coroners more feasible.

Introduction: an historic opportunity

This inquiry is an historic opportunity. It is literally a once-in-a-generation chance to review and modernise of one of our society's most ancient and significant legal institutions. In NSW, despite a number of internal reviews resulting in two new Coroners Acts (1980 and 2009), the coronial system has not been subjected to a public review since 1975 when the NSW Law Reform Commission examined it.[1] This inquiry is timely because the current Coroners Act has been in operation for little more than 10 years. The statutory review due in 2015 has not been completed. A fresh examination of the Act and the coronial jurisdiction is therefore opportune.

Since the Law Reform Commission's 1975 review, comprehensive public reviews of comparable coronial systems have been undertaken in Victoria (1980 and 2006); Queensland (1997, 2006 and 2018); NZ (2000 and 2014); England & Wales (2003); Ontario (2008); and Western Australia (2012). The Royal Commission into Aboriginal Deaths in Custody (1987-1991) also examined the operations of coronial systems in respect of deaths in custody of Aboriginal people. A significant section of the report by the Select Committee on the High Level of First Nations People in Custody also considered the performance of the NSW coronial system.

The 2009 Act was enacted to increase the efficiency of the coronial system and to reimpose the high professional standards of the general bench of the Local Court on a jurisdiction that had been let slide over a number of years. It was also intended, by replacing court registrars with magistrates as local coroners, to lift the prestige and professionalism of coronial services provided in country and regional areas. But it made no fundamental alterations to the overall structure of the system. The review leading to the 2009 Act apparently did not take into account modern theoretical and policy developments in coronial practice which had been explored in other inquiries and implemented following them. Thus an opportunity to fundamentally modernise the NSW system was missed in 2009. The importance of this inquiry therefore cannot be over-estimated.

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[1] NSW Law Reform Commission *Report on the Coroners Act 1960*, LRC 22, (Sydney: 1975) https://www.lawreform.justice.nsw.gov.au/Documents/Publications/Reports/Report-22.pdf

In 1991, at a seminar on coroners, the Public Interest Advocacy Centre asked, "What is the proper role of the coronial system? To what extent should it be investigative? To extent should it be preventive? What should we learn from the differences and reforms in other jurisdictions? What should its objects be? Should they be articulated…? How should it achieve them?"[2] Unfortunately, although most of these questions have been answered in other comparable jurisdictions, they remain largely unresolved in this state. This inquiry is a chance to do that.

The coronial system deals literally with life-and-death issues and it operations affect thousands of people annually. Each year about 6,500 deaths are reported to NSW coroners. In most cases they leave behind them bewildered, confused and even horrified relatives whose lives are radically altered by the experience of sudden, unexpected and sometimes violent deaths. It would be reasonable to estimate that at least 20,000 bereaved relatives per year undergo this shattering experience.

Many more people, such as doctors, nurses, police officers, correctional officers, carers and colleagues are traumatised by these deaths. Caring for the dead, and caring for these people, and others who are also badly affected by these deaths, is an honourable trust the state has placed in the hands of the coronial system. The system that provides that care should be as good as the state can reasonably make it. At present, it falls well short.

In these submissions I will contend that, because the purposes and structure of the coronial system have not been subjected to thorough review since 1975, it has not adapted to modern conditions and thinking. As a result, compared with other Australian and international jurisdictions, it labours with the disadvantages of an obsolete, inefficient and badly designed Act and administrative structure. An outmoded and narrow conception of the role and functions of the coronial system have retarded the development of a modern coronial system in this state.

I will argue that NSW urgently needs a reformed and better-resourced coronial system. I contend that the Coroners Act and the structure of the current system are incapable of providing

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[2] Michael Hogan, "Towards a NSW coronial system for the Nineties", (1991) 2:2 *Current Issues in Criminal Justice* 75 at 77.

the coronial services the people of NSW have a right to expect in the 21st century. The publicly available empirical data, which I will analyse in this submission, demonstrate this.

Successive governments have proceeded for years apparently oblivious to the deficits of the system. A lack of incisive analysis of the system and strategic planning has left the coronial system straining dangerously at the seams due to under-resourcing. This inquiry, however, has the opportunity to make recommendations to government that could give NSW, at relatively modest cost, a world-leading coronial system.

Lest there be any misunderstanding of my submissions, I emphasise that my critique is intended to be constructive and is not an attack on any person or group of people involved in this system. I am a former magistrate and Deputy State Coroner. I have sincere respect for the Local Court as an institution and the professional, very hardworking magistrates who make up its bench. Some of them are my friends. The quality of the people is what holds together an outmoded and under-resourced system.

A The law, practice and operations of the NSW coronial system

A.1 The scope and limits of the coronial jurisdiction

It is a fundamental axiom of systems architecture that form follows function: identify the function then design the system accordingly.

The current structure of the coronial system was designed in 1901 when the magistrates court was given administrative responsibility for coroners. The small group of specialist coroners at the Lidcombe Forensic and Coronial Facility are the direct descendants of the City Coroners who held office in Sydney and worked in The Rocks in the early 20th century. The country and regional magistrates who were given coronial responsibilities in the 2009 Coroners Act mirror the position of the Police and Stipendiary Magistrates who managed circuit courts of Petty Sessions across NSW until the creation of the Local Court in 1986.

This structure has taken on such an air of permanence that it has not been closely scrutinised until recently. The magistracy was given control of the coronial system for three principal reasons: (i) in the early part of the 20th century, magistrates and court officials were regarded as well-educated and efficient administrators, more competent and reliable than untrained civilians and idiosyncratic local juries; (ii) the circuit court structure covered most parts of the state; and (iii) a narrow concept or theory of coronership then prevailed. It was based on answering only five questions: Who died? When and where did the death take place? What were the cause and manner of death? (Hence the coronial jurisdiction was sometimes described by 'old school' magistrates as a 'tick-a-box' jurisdiction.)

If, serendipitously, a coronial investigation suggested that changes should be made to prevent future deaths, coroners or their juries could add 'riders' or recommendations to their findings. But a systematic approach to death prevention and public health and safety was not part of this system. Although the 2009 Act has more refinements than the Coroners Acts of the 20th century, it does not fundamentally reformulate the historical philosophy or structure established in the early 1900s.

The Coroners Act implies a pyramidal structure.[3] (See Appendix A.) That structure is consistent with a narrow philosophy or concept of coronial work as a secondary activity of the Local Court. I will argue that modern thinking about the purposes of the coronial system has rendered that philosophy, and it administrative structural manifestation, obsolete.

Before returning to the question of an appropriate structure, I will first discuss modern thinking about the basic purposes of coronial death investigation systems. I anticipate that the NSW Bar Association's submission will present a detailed treatment of this topic. I contributed to that discussion. I will therefore confine my observations about the purposes of coronial systems to a few points.

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[3] This is my own representation of the pyramid. It is not an official document and there may be argument about the levels of the various strata. What is unarguable, however, is that the Act constructs a hierarchy with the Chief Magistrate, as head of jurisdiction in the Local Court, at the top. See s 10(2) of the Act in particular.

A.2 The purposes of coronial death investigations

The office of coroner dates back to the 12th century. As the office evolved in England, it came to be accepted that the fundamental responsibility of coroners was to care for the dead, and by extension, their relatives and communities, by investigating the causes and circumstances of their deaths. This was a moral as well as an administrative responsibility.[4] Over time, especially in the second half of the 20th century and the first decade of the 21st, the substantive content of concept of 'care of the dead' developed considerably away from the baseline of the 'five questions'.

Modern coronial theory has emphasised four primary purposes of coronial death investigations:[5]

- fact-finding in relation to reported deaths;
- prevention of future death and injury;
- therapeutic and restorative processes; and
- accountability of state agencies involved in reported deaths and support of human rights.

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4 See Marc Trabsky, *Law and the dead: Technology, relations and institutions,* (Abingdon: Routledge, 2019).

5 An extensive literature on the modern purposes of coronial systems has developed since the 1990s. See, for example, Graeme Johnstone, "An avenue for death and injury prevention" in Hugh Selby (ed), *The aftermath of death,* (Sydney: Federation Press, 1992); Graeme Johnstone, "Coroners' inquiries and recommendations" in Hugh Selby (ed), *The inquest handbook* (Sydney: Federation Press, 1998); Ian Freckelton and David Ranson *Death investigation and the coroner's inquest,* (Melbourne: Oxford University Press, 2006); Jennifer Moore *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016); Ian Freckelton, "Death investigation and the evolving role of the coroner" (2008) 11:4 Otago Law Review 565; Ian Freckelton, "Death investigation, the coroner and therapeutic jurisprudence", (2007) 15 *J of Law & Medicine* 242; Ian Freckelton, "Reforming coronership: international perspectives and contemporary developments" (2008) 16 *J of Law & Medicine* 379; Ian Freckelton and Simon McGregor, "Coronial law and practice: A human rights perspective" (2014) 21 *J of Law & Medicine* 584; Ian Freckelton, "Minimising the counter-therapeutic effects of coronial investigations: In search of balance", (2016) 16:3 *QUT Law Review* 4; Rebecca Scott Bray and Greg Martin, "Exploring fatal facts: current issues in coronial law, policy and practice",(2016) 12:*2 International Journal of Law in Context,* 115; Rebecca Scott Bray, "Coronial law reform", (2010) 35 Alt Law Journal 232; Rebecca Scott Bray, Belinda Carpenter and Michael Barnes, "Southern death investigation: Theorising coronial work from the Global South" in Kerry Carrington et al., *The Palgrave Handbook of Criminology and the Global South* (2018) https://doi.org/10.1007/978-3-319-65021-0_8 ; Michael King, "Non-adversarial justice and the coroner's court: A proposed therapeutic, restorative, problem-solving model", (2008) 16 *J of Law & Medicine* 442.

Underlying these four functions is, I believe, a concept of recognition of the common humanity of the dead, the bereaved and those who investigate reported deaths.[6] The poet John Donne expressed this when he wrote his famous meditation on that theme:

> No man is an island entire of itself; every man is a piece of the continent, a part of the main; if a clod be washed away by the sea, Europe is the less, as well as if a promontory were, as well as any manner of thy friends or of thine own were; any man's death diminishes me, because I am involved in mankind. And therefore never send to know for whom the bell tolls; it tolls for thee. [7]

If we accept that concept of a common humanity, we must then also accept that the sudden, unexpected, unexplained or violent deaths of members of our community are, in a sense, public events. Most will not need to be discussed in public forums such as inquests. In NSW, approximately 60% of reported deaths are diagnosed as due to natural causes. Less than 2% of reported deaths go to inquest. But, because all members of our society have individual and social significance, all deaths reported to coroners have inherent significance for our society as well as for bereaved relatives, friends and communities. Those deaths may also have wider implications – they may have been preventable; they may raise questions about the conduct or systems of state organisations and agents; issues may be raised about how people – the dead or the living – have been treated; life-saving lessons may be available.

The specialist coroners and others involved in the operations of the NSW coronial system are well aware of these facts. The question for this inquiry, and ultimately the government, is whether the coronial system's design, construction and resources permit it to operate in something approaching an optimal fashion. The empirical evidence says it does not.

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6 See Raimond Gaita, *A common humanity*, (Abingdon: Routledge, 2002).

7 John Donne, "Meditation XVII", Devotions upon Emergent Occasions. https://web.cs.dal.ca/~johnston/poetry/island.html

A.3 Some implications of the modern coronial philosophies

A.3.1 The potential for saving lives

The need for a rethinking of the coronial system in NSW is most evident in respect of its preventive function. In 1907, an English coroner, John Brend, who was a doctor, lawyer and forensic pathologist, lamented that 'the value of the [coroner's] statistics is diminished by absence of co-ordination. Hence we have the anomaly that while a full inquiry is conducted into deaths from violent and unnatural causes, practically no subsequent use is made of the information for public health purposes.'[8] Those observations could be applied to the NSW coronial system in the present day.

Every year approximately 6500 deaths are reported to NSW coroners. Some of the key data concerning these deaths are collected and reported to the National Coronial Information System. Until very recently, when a Suicide Register was established at Lidcombe, the only data collected *and analysed* in the NSW coronial jurisdiction related to family violence homicides.[9] In interviews I conducted in 2020 with coroners and others in the NSW coronial system, a number of participants in the research told me that it was only by serendipity that coroners could identify or discern fatal trends or patterns of deaths.

One coroner said:

> When I talk about the problems with our coronial system, data to me is the huge problem… data and the way we use our health data and the capacity for us to find these trends, that is a massive issue for New South Wales, in my opinion.[10]

Similar opinions were expressed by others. Another coroner told me:

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8 John Brend quoted by Graeme Johnstone, "An avenue for death and injury prevention" in Hugh Selby (ed), *The aftermath of death*, (Sydney: Federation Press, 1992), 140.

9 See Coroners Act 2009 Ch. 9A Domestic Violence Death Review Team

10 Interview between Hugh Dillon and Participant 15, Sydney, 17 June 2020.

> I think that there are much better ways to work out what is going to help prevention than having an inquest in some cases because especially when we can't be having inquests for every suicide because there are so many. So obviously having a suicide register and a suicide mortality review is going to come up with a lot more fruitful information to inform recommendations and prevention than having the odd inquest.[11]

This is the kind of thinking that John Brend was writing about in 1907. It is the kind of thinking that in the 1990s motivated Victorian State Coroner Graeme Johnstone to press for the establishment of a national coronial database.[12] It is the conceptual compass of the Victorian system which orients its statute and its administrative structures towards death and injury prevention.[13] In an address at the UNSW Law School in February 2020, the Chief Coroner of Ontario echoed this thinking:

> We are collecting the data in ways that we believe are based on the determinants of health because we know that prevention is best driven by the determinants of health so we model ourselves to collect that to inform data-driven public safety. And so we work with those in the areas and say "What do you want to know about your particular area? We'll try to collect those data for you." We won't get everything that people want but we try to get at least a determinants of health perspective to inform people in the public health realm because we believe they're in the best position to do prevention. [14]

If the death preventive function is to be given increased weight in the NSW coronial system, as I submit it should be, questions about the Act, the structure of the system, how coroners exercise their discretions to hold inquests, how coroners are selected and trained, what guidance they receive, how recommendations and made and responded to, how coronial data are collected and analysed (or not), and how the system is resourced must be asked. At present,

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11 Interview between Hugh Dillon and Participant 6, Sydney, 15 May 2020.

12 The National Coronial Information System was established in Melbourne in 2000.

13 Coroners Act 2008 (Vic) s 1(c).

14 Dr Dirk Huyer, Address to Coronial Workshop, UNSW Law School, Sydney, 13 February 2020.

despite having an excellent team of specialist coroners in NSW, the defects in the architecture and resources of the system are impeding its preventive potential from being realised.

Although the current NSW State Coroner and her colleagues have been constantly steering the NSW system towards the preventive approach, it lags behind Victoria and Ontario a very considerable distance in terms of collecting and analysing coronial data for public health and safety purposes. That is the next frontier for the NSW system.

A.3.2 Accountability of state organisations for deaths – supporting human rights

The coronial system has the unique role in our justice system of investigating government agencies and agencies when deaths occur in custody, in police operations, or in care facilities. Holding public inquests into such deaths is one means by which agencies and agents are held to account and are prompted to identify and remedy systemic faults.[15] This is one institutional means of supporting and seeking to protect human rights in our society. It is a critical function in maintaining the legitimacy of our institutions, especially police and corrections, but also other elements of the health and welfare systems.[16]

Several of the submissions made to the Inquiry into High Level of First Nations People in Custody dealt with problems in conducting s 23 inquests.[17] In that inquiry the focus was on deaths in custody of Aboriginal people. But the capacity of the coronial system to conduct s23 inquests in a way that is both timely and thorough is inadequate.

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15 See, for example, Carol Robinson, "The anticipation of an investigation: The effects of expecting investigations after a death from natural causes in prison custody", Criminology & Criminal Justice (2021) 1–17 https://doi.org/10.1177/17488958211028721

16 See Ian Freckelton and Simon McGregor, "Coronial law and practice: A human rights perspective" (2014) 21 *J of Law & Medicine* 584. The requirement for coroners to conduct thorough investigations into deaths in custody was emphasised in the Royal Commission into Aboriginal Deaths in Custody, Final Report, Vol 1, Ch 4 (1991). This function is explicit in Britain where the Human Rights Act applies. Although NSW does not have an equivalent statute, human rights protection is implicit in the fact that ss23 and 27 of the Coroners Act require inquests to be conducted by 'senior coroners' in all cases of deaths in custody or where police may have caused or contributed to a death.

17 Sections 23 and 27 of the Coroners Act make inquests into deaths in custody and caused by police operations mandatory.

In the last year or so, the rate of growth of the s23 backlog has been substantially reduced by the State Coroner's and the Deputy State Coroners' very considerable efforts. However, by concentrating so much of their effort on s23 and other mandatory cases, relatively little is left for conducting discretionary cases into, for example, deaths of children or disabled people in care in respect of whom the State Coroner and Deputy State Coroners have exclusive jurisdiction.[18]

A.3.3 Therapeutic jurisprudence and restorative methodologies

In the 1990s, Ontario shifted from heavy reliance on inquests to more therapeutic and restorative methodologies.[19] Most specialist coroners and counsel assisting in NSW are familiar with both the therapeutic, sometimes cathartic, effects inquests can have and the counter-therapeutic effects of lengthy delays, inappropriate adversarialism and excessive formality on bereaved families and others affected by reported deaths.

Because coroners investigate deaths, they are not bound by rules of evidence and procedure. The process is not intended to adjudicate contests between litigants but to find facts and, if possible, identify solutions for the problems that are evidenced by reported deaths. Coroners, therefore, have much more methodological flexibility than trial courts have. A coronial investigation is an opportunity to apply different methods, depending on the circumstances of the case. A recent inquest conducted by the State Coroner is a good example of procedural flexibility.[20]

In some cases, using non-adversarial methods, such as those developed in problem-solving courts like drug courts, may be very appropriate in the coronial system. For example,

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18 See Coroners Act s 24.

19 Justin Malbon, "Institutional responses to coronial recommendations", (1998) 6 *Journal of Law & Medicine* 35, 46-47. See also the commentary on the Ontario methodologies in the report of the Victorian Parliament's inquiry into the Victorian coronial system in 2006: Victoria. Parliament. Law Reform Committee, *Report on Coroners Act 1985*. (Melbourne: 2006) https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

20 See Ann Bonnor, "Changing the landscape: Inquest into the disappearance of Ben Dominick", NSW Bar News, Autumn 2021, https://barnews.nswbar.asn.au/autumn-2021/40-changing-the-landscape-inquest-into-the-disappearance-of-ben-dominick/

unexpected deaths following health-related procedures are reportable to coroners. When they occur in a public hospital, it is standard practice not only for a Root Cause Analysis investigation to be conducted but for an 'Open Disclosure' meeting to be offered to bereaved families by the hospital administration. Families' dissatisfaction with Open Disclosure meetings often results in requests being made for an inquest.

Such inquests can be as factually complex as Supreme Court medical negligence cases and can take a number of years to see through, with all the counter-therapeutic effects they can cause to families, medical practitioners and nurses. In Ontario in the 1990s, it was discovered that in many cases, a less complex, less formal, less adversarial process could produce effective outcomes for families, hospitals and health practitioners.[21] It may be possible in NSW to explore using such methods.

In introducing new measures, such as the draft protocol for managing Aboriginal deaths in custody, lobbying government for the appointment of Aboriginal family liaison officers, and applying more flexible procedures in inquests, State Coroner O'Sullivan has demonstrated a refreshingly innovative attitude to improving the performance of the coronial system and making it more restorative and therapeutic. Her colleagues are, I am aware, very supportive of this approach.

Specialist problem-solving courts and other non-adversarial forums, such as youth conferences, have shown that restorative and therapeutic techniques can produce excellent outcomes. But they require careful selection of cases and specialist skills, processes and environments to be successfully practised. These are not part of the Local Court's general suite of practices and methods. If the coronial jurisdiction continues to develop its use of therapeutic and restorative methodologies, as I hope it will, this would require enhanced specialist training and professional development. It would also reduce the value of general bench magistrates 'dropping in' to provide occasional assistance to specialist coroners. That, in turn, strengthens

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[21] Justin Malbon, "Institutional responses to coronial recommendations," (1998) 6 *J of Law & Medicine* 35 at 46-47.

the argument for establishing a centralised specialist court to manage all coronial matters in NSW.

A.4 The underlying strengths of the current system

The NSW coronial system has considerable strengths which, if built upon, could give the state world-leading coronial services.

A.4.1 Deaths are investigated

In Australia, we take for granted that sudden and unexpected deaths will be investigated. In many parts of the world, especially those where authoritarian governments hold sway, or in regions riven by violent conflict, this is not the case. If they fall within the definition of a 'reportable death',[22] these deaths are investigated by skilled professionals without discrimination but with an egalitarian ethos.[23] This is an important characteristic of a civilised society.

In 2020, I conducted research interviewing coroners and others involved in the NSW and other coronial systems. I asked one coroner what she thought the best things about the NSW coronial system were. Her immediate response was:

> I think that every reportable death is looked at and cause and manner of death is ascertained if it can be. Which you usually can. So the family should always end up with, "Yes, they died of this and this is why." I think that's quite important to most people. So it does provide that service… Yes. The family shouldn't die wondering. That's a fundamental, basic one we can do and do do… it can shed a light or highlight things where you don't think it's going to happen any other way. I've got a feeling that organisations should take responsibility for their own things but if it's not going to happen or they can't or won't then we will.

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22 Coroners Act 2009 s 6.

23 Hugh Dillon, "The roles of counsel in the coronial jurisdiction" (2010) 33 *Aust Bar Rev* 293.

> It provides a mandatory system for certain types of deaths where I think by and large the categories are still important. They are usually deaths of people who don't have a lot of choice about what's going to happening to them like prisoners, or children or disabled people.[24]

The inquisitorial method is quite different from the method used in trial courts. Coroners work hand-in-glove with medical and police investigators, lawyers, ad hoc experts, family liaison officers in an exercise intended, if possible, to discover the true facts concerning the cause and circumstances of deaths, and whether there may be ways of preventing similar deaths. Families have burning questions that need answering, if possible. They need to feel that if a death was preventable, lessons are learned and the life lost is not wasted. They want the truth and they want to make sense of the catastrophe that has hit them. The coronial system tries to meet those needs.

A.4.2 The people

The people who work in this system are its central pillar. They know they are dealing with what are literally life-and-death issues and with the pain and grief and confusion of bereaved families and communities. In my experience, they are kind, compassionate, very caring, very committed people who know that the work they do can make a real difference to the lives of others. It was an enormous privilege to work with such fine people in trying to those differences for bereaved families and the wider community.

I have the greatest of respect for the coronial team at Lidcombe, for the people who work in the Dept of Forensic Medicine in various roles, for the counsellors who support families, for the police advocates and lawyers who support the coroners, for the Coroners Court registrar and the public servants who work tirelessly to care for bereaved families and to keep the operation running efficiently, and for the police investigators who carry out inquiries on behalf of coroners, families and communities. Others, such as the Legal Aid lawyers who represent families in many inquests, and lawyers who represent interested parties, also play vital roles in

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[24] Interview with Participant 3, 17 March 2020.

the system. The country and regional magistrates and court registrars who are required, with none of the resources of their city colleagues, to carry onerous coronial loads have my genuine respect.

A.4.3 Forensic Medicine

All forensic medical investigations of reported deaths are carried out by consultant forensic pathologists. Under-skilled local medical practitioners no longer have any role in NSW forensic medicine. To my knowledge, in other coronial jurisdictions, such as England, Canada and the United States, the quality of forensic medicine is much more variable than in NSW. Our forensic medicine is as good as or better than in most places. I am aware of the serious effort being made to reduce delay and improve the efficiency of forensic services in this state.

A.4.4 Judicial impartiality, independence and status

The independence and impartiality of the judiciary is a key feature of the NSW system. Although I will argue that the link with the Local Court should be broken, there is no doubt that the magistrates who transfer from the general bench to the coronial jurisdiction are good lawyers who bring a judicial mindset – 'without fear or favour, affection or ill-will' – to their fact-finding role as coroners. In my Churchill Fellowship visit to the Ontario coronial facility in 2015, the Chief Forensic Pathologist, Dr Michael Pollanen, told me he thought that having judicial coroners working with medical investigators (pathologists) was one of the key strengths of Australian coronial systems. The lawyers brought a judicial methodology to fact-finding that, in his opinion, enhanced the process.

The judicial status of NSW coroners lends authority and prestige to our coronial system that other coronial systems, such as those in most Canadian provincial systems, or coronial systems in the United States, lack to their detriment.

A.4.5 High quality published coronial findings

The quality of coronial findings following inquests in NSW impresses visitors from England where the enormous volume of inquests tends, in many cases, to produce short form findings

of a 'tick-a-box' variety. NSW findings are described in England as 'narrative findings'.[25] This means that the circumstances of deaths are explored and the evidence for the findings is explained. This is not standard practice in England. Counsel Assisting, lawyers representing interested parties and family members all contribute to coroners' findings. NSW can be proud of the efforts of its coroners and others who have set such internationally high standards. The Local Court, in training its magistrates in the arts of judicial decision-making and judgment writing, also deserves credit for this. Those are transferable skills.

A.4.6 Excellent legal assistance

To my knowledge, coroners in few other jurisdictions receive such consistently high quality legal assistance as in NSW. In England, coroners, who are legally qualified, do not receive legal assistance in most inquests. They are true inquisitors and generally ask most of the questions in inquests. In other states, such as Queensland and Victoria, in-house lawyers usually fill the Counsel Assisting role. (A small team of police advocates, trained in the NSW Prosecutors Branch, provides some of the legal assistance coroners receive).

In NSW, the Crown Solicitor's Office Inquiries team or the DCJ's Office of General Counsel provides legal assistance to coroners. The CSO has a number of skilled solicitor-advocates who sometimes operate as Counsel Assisting. In other cases, the CSO or OGC may brief counsel. The NSW Bar has an excellent public law bar, some of whom are ex-CSO lawyers. The benefits of a number of excellent lawyers working together in a coronial team in a complex case cannot be over-estimated. In this respect, the NSW system is much superior to the English and Canadian systems.

A.4.7 Recognition of families: a culture of kindness

When I began work as a coroner in 2008, one of the Coronial Information and Support Team leaders told me, "We have a culture of kindness here, Hugh". It was both an education and a warning. The CISP team (part of the Coroners Court) and Dept of Forensic Medicine

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[25] David Baker, *Deaths after police contact: constructing accountability in the 21st century,* (London: Palgrave Macmillan, 2016), 61.

counsellors, all of whom liaise with and support bereaved family members, impressed me enormously. They taught me a great deal not only about the coronial system but its culture and many other things, such as the psychology of grief.

Apart from arranging viewings of bodies, immediate grief counselling, information about coronial processes and what is happening to loved ones in the mortuary, the CISP and DOFM counsellors frequently act as advocates for families concerning objections to autopsies or organ retentions.

The State Coroner's drive for the appointment of Aboriginal family liaison officers is intended to provide Aboriginal families with culturally safe, 'wrap-around' support. Her draft protocol will enhance their opportunities to participate fully in inquests into deaths of their loved ones.

Procedural innovations being introduced in the Coroners Court are likely to enrich the participation of families in coronial investigations and may provide restorative and therapeutic opportunities.

A.4.8 Improved co-ordination of coronial services

The establishment of the new Coronial Services Committee is one of the most important innovations yet introduced into the coronial system. It demonstrates a recognition that the system is a network or multidisciplinary complex, effectively a partnership, in which the four main actors, the Local Court, NSW Health, NSW Police and the DCJ have indispensable roles to play. It recognises that for the system to be its most effective, coroners must provide direction from the centre of the system but also that it works best as a collaborative partnership.

The Coronial Case Management Unit, which was established about 5 years ago as a pilot scheme, is to become a permanent fixture in the coronial system. Coroners, police officers, NSW Health staff and counsellors work together to gather as much information about reported deaths as is available shortly after a death is reported. The objectives of the CCMU are to ensure that reportable deaths are assessed in according to a consistent set of standards, and that appropriate decisions concerning further investigative action are taken in timely and consistent ways. Families receive preliminary information about the causes and circumstances of death

and bodies can be released to them.[26] This collaborative approach, I am told, provides better quality information to families than before the unit was set up and has improved the quality of initial decisions concerning further investigations.

A.4.9 A world-class forensic facility and coroners complex

The Lidcombe forensic and coronial facility is excellent. Until it was opened in 2019, the facility in Ontario was probably best-in-class. The NSW facility is on par with the best now.

These are the solid foundations upon which a better system can be built. I now turn to examine what's wrong with this system.

A.5 The wrong blueprint for a modern coronial system

If a modern coronial system has multiple and complex functions, it requires a purpose-built structure to work effectively and produce the desired outcomes. NSW has part of the necessary framework but the coronial system is hobbled by being built into the Local Court with which it is culturally and structurally incompatible. The Local Court is essentially a high-volume criminal trial court whereas as the coronial system is a multi-disciplinary investigative institution with unique social and legal responsibilities of caring for the dead and the bereaved.

While conducting interviews for my research about the NSW coronial system in 2020 I had the following exchange with one NSW coroner:

> ***What do you think of the structure? Does it fit in the Local Court?***
>
> No. It's totally different work to Local Court work. It takes a different approach. It's done in chambers. It's a different system. It's got a different aim altogether.
>
> ***Do you think it fits in the criminal justice system at all?***

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[26] See Local Court Annual Review 2020, 22.

> No. Not at all. It's not criminal. It's not civil. It overlaps with criminal; it overlaps with civil, health, medical negligence, all kinds of things, but you are in no sense a criminal justice judicial officer when you're doing this. And that's hard to get out of. My first two months here, I kept looking for people to charge with things. [Laughs]… it took a little bit of a while for that to wear off, but it has. It's not like that, it's a totally different thing to that kind of judicial exercise.[27]

That coroner had had broad experience practising in the criminal law and on the Local Court general bench before being appointed to the coronial jurisdiction. The 2006 parliamentary inquiry into the Victorian coronial system observed that, because no statutory Coroners Court had then been established in Victoria or NSW, the coronial role was administrative rather curial in those two states.[28] In practice, coroners spend much of their time out of court reading files and reports, making administrative decisions concerning post mortem examinations and police investigations, writing letters to families, meeting pathologists, investigators and counsel assisting, drafting findings and recommendations. Conducting inquests in court is only fraction of their work.

My own experience and background was similar to that of the coroner I quote above. It took me some time to realise that the criminal justice lens was not the most useful to apply in this field. That raises the question to which I now turn.

A.5.1 A two-tier system

In my submission, the fundamental flaw with the current system is that its structure reflects an outmoded theory of coronership which denies the desirability of a centralised specialist coroners court and assumes that all magistrates are interchangeable. This has resulted in a two tiers of coronial services – one provided by specialist coroners in the metropolitan area and another provided by non-specialist local magistrates in the country and regional centres.

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27 Interview with Participant 3, 17 March 2020.

28 Victoria. Parliament. Law Reform Committee. *Coroners Act 1985 Report.* (Melbourne: 2006, 585-586. https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

In the current structure country and regional magistrates are required to manage almost half the coronial cases reported in NSW. Although only about 35% of the NSW population lives outside the Greater Sydney metropolitan area, country and regional magistrates receive approximately 45% of reports of death.

In Sydney, a specialist group of coroners works collegially in a facility which also brings together forensic medicine, family counselling and police liaison and legal assistance to coroners. In the regions, coronial services are provided in part from Sydney or Newcastle and in part from the local courthouse. All NSW magistrates are coroners ex officio[29] but only in the regions are coronial responsibilities imposed upon local magistrates.

This structure was intended provide the country and regional areas of the state with coronial services no less professional or skilled than those provided within the Sydney metropolitan area. In itself, that is a laudable ambition but it was based on two debateable concepts.

First, it assumed that coronial duties and responsibilities are relatively simple. That assumption was based on the narrow theory of death investigation that only five, usually straightforward, questions are to be asked.[30] This theory takes a particularly narrow approach to questions of causation and manner or circumstances of death. For example, it construes 'manner of death' as meaning 'by what means' (eg, hanging, motor vehicle accident, drug overdose).

A broader approach construes 'manner of death' as requiring examination of the circumstances leading to the death, and asks questions about the preventability of the death and whether recommendations to prevent similar future deaths can be made. Most, if not all, specialist coroners in NSW take the broader view but many country magistrates, in my experience, preferred the narrower approach as it was administratively more comfortable for them.

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29 Coroners Act s 16.

30 The 'five questions' are: Who died? When? Where? What was the (physiological) cause of death? What was the 'manner' of death? "Manner of death" is not defined in the Act nor is there clear authority on this question.

In most parts of Australasia, the coroner's role (and the coronial system's role) is no longer conceived of as a narrow 'tick-a-box' exercise. Were that still the case, it is arguable that busy regional and country magistrates may be able to manage the role. Once the coronial role is conceptualised as caring for the dead and the bereaved, and is theorised in a modern way, however, it becomes obvious that specialist coroners working within an appropriately resourced and managed coronial system must do this work.

Secondly, the idea that all magistrates can provide equally professional coronial services appears to be based on a long-standing theory of the Local Court that magistrates are generalists, not specialists and that specialisation within the magistracy degraded rather than enhanced the court as an institution. The historian of the magistracy, Hilary Golder, noted that the NSW magistracy was traditionally antipathetic to specialisation because it reduced the interchangeability of magistrates and, in the days before the magistracy became part of the independent judiciary in 1986, was also associated with the low status and grading of public servant magistrates.[31]

Even if the general proposition that all magistrates can be interchanged into the coronial jurisdiction is accepted, a practical difficulty arises from the fact that, at any given time, a significant proportion of regional magistrates are new appointments undertaking their two years of country service. They are in the first stages of developing their *general bench* skills. They generally come from criminal law backgrounds and are exposed to a large volume of criminal cases, Apprehended Violence applications and the like. Although the transition to the general bench is not easy, that background is a solid foundation for it. But most have no experience or background in the coronial jurisdiction or even in related fields such as medico-legal work or public law.

A.5.2 Magistrates are specialists – but not in coronial work

The theory that magistrates are generalists, not specialists, may once have been true but is no longer. Most NSW magistrates are criminal law specialists and have been appointed because

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31 Hilary Golder, *High and responsible office: A history of the NSW magistracy,* (Sydney: Sydney University Press, 1991), 180.

of their extensive experience in practice in this specialty. This is appropriate because most of the work most magistrates do is criminal. Criminal law skills and experience, however, cannot readily translated into the civil, children's, coronial or any other specialist field. The additional skills needed must be learned.

Developing competence and expertise in a specialist field requires training, learning and practice.[32] An expert can be defined as a person who can produce reliably superior performance in representative tasks.[33] Country and regional magistrates can develop into competent and expert magistrates in the criminal justice domain relatively quickly because they have a base of knowledge and experience to build on. In the coronial sphere, however, it is virtually impossible for country magistrates to become truly expert because in most cases they will receive only small numbers of coronial cases to consider. They simply do not get sufficient volume of cases to develop true expertise.

During my interviews, one country magistrate told me that he had a large coronial caseload – about 40 current cases.[34] Specialist coroners in Sydney, on the other hand, have individual loads of between 600 and 700 cases per annum. They therefore get a lot of practice. The Sydney-based specialist coroners also have the advantages of working with other specialist coroners, forensic pathologists, family counsellors, police officers, and Counsel Assisting and solicitors experienced in the field. Even so, because it is a complex, multidisciplinary field, it takes even experienced, competent magistrates some time to develop a new range of skills. In my own case, I would estimate that I was reasonably competent after 2 years and had developed a real degree of expertise only after 5 years.

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32 See, for example, K. Anders Ericsson, Ralf Krampe & Clemens Tesch-Römer, "The role of deliberate practice in the acquisition of expert performance" (1993) 100:3 *Psychological Review* 363. This paper was the source of the "10,000" hour rule for developing expertise. See also K. Anders Ericsson et al. *The Cambridge Handbook of Expertise and Expert Performance,* (Cambridge: Cambridge University Press, 2006).

33 K. Anders Ericsson et al. *The Cambridge Handbook of Expertise and Expert Performance,* (Cambridge: Cambridge University Press, 2006), 13

34 Interview with Participant 2, 5 March 2020.

A.5.3 Why country magistrates should not have coronial responsibilities

In 2017, the State Coroner Michael Barnes was so concerned about serious errors being made by country and regional magistrates in coronial cases that he sought (unsuccessfully) to have coronial work removed from them.

In a memorandum to the Attorney-General in August 2017, the then State Coroner, Magistrate Michael Barnes, criticised this structure and described the coronial performance of regional magistrates as 'sub-optimal'.[35] He wrote:

> The current arrangements for the delivery of coronial services in NSW are suboptimal because outside of the metropolitan area it is overseen by local magistrate coroners many of whom have insufficient experience and/or time to do the work well and the jurisdiction is grossly under resourced.
>
> This leads to inconsistent and inappropriate decisions being made and to delays at crucial stages in the process.
>
> These problems could be addressed by the creation of a Coroners Court presided over by full time coroners.
>
> Half of the approximately 6000 deaths reported to NSW coroners each year are dealt with by 36 regional magistrate coroners who preside over 71 country courts outside metropolitan Sydney. As a result some never gain significant experience in dealing with such matters. In reality, much of the work is done by court officers.
>
> All of these magistrate coroners are also responsible for a full caseload of criminal and civil matters. None other than the Newcastle coroner get any time out of court to deal with coroner's matters. Most circuit to a number of courts and coroners' files either lie fallow awaiting the coroner's arrival or chase them from court to court…

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35 Michael Barnes, "A bereaved families focussed Coroners Court restructure", August 2017. (See Appendix B)

> I am regularly made aware of regional coroners or their clerks making serious errors in each of these three stages. This is not their fault – the clerks have to take charge because the magistrate is either in another centre or is in court. Even when the magistrate coroners are involved, because coronial work is so different from that which takes up most of their time, poor decisions are made. It is a specialist jurisdiction which requires an understanding of and collaboration with other technical specialities.
>
> The inadequacy of resources also manifests in inquest being dispensed with when a hearing should be held having regard to the proper purpose of inquests.[36]

The performance of country and regional magistrates is not 'sub-optimal' because they are bad magistrates. On the contrary, they are hardworking, dedicated, well-educated judicial officers, well-qualified to work in a criminal jurisdiction. Few, however, have any qualifications for the coronial jurisdiction which, contrary to popular belief, has little to do with the criminal justice system.

The coronial system has much more to do with medicine, grief counselling and public health and safety than with crime. That is demonstrated by the fact that only a small fraction of reported deaths or suspected deaths relate to suspected homicides. Of the 6500 reported deaths per annum, NSW crimes statistics show that slightly more than 1% are homicides.[37]

If coroners are to fulfil their death preventive roles, they need to develop a range of intellectual skills which are additional to the generic judicial skills of assessing evidence and making decisions. For example, if a person dies in a psychiatric unit, there may be fault on the part of nursing staff. If so, it is likely that some sort of systems failure has occurred. Thinking in terms of the interaction between human error and systems failure, and possible solutions to systems problems is not something magistrates commonly inquire into or have much knowledge of. But a whole science has developed in this field and coroners much become familiar with the basic

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36 For the full memorandum, see Appendix B.

37 See NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics: Quarterly Update,* March 2021, Table 2.3. This report shows that in the 69 murders and 9 manslaughters were committed in the 12 month period being surveyed. The report also showed that the homicide rate had been stable for the previous 5 years.

tenets of it.[38] If a systems failure has occurred and the magistrate-coroner does not recognise this, at least three systems failure have then gone undetected: at least one in the hospital and two in the Local Court – (a) placing an insufficiently trained and experienced magistrate in that position; and (b) failing to provide the necessary training to that magistrate.

This example is drawn from an actual case in which an inquest was followed by a disciplinary hearing in the NSW Civil and Administrative Tribunal[39] and a NSW Health inquiry.[40] The country magistrate-coroner involved appears to have applied a typical criminal justice approach: 'Has there been misconduct? Who is to blame?' But prevention of future death and injury requires broader thinking than this. The famous industrial psychologist Professor James Reason has argued that taking a 'systems' approach to human error and disasters is a superior method to taking a 'person' (or blame) approach. Fixing systems can produce high reliability organisations – finding a blameworthy person does not do that.[41]

I do not criticise the magistrate involved – a very decent, hardworking person and a skilled magistrate highly respected in his own specialist field of crime. As the NCAT found, the nurses deserved to be disciplined. In this he was correct. But he lacked the specialist coronial skills to identify the systems failure in the hospital and the inquest was therefore unsuccessful.

He should not have been placed in the position of having to investigate a complex systems failure like this one. Because of the structure of the coronial system, despite his acknowledged expertise in the criminal domain, he did not have the opportunity to develop a superior level of

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38 See, for example, Henry Petroski, *To forgive design: understanding failure*, (Cambridge: Harvard University Press, 2012); Atul Gawande, *The checklist manifesto: How to get things right*, (London: Profile Books, 2009); Sydney Dekker, *Drift into failure: From hunting broken components to understanding complex systems*, (Boca Raton, FL: Ashgate, 2011); James Reason, *The human contribution: Unsafe acts, accidents and heroic recoveries*, (Farnham: Ashgate, 2008).

39 *Health Care Complaints Commission v Borthistle* [2017] NSWCATOD 56 at [2].

40 Nour Haydar "Sweeping mental health reforms in NSW announced after Miriam Merten's death", Sydney Morning Herald, 11 May 2018 https://www.abc.net.au/news/2018-05-11/nsw-government-announces-sweeping-mental-health-reforms/9750650

41 James Reason, "Human error: models and management", (2000) 320 *British Medical J* 768; James Reason, "Achieving a safe culture: theory and practice" (1998) 12: 3 *Work and Stress* 293-306.

competence in coronial work. As Barnes's paper shows, in that regard he is typical, not atypical, within the Local Court.

Inquiries by the Victorian Parliament (2006)[42] and the WA Law Reform Commission (2012)[43] both examined the coronial systems in those states and concluded that the hybrid model of a small number specialist coroners working the metropolitan areas and the regional coronial work being conducted by local magistrates did not provide adequate coronial services to the country areas.

The Victorian inquiry report observed:

> The Committee wishes to highlight the fact that there are significant differences between coronial investigations conducted in Melbourne and those conducted in regional Victoria. The State Coroner's Office has identified the standard of coronial services available to communities in regional Victoria as one of the areas in which there is scope for substantial improvement…
>
> The Committee notes that at present there is no state-wide case management system for coronial investigations, which means that there are limitations on the scope for monitoring and supervising the standard and progress of regional cases by the State Coroner's Office.
>
> Another factor affecting the standard of coronial investigations in regional Victoria is that coroners do not have access to the specialist investigative expertise that is available to Melbourne coroners. This can be problematic in complex cases which require specialist knowledge, particularly those involving medical treatment issues. In these cases Melbourne coroners have the advantage of Clinical Liaison Service support,

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42 Victoria. Parliament. Law Reform Committee. *Coroners Act 1985 Report.* (Melbourne: 2006) https://www.parliament.vic.gov.au/images/stories/committees/lawrefrom/coroners_act/final_report.pdf

43 WA Law Reform Commission, *Review of coronial practice in Western Australia: Final Report* (Perth: 2012) https://www.wa.gov.au/sites/default/files/2021-02/LRC-Project-100-Final-Report_0.pdf

> which [a specialist coroner] describes as critical for investigative processes such as being able to read and interpret medical files.[44]

Similar comments could be made about the current NSW system.

The WA Law Reform Commission, considering the same problem in 2012, was particularly concerned about the quality of regional coronial services. In its report on Western Australian coronial services it stated:

> The Commission's consultations and research identified a number of problems plaguing the coronial system in Western Australia. Some of the key concerns were systemic in nature, reflecting problems that impact across the coronial system and *which may be exacerbated by the semi-centralised model set up by the Coroners Act*. Principal among these were lengthy delays in completion of coronial cases; lack of communication and cooperation between the Office of the State Coroner in Perth and regional magistrates, registrars, contractors and investigators; and limited guidance, information, training and oversight being provided to those responsible for the delivery of coronial services in the regions.
>
> Over the past decade only a handful of regional inquests have been undertaken by a regional magistrate and this (in combination with a notable absence of training and guidance) has led to magistrates becoming deskilled in coronial matters. Over the same period the coronial jurisdiction has become increasingly specialised, particularly in respect of the research and prevention function being embraced by dedicated coroners in Australian jurisdictions.[45] (Emphasis added).

Again, similar comments could be made about the NSW system.

The WA Law Reform Commission recommended that only specialist coroners manage coronial work and that magistrates no longer hold office as coroners *ex officio.* The Victorian

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44 Victoria. Parliament. Law Reform Committee. *Report on Coroners Act 1985,* (Melbourne: 2006), 12ff.

45 WA Law Reform Commission, *Review of coronial practice in Western Australia,* (Perth: 2012), 14.

Parliament's Law Reform Committee inquiry made 138 recommendations to improve the performance of the Victorian system but did not recommend a stand-alone court be established.[46] The Victorian Government, however, having considered the report and having consulted further, decided that the best approach was to break the nexus between the Victorian Magistrates' Court and to set up a new, stand-alone court.[47] That was done in 2008.

The Hon. Jennifer Coate, an ex-State Coroner of Victoria, emphasised that coronial work was specialist work and that this had been a prime factor in removing coronial jurisdiction from Victorian magistrates:

> The specialist nature of the court was… part of the driving force in terms of the legislative underpinning … making the coroners jurisdiction a stand-alone court… [T]his is a specialist jurisdiction and *so it's not just about you know plucking someone out of the general division of another court and sticking them in there and saying; okay this is sort of interesting work have a look at it...*[48] (Emphasis added.)

In the course of my interviews with coroners, country magistrates and others involved in the NSW coronial system, a persistent theme arose that country magistrates found coronial work difficult both in terms of the skills required and the problems of managing the work while having to concentrate on their core criminal work.

One magistrate said: 'The system we currently have I think the country coroners lack time to do their work and so we have a patchy system across New South Wales.'[49] A country magistrate

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46 Victoria. Parliament. Law Reform Committee. *Report on Coroners Act 1985*, (Melbourne: 2006), Ch.9.

47 Victoria. Parliament. Legislative Assembly. Attorney-General Hulls, Coroners Bill Second Reading Speech, Hansard 9 October 2008, 4033. https://www.parliament.vic.gov.au/downloadhansard/pdf/Assembly/Jul-Dec%202008/Assembly%20Extract%209%20October%202008%20from%20Book%2013.pdf

48 Interview with Jennifer Coate, 15 June 2020.

49 Interview with Participant 15, 17 June 2020.

told me that, due to his 25 years' experience in practice, he felt comfortable with most other aspects of the work of magistrates, but coronial work made him feel 'a bit nervous'.[50]

Another country magistrate (who had had experience as a practitioner in the jurisdiction) told me:

> But without that [prior coronial] expertise it's hard to see what the utility is in having people who are brand new in a job which takes in my experience 5 years to get across as a magistrate. Trying to do that coronial aspect of the job in circumstances where the main aspects of the job themselves are so overwhelming. I mean it takes two years to be basically competent, I think.[51]

The same magistrate said:

> Look I had a conversation with another magistrate who has done coronial work in the country and that really worried me, because he was saying how straightforward the jurisdiction was to me and you know how it really wasn't that complex and I've got to say I didn't drill down into what was going on there but it worried me because that just isn't the case. And so, the example I gave him of a matter, I had more than one, Aboriginal deaths in hospital of women. I think I had two of them and it just screamed off the page to me that it needed to be explored and it turned into a full inquest and you know it was something where I don't know what the recommendations ultimately were actually I didn't follow that through but it, it, it was very satisfying that I had correctly identified it. The ones that worry me are where it's not a mandatory inquest and you miss it. You miss the fact that it needs it.

Another country magistrate said:

> The Victorians have such a different approach to it. They have all of that support that's available for the crafting of recommendations and the research that underpins it. And

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50 Interview with Participant 5, 7 may 2020.

51 Interview with Participant 7, 5 June 2020.

> we have none of that! And if I'm a country coroner, I *absolutely* have none of that. I don't even have someone I can walk down the corridor and talk to.[52]

A NSW magistrate who had worked in country courts and the coronial jurisdiction told me that she found 'a varying degree of interest' by country and regional magistrates in coronial work. Some were very concerned with trends they discerned in their local areas and wondered whether similar phenomena were being observed by the specialist coroners in Sydney. Some, she thought, had a deep commitment to the public health and safety aspects of coronial work but 'others seem to have difficulty coping with it all.'[53]

Another NSW magistrate told me that when he had been posted to a regional court, he had taken over managing the coronial files from another magistrate. That magistrate, he said, had had little interest in coronial work so a backlog of over 150 files had built up. My interviewee told me that he 'got stuck in' and cleared the backlog (but did not conduct any inquests).[54]

Professor David Ranson, of the Victorian Institute of Forensic Medicine, told me that it was 'a striking feature of non-centralised [Victorian] coroners' findings and also small jurisdictions [ie, the ACT] which have limited resources' that they produce weak recommendations for preventing future death and injury.[55] In his view, a lack of specialist skills and resources undermined the capacity and potential of country magistrates to make robust recommendations. (That opinion is supported by Victorian research in relation to Victorian magistrates before a specialist Coroners Court was created.)[56]

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52 Interview with Participant 2, 5 March 2020.

53 Interview with Participant 3, 17 March 2020.

54 Interview with Participant 5, 7 May 2020.

55 Interview with Professor David Ranson, 11 June 2020.

56 Lyndal Bugeja and David Ranson, "Coroners' recommendations: A lost opportunity", (2005) 13 *J of Law & Medicine* 173: Lyndal Bugeja, "Determinants of coroners' recommendations on external causes of death in Victoria, Australia", PhD thesis, Monash University 2011.

I asked a barrister who had worked as Counsel Assisting in NSW and other Australian jurisdictions what improvements should be made in the NSW coronial system. Among other things she said:

> I would also like to see the involvement of country coroners as little as possible. That you would just have the capacity of our [specialist] coroners, well-trained, experienced, with an understanding of the broader jurisdiction and what the issues are going out to the country doing those inquests.[57]

The problems with the hybrid structure of the coronial system have been well-known within the Local Court and the government for several years.

The inherent tensions arising from harnessing two incongruent cultures together are exacerbated by s 10(2) of the Coroners Act which places the responsibility for strategic direction and planning of the coronial system in the hands, not of the State Coroner, who is the operational co-ordinator, but the Chief Magistrate. If a Chief Magistrate is determined to apply uniform methods of case management within the Local Court, regardless of the singular nature of specialist 'lesser jurisdictions', this is likely to result in unanticipated operational difficulties in those jurisdictions. Inappropriate performance indicators are likely to be applied to specialist jurisdictions simply because they work in the Local Court's core criminal work. The criminal justice culture is likely to predominate, regardless of its inappropriateness in 'lesser jurisdictions', because it is the common currency of the NSW magistracy.

A.5.4 Temporary fix

Barnes proposed two options for fixing the problems he had identified. The first was a properly resourced specialist court to manage all coronial work. The second, his fall-back position, was to give more responsibility for managing the initial assessment of all reported cases to the specialist coroners in Sydney, with regional cases then being sent back to the country magistrates.

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[57] Interview with Participant 21, 2 July 2020.

During the Covid outbreak in 2020, the second option was implemented. I am informed that taking over the initial assessments of incoming regional cases increased the overall workload of the specialist coroner group by approximately 20%. To manage this additional load, I understand that funding has been provided in the most recent budget for one additional specialist coroner position.

Welcome as these developments are, they do not fix the fundamental flaws in the design and structure of the NSW coronial system. They are, at best, a short-term fix for a fraction of the problems identified by Barnes. Managing the first phase of triaging cases and making the initial decisions concerning autopsies and police investigations from Lidcombe will increase the quality and consistency of those decisions. But the regional cases are then referred back to the regional magistrates for further management, investigation and inquests (if they are held).

A.5.5 A crying need for better death prevention in regional NSW

As I have explained, prevention of future deaths and injury is now considered one of the primary roles of coroners. But despite the fact that 45% of reported deaths occur in the country and regional centres, the number of coronial recommendations by regional magistrates is small. In 2019, I carried out a study of coronial recommendations for the period 2010-2018. The data I studied were the recommendations and responses by government agencies listed on the Justice Department website.[58] In the period 2010-2018, recommendations were made in 164 regional inquests. In those 9 years, only 30 (18.2%) of those inquests were conducted by regional magistrates; the remaining 134 were carried out by specialist coroners from Sydney.

Because, as public health statistics show, the risk of preventable deaths and injuries is higher in the regions than in the metropolitan area, the potential for prevention of death and injury is also higher in the regional and remote areas of NSW. People live further from doctors and hospitals than city people do. The most dangerous industries have a heavy presence in the

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58 "Government responses to coronial recommendations" https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx

country. Agriculture, fishing and forestry are the most dangerous of all.[59] A greater proportion of people in lower socio-economic circumstances live in the regions than the capital cities.[60] Lower socio-economic status correlates with higher rates of potentially preventable death.[61] Remoteness increases the chances of potentially avoidable death.[62] Suicide rates are higher in the regions[63] and transport deaths occur disproportionately outside the metropolitan area.[64]

It might be expected, then, that proportionately more inquests would be conducted by country magistrates than the city-based fulltime city coroners. The reverse, however, is the case. This empirical evidence shows that (i) regional magistrates make a small fractional contribution to the total death preventive effort; and (ii) many country cases are transferred from the regions to the Sydney specialist coroners by country magistrates, probably on the grounds of (a) complexity and (b) lack of capacity to conduct inquests adequately in the middle of busy lists and circuits.

The specialist coroners based in Sydney conduct about 80% of the regional cases that are productive of recommendations. This begs two questions: Why doesn't NSW have a fully resourced, specialist court like Victoria's? What serious contribution to the coronial system

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59 See Safework Australia, "Fatality statistics by industry", https://www.safeworkaustralia.gov.au/statistics-and-research/statistics/fatalities/fatality-statistics-industry#number-of-fatalities-and-fatality accessed 16/10/19.

60 RMIT / ABC Fact Check, "Fact Check: Do the Nationals represent Australia's poorest electorates? 11/12/15", https://www.abc.net.au/news/2015-12-10/do-the-nationals-represent-australias-poorest-electorates/6952166 accessed 17/10/19.

61 NSW Health – Health Stats "Potentially avoidable death – socio-economic status" http://www.healthstats.nsw.gov.au/Indicator/bod_avodth/bod_avodth_ses_comparison accessed 09/10/19.

62 See NSW Health, HealthStats, "Potentially avoidable deaths by remoteness from service centres 2016-2017", http://www.healthstats.nsw.gov.au/Indicator/bod_avodth/bod_avodth_aria accessed 09/10/19.

63 Centre for Rural and Remote Mental Health. "Suicide & Suicide Prevention in Rural Areas of Australia: Briefing Paper" - Rural Suicide Prevention Forum, 11th April 2017. (Orange NSW: University of Newcastle, Australia,2017) Graph 1, p.13

64 Transport for NSW, Centre for Road Safety, "Road casualty crashes in NSW: Statistical statement for the year ended 31 December 2017", https://roadsafety.transport.nsw.gov.au/downloads/crashstats2017.pdf accessed 20/11/19.

and, in particular, the prevention of future death and injury can be expected of busy country and regional magistrates who lack specialist skills and training?

A.5.6 NSW – lagging behind the rest of Australia

The fact that the first phase of the management process is being conducted from Lidcombe now demonstrates that the Local Court itself has recognised that the country magistrate-coroners are not as proficient in coronial work as specialist coroners. That raises the question why *any* coronial responsibilities are imposed on heavily burdened regional magistrates.

During the statutory review, the Crown Solicitor's Office, which knows more about the coronial system than most magistrates or Justice Department public servants, recommended that a statutory court, attached, like the Children's Court, to the Local Court but recognised as a specialist court, be established. As we have seen, State Coroner Barnes also argued for a specialist court in 2017.

Once the ACT reforms its coronial arrangements, which is expected to happen later this year, NSW will remain the last jurisdiction to rely on non-specialist coroners to manage a significant proportion of coronial cases *in Australasia*.

The level of experience and professionalism of coronial services provided in the regions and the country should not be of lesser quality than in the city. Therefore specialist coronial services must be provided to the regions. How this is to be done, I will discuss in the last section of these submissions.

A.6 A poorly drafted and obsolete Coroners Act

A large number of flaws in the current Coroners Act have been identified. The June 2017 draft report of the statutory review made 49 recommendations for improving the Coroners Act without even touching on the question of establishing a specialist court.[65] The State Coroner's

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65 Statutory Review Draft Report June 2017 Recommendations, Appendix C.

submissions to the statutory review made numerous suggestions for reform.[66] As I have noted above, the 2006 Victorian parliamentary inquiry made 138 recommendations for reforming that state's coronial system, many of which are relevant to the current NSW Act.

Especially when the current NSW Act is compared with the Queensland (2003), New Zealand (2006) and Victorian (2008) Coroners Acts – all of which were reformed *before* the NSW Act was even drafted – it is strikingly obvious that the current NSW Act is now outdated. Minor amendments will not do. The Act needs to be rewritten from the ground up.

A.7 Resources and delay -- coming apart at the seams

The coronial system of NSW is under internal pressure from insufficiency of resources, external pressure from incoming work, and has a structure that cannot cope with the building forces. Successive governments have proceeded for years apparently oblivious to this growing problem, perhaps deceived by 100% clearance rates that all is well. But I submit that, as a result of lack of strategic planning, the coronial system is now straining dangerously at the seams.

Form should follow function but even with the appropriate form, resources are also needed to fulfil functions effectively. Identifying the necessary resources requires government and the various elements of the coronial system to clarify and decide what they are trying to achieve, the most effective ways of meeting those objectives, and then gathering together the necessary tools and other resources to do so. Resources, outputs and *outcomes* are directly correlated.

There can be little doubt that the coronial system is under-resourced. To assess the performance of an organisation, a range of data is required. Courts, and bodies such as the Productivity Commission and Justice Departments, tend to place great emphasis on clearance rates as a critical measure of a court's efficiency and overall performance. Governments and heads of jurisdiction are, rightly, concerned about delay as a marker of inefficiency.

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66 State Coroner Barnes, Submissions to Statutory Review, Appendix D.

But an overemphasis on this single measure can elevate it above other equally (or more important) measures and degrade the quality of a court's overall performance.[67] "Outputs" are what organisations deliver. "Outcomes", on the other hand, are what happens as a result of the activities and outputs of organisations.[68] Clearance rates are a measure only of outputs, not outcomes. Moreover, they are a measure of only one type of output – cases finalised. Targets can be beneficial in public sector planning and management. They can also damage public services by prioritising easy wins, ignoring important issues and presenting a distorted picture of the true performance of an organisation.[69]

In the general bench of the Local Court, efficiency, measured by high clearance rates, is probably a good indicator of reasonably high quality performance and outcomes. The coronial system has other important outputs, however, such as inquests completed and recommendations made. It seeks, or hopes for, certain outcomes, such as reducing the distress of relatives by providing answers to questions they have about the cause or circumstances of death. Mitigation of risk of future deaths and injury is another important desirable outcome. These are not measured by the Local Court and, in contrast with the Victorian Coroners Court, it is not clear whether any attention is paid to them at all.[70]

The Productivity Commission annual Reports on Government Services concede that the *quality* of court services is difficult to measure. The Productivity Commission therefore measures what

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67 See James Spigelman, "The qualitative dimension of judicial administration", (1999) 4 *The Judicial Review*, 179. Spigelman has delivered a number of speeches on the issue of quality v quantity in court performance. See http://www.supremecourt.justice.nsw.gov.au/Pages/SCO2_publications/SCO2_judicialspeeches/sco2_speeches_pastjudges.aspx#spigelman accessed 20/11/19.

68 Deborah Mills-Scofield, "It's not just semantics: Managing outcomes v outputs", *Harvard Business Review*, 26 November 2012, https://hbr.org/2012/11/its-not-just-semantics-managing-outcomes accessed 20/11/19.

69 Nick Davies et al., "Using targets to improve government services", (London: Institute for Government, 2021), 6**.** www.instituteforgovernment.org.uk

70 See Coroners Court of Victoria *Annual Report 2019-20*, 3. It outlines the numbers of recommendations made, how many were accepted and rejected, and how many were still being considered at the time of publication. https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019-20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf

it can – clearance rates, cost of cases, the number of judicial officers and so on.[71] Those data provide only a partial picture of the performance of the NSW coronial system. Because it does not capture all the relevant data, it is a misleading one.

In 2019, I conducted a study reviewing coronial data from the nine most recent Reports on Government Services and Local Court Annual Reviews.[72] I found that clearance rates in the NSW coronial system – i.e., the number of finalised cases divided by the number of new cases as a percentage – had held steady at about 100% over the previous decade or so: see Table 1 below. Taken alone, those data suggested that the coronial system was performing well. In terms of overall clearance rates, NSW compares well with other Australian jurisdictions. The Local Court takes pride in its performance in maintaining that high clearance rate.

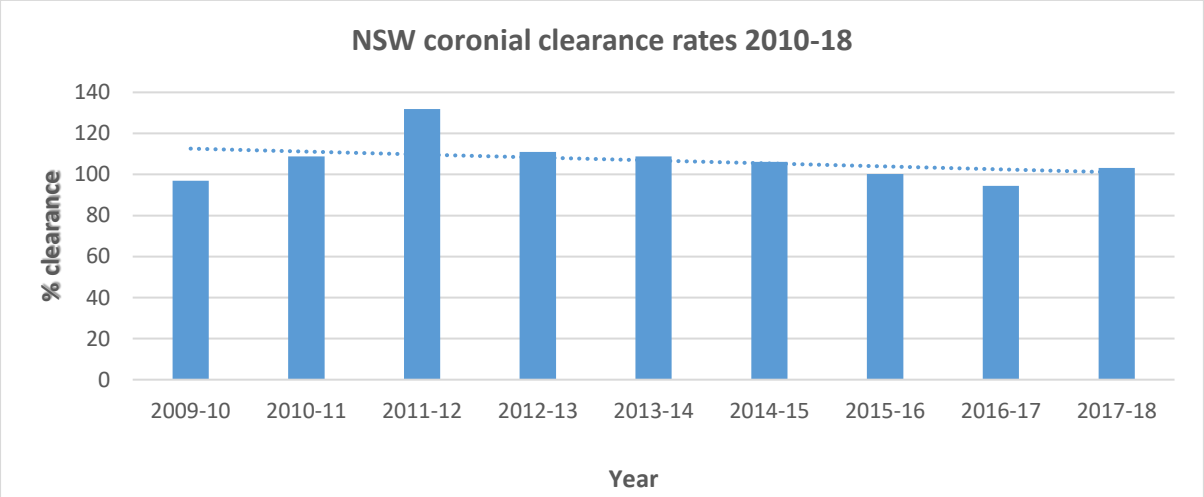

Table 1: NSW coronial clearance rates 2009-10 to 2017-18.

Source: Productivity Commission, *Reports on Government Services* 2009-10 to 2017-18.

[NOTE: All tables and graphs in this paper have been produced by me in reliance on data found in or extrapolated from the sources noted. HD]

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71 See Productivity Commission, *Report on Government Services 2019*, Chapter 7, "Courts" https://www.pc.gov.au/research/ongoing/report-on-government-services/2019/justice/courts accessed 22/11/19.

72 "Rethinking the NSW coronial system – why we need to and what it should look like". Address to the Australian Academy of Forensic Sciences, Sydney, 20 November 2019 (unpublished).

However, the high clearance rates masked serious problems emerging. Perhaps the most revealing data contradicting the impression given by the clearance rates are those showing a slow decline in the number of inquests being performed in NSW over the nine years I studied. They also showed a growing backlog of cases, and a very small number of recommendations to reduce risk of death and injury being made by regional coroners. The downward trend in numbers of inquests being conducted is shown in Table 2 below:

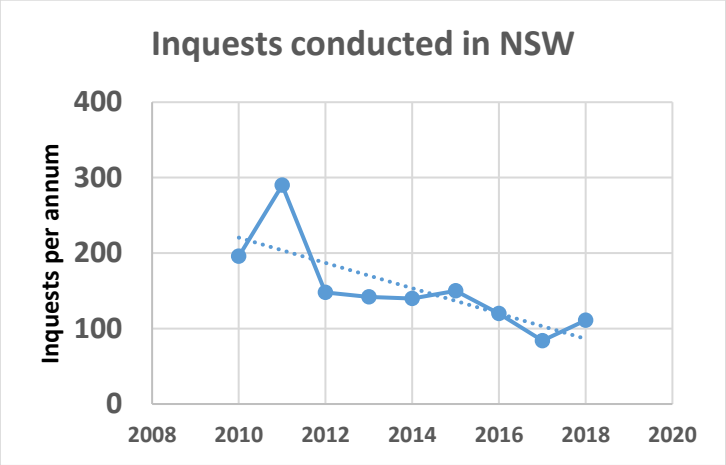

Table 2: NSW inquests 2010-18 - trend

Source: Local Court Annual Reviews 2010-2018.

I selected 2010 as the starting point for this study because that was the year that the Coroners Act 2009 commenced. In Table 2, the year 2011 appears to be anomalous – this suggests a one-off effort to clear a backlog of short mandatory inquests, such as missing persons cases.[73] Overall, the trend was been gradually downward from 2010. From a low point in 2017, when only 84 inquests were conducted in the whole state, inquest numbers rose to 111 in 2018. In 2019, the number of inquests rose to 117. In 2020, 112 inquests were carried. Thus from an annual average of about 140 inquests up to 2015, NSW coroners (including country and regional magistrates) have averaged only about 108 inquests in the past 5 years.

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[73] Section 27(1), Coroners Act 2009 requires an inquest to be held if a person is suspected of having died but the date, place, cause or "manner" (ie, circumstances) of death are not known. Such inquests are usually very short.

The fact that the system is under stress is evidenced even more clearly by its performance in respect of inquests into deaths in custody and deaths in police operations. Under s23 of the Coroners Act, it is mandatory to hold inquests in such cases. Those inquests must be conducted by the State Coroner or Deputy State Coroners. In my 2019 study, I found that over the nine years of the study period, coroners had achieved an average clearance rate in these cases of about 80% per annum. It appeared that the 'senior coroners' could not keep up with the incoming s23 cases.

As the 2019 Deaths in Custody & Police Operations report by the State Coroner to Parliament shows, a large effort is being made to staunch the rate of increase of the backlog. However, the rate of s23 inquests is only just matching the rate of incoming cases, rendering the problem of reducing the backlog insurmountable without additional resources or diversion of effort from other mandatory and discretionary inquests.

One relatively straightforward temporary expedient for reducing the backlog could be to commission members of the legal profession experienced in the jurisdiction as acting magistrates and coroners. In the longer term, however, it is obvious that more specialist coroners are needed to manage s 23 cases *and* continue to carry out other coronial work such as discretionary inquests.

Reconceptualising the coronial system to focus largely on public health and safety, however, implies equipping it to carry out that function as well as possible. In my submission, the Select Committee should closely examine how the Victorian Coroners Prevention Unit operates to collect and analyse data, assist coroners, work with other agencies with a role in protecting public health and safety, and measure the performance of the coronial system.[74] The Victorian Coroners Prevention Unit has a staff of 28 people (18.8 FTE). In its preventive role, the court

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[74] See Lyndal Bugeja and Jeremy Dwyer, "Enabling public health and safety through the coroners' death investigation system: The principles and practice of the Coroners Prevention Unit", (2016) 19:2 *Grief Matters* 47; see also Lyndal Bugeja et al., "Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention" (2012) 18 *Injury Prevention* 326.

is linked with the Victorian Institute of Forensic Medicine and also with Monash University researchers.

At present, much of the potential value of the large amounts of coronial data being collected is being wasted. Coronial data have real potential for protecting and improving public health and safety. Aggregating data and analysing them – possibly using Artificial Intelligence -- to identify emerging patterns and trends would both enhance the value of the coronial system and potentially save lives and the economic and social costs of preventable trauma and death.[75] The economic value of an Australian life has been various estimated as being in a range of $4-10 million.[76] Investment at the Coroners Court in the capacity to collect and analyse coronial data to prevent even a small number future deaths and injury would be highly like to reap economic rewards for the NSW community.

I have observed that one of the major strengths of the NSW coronial system is the assistance that coroners receive from the Crown Solicitor's Office, the Office of General Counsel in the Dept of Communities and Justice, and the NSW Bar. It is therefore troubling that the Crown Solicitor's Office is rumoured to be under-funded to carry out this complex and important work in a timely way. In examining the resources of the coronial system, the Select Committee may wish to investigate the funding arrangements for the inquiries and inquests team at the Crown Solicitor's Office.

That issue underlines the fact that the coronial system is a multidisciplinary network. It is not a 'lesser jurisdiction' of the Local Court. Rather than the pyramid shown in Appendix A, which represents how the system might be viewed from the traditional Local Court perspective, the following diagram is a more realistic representation of the complexity of the system. For it to

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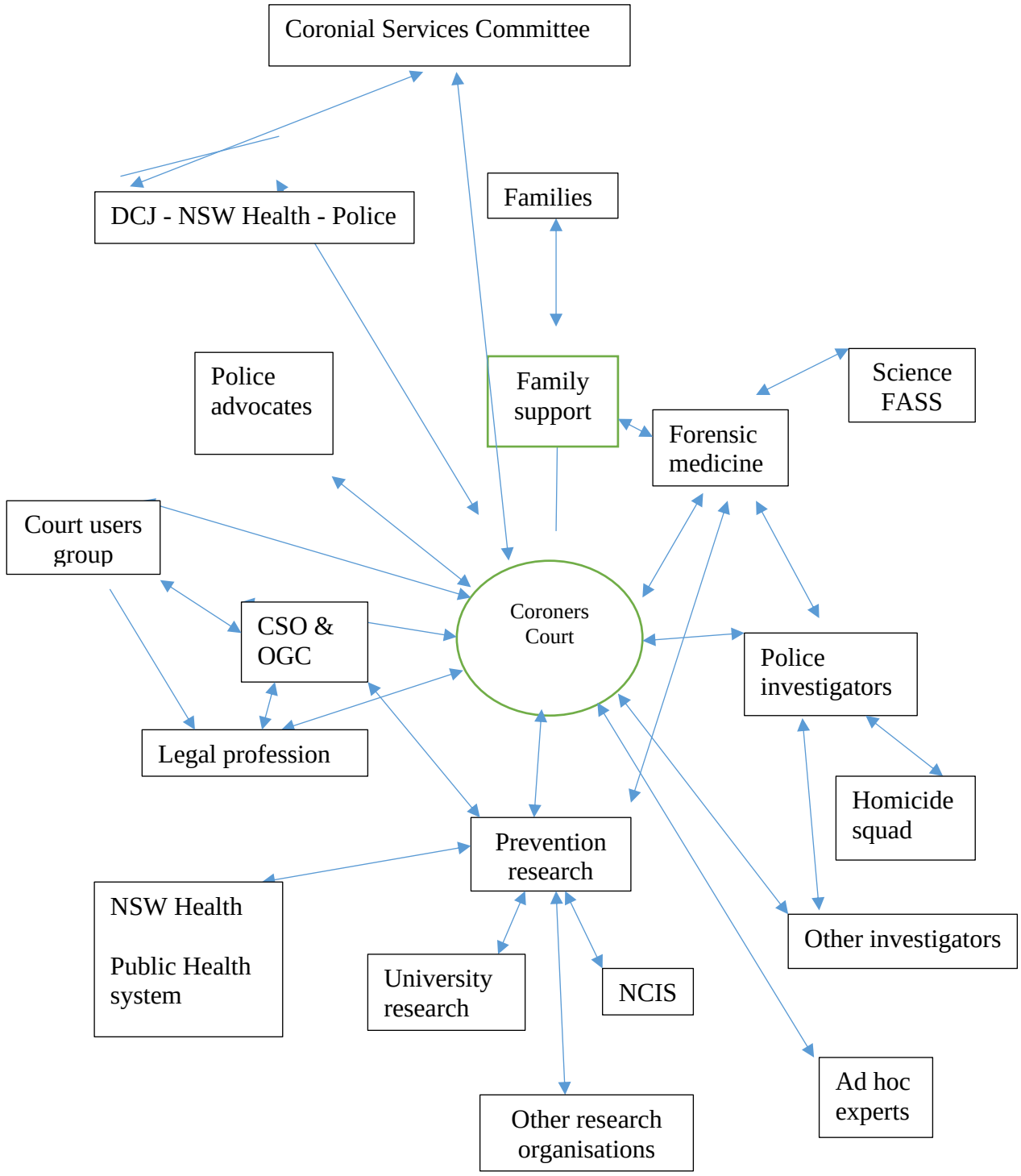
75 See, for example, Ravi Iyer et al., "Using machine learning to understand suicide: a new approach to classifying Australian coroner's court decisions", Research Square (2021) https://doi.org/10.21203/rs.3.rs-640308/v1

76 Kip Viscusi, "Pricing lives: International guideposts to safety", (2018) *Economic Record* 94, Special Issue, June 2018, 1-10. Department of Prime Minister and Cabinet, "Best Practice Regulation Guidance Note: Value of statistical life" (December 2014), https://www.pmc.gov.au/sites/default/files/publications/Value_of_Statistical_Life_guidance_note.pdf

function well, the key elements – coroners, family support, forensic medicine, police, legal profession – must be co-ordinated and resourced sufficiently and appropriately.

The NSW coronial system 2021 – how it really looks



The adverse effects of delay in the coronial system are well known. In the Inquiry into High Level of First Nations People in Custody, as this Select Committee is well aware, a number of Aboriginal people and organisations presented moving accounts of the pain and distress of lengthy delay. Others, such as the NSW Legal Aid Commission, also gave powerful evidence about this. I cannot add usefully to those accounts except to say that my own experience and observations in the coronial jurisdiction supports those claims. I am conscious that, as a coroner, I may have contributed to delay in some cases and I very much regret any added distress this caused family members or others.

In 2015, as a Churchill Fellow, I visited Toronto and spoke to the Chief and Deputy Chief Coroners as well as the Chief Forensic Pathologist. One of the most impressive features of the Ontario system is its use of relatively informal, non-adversarial procedures much more than inquests.[77] In my view, the NSW coronial system would benefit from adapting and applying the Ontario techniques in some cases. Not only would they be more therapeutic or restorative than adversarial forms of inquest, but it seems probable that they would be less resource-intensive, less costly and quicker than the methods that currently predominate.

Shifting more towards non-adversarial approaches, as in Ontario, however, would mean enhanced training of coroners and others involved in such work. Moving in that direction would widen the gap between general Local Court practice and coronial practice even further. It would strengthen the argument for creating a specialist Coroners Court and removing coronial responsibilities from the general bench of the Local Court.

A.8 Recommendations and responses – what's missing here?

The most fundamental purpose of empowering coroners to make recommendations is to alert public entities and other recipients to potential dangers and prompt them to mitigate risk of future death and injury.

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77 But see Justin Malbon, "Institutional responses to coronial recommendations" (1998) 6 *J of Law & Medicine* 35 at 46.

The making of recommendations can also be therapeutic for bereaved families. Sometimes the only solace families can draw from their losses and involuntary participation in the coronial system is that recommendations will be made and that recipients will respond thoughtfully and expeditiously. Therefore designing a response system needs to be carefully thought through. The current NSW response system was a hasty political solution by a government under pressure in 2009. A redesigned system is needed.

A.8.1 Improving the quality of coronial recommendations

As the observations of Professor Ransom (above) and several Australian and New Zealand studies make clear, a coronial system that does not produce robust, practicable recommendations is not fulfilling its death preventive potential.[78] Professor Ranson told me, 'There are recommendations and recommendations.' He was critical of 'very generic recommendations which didn't really go to anything… [recommendations with] no substance … in any real form.' In his research, he found that insubstantial recommendations are common in 'non-centralised' jurisdictions, such as the Victorian system pre-2008, and in very small jurisdictions, such as the ACT.[79]

Associate Professor Jennifer Moore's 2016 study of New Zealand coronial recommendations found many flaws including recommendations not being correctly targeted, lacking an evidentiary basis, being erroneous in law, being impracticable or ambiguous. Consultation with recipients would, she found, improve the quality of recommendations.[80] A 2016 Melbourne University analysis of Victorian coronial recommendations and responses argued that some

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78 Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016); Jennifer Moore, "An empirical approach to the New Zealand government's review of the coronial jurisdiction", (2014) *Journal of Law & Medicine* (2014) 602; Lyndal Bugeja and David Ranson, "Coroners' recommendations: A lost opportunity", (2005) 13 *J of Law & Medicine* 173: Lyndal Bugeja, "Determinants of coroners' recommendations on external causes of death in Victoria, Australia", PhD thesis, Monash University 2011; Ray Watterson, Penny Brown and John McKenzie "Coronial Recommendations and The Prevention of Indigenous Death" (2008) 12 Special Edition 2 Australian Indigenous Law Review 4.

79 Interview with Professor Ranson, 11 June 2020.

80 Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edward Elgar, 2016), Ch 4.

recommendations were 'soft' or of 'low quality' prompting virtually meaningless responses.[81] Although I was a coroner for 9 years, I was never trained in how to write effective recommendations. Both these studies prompted in me a slightly anxious recollection of some of my errors.

Associate Professor Lyndal Bugeja, now of Monash University but previously the manager of the Victorian Coroners Prevention Unit, states that recommendations should be clear and evidence-based, identifying the populations to be protected, the risks, counter-measures and timeframes for implementation.[82] One of the strengths of the Victorian system is that it has trained researchers, like Professor Bugeja, available to train new coroners in this important skill and to assist all coroners in formulating effective recommendations.

In my view, a coronial training and professional development syllabus should be developed in NSW. One of its principal topics should be the development and formulation of high quality recommendations.[83]

A.8.2 Improving mandatory response to recommendations

Although NSW instituted a limited mandatory response scheme in 2009, it was not well designed.[84] It applies only to NSW government entities. Recommendations and responses are not neatly co-ordinated in a single, user-friendly website. Responses are not linked to

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81 Georgina Sutherland, Celia Kemp and David Studdert, "Mandatory responses to public health and safety recommendations issued by coroners: a content analysis", (2016) 40:5 *ANZ J of Public Health* 451.

82 Lyndal Bugeja et al., "Application of a public health framework to examine the characteristics of coroners' recommendations for injury prevention", (2012) 18 *Injury Prevention* 326.

83 See Hugh Dillon, "Raising coronial standards of performance: Lessons from Canada, Germany and England", Report to the Winston Churchill Memorial Trust of Australia, August 2015 (Appendix F). See also, Hugh Dillon, "The professional development of coroners in NSW", Unpublished paper presented to International Coroners Conference, London 2016. (Appendix G).

84 Premier's Memorandum M2009-12, "Responding to coronial recommendations" https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/

recommendations as soon as they come in. NSW Government agencies frequently miss set deadlines and sometimes do not appear to respond at all.[85]

Responses are collected and published on the website of the Department of Communities and Justice *annually* rather than on the Coroners Court website where they could be linked to coronial findings and recommendations – a more logical repository for them. For reasons that are unclear, the Premier's Memorandum requirement of 6-monthly publication of responses appears to have been abandoned but the Memorandum has not been amended.

By comparison with the Victorian mandatory response system, the NSW mandatory response regime is awkward, slow, and inefficient. This reflects a poor understanding of the purposes and potential value of coronial recommendations and responses. The poor design also inhibits research and development of preventive public policy. A project currently being undertaken by Austlii to gather together all Australian coronial recommendations and responses in a single database is very promising but it is impeded by the difficulties of collecting NSW data.[86]

The Victorian system, although imperfect, is the best of the Australian response regimes. It applies, however, only to recommendations made to government agencies and entities. In NSW many recommendations are made to important non-government bodies such as private hospitals and prisons. Transport, agricultural and industrial accidents frequently involve non-government entities. Recommendations should be made in appropriate cases with an expectation that non-government bodies will consider and respond to them in the same ways that government agencies do.

The Premier's Memorandum grants a period of 6 months to respond to recommendations. In my submission, this is too long. The Victorian Coroners Act permits 3 months. The English Coroners and Justice Act 2009 requires a response to Reports to Prevent Future Deaths within 56 days. Permitting up to 6 months is an incentive to delay consideration and action. Eight

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86 The Austlii project is also hampered by the fact that not all NSW coronial findings are published. In 2020, for example, the Local Court's Annual Review statistics show that 112 inquests were conducted but findings in only 77 were published.

weeks, however, may not permit time for sufficient consideration to take place. The Victorian timeframe appears reasonable.

Coroners in NSW have no statutory authority to follow up their recommendations by seeking a response or a more adequate response to their recommendations. It is appropriate, of course, that they have no power to enforce recommendations but the lack of capacity to follow up devalues the death preventive potential of the coronial system.

The NSW Ombudsman, another inquisitorial institution, has power to make reports to parliament about matters of concern.[87] The Coroners Act requires the State Coroner to produce an annual report concerning investigations of deaths in custody and police operations.[88] There seems no reason, in principle, why a power similar to the Ombudsman's should not be given to the State Coroner to report, through the Attorney-General, to the Parliament on matters of concern such as persistent failures by government entities to respond, or respond in a timely or adequate way, to coronial recommendations. It is likely to be exercised only rarely but it would enhance the value and legitimacy of the response regime.

A.9 Capacity to meet culturally diverse needs

A.9.1 Aboriginal deaths in custody

As the protests and Inquiry into High Level of First Nations People in Custody showed last year, and as the State Coroner has clearly recognised, trust in the coronial system needs to be built up. This will be a slow process and symbolic action does count. It is anomalous, to say the least, that the Local Court of NSW, the busiest criminal court in Australia, is also the organisation which investigates deaths in custody. In my view, there are many reasons why NSW should have a stand-alone Coroners Court but this single reason would be sufficient to justify it.

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87 Ombudsman Act s 31.

88 Coroners Act s 37.

A.9.2 Investigating deaths of Aboriginal people and relating to Aboriginal families

The State Coroner has initiated a number of important developments in the ways the Coroners Court and the coronial system relates to and interacts with Aboriginal families. Recognition of Aboriginal people and their unique position in Australian society has been shown by the installation of Aboriginal artworks in the Lidcombe courthouse, smoking ceremonies and other symbolic ways. These are not empty or 'woke' gestures. They are acts of recognition of the humanity and cultural needs of Aboriginal people in times of great distress for them. The employment of Aboriginal family liaison officers and the drafting of a protocol for managing deaths in custody, with special emphasis on engaging with Aboriginal families, are demonstrations of a genuine commitment on the part of the specialist coroners and others working within the system to make it work better for Aboriginal people.

Notwithstanding the goodwill, commitment and dedication of the coroners and staff working at Lidcombe, and no doubt of magistrates and staff in regional courthouses, in my opinion, much more needs to be done to address reported deaths of Aboriginal people.

It is estimated that approximately 3.5% of the NSW population are Aboriginal people. Local Court statistics do not reveal what proportion of reported deaths are of Aboriginal people. Such statistics are, to my knowledge, not collected. But, given endemic socio-economic disadvantage, and the significant numbers of Aboriginal people living in the country and regional parts of the state, it seems likely that a disproportionate number of reported deaths are of Aboriginal people. If so, that is an important social indicator and the coronial system should be aware of it and its statistics should show it publicly.

Even assuming that only 3.5% of reported deaths are of Aboriginal people, about 225 reports of Aboriginal people's death would be made annually. This greatly outnumbers Aboriginal deaths in custody or police operations. Deaths in custody or police operations are thoroughly investigated and mandatory inquests are held. Suspected deaths of missing persons and

suspected homicides are also subject to mandatory inquests. But discretionary inquests into possibly preventable deaths of Aboriginal people are much less common.[89]

Although there are no clear data, it seems probable that preventable deaths of Aboriginal people are under-investigated and are possibly under-reported. If they die of natural causes but the circumstances are 'unusual' in the sense that they have not received appropriate treatment, such deaths should be reported.[90] Making a contribution to 'closing the gap' and preventing future deaths of Aboriginal people, I submit, should be considered a priority of the NSW coronial system. But the resources of the Coroners Court are stretched as far as they can go.

A.9.3 Cultural diversity and coroners

The system relies heavily on the knowledge, experience and emotional intelligence of the Coronial Information and Support Team (Coroners Court) and the Forensic Medicine family counsellors to manage the needs of a very culturally diverse population in times of great distress and bewilderment. During my time as a Deputy State Coroner I was impressed by the CISP and Forensic Medicine counsellors' ability to relate compassionately to families from many diverse cultures. They are one of the major strengths of the NSW system.

The official guidelines and other materials available to coroners, however, are not so useful in dealing with cultural diversity. Neither the *Local Court Bench Book* chapter on coronial matters[91] nor the Judicial Commission's *Equality before the Law Bench Book* deal with practical issues of cultural diversity in a coronial context. Nor, in contrast with the NZ Coroners Act,[92] does the NSW Coroners Act make any specific reference to cultural diversity or

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89 In the published findings for 2020, I could find only one instance of a discretionary inquest into the death of an Aboriginal person. The data are incomplete – not all inquest findings are published. Although coroners usually publish a short 'social history' of the persons whose deaths they are investigating, they may not know that the deceased person is Aboriginal or they may choose not to mention this fact.

90 A death is reportable if, among other things, a person dies in 'unusual circumstances': Coroners Act s 6(1)(c).

91 Judicial Commission of NSW, *Local Court Bench Book* (online edn) Ch.44-000 https://www.judcom.nsw.gov.au/publications/benchbks/local/toc_coronial_matters.html as at 27 June 2021.

92 Coroners Act 2006 (NZ) s 3(2)(b)(i).

sensibilities. Yet objections to autopsies and organ retention, and requests for expedited medical examination of bodies, on religious and cultural grounds are common in the coronial jurisdiction.

My colleague Marie Hadley wrote an excellent chapter on cross-cultural issues and perspectives in our book *The Australasian Coroner's Manual.*[93] To my knowledge, however, this is the only guide to multicultural issues in a NSW coronial context. It is not an official publication. Some NSW magistrates have bought it because it partly fills a gap in the official materials but a gap remains.

Finally, during the Inquiry into High Level of First Nations People in Custody a number of submissions were made suggesting that Aboriginal people should be involved in a variety of ways in managing the coronial response to deaths in custody. I agree with that but submit that Aboriginal people could be invited to make a greater contribution. For example, a considerable number of Aboriginal people are qualified as lawyers in NSW. There is no reason in principle why Aboriginal lawyers could not be recruited as coroners. The Coroners Act provides that the only qualification for coroners is that they be Australian lawyers under the age of 72. (The State and Deputy State Coroners must, however, be magistrates.)

The practical impediment is that the pathway to coronership is, at present, through the magistracy. But it is open to the government to appoint lawyers to the magistracy and simultaneously as Deputy State Coroners. One or more Aboriginal Deputy State Coroners could bring a different range of experience and perspective to investigating not only to the issues raised by Aboriginal deaths in custody but many other aspects of life and death. Grief, confusion, bewilderment are universal experiences for bereaved families in the coronial system. Aboriginal people are usually well acquainted with them. A strong Aboriginal presence in the coronial system would enhance it for *everyone* and generate greater trust and confidence in it from Aboriginal people.

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93 Hugh Dillon & Marie Hadley, *The Australasian Coroner's Manual,* (Sydney: Federation Press, 2015), "The bereaved and their grief", Ch 3.

A.10 Operational arrangements – tactics are right but what's the strategy?

In 2018, the Queensland Auditor-General wrote a report criticising the lack of co-ordination of the Queensland coronial system. In an attempt to solve those problems, the Queensland Government established a Coronial Services Governance Board.

The problems of co-ordinating coronial services in NSW are even more difficult than in Queensland because of our hybrid system. A Coronial Services Committee has been established in NSW. This is described in the Local Court Annual Review for 2020 as 'a high level strategic committee that aims to improve the delivery of coronial services in NSW.'[94]

My information is that this committee is concerned with operational issues rather than 'high level' strategic planning of the coronial system. (I understand 'high level' strategy to be of a higher order of planning such as can be found, for example, in the Strategic Plan for Ontario's Death Investigation System.[95]) The NSW committee meets quarterly. I am told that it works well and has improved the operations of the NSW coronial system. Having an established committee for this purpose is long overdue and is a very welcome development.

Excellent development as it is, the establishment of the Coronial Services Committee, does not, however, solve the real strategic problems of an inappropriate structure and inadequacy of resources. That lesson was learned in Victoria in 2006-2008. I will now turn to focus on comparisons with other jurisdictions, one of the most important being Victoria.

B Comparison with other jurisdictions

All coronial systems derive from an English institution which dates back to the 12th century or possibly earlier.[96] The office of coroner was exported by the British as they created an empire. Despite their common provenance and fundamental purpose of investigating death, for

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94 Local Court *Annual Review 2020*, (Sydney: 2021), 25.

95 Ministry of the Solicitor General, Strategic Plan for Ontario's Death Investigation System 2015-2020 https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/Ourcommitment/DI_Strat_plan_15_20.html

96 Paul Matthews, *Jervis on coroners* 13th ed. (London: Sweet & Maxwell, 2014), 4.

historical and cultural reasons coronial systems throughout the common law world differ significantly. In 2006, Freckelton and Ranson remarked that it was not possible to identify a model system.[97] Two years after publishing that observation, a new system was established in Victoria. In several respects, it is arguably the best model available in the common law world.

It is impossible to compare all aspects of other coronial systems with that of NSW. In this section, however, I will point to a number of key elements of other coronial systems that this inquiry should consider.

B.1 Different models of death investigation systems

In Australia, New Zealand and England,[98] coroners are required to be legally qualified and are generally judicial officers.[99] In all Australian states and territories, magistrates (or in the Northern Territory, Local Court judges) are coroners *ex officio.* In North America, coroners are usually not legally qualified. In British Columbia, for example, although judges may act as coroners[100], no particular qualifications are required for appointment as a coroner.[101] In Ontario, Canada's largest province by population, coroners must be medically qualified.[102] In North America, the major division in death investigation systems is not along legal v medical lines. Rather, the debate there has focussed on whether a Medical Examiner model should supplant non-medically qualified coroners.[103]

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97 Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest,* (Melbourne: OUP, 2006), 94. See also Jennifer Moore, *Coroners' recommendations and the promise of saved lives,* (Cheltenham: Edgar Elgar, 2016), 29.

98 Although the same coronial system covers England and Wales, for convenience, with apologies to Wales and Welsh coroners, I will refer only to "England" in this chapter.

99 For Australia, see Coroners Act 1997 (ACT) s5; Coroners Act 2009 (NSW) s12(2); Coroners Act 1993 (NT) s 4; Coroners Act 2003 (Qld) ss 82, 83; Coroners Act 2003 (SA) ss 5,6; Coroners Act 1995 (Tas) s 5(2); Coroners Act 1996 (WA) s11. For NZ, see Coroners Act 2006 (NZ), ss 10, 103. For England & Wales, see Coroners and Justice Act 2009 (UK) s 23, Sched 3, [3].

100 Coroners Act 2007 (BC) s 57.

101 Coroners Act 2007 (BC) s 54.

102 Coroners Act 1990 (Ont) s 5(1).

103 See, for example, Randy Hanzlick, "Medical Examiners, Coroners, and Public Health: A Review and Update" (2006) 130:9 *Archives of Pathology & Laboratory Medicine* 1274-82.

Apart from considering aspects of the Ontario system, this chapter will not further consider North American models. In my view, none of them provides useful lessons for improving coronial services in NSW. While the Ontario system has received considerable praise,[104] the fundamental differences between medical models and judicial models of coronership limit the practical value of medical models for NSW.

Despite its medical base, the Ontario system provides valuable pointers for the NSW coronial system. Two of the most important features of the Ontario system for the purposes of this submission are that it has historically been oriented towards public health and safety and that it has been highly innovative in the use of restorative processes.

I now turn to focus in more detail on the coronial systems of England, New Zealand, Ontario, Queensland, Victoria and NSW. In the following section, I will examine their legislative objectives and guiding theories or concepts of the purposes of coronership.

B.2 Statutory objects and purposes: Queensland, NZ, Victoria, Ontario, England & NSW

The Hon. Jennifer Coate, ex-Victorian State Coroner, stresses the central importance of statutory objects for setting the direction of coronial systems:

> '…it is really important in terms of best practice to have a legislative framework that spells out the purpose of the jurisdiction:. what is it to be a coroner? How do I define my role as coroner? What are the ethics that I uphold? That's all going to be determined by those lofty ideals in the legislation.'[105]

The Queensland, NZ and Victorian Coroners Act all provide clear guidance as to the objects and purposes of coronial systems. Each emphasises the death preventive role coronial systems can play. The Queensland Act of 2003 was the first in Australia to explicitly adopt an object

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105 Interview with the Hon. Jennifer Coate, 15 June 2020.

of ‘help[ing] to prevent deaths from similar causes happening in future’ as one of the principal aims of its coronial system.[106]

The NZ Coroners Act of 2006 broke ground by explicitly addressing the experience of families and the need for cultural sensitivity, especially in relation to Maori spiritual beliefs and practice concerning the dead. One of the principal reasons for the Law Commission’s review was dissatisfaction with the system on the part of Maori people. A feature of the NZ Act, therefore, is that its objects emphasise ‘the cultural and spiritual needs of the family of, and of others who were in a close relationship to, a person who has died’.[107] The cultural sensitivities and death rituals of Maori and others are specifically catered for in the Act as well.[108]

Keeping families informed is an important responsibility of the NZ coroners. The NZ Coronial Services website states, ‘*Families can be involved as much as they want to be*’ and provides information for families about how Coronial Services can help them.[109] The website also informs families that they have ‘a right to be kept informed’.[110] Section 23 of the NZ Act specifically provides that coroners must give notice of ‘significant matters’ which include directions the coroner makes concerning post mortem examinations, inquiries (the NZ term for inquests) and other matters to ‘interested parties.’

The NZ Act specifically declares the preventive potential of coronial systems as one of its principal raisons d’être: it states that ‘The purpose of this Act is to help to prevent deaths and to promote justice’.[111] It then pronounces that the methods it will use for those purposes are investigations of deaths and the making of preventive recommendations.[112] No other coronial system, except Victoria’s, has such a clear statement of purpose and guiding principles.

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106 Coroners Act 2003 (Qld) s 3(d)

107 Coroners Act 2006 (NZ), s 3(2)(b).

108 Coroners Act 2006 (NZ) ss 25 and 26.

109 Coronial Services of NZ website https://coronialservices.justice.govt.nz/what-to-expect-during-an-inquiry/#family

110 Coronial Services of NZ website https://coronialservices.justice.govt.nz/the-familys-rights/

111 Coroners Act 2006 (NZ) s 3(1).

112 Coroners Act 2006 (NZ) s 3(1)(a) and (b).

The statutory purposes of the Victorian Coroners Act of 2008 highlight the preventive role of that coronial system in holding investigations and making recommendations, and emphasise sensitivity towards bereaved people.[113] A number of factors must be taken into account when statutory functions are exercised by any person. They include the distress of family members and others, cultural beliefs and practices, the family's need for information and 'the desirability of promoting public health and safety and the administration of justice.'[114]

Ontario coroners are medical practitioners rather than lawyers and therefore have a general focus on public health. The public health and safety orientation of the Ontario coronial system is deeply ingrained. In 1971, the Ontario Law Reform Commission argued that the coronial system should move towards a public health and safety model.[115] The Commission stated, 'The death of a member of society is a public fact, and the circumstances that surround the death, and whether it could have been avoided or prevented through the actions or agencies under human control, are matters that are within the legitimate scope of all members of the community… the role of the office of coroner must keep pace with societal changes…'[116]

Moskof and Young observed in 1988 that the primary purposes of Ontario inquests were to ascertain the facts relating to reported deaths, to satisfy the community that deaths of its members were not overlooked or ignored and 'as a means for formally focussing the attention on and initiating community response to preventable deaths'.[117]

In 1992, Grahame Johnstone, Victoria's State Coroner, enthused that 'Ontario can be seen as one of the jurisdictions in the forefront of the development of a modern, adventurous approach

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113 Coroners Act 2008 (Vic) s 1(c).

114 Coroners Act 2008 (Vic) s 8.

115 Grahame Johnstone, "An avenue for death and injury prevention" in Hugh Selby (ed.) *The aftermath of death*, (Sydney: Federation Press, 1992), 141.

116 Ontario Law Reform Commission, *Report on the coroner system in Ontario,* (Toronto: Dept of Justice, 1971) quoted by Allan Manson, "Standing in the public interest at coroner's inquests in Ontario", (1988) 20:3 *Ottawa Law Journal* 637, 647.

117 Moskof & Young (1988), 202.

to coronial inquiries and recommendations with proper recognition of the obvious benefits of the coronial service to prevention in the community.'[118]

Although, unlike the Victorian, Queensland and NZ Coroners Acts, the Ontario Act[119] has no legislative objects emphasising the preventive function of coroners, the motto of the Ontario Coronial Service '*We Speak for the Dead to Protect the Living'* speaks to that. Its mission statement declares: 'The Office of the Chief Coroner for Ontario serves the living through high quality death investigations and inquests to ensure that no death will be overlooked, concealed or ignored. The findings are used to generate recommendations to help improve public safety and prevent deaths in similar circumstances.' [120]

Ontario's influence on coronial theory and practice has possibly been greater in Australia than in Canada itself. The 1971 Ontario Law Reform Commission report noted the potential significance of properly collected and analysed coronial data for the prevention of death.[121] That report influenced the later Norris report (1980) which resulted in some reform of the Victorian system, especially an emphasis on death prevention, and the advocacy of Victorian State Coroner Johnstone for an Australian national coronial data system.[122] The National Coronial Information System was established in 2000 for use by Australian and NZ coroners and researchers.

The English system has always paid lip service to the role of coroners in preventing future deaths. Under the common law, coroners or coronial juries were permitted to add 'riders' (comments or recommendations) to their verdicts.[123] Following the Brodrick Committee inquiry (1971), however, the Coroners Rules were amended to remove the right to append

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118 Johnstone (1992), 152

119 Coroners Act 1990 (Ontario).

120 Office of the Chief Coroner website https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/coroner.html

121 Johnstone (1992), 141.

122 Johnstone (1992), 141.

123 Freckelton & Ranson (2006), 20.

riders to verdicts.[124] The 2009 reforms of the English system recovered much ground by imposing a duty on coroners (but not juries) to refer matters of concern to parties in a position to take action to prevent future deaths.[125] Recipients must respond to such coronial reports within 56 days.[126]

The objects of the NSW Coroners Act 2009 are primarily oriented towards structural and procedural matters. The fifth object of the Act is to enable coroners make recommendations concerning issues of public health and safety and investigations by other bodies.[127] A statutory power to make recommendations was inserted in an earlier Coroners Act following the Royal Commission into Aboriginal Deaths in Custody (1987-1991).[128]

Read in the context of s3 of the Act (the objects) and the Act overall, as well as legal authority,[129] death prevention would appear to be a secondary consideration of the NSW legislation. Nevertheless, the NSW Supreme Court has stated that coronial recommendations, unlike common law 'riders', are not 'mere surplusage'. But from the very fact that the coronial system is built into the Local Court as one of its 'lesser jurisdictions', it can be inferred that when the 2009 Act was drafted the death preventive role and potential was not accorded high priority.

That is a convenient note on which to turn the focus towards organisational structures of comparable coronial systems.

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124 Freckelton & Ranson (2006), 23.

125 Coroners and Justice Act 2009, Sch. 5[7].

126 Coroners (Investigations) Regulations 2013 r.29(4)

127 Coroners Act 2009 (NSW) s 3(e).

128 John Abernethy et al. *Waller's Coronial Law and Practice in NSW* 4th ed. (Sydney: LexisNexis), 222.

129 *Harmison v State Coroner of Victoria* (1989) VR 989 at 996; *X v Deputy State Coroner of NSW* [2001] NSWSC 46.

B.3 Organisational structures

The English, Ontario, NZ, Queensland and NSW coronial systems are all decentralised to a greater or lesser extent. Victoria has a centralised coronial system based in Melbourne.

B.3.1 England & Wales

The English coronial system is over-stretched and under-resourced. The combined population of England and Wales is approximately 60 million people.[130] According to the England & Wales Judiciary website, in May 2021, for 92 coronial districts, there were only 32 fulltime coroners.[131] This seems a very small number given that the workload for coroners was very large: in 2020 about 205,000 deaths were reported. The proportion of registered deaths reported to coroners was 34% of total deaths (about 3 times higher than in NSW).[132] In 2020, almost 31,000 inquests were concluded in 2020 by English and Welsh coroners.[133] If so many inquests are being conducted by so few coroners in such short times, this suggests that the quality of the outcomes must, in many cases, be dubious.

The English system remains highly dispersed and is apparently largely administered by part-time coroners. Although coroners are judicial officers, they are funded by local authorities rather than central government (which underpins the rest of the English judiciary).[134] Despite the appointment of a Chief Coroner in 2009, the comments of Dame Janet Smith in the Shipman

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130 Statista, "Population of the United Kingdom in 2019, by country" https://www.statista.com/statistics/294729/population-united-kingdom-uk-by-country/

131 This seems a remarkably low figure but see UK. Courts and tribunals – The judiciary – coroners. https://www.judiciary.uk/about-the-judiciary/the-justice-system/coroners/ accessed 27 May 2021.

132 Ministry of Justice. National Statistics, "Coroner statistics 2020: England & Wales" https://www.gov.uk/government/statistics/coroners-statistics-2020/coroners-statistics-2020-england-and-wales This seems an unnecessarily high proportion. In NSW, only about 11% of registered deaths are reported to coroners. Of those about 60% turn out to be due to natural causes. (See National Coronial Information System Annual Report 2018-19, Table 2, p.12 https://www.ncis.org.au/wp-content/uploads/2020/10/NCIS-Annual-report-2018-19-Final.pdf

133 Ministry of Justice. National Statistics, "Coroner statistics 2020: England & Wales" https://www.gov.uk/government/statistics/coroners-statistics-2020/coroners-statistics-2020-england-and-wales

134 Matthews (2014), 13.

inquiry[135] that the system as it was in 2003 was fragmented, insufficiently professional, applied variable standards in different parts of the country and did not meet the needs of the public, especially the bereaved, may still be apt.[136] Dame Janet also thought it also made an inadequate contribution to the improvement of public health and safety.[137] The comments of the Luce inquiry (2003) that the English coroner service was 'not fit for purpose' in a modern society may still carry some weight.[138]

One major exception to this general situation of under-resourcing and over-stretching of coroners is that English system allows for the appointment of senior judges to conduct complex, high-profile inquests. For example, Lady Justice Hallett, a High Court judge, conducted the inquest into the 7th July 2005 London bombings as a 'deputy assistant coroner'. That inquest, and the second Hillsborough inquest, also conducted by a High Court judge, seems to bear out the criticism that the general English coronial system has not the capacity or resources to conduct major investigations.[139]

B.3.2 Ontario

Ontario is jointly directed by the Chief Coroner and the Chief Forensic Pathologist. Coronial and forensic pathology services are fully integrated in Toronto but outside the capital city 11 regional coroners manage 350 part-time coroners dispersed across the province, presenting a

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135 *The Shipman Inquiry, Third Report: Death certification and investigation of deaths by coroners* (2003), Cmnd 5854. It was an inquiry into the murders by Dr Shipman of more than 200 elderly patients.

136 For an interesting insider's perspective on the experience of English families in inquests see Sarah Ferguson, *On mother,* (Melbourne: Melbourne University Press, 2018) in which she describes her mother's inquest in an English coroner's court.

137 *The Shipman Inquiry, Third Report: Death certification and investigation of deaths by coroners* (2003), Cmnd 5854, v.

138 Luce Committee, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003* ("The Luce report") Cmnd 5831, 16-18.

139 See statement of Home Secretary Theresa May "Determination and finding of the Hillsborough inquests" 27 April 2016 https://www.gov.uk/government/speeches/determinations-and-findings-of-the-hillsborough-inquests

significant managerial challenge.[140] Approximately 17,000 deaths are reported annually to coroners. This suggests an average caseload for Ontario coroners of about 50 cases. However, in practice the load is spread unevenly with the Toronto facility carrying the greatest number of cases.[141]

Following the Goudge Inquiry into paediatric forensic pathology (2008), the Ontario government recognised the desirability of a permanent council to provide strategic managerial oversight and direction to the coronial system. The Death Investigation Oversight Council was established to provide that oversight and also to ensure accountability of coroners and forensic pathologists within the system when complaints are made about them.

B.3.3 New Zealand

NZ does not have a statutory Coroners Court. It has a stand-alone coronial service with 26 coroners (including the Chief Coroner) with offices in Wellington and 8 regional centres with the Chief Coroner (a judge) headquartered in Auckland. Coroners are appointed as judicial officers with tenure until they turn 70.[142] In 2019-20, 5198 deaths were initially notified and coroners took jurisdiction in 3603 cases (about the half the number of cases reported in NSW per annum).[143] Including the Chief Coroner, therefore, NZ coroners carry an average annual caseload of about 180 cases, much smaller than those of English, NSW, Queensland or Victorian coroners.[144]

B.3.4 Queensland

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140 Address by Dr Dirk Huyer, Ontario Chief Coroner, Coronial Workshop, UNSW Law School, 13 February 2020. (Unpublished transcript and notes held by Hugh Dillon)

141 Office of Chief Coroner of Ontario Report 2015-2019. https://www.mcscs.jus.gov.on.ca/english/Deathinvestigations/OfficeChiefCoroner/Publicationsandreports/OfficeChiefCoronerOntarioReport201519.html

142 Coroners Act 2006 (NZ), s 103.

143 Office of the Chief Coroner of NZ, *Annual Report 2019/20*, (Wellington: 2020).

144 The comparison may not be as direct as would appear at first blush: NZ coroners may carry a heavier administrative load than their NSW and Victorian counterparts.

In recent years, although the Queensland Coroners Act still provides that magistrates hold coronial office, it has been recognised that the coronial jurisdiction is a specialist jurisdiction. Eight fulltime coroners (including the State Coroner), all of whom are members of the Magistrates Court bench, now handle all Queensland's coronial work. Five are based in Brisbane, one is based in North Queensland (Cairns) and one in Central Queensland (Mackay).[145] In the financial year 2019-2020, 5631 deaths were reported in Queensland, an average caseload for each coroner of 704.

B.3.5 Victoria

Victoria established an autonomous Coroners Court in 2009, abandoning the hybrid structure that previously managed coronial cases. Including the State Coroner, the court has 10 coroners.[146] In the year 2019-20, the court commenced 7323 investigations, an average workload for each coroner of 732 cases.[147]

Curiously, according to the court's annual report,[148] about 60% of reported cases are due to non-natural causes whereas in NSW, with a quite similar number of reported cases, 60% are diagnosed as being due to natural causes.[149] Given the similar cultural and demographic characteristics of the populations of the two biggest (by population) Australian states, this discrepancy is difficult to understand.[150]

The Victorian Coroners Court is unique in Australia (and, to my knowledge, in the world) in having a well-staffed, multi-disciplinary in-house research unit (the Coroners Prevention Unit) to support coroners in their preventive role and to conduct research for public health and safety purposes. As I have noted above, the CPU has large staff (18.8 FTE positions) and 4 sub-units

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145 Queensland Coroners Court "Our coroners" webpage https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/coroners-list accessed 31 May 2021.

146 Victorian Coroners Court *Annual Report 2019-2020,* (Melbourne: 2020).

147 Victorian Coroners Court *Annual Report 2019-2020,* (Melbourne: 2020).

148 Victorian Coroners Court *Annual Report 2019-2020,* (Melbourne: 2020).

149 National Coronial Information System *Annual Report 2018-19* Table 2, p.12.

150 In Queensland, in 2018-2019 about 2/3 of reported cases were non-natural deaths. National Coronial Information System *Annual Report 2018-19* Table 2, p.12.

dealing health and medical matters; mental health; family violence; and other matters. Not only does the CPU assist coroners in their investigations but it collects and analyses incoming data *on a daily basis* to identify patterns and trends to inform public health and safety responses.[151] One example of this kind of research work was its report on suicides of Aboriginal people in Victoria.[152] The CPU, the Victorian Institute of Forensic Medicine and the Monash University researchers have working research relationships.[153]

Victoria, like Ontario, has a Coronial Council to provide strategic oversight and advice to the State Coroner and government.

B.3.6 NSW

In practice, NSW has four full-time and two part-time specialist coroners plus about 36 country magistrates who do some coronial work in addition to their general Local Court duties. Some assistance to the specialist coroners is also provided by general bench magistrates from time to time at Lidcombe. The effect, however, is that instead of one Coroners Court, NSW has, in effect, a large number of stand-alone coroners courts, a sort of cottage industry instead a single co-ordinated coronial system.

Although the initial decisions concerning reported deaths are made by specialist coroners at Lidcombe, thereafter each coroner has a virtually unfettered discretion to make orders in respect of investigations, whether or not an inquest will be held, and whether and how recommendations for the mitigation of risk of death will be made following an inquest. This is a recipe for inconsistency and inefficiency.[154] The Lidcombe specialist coroners are also able to exercise largely unfettered discretion but have strong sense of the preventive potential of the coronial system. All coroners in NSW labour without guidance for their discretion to hold or

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151 Victorian Coroners Court *Annual Report 2019-2020,* 36.

152 Victorian Coroners Court *Annual Report 2019-2020,* 16.

153 Hugh Dillon interview with Lyndal Bugeja, 17 June 2020.

154 See Hugh Dillon, "Why NSW needs a specialist Coroners Court", (2018) Issue 48 *Law Society Journal* 26-27; see also the reports of the Victorian Parliamentary Law Reform Committee (2006) and the WA Law Reform Commission (2012), both of which found that country magistrates did not have the skills, training or resources to carry out coronial duties to an appropriate level.

dispense with holding inquests. The Act and the Local Court Bench Book are silent on this issue. In other states, such as Queensland and Victoria, strong guidelines have been provided by State Coroners or in bench books.

When combined with a lack of data analysing trends and patterns in reported deaths, coroners have to use their individual clinical judgments as to where to direct their energies. In my view, this is not best practice. The effort of the specialist coroners ought to be guided more than this to achieve the maximum preventive benefit for NSW. Data analysis capacity would greatly enhance their ability to focus on the most productive areas.

The model of a coronial system based around inquests, with coroners at the apex of the system, needs reconsideration. As I have submitted above, a better model is one that recognises and respects the complementary roles of different actors in the system. The Coronial Services Committee recently established is a long stride in that direction. More remains to be done, however.

One unique feature of the NSW system is that, under the Coroners Act, the State Coroner is subject to the direction and control of the Chief Magistrate.[155] The rationale for this unique provision presumably is to ensure that the operations and interests of the Local Court will always take precedence over decisions the State Coroner may wish to make. The potential for conflict is obvious especially if the priorities of the State Coroner and Chief Magistrate diverge.

NSW has no equivalent of the Victorian or Ontario strategic councils. Such matters lie primarily in the hands of the Chief Magistrate and the Attorney-General. Under the Coroners Act, the State Coroner has a subordinate role in such concerns, having the status only of a Deputy Chief Magistrate.[156] Because the coronial system overlaps several departmental boundaries, NSW would benefit from establishing a high level *strategic* council with direct links to the Attorney-General, the Minister for Health, the Police Minister, and the Premier.

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155 Coroners Act 2009 s 10(2).

156 Coroners Act 2009 s 7(6).

B.4 Aboriginal and Maori engagement

The Victorian Coroners Court has also led Australia in 2019 by establishing a dedicated Aboriginal family liaison unit, the Coroners Koori Engagement Unit. An Aboriginal Registrar (a senior public servant) has been recruited with specific responsibility for ensuring that the needs of Aboriginal people are met through a more culturally informed and safe system.[157] The Koori Engagement Unit not only provides support to families and communities but also informs and educates coroners and Court staff about Sorry Business, the cultural practices and protocols that apply to Aboriginal and Torres Strait Islander deaths, to ensure that the particular needs of these families are met.[158] I understand that the unit is engaged with approximately 100 families.

The NSW Coroners Court has followed suit and is in the process of setting up a similar unit, expected to commence work in July 2021. If my estimates in section A.9.2 are correct, the NSW unit may have 225 families or more to engage with. If so, the NSW Aboriginal family liaison unit may need to be twice as large as the Victorian unit.

Since the Treaty of Waitangi in 1840, the colonial settlers and later NZ governments have recognised (perhaps sometimes grudgingly) the unique status of Maori people in NZ. The coronial service has 5 Maori coroners who play a critical role in enhancing the service's engagement with Maori people and legitimising the service in the eyes of Maori communities.[159] Out of respect for Maori people, the NZ Government amended the Coroners Act in 2018 to give statutory recognition of Maori mourning and death rituals.[160] As yet, NSW has no Aboriginal coroners and makes no statutory provision for recognition of cultural practices and beliefs.

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157 Aboriginal Justice. Victorian Government. "Koori Registrar in Coroners Court" https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-7 26 March 2021.

158 Victorian Coroners Court *Annual Report 2019-2020*, 6.

159 NZ Law Commission, *Coroners R62*, (Wellington: 2000), [44].

160 The *Coroners (Access to Body of Dead Person) Amendment Bill* amended s26 of the Coroners Act.

B.5 Process

B.5.1 England & Wales

The English system has relied traditionally on inquests and coronial juries to investigate reported deaths. Since 2009, greater flexibility and discretion has been incorporated into the system but it remains fixated on inquests. They must be held when there is reasonable suspicion that the deceased has died a violent or unnatural death, where the cause of death is unknown, or if the deceased person died while in custody or state detention. In NSW, approximately 40% of reported deaths fall into these categories.

If the English practice was followed in NSW, it would be necessary to conduct approximately 2500 inquests per annum. In fact, only 117 inquests were held in NSW in 2020. NSW coroners have far greater powers to dispense with holding inquests than English coroners. It seems that many English inquests are relatively perfunctory affairs which investigate deaths in only a quite superficial fashion. The inordinate pressure to push inquests through the system has caused great dissatisfaction for many years.[161] The 2009 reforms did not resolve this fundamental problem of overloading an under-resourced system.

B.5.2 Ontario

Ontario falls at the other end of the spectrum. As I have noted above, for the past 30 years or so Ontario has applied relatively flexible processes to death investigations. With a population of over 14,000,000 people and 17,000 reported deaths per annum, only about 40 mandatory inquests are conducted per annum. The annual number of discretionary inquests can usually be counted on one hand. Ontario relies on other ways of reviewing deaths and promoting public health and safety. In particular, it relies on a variety of death review panels and non-adversarial conferences with families, organisations involved in reported deaths, investigators and

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161 See, for example, Phil Scraton and Kathryn Chadwick, *In the arms of the law: coroners' inquests and deaths in custody*, (London: Pluto Press, 1987); Luce Committee, *Death Certification and Investigation in England, Wales and Northern Ireland: The Report of a Fundamental Review 2003* ("The Luce report") Cmnd 5831; *The Shipman Inquiry, Third Report: Death certification and investigation of deaths by coroners* (2003), Cmnd 5854.

coroners.[162] The non-adversarial methodology is a good one but whether it should be so dominant is debateable. If the public element of coronial investigations is abandoned, much of the unique social significance and contribution of the coronial system is lost.

B.5.3 Victoria

The number of full inquests being conducted by the Victorian Coroners Court has been declining in recent years. It appears that greater emphasis is being placed by coroners on making 'chamber findings' than previously. Victorian coroners have power to make findings concerning the identity of deceased person and the cause and circumstances of their deaths without holding inquests. When they do so, they are also entitled to comment on any matter relating to public health and safety or the administration of justice.[163] Chamber findings are published on the Victorian Coroners Court website.

Although making chamber findings is more efficient than running public inquests, much is sacrificed in the interests of efficiency. Michael Barnes, ex-State Coroner of Queensland and NSW has written:

> Many of the important performative aspects are unique to the inquest. Absent the rules of evidence and exposure to liability, restorative rich material can be exchanged – accusations shrieked from the body of the court; heart wrenching eulogies and tearful personal and institutional apologies from the witness box and bar table.
>
> Because the inquest is presided over by a judicial figure whose judgement encapsulates the state's pronouncement of the loss and responsibility for it, and a way forward, the significance of the death and the suffering of the bereaved is validated.

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162 Justin Malbon, "Institutional responses to coronial recommendations" (1998) 6 *J of Law & Medicine* 35 at 46-47; Email from Dr Dirk Huyer to Hugh Dillon, 7 June 2021.

163 Coroners Act 2008 s 67.

> Because a disproportionate number of reportable deaths come from the lower socio-economical strata of society whose members are less likely to access other sources of justice the cost free inquest is a boon.
>
> None of this occurs when a coroner in chambers dispenses with an inquest and the family merely receives a jargon-laden form letter with a registrar's electronic signature attached.
>
> Before 1980 all unnatural deaths in NSW were mandatory inquests. Now, less than 2% go to inquest. By vacating this field the state has abandoned vulnerable citizens in a time of great need.[164]

In my view, there is real merit in 'chamber findings' in cases which do not raise issues of serious public interest and in which families do not seek an inquest. Nevertheless, the temptation to abandon inquests simply because it is more bureaucratically efficient needs to be strongly resisted.

The English method over-emphasises the public element of reported deaths. The Ontario and Victorian approaches seem to underestimate the public significance of such deaths and what Barnes describes as the 'performative aspects' of inquests. Efficiency is important but is not the *most* important value at stake in the coronial sphere – proper recognition of the dead and those who mourn, proper care and support for them is the primary value. An explicitly public form of recognition – an inquest – is in many cases highly desirable.

B.5.6 New South Wales

NSW is still largely oriented towards the traditional inquest to achieve its goals, especially in relation to death prevention. Specialist coroners, being experienced judicial officers, are comfortable in a traditional courtroom. NSW is beginning to develop more imaginative,

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164 Michael Barnes, "The death of the inquest", unpublished draft memorandum copied to Hugh Dillon 14 June 2018.

family-friendly flexible processes. I expect this trend towards more restorative and therapeutic approaches to accelerate under the leadership of State Coroner O'Sullivan.

B.6 Death prevention – Inquests, recommendations and response and other approaches

In England coroners are not well-resourced to conduct death preventive research. Their primary method of contributing to public health and safety is by conducting inquests. If their investigations suggest that action should be taken to prevent future deaths they are obliged to raise their 'concerns' by making reports to relevant authorities (simultaneously notifying the Chief Coroner).[165] Because they lack research support, they have limited institutional capacity to provide answers to the questions their concerns raise: the legislation places the onus on the recipients to do so by requiring a response to Reports to Prevent Future Death within 56 days.[166] Given the very large workloads of English coroners, and chronic under-resourcing, the quality of many investigations is likely to be questionable. Whether many inquests contribute to improving public health and safety must be an open question.

As in the English case, the main ways the NSW, Queensland and NZ systems contribute to death prevention are by holding inquests and making recommendations. None of these systems, however, has the sophisticated expert support that the Ontario and Victorian systems incorporate into their organisational structures.

NSW has taken an important step towards using coronial data for public health and safety purposes in the ways that Victoria and Ontario do. In October 2020, a Suicide Register was established. This is an inter-agency project which was established in 2020 in collaboration with NSW Health, Department of Communities and Justice and NSW Police. Its purpose is to collect

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165 Coroners and Justice Act 2009 (UK) Sched. 5, para. 7(1) and Coroners (Investigations) Regulations 2013 r.28

166 Coroners (Investigations) Regulations 2013 r.29(4).

and report on suspected and confirmed suicides in NSW.[167] NZ also maintains a suicide database. Its suicide data are published in the Annual Report of the NZ Chief Coroner.[168]

NSW and Queensland have established domestic violence death review units. In Queensland this is called the 'Domestic and Family Violence Death Review and Advisory Board'.[169] In NSW, the equivalent entity is called the Domestic Violence Death Review Team.[170] Each is responsible for the systemic review of domestic and family violence deaths in their states. Both states, however, lag behind Victoria and Ontario in terms of multifaceted approaches to death prevention.

Ontario approaches its death prevention task in a variety of ways, making it, in this respect, one of the most sophisticated coronial systems in the world. As outlined above, the Ontario system has a strategic plan. One of its key strategic objectives is to collect and analyse coronial data to enable trends and patterns of death to be identified. Second, like other systems, it conducts mandatory inquests into certain categories of deaths.[171] Third, it utilises expert panels to review various types of deaths with a view both to providing advice to coroners in particular cases but also in bringing a systemic approach to death investigation. Fourth, rather than awaiting inquest findings, which may be subject to lengthy delay, the Chief Coroner can and does make public announcements concerning matters of immediate public interest.[172] For example, in 2020 a report on Covid-related deaths of temporary foreign agricultural workers

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167 Local Court *Annual Review 2020*, 24.

168 Office of the Chief Coroner, *Annual Report 2019/20*, 28.

169 Coroners Act 2003 (Qld) Part 4A. See also Queensland Coroners Court, "Review of deaths from domestic and family violence" webpage, https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence

170 Coroners Act 2009 (NSW) Ch. 9A.

171 Coroners Act 1990 (Ont) s 10.

172 Dr Dirk Huyer interview with Hugh Dillon, Sydney, 14 February 2020. See also Office of the Chief Coroner, "Publications and reports" for a range of such announcements and reports. https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html

was published.[173] Fifth, the Office of the Chief Coroner publishes detailed reports arising from the expert review committees.[174] Sixth, although its effectiveness has been questioned, Ontario has a strategic oversight council to provide advice to the Chief Coroner and Chief Forensic Pathologist.[175]

The Victorian coronial system is also highly sophisticated in its approach to death prevention. Like other Australian and international jurisdictions, such as England, NZ and Ontario, the Victorian Coroners Court conducts mandatory inquests in relation to deaths in custody or care, homicides and other matters. [176] It also conducts discretionary inquests.[177] In the 2019-2020 year, the court completed 58 inquests and made 166 recommendations, the majority of which were accepted.[178] Unlike other Australian coroners courts, the Victorian Coroners Court not only publishes inquest findings but, in many cases also, 'chamber findings' – findings made without an inquest.[179]

Secondly, to contribute to reducing preventable deaths, the Victorian Coroners Court maintains a variety of death registers or databases: a drug overdose register; a suicide register; and a homicide register. It also contributes to the Victorian Family Violence Data Portal which deals with homicides due to family violence. A Coroners Court research team conducts the continuous Systemic Review of Family Violence. A senior coroner is also a member of the

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173 Office of the Chief Coroner, "Publications and reports" https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html

174 Office of the Chief Coroner, "Publications and reports" https://www.mcscs.jus.gov.on.ca/english/DeathInvestigations/office_coroner/PublicationsandReports/coroners_pubs.html

175 Dr Dirk Huyer, in an interview with Hugh Dillon for this project in February 2020, commented that the Death Investigation Oversight Council had not performed to expectations.

176 Coroners Act 2008 (Vic) s 52(2). But note that inquests into deaths in custody or care are *not* mandatory if they are due to natural causes: s 52(3A).

177 Coroners Act 2008 (Vic) s 52(1)

178 Victorian Coroners Court *Annual Report 2019-20*, 3. At the time of publication 92 recommendations had been accepted, 9 had been rejected and 65 remained under consideration.

179 See Coroners Court "Findings" webpage https://www.coronerscourt.vic.gov.au/inquests-findings/findings?combine=&order=field_date_of_finding&sort=desc&page=0%2C5 Victorian coroners have power to comment in their findings on 'any matter connected with' a death they investigate, including issues of public health and safety: s 67(3)

Victorian Judicial Advisory Group on Family Violence. The court is also a member of the Australian Domestic and Family Violence Death Review Network.[180]

Thirdly, it places a great emphasis on promoting public health and safety by collaborating with researchers in public health and medicine to develop insights into preventable deaths. The court has a research committee for this purpose.[181] It actively seeks to share coronial data with service providers, such as those involved in suicide prevention.[182] As noted above, the Coroners Prevention Unit, with a comparatively large staff of professional researchers, contributes to the death prevention work of the Coroners Court in a variety of ways. Apart from providing advice to coroners, and engaging with researchers in the wider community, it is arguable that the CPU, by incorporating a public health framework into its work, disseminates that approach throughout the whole coronial system.[183]

C Institutional arrangements for NSW coronial system

C.1 Introduction

In 1971, the Brodrick Committee inquiring into the English coronial system made the salient point that conceptualising the coronial system primarily in terms of criminal justice was 'completely outmoded.'[184] It placed emphasis on other socially significant functions, including the prevention of future death and injuries. As I noted earlier, investigation of unsolved homicides is undeniably important but they constitute a relatively small proportion of coronial

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180 Victorian Coroners Court *Annual Report 2019-20*, 24-34.

181 Victorian Coroners Court *Annual Report 2019-20*, 38.

182 Victorian Coroners Court *Annual Report 2019-20*, 37.

183 See Lyndal Bugeja and Jeremy Dwyer, "Enabling Public Health and Safety Through the Coroners' Death Investigation System: The Principles and Practice of the Coroners Prevention Unit", (2016) *Grief Matters* 19(2) 2016

184 Quoted in Ian Freckelton and David Ranson, *Death investigation and the coroner's inquest,* (Melbourne: Oxford University Press, 2006), 23.

work – about 6500 deaths are reported annually of which about 80 are homicides.[185] So the greatest contributions the coronial system can make are not in the criminal domain. That is one reason why I submit that it is not appropriate in the 21st century – 50 years after Brodrick – to keep the coronial system attached to the largest criminal court in Australia. It should be detached and its specialist functions and strengths recognised and resourced by establishing a specialist court.

C.2 Towards a reformed, world-leading coronial system

Two main options for a specialist court seem to present themselves – a stand-alone court or a court attached to the Local Court (like the Children's Court). Either model could be adopted and it would constitute a major advance.

Adopting a 'Children's Court' model could be an attractive option for three main reasons:

(i) This is a familiar model. Adopting it would, in practice, be an evolutionary development;
(ii) The 'blood supply' of magistrates to the coronial system would be continued;
(iii) Economies of scale, especially in terms of shared resources.

Nevertheless, this solution is not quite as neat as may seem at first blush. The objectives and cultures of the general bench of the Local Court and the coronial jurisdiction are significantly different. Difficulties can arise if the Chief Magistrate and a head of a specialist jurisdiction do not see eye to eye on appointments, strategic policy in the specialist jurisdiction, specialist judicial training and professional development, allocation of resources, case management practice and other things.

Secondly, the advantages of recruiting specialist coroners solely from the ranks of the magistracy are limited and should not be overstated. One of the strengths of the Victorian

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185 NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics: Quarterly Update*, March 2021, Table 2.3. This report shows that in the 69 murders and 9 manslaughters were committed in the 12 month period being surveyed. The report also showed that the homicide rate had been stable for the previous 5 years.

system is that, because coroners are not recruited exclusively from the magistracy, the pool of potential recruits is wider and deeper than if the only available candidates are magistrates. Under the Victorian Act, magistrates and judges (or ex-judicial officers) may be appointed as coroners but, according to the 2019-20 Annual Report of the Victorian Coroners Court, the coroners come from a wider range of legal backgrounds.

The State Coroner was the Solicitor for Public Prosecutions; three coroners, including the Deputy State Coroner, are ex-magistrates. One coroner was a solicitor with a workplace health and safety background; another was a nurse then a solicitor with a personal injury practice and training in bioethics; another is an ex-barrister with a public law and medico-legal background. Another ex-barrister has brought a broad public law and human rights background. One coroner has a mixed experience of working on the Royal Commission into Aboriginal Deaths in Custody, the establishment of Koori Courts in Victoria and other such administrative initiatives, and has qualifications in forensic science. The most recent appointment was an Assistant Government Solicitor whose work included, among other things, helping prepare the Victorian Government's responses to the Victorian Royal Commissions into the Mental Health System and Aged Care.

Over the past decade, I have spoken to numerous barristers and solicitors who have told me that they would be interested in working as coroners, at least for a few years. But they have no interest in being magistrates. These people are excellent practitioners who would bring a breadth and depth of experience to the coronial jurisdiction. In my submission, it would considerably enhance the strength of the coronial system if barristers and solicitors with a background in inquests, in medico-legal work, in workplace health and safety, in mental health practice, child welfare law, disability law and other such relevant fields could be recruited to the NSW system without having to go through the Local Court magistracy.

The coronial system would function better if allowed to develop in its own appropriate ways, rather than being directed strategically and allocated resources by the Chief Magistrate whose first priority must always be the core work of the Local Court. The Victorian experience suggests the way forward.

The main arguments against the establishment of a stand-alone court are:

(i) Additional costs;

(ii) It is easier to 'hide' poor performers in a large organisation than a small one.

The problem of coroners becoming stale or under-performing is an issue. It should not, however, determine the choice between the two options. The better model should be chosen on its merits. Rigorous selection of coroners and good internal personnel management should be capable of ensuring levels of performance are kept high and that coroners are not burned out. From time to time new blood should be introduced.

In the Local Court, magistrates are subject to rotation every three years. Magistrates can volunteer for the coronial jurisdiction. Few do but the volunteers, once appointed, usually prefer to stay in the jurisdiction for longer than 3 years. Specialist coroners are usually permitted to remain in the jurisdiction for at least two triennial rotations. This permits them to build experience and expertise. The Chief Magistrate and State Coroner discuss appointments to the coronial jurisdiction but the Chief Magistrate has ultimate power under the Local Court Act to allocate magistrates to courts.[186]

While the rotation policy is intended to refresh the jurisdiction periodically, it can cause inadvertent adverse consequences. If too many specialist coroners are rotated out or retire simultaneously, the performance of the coronial jurisdiction can deteriorate. This happened in 2016 when a number of Deputy State Coroners, realising that they were unlikely to be permitted another rotation in the coronial jurisdiction, either retired or sought transfers. They were replaced by magistrates with little coronial experience. The number of inquests fell from 150 in 2015 and 120 in 2016 to 84 in 2017 as the new coroners took time to adjust to their new jurisdiction.[187]

Victorian coroners are appointed for 5 years. Their appointments may be renewed until they reach statutory retirement age.[188] They receive the salary and conditions (but not the title) of

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186 Local Court Act s 23.

187 Local Court Annual Review 2020, 22.

188 Coroners Act 2008 (Vic) s 94(3).

magistrates. During their period of appointment, they can only be removed from office in the same way as magistrates can be.[189] In my view, the Victorian system of appointment for 5 years is superior system to that currently operating in the NSW Local Court. It enables coroners to develop experience and expertise, provides greater continuity to the court than the NSW rotational policy does, and allows for a degree of turnover to refresh the jurisdiction.

The Productivity Commission estimated that the real recurrent costs of the Victorian Coroners Court in 2019-20 were approximately $22 million whereas those of the NSW Coroners Court were about $7 million.[190]

A stand-alone court would be somewhat more expensive than the current NSW system but, when a proper comparison of the true costs of the NSW coronial system is made with Victoria's, probably not as expensive as the Productivity Commission's Report on Government Services suggests.

I have previously noted that the value of a statistical human life has been estimated at between $4million and $10 million.[191] In 2019, the Australian Government placed a value of $4.9 million on an Australian statistical life, with each year prematurely lost being valued at $213,000. No doubt the NSW Treasury could provide an updated estimate.[192]

According to the latest Productivity Commission Report on Government Services, in NSW total real net recurrent expenditure on *criminal courts* in 2019-20 was $280,105,000; total real net recurrent expenditure on *civil courts* was $102,877,000. Against these figures, the real net

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189 Coroners Act 2008 (Vic) s 94(3)(c)

190 Productivity Commission *Report on Government Services 2019-20,* Table 7A.12.

191 See also Richard Denniss, "What the government thinks you're worth", The Monthly, February 2019, https://www.themonthly.com.au/issue/2019/february/1549026000/richard-denniss/what-government-thinks-you-re-worth

192 Australian Government. Dept of Prime Minister and Cabinet. "Best practice regulation guidance note: Value of statistical life" (Canberra: 2019) https://pmc.gov.au/sites/default/files/publications/value-of-statistical-life-guidance-note_0_0.pdf

recurrent expenditure of $7,161,000 on the NSW coroners court is a minor impost on the state's budgetary resources: less than 2% of the total real net recurrent expenditure on courts.[193]

According to the NSW Government's budget 2021-22 budget papers, recurrent expenditure on the legal system in the next year will be $1.8 billion and on the health system $27.1 billion. Recurrent expenditure on 'safer communities' is estimated to be $4.3 billion the coming year.[194] Rather than being categorised as part of the court system for budgetary purposes, the coronial system, I submit, should be considered part of the NSW strategy to enhance safety in the community or as part of the state's public health framework. Against the background of those expenditures, a reformed coronial system on the Victorian model would add an almost imperceptible increase to overall recurrent expenditure.

If a NSW Coroners Court was placed on a similar footing as Victoria's, its real recurrent expenditure would rise but its capacity and potential to produce death preventive data and recommendations would be greatly enhanced. Given the value of a statistical life, a few saved lives would economically justify the expenditure.

C.3 Conclusion – A stand-alone court is best

A reformed Act and a stand-alone court on the Victorian model would improve the current system in numerous ways:

- A clear, modernised philosophy or concept of coronial services could be enunciated as in Ontario, New Zealand and Victoria;
- That philosophy could be expressed in contemporary statutory objects;
- A specialist court would be seen as the hub of a multi-disciplinary death investigation system rather than as minor and relatively unimportant adjunct jurisdiction of a large criminal court;

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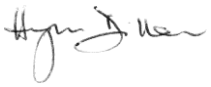
193 See Productivity Commission *Report on Government Services 2019-20*, Tables 7A.14 and 7A.15. I note, however, that the real costs are likely to be higher because some of them are probably hidden in the costs of the Local Court.

194 NSW Budget Paper No 2, Ch 7 https://www.budget.nsw.gov.au/sites/default/files/2021-06/7.%20Stronger%20Communities%20cluster-BP2%20Budget%202021-22.pdf

- Strategic planning and oversight would focus on the objectives of the coronial system rather than being subject to the imperatives of a much larger organisation with different objectives;
- A stand-alone court would potentially be much more flexible and responsive to changing needs or situations than the Local Court or even a court attached to the Local Court;
- A more appropriate set of performance measures and standards could be developed;
- This would result in greater transparency and accountability of the coronial jurisdiction and would, in turn, promote higher performance standards;
- Training and professional development of coroners would be enhanced;
- A significantly greater contribution to public health and safety, especially in regional and country areas, could be expected;
- A stand-alone court could more easily make connections with external public health and safety bodies and organisations than a court that would have to make these connections through, or in with permission of, the Local Court;
- A stand-alone court could develop and manage its own processes more efficiently than having to adapt those of the Local Court to its own purposes;
- Development of its own more flexible, therapeutic and restorative processes could proceed more efficiently and expeditiously than having to be approved by the Local Court;
- Detaching coroners from the Local Court and the criminal justice system would be a symbolic step towards improving relations with Aboriginal families and communities, enhancing trust and confidence of Aboriginal people in the coronial system;
- Breaking the nexus with the Local Court would broaden the pool from which coroners could be recruited, adding range and depth to the expertise available within the coronial system;
- Breaking the connection with the Local Court may also make recruitment of Aboriginal lawyers as coroners more feasible.

For these reasons a stand-alone court on the Victorian model is the better option.



Hugh Dillon

4 July 2021

APPENDICES

Appendix A – The coronial system pyramid

Appendix B

A bereaved families focussed Coroners Court restructure

Summary

The current arrangements for the delivery of coronial services in NSW are suboptimal because outside of the metropolitan area it is overseen by local magistrate coroners many of whom have insufficient experience and or time to do the work well and the jurisdiction is grossly under resourced.

This leads to inconsistent and inappropriate decisions being made and to delays at crucial stages in the process.

These problems could be addressed by the creation of a Coroners Court presided over by full time coroners.

The problems and their causes

Half of the approximately 6000 deaths reported to NSW coroners each year are dealt with by 36 regional magistrate coroners who preside over 71 country courts outside metropolitan Sydney. As a result some never gain significant experience in dealing with such matters. In reality, much of the work is done by court officers.

All of these magistrate coroners are also responsible for a full caseload of criminal and civil matters. None other than the Newcastle coroner get any time out of court to deal with coroner's matters. Most circuit to a number of courts and coroners' files either lie fallow awaiting the coroner's arrival or chase them from court to court.

Coronial processes can be divided into three discrete stages that each case moves through until it is finalised. Each stage poses different challenges for inexpert coroners.

1. **The initial stage** which every case moves through is particularly sensitive because the bereaved families' grief is so raw, the decisions touch upon such deeply personal

issues and need to be made quickly based on sparse evidence so that the state's intrusion into the most private grief can draw back to allow death rituals to proceed. The challenges include:

- Determining who is the senior next of kin with statutory rights to participate in coronial decisions and to receive the body for burial can require the coroner to evaluate the quality of domestic relationships. Blended families and indigenous sensibilities add to the uncertainty.

- Deciding what type of autopsy to order or whether organs should be retained involves balancing the public interest in knowing the manner and cause of an unexpected death against what are often the most deeply held spiritual beliefs.

- These decisions require a nuanced appreciation of very sensitive matters and the making of qualitative contested assessments rather than definitive binary choices. All are time critical.

2. **Reviewing the autopsy and investigation reports** requires the coroner to determine what issues to pursue and how far to pursue them. An inquest can only be dispensed with if the coroner is satisfied that the manner an cause of death are "sufficiently disclosed" – a threshold over which reasonable minds may differ

3. **At inquest** the rules of evidence do not apply, witnesses can be compelled to answer incriminating questions. In adversarial fora the parties determine what material to put before the adjudicator. In an inquest the issues can be as broad or as narrow as the coroner can be persuaded to allow. The making of recommendations requires an ability to undertake policy analysis and development.

I am regularly made aware of regional coroners or their clerks making serious errors in each of these three stages. This is not their fault – the clerks have to take charge because the magistrate is either in another centre or is in court. Even when the magistrate coroners are involved, because coronial work is so different from that which takes up most of their time, poor decisions are made. It is a specialist jurisdiction which requires an understanding of and collaboration with other technical specialities.

The inadequacy of resources also manifests in inquest being dispensed with when a hearing should be held having regard to the proper purpose of inquests. Approximately 97.5% of matters are now finalised without an inquest.

Unlike in the civil or criminal jurisdictions:

- those most affected by coroners decisions are rarely legally represented;
- there are scant precedents to guide the decision makers or condition consumers' expectations;
- there are no tangible benefits in the aggrieved appealing - the damage is done in most cases; and
- coroners are required to collaborate with diverse agencies and disciplines.

Unlike in all states other than Tasmania, the *Coroners Act 2009* (NSW) does not create a coroners court.

Unlike in all states other than Western Australia, local magistrates in NSW still exercise coronial jurisdiction. In all other states full-time coroners complete all coronial cases.

Resources

The NSW coronial system is starved of resources. The most recent ROGS demonstrates that:

- Recurrent expenditure on coronial matters in Victoria ($12.8M) and Queensland ($10.3M) exceeds that of NSW ($5.6M) by 128% and 83% respectively.
- Both of those states also have double the FTE of judicial officers devoted to coroners work as does NSW - 0.1 cf 0.2 per 100K of population; and
- Coronial services in the other eastern states deploy almost double the number of FTE administrative staff – NSW 0.6, Vic and Qld both 1.1 staff per 100 coronial finalisations.

Unlike in all states other than Tasmania, there is in NSW no deputy head of the coronial jurisdiction.

The solutions

Option 1

1. In recognition of the specialist nature of the coronial jurisdiction the Act should create a coroners court.

2. In recognition of the importance of the work and the responsibilities of the position, the head of jurisdiction should be a District Court Judge appointed for a fixed term renewable. That is likely to attract applications from among the experienced lawyers who specialise in inquiry work and who are unlikely to apply to become a magistrate.

3. In recognition of the extent of the administrative and policy work and high profile complex inquests the head of jurisdiction must undertake, a deputy head of jurisdiction should be appointed for a fixed term renewable.

4. All coronial cases should be dealt with by full time coroners – the state coroner, the deputy state coroner and however as many magistrates as are required. Currently there are 5 FTE coroners at Glebe including the state coroner. Victoria has 10, Qld has 7. Magistrates identified as suitable by consultation between the Chief Magistrate and the state coroner should be appointed to the coroners court for a fixed term renewable.

5. **Budget implications**. Appointing a DCJ to the position of state coroner has a cost. Aggregating the work currently done by the 36 regional magistrate coroners into full time positions at Glebe/Lidcombe/regional centres is theoretically cost neutral – the same amount of work is to be done, just differently distributed. In reality there is likely to be *some* transaction cost.

Option 2

1. Items 1 and 3 of option 1

2. The initial stage of all coronial cases described in point 1 on page 1 should be dealt with by full time coroners. The 5 FTE coroners currently at Glebe plus one other coroner's position relocated from the regions and two administrative staff positions also relocated from the regions could undertake this work.

   As described on p1, this is the high risk, time critical work undertaken with little outside assistance and minimal opportunity for correction.

3. **Budget implications** Redeploying one coroner and two administrative staff from regional positions to Sydney would be cost neutral. The work that would no longer need to be done in the regions should allow these transfers to occur without negatively impacting the regions.

Michael Barnes
State Corone
August 2017

Appendix C

Recommendations of June 2017 Draft statutory review report

Recommendations

Recommendation 1

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

- the inquisitorial nature of the coronial jurisdiction
- the coronial jurisdiction's preventative role in the reduction of deaths, fires and explosions through findings and recommendations
- that the coronial system should avoid the unnecessary duplication of investigations, inquests or inquiries, expedite those processes, and operate in a fair and efficient manner.

Recommendation 2

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

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

Recommendation 3

That the Act be amended to provide that coronial proceedings should be conducted with as little formality and technicality as the interests of justice permit, and in a non-adversarial manner.

Recommendation 4

That the structure of the Act be amended to represent the sequential order of the coronial process, and expressly recognise the functions of investigations pre-inquest and pre-inquiry.

Recommendation 5

That the Act be amended to:

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

Recommendation 6

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

Recommendation 7

That the category of reportable deaths in circumstances where the death was not the reasonably expected outcome of a health-related procedure carried out in relation to the person under s. 6(1)(e) of the Act, be amended to:

- require a causal connection between the health-related procedure, including the failure to provide the health-related procedure, and the subject death
- prescribe that the standard of 'reasonableness' is determined according to an appropriately qualified independent person
- include circumstances of a failure to provide a health-related procedure.

Recommendation 8

That the Act be amended to clarify that 'lawful custody' under s. 23 includes the involuntary admission and detention in mental health facilities under the:

- *Mental Health (Forensic Provisions) Act 1990*
- *Mental Health Act 2007.*

Recommendation 9

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

Recommendation 10

That the Act be amended to provide:

- coroners with a general discretion to hold, rather than dispense with, an inquest if there is a public interest in holding an inquest
- the factors coroners must consider in exercising that discretion, to include:
  - whether the identity, date, place, cause or manner of death is not clear
  - whether the person has died is not clear
  - whether the person died of natural causes (whether or not the precise cause of death is known)
  - whether there are any issues of public health or safety to address
  - whether there are any suspicious circumstances
  - whether holding an inquest is likely to provide additional information
- the views of the deceased person's family, if known
  - any request made by persons with sufficient interest in the circumstances of the death for an inquest to be held
- for the Regulations to stipulate a process for persons with sufficient interest in the circumstances of the death to request a coroner to hold an inquest. This should include the period of time within which a request for an inquest to be held may be made.

Recommendation 11

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

- if it appears to the coroner concerned that the person died or might have died as a result of homicide (not including suicide)
- if the jurisdiction to hold the inquest arises under s. 23 (i.e. deaths in custody or in police operations).

Recommendation 12

That the Act be amended to provide, where a decision is made not to proceed to inquest following a coronial investigation, that:

- coronial findings are to be delivered in all matters, except for deaths found not to be reportable, in which case written reasons must be delivered
- persons with sufficient interest in the findings delivered will have the opportunity to make submissions before any adverse findings are made
- coronial findings in such matters are to be provided to the senior next of kin and persons with sufficient interest in the findings delivered
- coroners may order that these coronial findings must not be published and that contravention of such an order is punishable by up to 10 penalty units or imprisonment for 6 months (in the case of an individual) or 50 penalty units (in any other case)

- coroners should not publish coronial findings unless it would be in the public interest to do so, and unless they have considered any objections to publication made by the senior next of kin and persons with sufficient interest in the findings delivered
- the Regulations can stipulate:
  - notification requirements to be included with any findings, which should include:
    * notice of an intention to publish findings
    * if considering publication, notice of a right to make an objection to publication
  - if publication is being considered, the process for making an objection to publication, which would include:
    * the time within which an objection may be made
    * the kinds of objections that may be made
    * the requirement to provide reasons for the objection
  - the process for seeking review of the decision to not hold an inquest.

Recommendation 13

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

Recommendation 14

That the Act be amended to authorise:

- a coroner who held an inquest/inquiry, or the State Coroner, to conduct a fresh inquest/inquiry on their own motion on the basis of the criteria in s. 83 of the Act
- any person with sufficient interest in the subject matter of the proceedings to apply for a fresh inquest/inquiry under s. 83
- repeal the reference to a 'police officer' in s. 83(5).

Recommendation 15

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

Recommendation 16

That the Act be amended to authorise the holding of concurrent inquests where several deaths occur as a result of a single incident or in similar circumstances.

Recommendation 17

That the definition of 'senior next of kin' be amended to enable coroners to appoint a person other than the default appointee, where appointing the default appointee is not appropriate or practicable in the circumstances.

Recommendation 18

That the Act be amended to:

- enable coroners to hear and determine competing claims to be the senior next of kin by any person with sufficient connection to the deceased person, within a reasonable time
- require coroners to notify and consult with the default appointee in regards to such competing claims.
-

Recommendation 19

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

Recommendation 20

That the Act be amended to provide medical investigators with the authority to perform a preliminary examination of a body upon the provision of a body by the coroner. Provision for a preliminary examination should only authorise procedures that are non-invasive, similar to those prescribed in s. 3 of the *Coroners Act 2008* (Vic).

Recommendation 21

That the Act be amended to require that:

- coroners:
  - consult with medical investigators in making post-mortem investigation directions (where practicable)

- order the least invasive post-mortem investigation direction appropriate in the circumstances
- specify the degree of examination required
- medical investigators use the least invasive procedures appropriate in the circumstances (within the scope of any applicable coroner's direction) for all tests and examinations.

Recommendation 22

That the Act be amended to allow, in appropriate cases, for the senior next of kin to object to a post-mortem examination under s. 96 and to authorise another person to exercise their functions under s. 98, orally.

Recommendation 23

That the Act be amended to make it a requirement for coroners to issue written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths in circumstances of delay under s. 34(2), rather than allowing for such notices to be issued.

Recommendation 24

That the Act be amended to allow coroners to issue written notices to the Registrar of Births, Deaths, and Marriages for the early registration of deaths where there may be delay in concluding a coronial investigation (similar to existing powers in relation to inquests).

Recommendation 25

That the Act be amended to prescribe the function of issuing written notices to the Registrar of Births, Deaths and Marriages for the early registration of deaths where there may be delay in concluding a coronial investigation or inquest, as one that may be delegated to assistant coroners under s. 15.

Recommendation 26

That the Act be amended to:

- require orders for the disposal of human remains to specify the person to whom those remains may be released
- provide a presumption for the human remains to be released to the senior next of kin (or someone authorised by the senior next of kin)
- allow for competing claims for the receipt of human remains to be made by persons with sufficient connection to the deceased person

- allow coroners to hear and determine competing claims for the receipt of human remains.

Recommendation 27

That the Act be amended to allow persons with sufficient connection to the deceased person to apply within a reasonable time to the State Coroner for review of decisions by coroners as to who is the senior next of kin, and to provide for a regulation making power to prescribe what constitutes such a reasonable time.

Recommendation 28

That the Act be amended to:

- repeal the provision allowing the senior next of kin to apply to the Supreme Court for a review of a decision not to uphold an objection to an exercise of a relevant post-mortem investigative function under s. 97
- enable the senior next of kin to apply to the State Coroner for a review of a decision not to uphold an objection to an exercise of a relevant post-mortem investigative function.

Recommendation 29

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

- authorising the disposal of human remains at the conclusion of coronial proceedings under s. 101
- issuing a warrant for the exhumation of the deceased person's remains under s. 91.

Recommendation 30

That the Act be amended to allow persons with sufficient interest in the circumstances of the death to apply to the State Coroner for review of the following decisions by coroners:

- that a death is not reportable (no jurisdiction)
- that an inquest will not be held (discretionary).

Recommendation 31

That the Act be amended to prohibit the State Coroner from delegating the exercise of their functions to review decisions by coroners.

Recommendation 32

That the Act be amended to provide that persons affected by the State Coroner's decision or review of decisions under Recommendation 27, Recommendation 28, Recommendation 29 and Recommendation 30, may appeal to the Supreme Court against that decision, on a ground that involves:

- a question of law alone
- a question of mixed law and fact, but only by leave of the Supreme Court.

Available remedies include allowing the Court to:

- set aside the decision under review
- set aside the original decision and remit the matter for reconsideration in accordance with any directions
- vary the decision under review
- dismiss the appeal.

Recommendation 33

That the Act be amended to provide coroners with a general discretion to hold, rather than dispense with, an inquiry if of the opinion that:

- the cause and origin of the fire or explosion is not sufficiently disclosed
- an inquiry into the cause and origin of the fire or explosion is necessary.

Recommendation 34

That the Act be amended to provide, where a decision is made not to hold an inquiry, for coronial findings to be delivered in all matters, except for fires or explosions found not to be within jurisdiction, in which case written reasons must be delivered.

Recommendation 35

That the Act be amended to allow the Commissioner of the NSW Rural Fire Service to request an inquiry into any fire or explosion within the Commissioner's jurisdiction under the *Rural Fires Act 1997*.

Recommendation 36

That the Act be amended to explicitly provide for the appointment of Counsel Assisting the coroner.

Recommendation 37

That the prohibition against indications or suggestions in the record of findings or recommendations that an offence has been committed by any person be amended to:

- prohibit the making of any statements that a person is or may be guilty of an offence (not found proven)
- apply to a record of written reasons contained in the record of findings or recommendations.

Recommendation 38

That the Act be amended to prohibit coroners from making findings or recommendations attributing civil liability and that this amendment mirror the prohibition against suggesting criminal liability in ss. 81(3) and 82(3) and in line with Recommendation 37.

Recommendation 39

That the Act be amended to enable coroners to refer matters (including relevant information and material) to relevant investigative, prosecutorial or disciplinary bodies, where appropriate.

Recommendation 40

That the Act be amended to require coroners to disseminate details of pending inquests and inquiries, on the Coroner's Court's website.

Recommendation 41

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

- require coroners to have regard to whether granting access may compromise a coronial investigation or proceeding, or related criminal proceeding
- allow a coroner to impose conditions upon access and provide for non-compliance to such conditions to be punishable by fine.

Recommendation 42

That the Act be amended to:

- enable the deceased person's family and persons with sufficient interest in the circumstances of the death to make requests for access to documents, material or things regardless of whether coronial proceedings have been held
- require the coroner or assistant coroner to have regard to the following matters in assessing these requests:
  - the impact access will have on the relatives of the deceased person
  - the applicant's connection to the subject proceedings
  - the reason for access sought
  - whether granting access may compromise a coronial investigation or proceeding, or related criminal proceeding
- allow a coroner to impose conditions upon access and provide for non-compliance to such conditions to be punishable by fine.

Recommendation 43

That the Act be amended to enable the State Coroner to grant particular research bodies access to documents in relation to the coronial process as a whole.

Recommendation 44

That the provision prohibiting the publication of suicide findings be repealed.

Recommendation 45

That the Act be amended to provide for the Chief Magistrate, in consultation with the State Coroner, to designate select magistrates as Deputy State Coroners.

Recommendation 46

That the Act be amended to provide for the electronic service of documents, if the recipient (or their legal representative) has provided an electronic address for service for that purpose.

Recommendation 47

That the Act be amended to:

- replace the requirement that subpoenas be served by a police officer or Sheriff with a provision that such service may be effected by a police officer or Sheriff
- allow for the electronic service of subpoenas only in circumstances where the recipient (or their legal representative) has provided an electronic address for service for that purpose.

Recommendation 48

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

Recommendation 49

That the Act be amended to allow the State Coroner to issue guidelines to persons exercising a function under the Act.

Appendix D

State Coroner Barnes's submission to Statutory Review

Review of the *Coroners Act 2009*

Submission by the State Coroner

[November 2014]

Contents

This submission is made on behalf of the state coroner and the deputy state coroners presiding at the Glebe Coroners Court.

It is in two parts: Part A details the structural and thematic issues of the *Coroners Act 2009* which, in our view, warrant reform. Generally, these are the more high-level issues. Part B contains the more precise or particular changes recommended.

Part A

1. Structure of the Act

It is submitted the structure of the Act should be reordered so that it follows the natural sequence of most coronial cases thus making the law more accessible. The following structure would achieve this.

- Preliminary – the objects of the Act; commencement date; reference to the dictionary.
- Reportable deaths defined, including locality jurisdiction.
- Obligation to report
- Coroners' jurisdiction to investigate
- Autopsies, orders and objections
- Powers of investigation
- Findings
- Inquests and inquiries
- Fresh inquests and inquiries, appeals
- Access to coronial documents and physical evidence
- Appointment of state coroner, deputy state coroners, local coroners, administration
- Miscellaneous

2. Coronial focus

In our submission, each step during the course of a coronial investigation should advance a legitimate coronial purpose and should be informed by all readily available information. This approach can be facilitated by amendments that enable the gathering of information from the scene, the family and the deceased's body prior to a coroner considering whether an autopsy is necessary. Similarly, amendments that ensure inquests are only convened when necessary enable a better use of limited resources.

3. Powers of investigation

A coroner's powers of investigation are extensive but incomplete and unclear in certain respects.

For example:-

- A coroner can authorise a police officer to enter, secure and search premises if the coroner considers it necessary for the purposes of an inquest, but not to establish whether there is in the premises a deceased person whose death is reportable to a coroner.
- A coroner can require a person to produce a document or thing relevant to an investigation but not to provide information by way of a statement.
- A coroner can make a non-publication order in relation to evidence heard in court or documents tendered into evidence but it is unclear whether a coroner can maintain confidentiality of material during the course of the investigation or release information to parties subject to a condition that it not be further disseminated.

It is submitted the investigative powers of coroners should be reviewed and rationalised so that coroners have ready access to the information they need to discharge their role while the interests of those who may be compelled to provide it are appropriately protected.

4. Inquest or dispense

The Act requires a coroner to hold an inquest into all reportable deaths unless an inquest is dispensed with. In NSW, as in all other Australian jurisdictions, less than 5% of deaths reported to a coroner go to inquest.

It is submitted it is illogical and unhelpful for the general rule and the exception provided for in the Act to be reversed in practice. It creates unrealistic expectations for family members and requires coroners to frame a principal case management decision in the negative.

Currently, inquests cannot be dispensed with unless the manner and cause of a death or a suspected death have been sufficiently ascertained by the investigation. This means that in numerous cases inquests must be held even though there is a very low likelihood that any further relevant information will be revealed. For example, every missing person case can only be finalised by an inquest.

These undesirable characteristics could be addressed if inquests were mandatory in particular categories of deaths – such as unnatural deaths in custody - and there was a general discretion to convene an inquest to be exercised with reference to stipulated criteria in all other cases.

In our view, inquests should be held only when there is a forensic or policy purpose. Accordingly, inquests should be held if a hearing is needed to attempt to resolve factual uncertainties in the circumstances of the death; to resolve differences among the opinions of relevant experts; or to explore possible changes to improve public health and safety.

5. Findings

Unless an inquest is held, a coroner can make no finding as to the manner of a death - i.e. whether the death was accidental, deliberate or self-inflicted - nor make findings as to any of the surrounding circumstances or issues. As a result, family members and other interested parties are deprived of a coroner's determination in relation to this central and primary focus of coronial investigations in all but a small percentage of cases.

It is submitted that coroners should be required to make finding in relation to the manner and cause of death in all cases, with or without an inquest, perhaps with the exception of natural causes deaths when the facts are not in dispute. The provision of comprehensive findings detailing the circumstances of the death would complement a move away from mandatory inquests: families would get the information they deserve without the expense and delay of participating in a public hearing.

6. Interface between coronial and criminal

Coroners seek to establish facts about sudden and unnatural deaths, criminal courts determine criminal responsibility for them but the two jurisdictions cannot be completely separated, looking as they do at many of the same issues. The Act needs to more clearly provide for the articulation between the two and transmission back and forth between them.

7. Right of review

A coronial investigation sequences through clearly defined decisions points each of which impact upon interested parties: is the death reportable; should a cause of death certificate be issued; who is the ranking family member; what level of autopsy is warranted; should organs

be retained; who is entitled to receive the body, etc? At each point those with sufficient interest should have access to a speedy and inexpensive right of review of the decision made by the case coroner.

It is submitted that right of review should at first instance be to the state coroner who should be obliged to provide reasons and then to the chief magistrate.

Part B

This part of the submission contains recommendations aimed at ensuring the objectives outlined in Part A can be achieved.

8. Objects of the Act

Although s3 as currently framed envisages coroners making recommendations, no purpose of those recommendations are articulated. Death prevention and improvements in public health and safety and the administration of criminal justice are now widely accepted as key coronial functions. In our submission the objects clause of the Act should give due prominence to this role. See s1(d) of the *Coroners Act 2008* (Vic) and s3(d) of the *Coroners Act 2003* (Qld) for examples.

9. Reportable death

The definition in s6 should be expanded to include all deaths which enliven a coroner's jurisdiction including a death in a police operation and a death in custody (s23) and a death of a child known to FaCS and a disabled person receiving state funded residential services (s24).

The definition of a health care related death should be clarified to make clear that the assessment of whether a death was unexpected should focus on what was known before the procedure that led to death was undertaken and relate to what an independent, properly informed clinician would expect – see the provisions in Victorian Queensland coronial legislation.

Death in custody and death in police operation should explicitly include deaths associated with Commonwealth agencies.

"Custody" should be more clearly defined to make clear whether it includes a person being held in protective custody. For example, in our submission it should include when a person is being held in a mental health facility under an involuntary treatment order.

The definition of death in a police operation should be clarified to stipulate that there needs to be some causal connection between the actions or inactions of the involved police officers and the death. Currently, it is unclear whether concerns about a person's welfare coming to police attention before the person dies the death necessarily results in the death being a death in a police operation.

There should be added to the definition of reportable death, a death where a cause of death certificate has not issued and is unlikely to issue in the near future.

Consideration should be given to including the locality jurisdiction within the definition of reportable death so that a death is not reportable unless it is of the type or occurs in the circumstances described in s6 and it has the requisite connection with NSW.

10. Senior next of kin

A mechanism for resolving competing claims to be recognised as the senior next of kin by relatives on the same level in the hierarchy of consanguinity provided for in the Act would spare blended and fragmented families added distress. For example, who is the ranking relative when a person is married to one person but living in a de-facto relationship with another and why should either have to initiate proceedings in the Supreme Court to clarify the issue?

In our submission the Act should explicitly give the power to the case coroner to decide this question with a right of review by the state coroner and chief magistrate as necessary.

11. Jurisdiction to investigate

A coroner should be authorised to investigate whether a particular death is a reportable death and a person dissatisfied with the coroner's ruling in that regard should be entitled to have it reviewed, initially by the state coroner, if the ruling was made by another coroner, and the chief magistrate if the person remains dissatisfied or if the initial ruling was made by the state coroner.

In our submission, the jurisdiction should be framed in terms of a coroner being authorised to investigate the death with a view to determining whether it is reportable and/or, if so, to make findings as to the manner and cause of the death, rather than jurisdiction to convene an inquest. As detailed below, an inquest should be seen as part of an investigation to be utilised when necessary or otherwise appropriate.

12. Powers of investigation

Notice to produce a thing

Currently, the power to require production of a thing to the coroner is provided for in s53 and s66 in terms that are not identical or mutually exclusive. This should be rationalised. A coroner should be authorised to require production of anything relevant to the death investigation, subject to a claim of client privilege, privilege against self-incrimination or public interest immunity.

Notice to produce a statement

In our submission, a person whom a coroner considers his likely to have information relevant to an investigation should be required to create and produce a statement detailing his or her knowledge of the issues identified in a notice requiring the statement. The recipient of such a notice should be able to claim privilege against self-incrimination and the coroner should in response be able to utilise the s61 certificate provisions as modified to suit these circumstances.

Self-incrimination

In our submission s61 is unnecessarily complicated in its current form and unclear in its application as a result of the recent decisions of the NSW Court of Appeal *in Rich v AG of NSW* and the High Court in *X7* and *Lee*.

There seems little utility in offering to allow a witness to give oral evidence with the protection of a certificate after they have objected to doing so on the basis that they may incriminate themselves.

Further, doubts about the legitimacy of "global" objections should be clarified and the uncertainty about the factors which should be considered when determining whether the interests of justice require the witness to give the evidence of concern should be resolved.

In our submission, the scheme could be simplified as follows: the witness raises the objection; the coroner indicates whether he/she accepts there are reasonable grounds; if the objection is accepted, the coroner indicates whether he/she considers the giving of the evidence is nonetheless in the interests of justice; if so, the coroner indicates a certificate will be provided and directs the witness to answer the questions in relation to specified topics.

In our submission the risk of compromising an accused's right to a fair trial as discussed in *X7* and *Lee* is slight provided the coroner focusses on matters connected with the death: in almost all cases the witness will have given a detailed account when being interviewed, either voluntarily or under direction, and that account will usually have exculpated the witness (they would have been charged otherwise and the inquest would not have proceeded.) Further, it is usual to first call the witnesses less involved in the death than the "principal actors" so by the time the objection is made the coroner will have a good understanding of all of the available evidence and the risk the objecting witness might face if required to give evidence.

The family of the deceased and the public generally, have a significant interest in being apprised of all of the circumstances of a violent or unnatural death. Frequently, the person most involved in the death is best placed to provide that information. It should not be supressed when there is little or no chance of the information being used to prevent a witness obtaining a fair trial.

In view of the authorities referred to above, the Act should expressly authorise a coroner to direct a witness with the benefit of a certificate to answer questions about the death in question unless there is a real likelihood that the witness could be charged with causing the death.

13. Autopsies

In our submission an autopsy examination should be the least invasive necessary to serve coronial purposes; should be based on consideration of all relevant information; and should take account of the deceased person's family's view about autopsies. The following recommendations seek to increase the likelihood of that occurring.

Preliminary examination

Officers of the NSW Police Force, and staff employed by the Department of Forensic Medicine (DoFM) and NSW Health should be authorised to undertake a number of steps in relation to a reportable death without a coroner needing authorise them so as to minimise the delay before the body can be returned to the family by ensuring all necessary information is available to the coroner in a timely manner. Currently, very little is done before the coroner first assesses a new matter as no power exists to do so.

In particular, it is submitted:-

- A police officer who reasonably suspects there may be a deceased person in any place should be authorised to enter and search the place in order to report the death to a coroner and to commence the coronial response.
- A police officer who discovers a deceased person whose death he or she believe must be reported to a coroner should be authorised to search the place where the body is found and seize anything he or she believes will be relevant to the investigation of the death by the coroner.
- A police officer should be authorised to direct that a body be transported to a place where a coronial autopsy can be undertaken.
- A police officer should be entitled to require a hospital or medical practitioner to provide medical records relating to a deceased whose death has or is to be reported to a coroner.
- DoFM staff members should be authorised to:-
    - receive and peruse the initial report by police to the coroner (the form P79A);

- undertake a non-invasive external examination of the body;
- receive and peruse medical records relating to the deceased;
- take samples of bodily fluid including blood, urine, saliva and mucus from the body (which may require an incision to be made) and the testing of those samples;
- take images of the body including the use of computed tomography (CT scan), magnetic resonance imaging (MRI scan), x-rays, ultrasound and photography;
- take samples from the surface of the body including swabs from wounds and inner cheek, hair samples and samples from under fingernails and from the skin and the testing of those samples;
- take sample of fingerprints of the body; and
- undertake any other procedure that is not a dissection or the removal of tissue.

Tissue donation

Coroners' cases are a major source of tissue used by the various tissue banks – heart valves; skin; retinas; bone sections etc. Pursuant to the Human Tissue Act retrieval of such material from the body of a deceased person whose death is reportable requires the consent of the family of the deceased, the forensic pathologist who will undertake the autopsy and the coroner. Retrieval of this material is time critical. In order to determine whether the deceased person is a suitable donor tissue bank staff need to view the body and review medical records and any available social history of the deceased.

In our submission the Act should authorise tissue bank staff members to access documentary material in possession of the coroner and the DoFM and to make an external examination of the body, provided they comply with any limitations the case pathologist may stipulate.

Type of autopsy – least invasive

In our submission, the Act should require a coroner to specify whether a medical records review, an external, partial internal or full internal autopsy should be undertaken. The obligation on the person undertaking the examination to use the least invasive procedure (s88(2)) should be maintained and extended to coroners.

A coroner should whenever practical be required to consult with a forensic pathologist when determining whether an autopsy should be ordered and if so the extent of the autopsy.

Family concerns

The current provision enabling the senior next of kin to make a written request that a coroner not make an autopsy order (s96) is impractical and fails to provide effective in-put by the family. In practice, it has been circumvented by requiring the police officer who reports the death to ascertain whether the family objects to an autopsy. When this isn't done, staff from the coroners' office contact the senior next of kin by telephone.

In our submission this should be regularised by amending the Act to require the coroner to have regard to any concerns the family may have about an internal autopsy, whenever it is practical* to do so, if the coroner is inclined to order an internal examination. The mechanism for ascertaining the family's views should be provided for by a practice note or direction by the state coroner.

If the family objects to an internal examination and the coroner considers it necessary having regard to advice received from a forensic pathologist, a speedy and informal resolution mechanism is necessary. This should be a review by the state coroner unless he/she has made the initial decision, in which case the review should be by the chief magistrate.

Families' concerns, if any, about the retention of whole organs after autopsy should also be considered, if practical,* when the coroner is determining whether to authorise the retention.

*In both cases, "if practical" should be defined to exclude cases where seeking the family's views, or alerting the family to the reason for the internal autopsy or retention of organs is likely to unduly delay or otherwise compromise the investigation.

Pathologist to report to BD&M

When an autopsy is ordered, the medical practitioner undertaking it should be required to provide to the Registrar of Births Deaths and Marriages sufficient information to enable the death to be registered, including the cause of death if it is known. This would significantly reduce delays in the provision of a death certificate to the family. If the subsequent coronial investigation leads to the coroner coming to a different conclusion as to any of the particulars of the death, the register can be amended when the coroner's file is finalised.

Second or subsequent autopsies

The Act in s89(1)(d) provides that a coroner may order another examination of the deceased person's body but only *"if it appears to the coroner that the cause of death of the deceased person has not been satisfactorily explained by a report given pursuant to a previous post mortem examination direction"* . In practice, second or subsequent autopsies are usually conducted at the request of the family of the deceased person because they lack confidence in

the independence of state government pathologists and wish to engage a pathologist themselves.

In our submission, coroners should have a general power to order a second or subsequent autopsy when it is in the public interest to do so and subject to consideration of any objection by the senior next of kin .

14. When to inquest?

In our submission an inquest should be mandatory if:

- a person dies an unnatural death while in custody;
- a person dies a natural death while in custody and the coroner has concerns about the quality of the health care provided to the deceased;
- a person is known or whose family is known to FaCS in the s24 sense and the coroner has concerns that the quality of the health care or supervision provided to the deceased may have contributed to the death;
- a disabled person, in the s24 sense, dies and the coroner has concerns that the quality of the health care or supervision provided to the deceased may have contributed to the death; and
- an unnatural death occurs in the course of a police operation and the coroner considers that police action or inaction may have contributed to the death.

In all other cases, an inquest should be at the discretion of the coroner, having regard to whether it is likely a hearing could better ascertain the manner and cause of death or it is in the public interest because it is likely to facilitate the making of preventative recommendations.

Any person with sufficient interest should be entitled to request an inquest be convened and the coroner to whom it is made must either grant the application or provide details as to why he/she is not prepared to do so. The applicant should be entitled to have that decision reviewed by the state coroner. If the person remains dissatisfied or if the initial ruling was made by the state coroner, the review or further review should be undertaken by the chief magistrate.

15. Chamber findings

Currently, unless an inquest is held, a coroner makes no findings as to the manner of death. This means the family and other interested parties receive no considered information about how the death occurred or the circumstances in which it occurred.

In our submission a coroner should make findings in relation to identity, date, place, cause and manner of death in all cases, whether or not an inquest is held.

Following consultation with the family, and in-put from the reporting police and a pathologist, a coroner should be authorised to make findings without an autopsy if there is sufficient information to do so. Further, if the family does not request an autopsy be undertaken, in cases that are not suspicious and do not raise issues of public interest, a coroner should be authorised to find that a person died from unascertained natural causes. The Act currently seems to authorise these procedures in s25, s35(2) and s89 but it is far from clear.

16. Re-opening investigations and fresh inquests

Currently, the Act provides in s29 that the state coroner can direct a coroner who has dispensed with an inquest to hold an inquest. Pursuant to s83(4), the state coroner can also order that a fresh inquest be held if an application is made by a police officers or a party to a previous inquest and the state coroner is of the opinion the discovery of new evidence makes it desirable to hold a fresh inquest.

In our submission these provisions do not provide sufficient flexibility to meet the reasonable needs of interested parties and the community. Further, if the recommendations for chambers findings are accepted a mechanism for setting such findings aside would be necessary.

Accordingly we submit that a coroner who has conducted an investigation and made findings should be authorised to re-open the investigation if he/she concludes the circumstances of the death warrant further investigation or new evidence casts doubt on the findings.

On his or her own initiative or on application of any person with sufficient interest, the state coroner should be authorised direct the coroner who has investigated a matter and made findings to re-open the investigation.

If an inquest has been held the coroner who conducted it should be authorised to re-open it if satisfied that new evidence casts doubt on the findings or re-opening is otherwise in the public interest. The state coroner should be authorised to direct that an inquest be re-opened on the same grounds.

17. Referral to prosecution and disciplinary authorities

Although for hundreds of years coroners played a central role in transitioning suspects into the criminal justice system, in the latter part of the 20thC, what we consider to be undue sensitivity led to a winding back of this aspect of a coroner's role.

In NSW, the 1980 Act provided that a coroner was required to terminate an inquest when a prima facie case was made out and to refer the matter to the DPP. Amendments to that Act have been carried forward in the 2009 legislation so that there is no longer an obligation to terminate, but rather an inquest *may* be suspended if the current committal test (prima facie case and reasonable prospects of a conviction) is reached. Alternatively, the coroner may complete the inquest and make findings in relation to all matters before referring the matter to the DPP.

In our view, having regard to the prohibition on a coroner making a finding suggesting that an offence has been committed – s82(3) - there is little basis for concern that an inquest will undermine a person's right to a fair trial, should one eventuate. Coroners find facts, juries determine questions of guilt. The two are easily kept separate.

In our submission the Act should require a coroner to refer cases for the consideration of prosecuting authorities whenever it appears a prosecution might be warranted. This function can be exercised independently of a coroner's duty to make findings, either with or without an inquest.

Equally, if as a result of considering the evidence gathered during an investigation or inquest, a coroner concludes disciplinary or remedial action may be warranted in relation to a government employee or the member of a profession the coroner should, in our submission, have explicit authority to refer the material to the person's employer or professional regulatory body for consideration of such action.

18. Release of coronial documents

People seek access to documents or things in the possession of a coroner for a variety of reasons. In our submission the response of a coroner to such requests should depend upon the nature of the document or thing sought, the interest of the requester and the purpose for which it is proposed the accessed document or thing will put.

During the course of an investigation, a person should only be granted access to a document or thing in the coroner's possession if:-

- the coroner is satisfied the person has sufficient interest;

- the granting of access will not prejudice the investigation, undermine a person's right to a fair trial; or
- there appears no basis on which the person or organisation who prepared or supplied the document or thing might claim public interest immunity or some other privilege in relation to it.
- In these last category of cases the document or thing should not be released without allowing that person or organisation to be heard on whether the release should proceed.

If an applicant for access does not have sufficient interest in the thing sought in the legal sense but seeks it to utilise for research the coroner should be required to satisfy him or herself that the researcher has ethics approval from a recognised research institution and that there are in place appropriate mechanisms to protect the confidentiality of the material.

The coroner should be authorised to release the material subject to conditions. For example, it will usually be appropriate to release material to parties participating in an inquest on the condition that it be used for that purpose only and not further disseminated.

Generally, once a document or thing has been tendered into evidence in an inquest it should be freely available, subject to the coroner being able to make non publication orders in relation to any material or part of it.

19. Control of the body

The Act should make explicit that the coroner has control of the body from the time the death is reported to the coroner until he/she rules that the death is not reportable or determines that possession of the body is no longer necessary for the purposes of the coronial investigation and orders its release to the senior next of kin.

That control should extend to directing the body remain in a particular mortuary while the coroner makes an informed decision as to whether an autopsy is necessary. Unnecessary removal of bodies from their communities of residence adds to the distress of the bereaved and a significant waste of public resources.

20. A Coronial Council

It is trite to observe that coroners deal with very sensitive matters and make determinations about matters which are highly subjective and may involve complex cultural issues. Coroners are lawyers, not necessarily knowledgeable in these matters.

Of course they receive assistance in individual cases from the various disciplines that participate in the coronial processes but more general advice from a policy perspective is not readily available.

In our submission a body of relevant experts: pathologists; clinicians; lawyers; police; and representative from the larger ethnic communities could make a valuable contribution and reassure coroners that their decisions are consistent with informed community expectations. The Coronial Council of Victoria, established by s109 of that state's Coroners Act, is an apposite example.

Appendix E

Hugh Dillon, “Raising coronial standards of performance: Lessons from Canada, Germany and England”, Report to the Winston Churchill Memorial Trust of Australia, August 2015.

This is a PDF document separately attached to this submission.

Appendix F

The professional development of coroners in New South Wales

Hugh Dillon
Magistrate, Deputy State Coroner for New South Wales
International Coroners Conference, London 2016

Introduction

Coroners and coronial systems hold a unique place in the judicial systems of the common law world. It is astonishing that a legal institution now about 900 years old remains in operation in a form that would be recognised in many respects by those who first established it.

Coroners and coronial systems have been reviewed a number of times in various parts of the world in the past 20 years to modernise them and, as a short-lived recent Prime Minister of Australia put it in another context, to "scrape the barnacles off".

One major issue that reviews of coronial systems tend not to focus upon is the professional development of coroners. Yet the questions of how coroners are selected, inducted, formed and maintained professionally are central to the effectiveness of coroners and coronial systems.

Others, including my Australian colleague, Dr Ian Freckleton QC, will consider systemic issues in the coronial system. I will advert to some of those questions to make the argument that the New South Wales coronial system is structurally flawed and is therefore not as effective as it could be or ought to be. Partly because of this structural weakness, our system of training and professional development of coroners is also flawed. In 2015 I was awarded a Churchill Fellowship to undertake a study tour of Canada, England and Germany with a view to

developing ideas that might, if implemented, bring about improvements in our system.[195] There may also be some free lessons for those from other jurisdictions in the NSW experience.

In this paper I will outline a number of challenges that the coroners and coronial systems face and then touch on ideas concerning initial training and continuing professional development of coroners.

The challenges

From my Australian experience and from the study my impression is that the main problems within coronial systems arise from or lie in three inter-related things: (a) a low regard by governments for the work that coroners do, and hence lack of resources; (b) structures or systems that isolate coroners from each other; and (c) uneven standards of professional practice within coronial systems.

Ian Freckleton QC and David Ranson are two of the foremost experts on coronial systems worldwide. Writing about a decade ago, they identified from their review of coronial systems in their magnum opus, ,[196] the following 30 weaknesses of, or flaws in, the modern institution of coroner:

- **Confused modern status of the coroner**
- Inconsistency of decision-making
- Inflexibility of inquest procedure
- Limited capacity to deal with complex cases
- Ineffectiveness in dealing with hospital deaths
- Lack of rigour in decisions
- Uninformed recommendations
- Inconsistency of recommendations
- Weaknesses of recommendations involving government
- Poor utilisation of data and expertise

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[195] My report to the Winston Churchill Memorial Trust can be found at https://www.churchilltrust.com.au/media/fellows/Dillon_H_2014_Best_practice_in_Australian_coroners_courts.pdf

[196] *Death Investigation and the Coroner's Inquest* Melbourne: Oxford University Press, 2006 pp 732-752.

- Limited implementation of coroners' recommendations
- Limited accountability of coroners
- Ineffective use of media by coroners
- **Lack of professionalism in coronial appointments processes**
- Anomalous culture of coroners' courts
- Inadequate training for coroners
- Unsatisfactory legal guidance for coroners
- Inadequate resources
- Reliance on the reporting of deaths
- Dependency on delegation of investigations
- **Excessive resort to autopsies**
- Undue focus on deaths
- **Descent into the cult of personality**
- Delays in inquests
- Inability to procure necessary evidence
- **Inconsistency in coroners' processes**
- Dissatisfaction on the part of families
- Cultural insensitivity
- Undemocratic role of coroners
- **Inadequacy of funding for participation in inquests.**

Some of these weaknesses are more important than others, and some overlap with others. But, taken as a whole, the adverse consequences for the community of mediocre coronial services and death investigation procedures include:

(i) Increased distress for bereaved family and friends;

(ii) Unaddressed risks (workplaces, hospitals, prisons, police lock-ups, transport, etc);

(iii) Unacceptable practices (medical, psychiatric, police, correctional services, etc);

(iv) Limited accountability for faulty or dangerous practices and systems;

(v) Unresolved concerns and suspicions within the community (whether well-

founded or not); and

(vi) Unidentified homicides.[197]

In my view, the keys to addressing the systemic weaknesses in coronial systems are: (a) adequate resourcing of coroners courts or systems; (b) centralization of administration and general policy; and (c) professionalisation of coroners.

The "profession" of coroner in New South Wales

The Commonwealth of Australia is a federation of six states – New South Wales, Victoria, Queensland, South Australia, Western Australia and Tasmania. In addition, there are two self-governing territories, the Australian Capital Territory and the Northern Territory. Each state and territory has a Coroners Act and a State or Territory Coroner plus a number of other coroners.

Until the turn of this century, much coronial work was allocated to country magistrates or court registrars. In New South Wales, until 2010 inquests held in country courts were conducted by Local Court (magistrates' court) Registrars. 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 complexity is now done by full-time professional coroners who are judicial officers with the rank and title of Magistrate.

New South Wales is the most populous state in the Commonwealth. The magistrates' court, known as the Local Court of NSW, is the largest single court in the country. Under the *Coroners Act (NSW) 2009*, all magistrates, of whom there are approximately 130, are coroners *ex officio*. The coronial system, however, has a hybrid or, some might say, mongrel structure. In Sydney there is a specialist coroners' court, known as the "State Coroner's Court". The State Coroner and three full-time and two part-time Deputy State Coroners are located at that court. About 3500 deaths are reported to the State Coroner's Court annually. A further approximately 2500 deaths are reported to country magistrate/ coroners. In larger centres, such as Newcastle and Wollongong, one of the local magistrates is appointed as a part-time Deputy State Coroner.

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[197] See Freckleton, Ian "Death investigation, the coroner and therapeutic justice" (2007) 15 *Journal of Law and Medicine* 1 at 2.

The reform of 2010, giving country magistrates not only the title of coroner but responsibility for coronial work, has not been a great success. Country magistrates have heavy loads of criminal and civil work which always takes precedence over coronial work. Most Australian magistrates are criminal lawyers who have practised as prosecutors or defenders with their state DPP offices, legal aid commissions or organisations such as the Aboriginal Legal Service. They are generally competent and professional judicial officers in that specialty. Most, however, when they are appointed as magistrates, have had little or no coronial experience, or experience in relevant legal specialties such as administrative law, medical law or industrial law.

The fundamental flaw in the NSW model is that it does not recognise coroners as specialists or coronial work as a profession. The complexity of the tasks and issues that coroners must consider and determine is not well understood within the Local Court itself much less by the judiciary, the legal profession or government in NSW. I have heard it described by one senior magistrate as a "tick-a-box" jurisdiction, meaning that "all" a coroner has to do is make simple findings concerning the identity of a deceased person, the date and place, and cause and circumstances of death.

It is true, of course, that it is relatively straightforward to make such findings in routine cases that constitute the majority of reported deaths. But it is the complex cases that raise controversial questions of fact and issues of significance concerning public health, safety and human rights that call for high degrees of professional skill and experience. Moreover, the inexperienced and the amateur may not even recognise or give full weight to issues that would raise concerns in the mind of a professional coroner.

The senior magistrate's throwaway line also indicates a lack of recognition of the fundamental difference between the adversarial method familiar to all judicial officers in common law jurisdictions and the inquisitorial method applied by coroners. In its 2015 prospectus the Victorian Judicial College comments on the coronial system and the need for improved professional development of coroners:

> *Its inquisitorial nature creates particular challenges for coroners. As coronial findings are increasingly reported in mainstream media, it has never been more important for coroners to further develop their understanding of the legal and practical issues which affect them on a daily basis.* [198]

[198] Judicial College of Victoria, Melbourne 2014 p. 34

For judicial officers whose entire careers have been spent in either advocacy or adjudication of litigation *inter partes*, the transition to the inquisitorial method is neither easy nor immediate.

According to Freckleton and Ranson, a sophisticated death investigation system is constituted of the following elements:[199]

(i) A therapeutic approach to all dealings with the deceased's family and friends;

(ii) Safe and empathic management of the remains of deceased persons;

(iii) Acknowledgment of the legal rights of families, friends and parties with legitimate interest in the death and helping them to exercise those rights;

(iv) Comprehensive employment of professionals with relevant expertise for the death investigation;

(v) Integrated application of appropriate technologies in the death investigation;

(vi) Clear communication of the results of the death investigation to all those with an interest in receiving them, including families, friends, government, agencies concerned with public health and safety; public health and safety policy-makers; and health staff involved in the prior care and treatment of the deceased person;

(vii) Effective audit and validation of death investigation processes; and

(viii) A mechanism for the continuous review and amendment of death investigation processes.

It is immediately obvious that these various elements do not mesh well with the quotidian work of busy magistrates. Nor do the administrative aspects of managing a coronial practice.

In reality, in New South Wales coronial work for regional magistrates is an adjunct to their main tasks and is largely performed, when it can be, out of hours. In practice, much of the work is delegated to registrars, defeating the purpose of the statutory reforms. Anecdotal evidence from regional magistrates is that they delegate much of the work because they are already very busy, they do not have the specialist skills and experience needed to do coronial work well, and they believe that the registrars have greater experience as well as more time to deal with the many administrative tasks involved. Moreover, while some magistrates take to the work enthusiastically but are frustrated by their lack of time and resources for it, others abhor it and find it so unpleasantly confronting that they prefer to avoid dealing with it as much as they can.

[199] Freckleton and Ranson (2006) p.772

In NSW, to provide excellent coronial services, especially to bereaved families, we need to move towards the model adopted in all other Australian states: a specialist Coroners Court that manages virtually all coronial work. Specialisation requires training and ongoing professional development as well as appropriate texts, guidelines and protocols, and study materials.

We are in transition towards that goal. The NSW Department of Justice, at the behest of the State Coroner, is conducting a full-scale review of the Coroners Act. Among the proposed reforms is statutory recognition of the Coroners Court as a specialist inquisitorial court. If introduced, this reform would be a stride towards centralising coronial work in the Coroners Court. Over the past five years two texts have been produced for use of NSW and other Australian coroners.[200] The NSW Judicial Commission publishes an online Local Court Bench Book that includes a chapter on coronial practice.[201] We have conducted in-house training for new Deputy State Coroners but this has been carried out on a fairly ad hoc basis. We are moving towards more structured, tailored training and professional development.

In the meantime, through the auspices of the Judicial Commission, the State Coroner and senior Deputy State Coroners conduct annual training sessions within the general judicial education programmes provided to regional coroners. We have also developed an online interactive training programme in basic coronial skills. We have presented this through the National Judicial College of Australia to a batch of NSW regional magistrates as well as to new and experienced coroners across the country. We are, however, in Australia, well short of the structured and complete training package that any person seeking to become a specialist in some discipline is entitled to expect will be offered to him or her. What might this Holy Grail look like?

Towards better professional development of coroners

Experience in most jurisdictions teaches us that the development of *effective* training and professional development programs for judicial officers requires that programmes be conceived and presented by senior judicial officers. The programmes should be judge-led. They should, however, be designed and presented according to adult education principles. This generally requires input from professional educationists. The same principles apply to the design and presentation of training programmes for coroners.

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[200] Abernethy, John; Baker, Belinda; Dillon, Hugh; Roberts, Helen *Waller's Coronial Law and Practice in New South Wales* Sydney: Lexisnexis, 2010; Dillon, Hugh & Hadley, Marie *The Australasian Coroner's Manual* Sydney: Federation Press, 2015.

[201] Dillon, Hugh "Coronial matters" Sydney: Judicial Commission, 2010 http://www.judcom.nsw.gov.au/publications/benchbks/local/coronial_matters.html accessed 11 May 2016.

This implies either that the senior coroners designing and presenting the programs are trained to do so in accordance with adult education principles or that they work closely with professional educators. Ideally, the senior coroners would have some training in programme design, facilitation and teaching skills *and* work with a professional educator.

To arm coroners with the requisite skills they need, Coroners Courts should develop curricula that will guide and structure the development of induction and continuous training programs. The curricula should be premised on the assumptions that it is a complex jurisdiction and that most new coroners have little or no experience in this jurisdiction.

A curriculum for ***new*** coroners should therefore concentrate on eight main areas:

(a) developing familiarity with the relevant legislation and procedures of the jurisdiction;

(b) developing an understanding of the experience of bereaved people whose loved ones' deaths have been reported to coroners;

(c) developing an understanding of the factors to be taken into account when making autopsy decisions, and applying the principle of ordering only the least invasive procedure appropriate to the case;

(d) developing an understanding of the basics of forensic medicine (including anatomy, pathology and toxicology);

(e) developing an understanding of the factors to be taken into account when deciding whether or not to hold a discretionary inquest;

(f) developing the skills of conducting and managing inquisitorial proceedings;

(g) developing judgment writing skills;

(h) developing the skills of formulating clear, reasonable, practicable and useful recommendations.

A curriculum for experienced coroners and ongoing professional development should concentrate on increasing the depth of coroners' understandings of complex types of cases and managing complex inquests. This could, for example, entail providing programs concerning:

(a) Hospital cases (surgical, misdiagnoses, care & treatment issues with an emphasis on systems failures rather than personal negligence issues);

(b) The problems of suicide (the psychology of young people, questions of intention, assessing risk of self-harm and self-inflicted death);

(c) The philosophy and legal principles concerning causation;

(d) Accident investigation (aviation, maritime, road transport, industrial, fires – again with an emphasis on systems failures and 'human factors');

(e) Research techniques and the use of epidemiological data to identify systems failures (eg, doctor-shopping drug overdoses; deaths in custody or police operations; rock fishing deaths; youth suicides);

(f) Crime scene investigation techniques;

(g) Case management techniques for conducting complex inquests (eg, using 'stop-watch' orders to limit cross-examination; taking expert evidence concurrently; managing unrepresented parties or difficult counsel, etc).

To work most effectively, a single program or training session should concentrate on one main skill. Generally, face-to-face group work is most effective but, depending on the topic or skill to be learned or reinforced, other delivery methods could be used.

Some topics are highly suitable for online presentation. The Canadian National Judicial Institute's online self-teaching modules provide an excellent and cheap model for presenting some kinds of programs. Both to save costs and to provide high quality professional development training to coroners in areas distant from main centres, online programmes can be highly effective provided that they are not overcomplicated. They are ideal for providing information and skills practice in relatively small chunks.