NSW Government response: Legislative Council Select Committee on the coronial jurisdiction in New South Wales

The NSW Government welcomes the Select Committee's *Report into the coronial jurisdiction in New South Wales*. The Government acknowledges the contribution by individuals and organisations that participated in the inquiry, particularly families who have experienced the coronial system for sharing their views on how the coronial system can be improved.

The Government recognises the trauma and grief experienced by families and communities affected by an unexpected or unexplained death and that the coronial jurisdiction must not add to this burden. It is critical that these important services are delivered in a professional, therapeutic and timely manner, which upholds the dignity of the deceased person and ensures respect for their family and friends.

The Government also acknowledges the importance of coronial processes being culturally safe and responsive to First Nations families, and effective in preventing the future loss of life for First Nations people. Within this context, the Government notes the commencement in April 2022 of the *State Coroner's Protocol – Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples*, which sets out arrangements for the case management of mandated inquests in respect of First Nations people.

Initially commencing ahead of and later running in parallel with the work of the Select Committee, the Government established the *Timeliness of Coronial Procedures Taskforce* (**Taskforce**), whose aim was to reduce delays in the coronial system and improve the experiences of families. The Taskforce's work has since resulted in the implementation of a range of initiatives to improve the timeliness of the coronial process, especially in relation to post-mortem investigations, and streamline early case management processes.

The Government has also boosted investment in the coronial jurisdiction to strengthen outcomes for families, reduce the number of preventable deaths, improve timeliness and support culturally safe and responsive processes. Following an investment of in the 2021-22 State Budget, an additional magistrate was assigned exclusively to the coronial jurisdiction, and additional resourcing was provided to the Coronial Case Management Unit to reduce delays and improve information and support for families. Two Aboriginal Coronial Information and Support Officer positions have also been established to improve support for First Nations families.

The Government has carefully considered the report and is pleased to support or support in principle 15 recommendations and to note 20 recommendations.

Recommendation	Government Response
1 – That the NSW Government finalise and publish the statutory review of the *Coroners Act 2009* (NSW) by the end of 2022.	**Noted**
2 – That the NSW Department of Communities and Justice undertake a review into the collection, management and reporting of data in relation to coronial cases, with a view to identifying system improvements that would enable greater monitoring of the coronial jurisdiction's performance.	**Supported**
3 – That the NSW Government allocate additional resources to the Coroners Court of New South Wales, including adequate funding and staffing, to ensure it can address current caseload pressures, delays and backlogs.	**Supported** The 2021-22 State Government Budget included funding for eight additional magistrates, including a magistrate assigned exclusively to the coronial jurisdiction. Additional resourcing was also provided to the Coronial Case Management Unit to reduce delays and improve information and support for families.
4 – That the NSW Government restructure the Coroners Court of NSW to be an autonomous and specialist court within the Local Court framework, similar to the Children's Court of NSW, with these key features: • the appointment of additional dedicated coroners to undertake all coronial work, including at least one full time coroner to each region, such that regional magistrates should no longer be required to perform any coronial duties • all specialist coroners still to be appointed also as Local Court magistrates, following consultation with both the State Coroner and the Chief Magistrate, but appointed solely to the coronial jurisdiction without limited term • the requirement for the office of the State Coroner to be a Judge of the District Court, with the authority to select and appoint coroners who are drawn from the Local Court, in consultation with the Chief Magistrate • any transfers from the Coroners Court of New South Wales to the magistracy to occur only with the agreement of both the State Coroner and the Chief Magistrate • the State Coroner to be a member of the Judicial Commission of NSW.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families, including those in regional locations, and support the jurisdiction's efforts to reduce preventable deaths and to enhance public safety.
5 – That the NSW Government ensure the Judicial Commission of New South Wales is sufficiently funded to design, develop and deliver a bespoke and comprehensive	**Supported**

training and professional development program for coroners, with input from the current State and Deputy State Coroners and former coroners.	
6 – That the NSW Government provide in-house legal officers and registrars to each coroner or alternatively establish a pool of legal officers and registrars to assist all coroners.	**Noted**
7 – That the NSW Government provide a greater level of case management, family liaison and administrative support for coroners, particularly for the triaging and management of natural cause deaths reported to the Coroners Court of New South Wales.	**Supported** In the 2021-22 State Budget, the NSW Government provided funding for an additional magistrate assigned exclusively to the coronial jurisdiction, and to enhance the Coronial Case Management Unit to reduce delays and improve information and support for families.
8 – That the NSW Police Force improve its training of police officers on coronial processes, including: • regular, comprehensive and specialist training for investigative police • specific training for officers in the preparation of high quality and timely coronial briefs of evidence.	**Supported** The NSWPF Specialist Advocacy Unit and the CCMU are implementing and facilitating comprehensive and specialist training for investigative police on coronial processes. The NSWPF is also currently developing online modules and resources for probationary constables and plan to hold conferences on the coronial jurisdiction for investigators and regional police prosecutors.
9 – That the NSW Government, to attract, recruit and retain more forensic pathologists: • work with relevant professional bodies and educational institutions, including universities, to ensure there are sufficient opportunities for the training and qualification of forensic pathologists • enhance financial and professional incentives for forensic pathologists in New South Wales.	**Supported in principle** There is a national and international shortage of forensic pathologists, with both professional training and accreditation, and market, factors impacting the supply of such pathologists. The Ministry of Health will continue to progress opportunities to increase the availability of forensic pathologists in NSW, including through engagement with university medical programs, students and the Royal College of Pathologists Australia. In addition, the Ministry of Health will continue to review and benchmark the remuneration and allowances for the profession. The NSW Health Workforce Strategy 2022-2032 prioritises equipping the health workforce with the skills and capabilities necessary to be an agile, responsive workforce (Priority 4); and establishing partnerships with education providers to develop health career pipelines (Outcome 4.4).
10 – That the NSW Government review and propose amendments to the objects of the *Coroners Act 2009* (NSW) to ensure that they reflect the key functions of modern coronial practice, including the therapeutic and restorative aspects of the jurisdiction and an express reference to the object of preventing future deaths.	**Supported**
11 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a power for coroners to make findings without inquest.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
12 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to require coroners to examine whether systemic issues played a role leading to any death, including: • an explicit power to make such recommendations as the coroner considers necessary or desirable, including in relation to any systemic issues connected with a death, suspected death, fire or explosion • a requirement to consider and report on whether the implementation of any recommendation of the Royal Commission into Aboriginal Deaths in Custody report could have reduced the risk of death in all cases where a person died in custody.	**Noted** The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
13 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to improve the accountability of responses to recommendations, including: • a requirement that government and non-government entities must respond in writing within six months of receiving coroners' recommendations, noting the action being taken to implement the recommendations, or if no action is taken the reasons why • a requirement that responses to recommendations, and any failure to respond to recommendations, be tabled in the Parliament of New South Wales • granting the State Coroner the power to report to the Parliament of New South Wales on any relevant matters or issues, including but not limited to the progress and implementation of recommendations and matters of concern	**Noted** The NSW Government notes that part of this recommendation reflects recommendation 32 of the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody. The NSW Government supports in principle creating a statutory requirement to strengthen accountability relating to, and transparency around the progress of, acquitting coronial recommendations made to government and non-government entities. The NSW Government does not consider it consistent with the function of the judiciary for it to have a monitoring and reporting function in relation to coronial recommendations, or coercive information to gather powers for that purpose. The NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.

• a power for the Coroners Court of New South Wales to require a response or further Response from any agency or body to which a recommendation is directed.	
14 – That the Coroners Court of New South Wales, in consultation with key stakeholders, enhance its website to ensure coronial findings, recommendations and responses to recommendations are published in an accessible manner.	**Supported**
15 – That the Parliament of New South Wales widen the remit of the joint parliamentary committee on the Law Enforcement Conduct Commission, the Ombudsman and Crime Commission so that it regularly reviews the adequacy of responses to coronial recommendations.	**Noted**
16 – That the NSW Government establish and fund a specialist preventive death review unit in the Coroners Court of New South Wales which: • is modelled on the goals and functions of the Coroners Prevention Unit in the Coroners Court of Victoria • expands on the processes of the NSW Domestic Violence Death Review Team to undertake in-depth qualitative analysis of a broad range of reported deaths, including but not limited to First Nations deaths, domestic violence deaths, suicide deaths and drug related deaths.	**Noted** The NSW Government notes DCJ is considering opportunities to strengthen the preventative capacity of the NSW coronial system to support reductions in preventable deaths. This includes considering, in conjunction with the State Coroner: • the scale, governance and purpose of a preventative death review function • how the function would contribute to reducing preventable deaths • its relationship to the Domestic Violence Death Review Team (**DVDRT**) established under Chapter 9A of the *Coroners Act 2009* (NSW) and Suicide Monitoring System.
17 – That the NSW Government ensure the membership of the Domestic Violence Death Review Team is expanded to include more non-government service providers.	**Noted**
18 – That the Coroners Court of New South Wales ensure that all of its practices and processes appropriately balance on the needs and interests of families in the coronial system with other considerations.	**Supported**
19 – That the NSW Government develop and propose reform options, legislative or otherwise, to ensure the provision of information and material to families in a timely manner, in order to support their meaningful participation in investigations and inquests. Specifically, unless contrary orders are sought, all materials provided to the Coroners Court of New South Wales should also be provided to the family or families concerned within one month of the brief being returned to the Coroners Court from the Crown Solicitor's Office or Department of Communities and Justice Legal.	**Supported in principle** The NSW Government invested in 2021 to support families involved in the coronial processes and to improve timeliness. This includes investments for an additional coroner, Aboriginal Coronial Information Support Officers and staff for the Coronial Case Management Unit and registry.
20 – That the NSW Government implement options to enhance the access families have to social support and counselling in the coronial system, with the aim of ensuring continuity in services and flexibility to meet families' needs.	**Supported in principle** The NSW Government invested in 2021 to support families involved in the coronial processes and to improve timeliness. The 'Digitising the Coronial Pathway to Improve the Family Experience' project is an example of an initiative that will support the handover of case-specific information between the Coronial Information and Support Program and forensic social workers to improve service continuity for families.
21 – That the NSW Government allocate additional funding to Legal Aid NSW and Aboriginal Legal Service (NSW/ACT) in order for these services to provide greater legal assistance and representation to families involved in coronial inquests.	**Noted**
22 – That the NSW Government implement a financial assistance scheme to cover the logistical costs incurred by families participating in coronial inquests, including the costs of transport, meals and accommodation.	**Noted** Assistance is already facilitated to families on a case-by-case basis to help meet the costs of transport and accommodation costs.
23 – That the NSW Government allocate funding to increase the First Nations workforce capacity at the Coroners Court of New South Wales, including expansion of the Aboriginal Coronial Information and Support Program Officer team, and the creation of other identified positions in the registry and other support positions, including in NSW Health Pathology's Forensic Medicine Social Work service.	**Noted** In 2021, the NSW Government allocated additional funding to support families involved in the coronial process. This included funding for additional Aboriginal Coronial Information Support Officers. Work is underway as part of DCJ's Aboriginal Employment Strategy to increase the number of Aboriginal people employed in courts, including in the coronial jurisdiction. In addition, the Ministry of Health is considering opportunities to enhance the continuity of care for First Nations families through the inclusion of First Nations forensic social workers in the Forensic Medicine Team.
24 – That the NSW Government ensure government departments provide ongoing cultural competency training to all staff, especially those departments working in the coronial jurisdiction.	**Supported** The NSW Government is committed to First Nations people involved in the coronial process being supported in a culturally safe and responsive manner. This work has included:

	• The NSW Public Service Commission has developed *Everyone's Business*, a cultural capability training package for the NSW public sector workforce. Through this training, NSW public sector employees learn how to support and build culturally safe workplaces and services across NSW. • A DCJ-wide *Cultural Development and Learning Framework* is currently in development to build Aboriginal cultural capability across DCJ, and will include a mandatory induction, cultural awareness training and ongoing development opportunities for all DCJ staff. • NSWPF, in addition to the current Aboriginal Cultural Awareness Training that is delivered, is also currently developing further Aboriginal cultural competency training for its senior leaders. • NSW Health run *Respecting the Difference*, an Aboriginal cultural training framework that is mandatory for all staff. This training program has recently been updated, and a roll-out of the revised training for all staff will commence in 2022. DCJ and the Ministry of Health are considering opportunities to strengthen the delivery and regularity of cultural competence training to staff working in the coronial jurisdiction. This includes, for example, NSW Health Pathology's forensic medicine staff being provided with cultural competency training, as emphasised through its Reconciliation Action Plan.
25 – That the Coroners Court of New South Wales and the NSW Health Pathology's Forensic Medicine unit consult with culturally and linguistically diverse communities and First Nations communities on the development of publicly available and clear guidelines that cover both the Court's practices and how cultural and religious considerations are best accommodated.	**Supported in principle** The NSW Government considers that the Coronial Services Committee is the appropriate forum for continuing to implement initiatives to address recommendation 25. Consultation has already occurred with culturally and linguistically diverse communities and First Nations communities. This consultation will continue to inform the nature and content of publicly available material regarding court practices and the accommodation of cultural and religious considerations.
26 – That the NSW Government appoint significantly more qualified First Nations people to the judiciary, including the appointment of First Nations persons as coroners and introduction of a First Nations Commissioner to sit with coroners dealing with First Nations deaths.	**Noted** The NSW Government notes the importance of NSW courts, including the coronial jurisdiction, reflecting the diversity of its population, including First Nations people. Applications for judicial appointments are encouraged from qualified Aboriginal and Torres Strait Islander lawyers. The Government notes that the State Coroner has initiatives underway to support culturally safe processes for First Nations peoples involved in the coronial process, including the First Nations Protocol launched in May 2022 and developing healing mechanisms as part of the coronial process.
27 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to mandate that a coronial inquest be held for workplace deaths, excluding deaths from natural causes.	**Note**d The NSW Government considers that current class of deaths that give risk to a mandatory inquest to be appropriate. However, the NSW Government will continue to assess opportunities to strengthen the structure and operations of the coronial jurisdiction in NSW, and in doing so improve outcomes for bereaved families and support the jurisdiction's efforts to reduce preventable deaths and enhance public safety.
28 – That the NSW Government, Coroners Court of New South Wales, and SafeWork NSW establish a framework for sharing information, expertise and outcomes of investigations and inquests, including: • the ability of the Coroners Court of NSW to engage, when appropriate, experts from relevant regulatory bodies to assist in an investigation • the timely provision of coronial findings and recommendations to SafeWork NSW • similar information and evidence sharing requirements as that that exists between the Coroners Court of NSW and the Office of the Director of Public Prosecutions.	**Supported in principle**
29 – That the NSW Government propose an amendment to the *Coroners Act 2009* (NSW) to ensure unions, employer bodies and other industry organisations be granted standing to appear at inquests.	**Noted**
30 – That the NSW Government consider the appropriateness of amending section 78 of the *Coroners Act 2009* (NSW) to change the threshold for referrals of matters to the Office of the Director of Public Prosecutions to the 'prima facie' test.	**Noted**
31 – That the Coroners Court of New South Wales and the Office of the Director of Public Prosecutions implement a protocol relating to referrals under section 78 of the Coroners Act 2009 (NSW) to minimise delays, ensure the timely provision of information to families and improve record keeping.	**Noted**
32 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to introduce a statutory timeframe with respect to referrals to the Office of the Director of Public Prosecutions.	**Noted**
33 – That the State Coroner consider issuing a practice note relating to referrals to the Office of the Director of Public Prosecutions, focusing on the need for timely decisions and information to be provided to families.	**Noted**
34 – That the Office of the Director of Public Prosecutions develop guidelines in relation to referrals under section 78 of the Coroners Act 2009 (NSW) to minimise delay in deciding whether to prosecute.	**Noted**

35 – That the NSW Government propose amendments to the *Coroners Act 2009* (NSW) to extend the protection against self-incrimination in section 61 of the *Coroners Act 2009* (NSW) to the giving of written statements, for example, when provided prior to an inquest or in an investigation when no inquest is held.	**Supported in principle**