LOCAL COURT
OF NEW SOUTH WALES

CORONIAL PRACTICE NOTE No. 3 of 2021

Case management of mandatory inquests involving section 23 deaths

ISSUED	24 August 2021
COMMENCES	24 September 2021
AMENDED	8 October 2021

PART A: INTRODUCTION

1. APPLICATION

1.1. This Practice Note is issued pursuant to section 52 of the *Coroners Act 2009* (the Act).

1.2. This Practice Note applies to all deaths or suspected deaths reported to a Coroner which fall within the scope of section 23 of the Act, being where it appears the person died:

- While in the custody of a police officer or in other lawful custody
- While escaping, or attempting to escape, from the custody of a police officer or other lawful custody
- As a result of police operations
- While in, or temporarily absent from, any of the following institutions or places of which the person was an inmate:
    - A detention centre within the meaning of the *Children (Detention Centres) Act 1987*
    - A correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999*
    - A lock-up

- While proceeding to any of the above institutions or places for the purpose of being admitted as an inmate and while in the company of a police officer or other official charged with the person's care or custody.

2. THE FIRST NATIONS PROTOCOL

2.1. State Coroner's Protocol: 'Supplementary arrangements applicable to section 23 deaths involving First Nations Peoples' (the First Nations Protocol) is to be read in conjunction with this Practice Note and sets out supplementary arrangements which apply where the deceased is a First Nations person.

2.2. Through this Protocol, the Court is committed to maintaining cultural appropriateness at each stage of an investigation into the death of a First Nations person, particularly in ensuring that the impact of the work of the coronial jurisdiction on First Nations families does not perpetuate cycles of grief and loss.

3. PURPOSE OF CORONIAL INVESTIGATION

3.1. When a death or suspected deaths falls within the scope of section 23 of the Act, the purposes of the coronial investigation are to:

a. Signify respect for life,

b. Ensure, as far as possible, that the full facts are brought to light,

c. Ensure accountability by identifying any systems failures or conduct warranting criticism and recommend remedial action for any such matters, and

d. Reassure the family and friends of the deceased that lessons learned from these deaths may save lives in the future.

4. OBJECTS

4.1. This Practice Note sets out the procedural requirements for the listing and case management of deaths which fall within the scope of section 23 of the Act.

4.2. In setting out these requirements, the objects of this Practice Note are to ensure:

a. All coronial investigations and inquests into reported deaths which fall within its scope are conducted in a timely and proper manner.

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

c. Together with the First Nations Protocol, all coronial investigations and mandatory inquests into deaths of First Nations Peoples are conducted in a culturally sensitive and appropriate manner which is respectful of the needs of First Nations Peoples.

5. COMMENCEMENT

5.1. This Practice Note commences on 24 September 2021 and applies to deaths which fall within the scope of section 23 which occur on or after this date.

6. PREVIOUS ARRANGEMENTS UNDER PRACTICE NOTE 2 OF 2018

6.1. Practice Note 2 of 2018: Case management of Mandatory Inquests Involving Critical Incident Investigations will continue to apply to those deaths which occurred prior to 24 September 2021 where the person died in any of the following circumstances:

a. While in custody of a policy officer (section 23(1)(a))

b. While escaping or attempting to escape from the custody of a police officer (section 23(1)(b))

c. As a result of police operations (section 23(1)(c).

7. DEFINITIONS

7.1. *Determination of jurisdiction* refers to the point at which a Senior Coroner makes a post-mortem direction pursuant to section 89 of the Act.

7.2. *Coronial advocate* refers to the advocate from the NSW Police Force who assists the Senior Coroner in relation to the coronial proceedings where no 'solicitor assisting' is instructed.

7.3. *Solicitor assisting* refers to the solicitor from the Crown Solicitor's Office (CSO) or DCJ Legal who is instructed by the Senior Coroner to assist in relation to the coronial proceedings.

7.4. *Officer in Charge* refers to a member of the NSW Police Force nominated by the Chief Commissioner of Police or any other person nominated by the Senior Coroner to assist with his or her investigation into a reportable death.

7.5. *Family legal representative* refers to the solicitor with carriage from the Aboriginal Legal Service NSW/ACT (ALS), Legal Aid NSW (Legal Aid) or other legal representative(s) nominated by the family of the deceased person who advises the senior next of kin.

7.6. *First Nations Peoples* refers to all Aboriginal and Torres Strait Islander peoples in Australia.

8. INTERESTS OF JUSTICE

8.1. Adjournments and other variations to the below timetable will not be granted unless the Senior Coroner is satisfied that departure is in the interests of justice.

9. RECOGNITION OF FIRST NATIONS FAMILY STRUCTURES

9.1. First Nations Peoples have an extended family structure and a complex and dynamic kinship system which defines where a person fits into their family and

community. These family structures and kinship systems are a cohesive force which binds First Nations Peoples together, providing support which is essential to their wellbeing. This support is critical throughout the coronial process.

9.2. In recognition of the above, references to 'family' throughout this Practice Note should be interpreted flexibly and with respect for these structures and systems. So far as is possible, arrangements should be made to accommodate the deceased's extended family and community, as is appropriate in the circumstances of each case.

PART B: PROCEDURE

10. STAGE ONE: JURISDICTION AND INSTRUCTIONS

10.1. Upon the report of a death, a Senior Coroner will make a determination of jurisdiction under section 23 of the Act.

10.2. Following a determination of jurisdiction, a Senior Coroner will ensure the Crown Solicitor's Office or DCJ Legal is instructed to assist in relation to the conduct of the coronial proceedings if the Senior Coroner considers it necessary and appropriate to do so.

10.3. Following a determination of jurisdiction, the Officer in Charge must contact persons identified as involved officers or employees to ascertain:

a. Whether the agency will represent the person(s) or whether they are otherwise represented, and if so, by whom, and

b. Whether voluntary accounts have been provided by the person(s), and if not, whether they are willing to provide statements voluntarily.

10.4. The Officer in Charge must advise the Senior Coroner of the outcome of these inquiries in the preliminary report to be provided at Stage Two (in accordance with [11.2.e]).

10.5. Throughout the coronial investigation, the Officer in Charge, or if instructed, the solicitor assisting must ensure that the senior next of kin (and any other family member as appropriate in the circumstances), or if applicable their legal representative, are kept informed of the progress of the coronial investigation, including:

a. Providing updates following completion of each of Stage Two to Stage Five below, and

b. Any delays arising in the completion of any of the abovementioned Stages and the reason for those delays.

11. STAGE TWO: PRELIMINARY REPORT AND EARLY PROVISION OF GUIDELINES AND POLICIES

11.1. Within 8 weeks of a determination of jurisdiction, the Officer in Charge must provide a preliminary report of no more than five pages to the Senior Coroner and the solicitor assisting or coronial advocate.

11.2. The report should contain the following information:

a. The background of the reported death (the known circumstances based on information currently available at the time of the report).

b. The current status of the investigation.

c. Identified issues arising from the investigation, including matters which are likely to delay the timely conduct of the investigation

d. The names of any doctors/ clinicians who treated the person while in custody (immediately before their death) and details of the role they played in treating the person.

e. The names of any persons identified as officers or employees involved in the death, details of their legal representative(s), and advice as to whether they have provided (or will provide) witness statements voluntarily.

f. In the case of a death that has occurred in a correctional centre, the names of any officers or employees on duty at the correctional centre, or at the relevant area of the correctional centre, at the time of the death of the person.

g. Identified NSW Police Force, Corrective Services NSW, Youth Justice NSW or Justice Health and Forensic Mental Health Network NSW policies or operational guidelines relating to the investigation and/or circumstances of death.

h. The status of the brief of evidence, including any outstanding items, and whether the brief of evidence will be provided in compliance with the timetable set out at [13.1.a] below.

i. In the case of a death that has occurred in a correctional centre, the status of any investigation being conducted by Corrective Services NSW and whether the investigation report will be provided in compliance with the timetable set out at [13.1.c] below (following consultation with the Corrective Services investigator).

j. Advice as to whether the senior next of kin (or any other family members as appropriate in the circumstances) has been contacted and if so, any issues which they have raised and, if not, the reason why this has not occurred and when contact is proposed to be made.

11.3. Upon assessing the advice provided at [11.2.e], the Senior Coroner may call an early directions hearing to obtain accounts from any involved officer or employee who does not wish to provide a statement voluntarily.

11.4. Upon receipt of the preliminary report, the solicitor assisting or coronial advocate:

a. Will provide to the relevant agency a list of its policies or operational guidelines that are identified in accordance with [11.2.g] above.

b. May request from the relevant agency copies of any policies or operational guidelines listed in accordance with [11.4.a].

c. May request the relevant agency to identify, and provide copies of, any policies or operational guidelines in addition to those listed in accordance with [11.4.a] which are of relevance, or potential relevance, to the circumstances of the death.

d. Will confer with the agency, or their representatives if applicable, in relation to any potential protective orders proposed to be made or sought, or public interest immunity claims proposed to be made, over such policies or guidelines.

11.5. Upon receipt of a request for copies of any policies or operational guidelines under [11.4.b] and/or [11.4.c], the agency must produce the copies requested to the Senior Coroner within 10 business days.

11.6. At the time of production of the policies or operational guidelines, an agency may provide notice to the Senior Coroner of an intention to make an application for protective orders or a claim for public interest immunity over particular material or parts of material should the Senior Coroner wish to serve that material on any other interested party. If such notice is provided, the identified material will only be accessed by the Senior Coroner and the solicitor and counsel assisting or coronial advocate, until such time as the foreshadowed application or claim is determined in accordance with any timetable set under [14.2.f], or is otherwise resolved by agreement.

11.7. A Senior Coroner may extend the timeframe set out in [11.5] on application by the agency where reasonable grounds are established.

12. STAGE THREE: SENIOR CORONER'S CONFERENCE

12.1. If the Senior Coroner considers it necessary and appropriate, upon receipt of the preliminary report a conference will be conducted to discuss the matters in the report with the Officer in Charge and the solicitor assisting or coronial advocate.

13. STAGE FOUR: BRIEF OF EVIDENCE, INVESTIGATION REPORT AND POST-MORTEM REPORT

13.1. Within 12 weeks of a determination of jurisdiction:

a. The Officer in Charge must provide the brief of evidence to the Senior Coroner.

b. The Forensic Pathologist who conducted any post-mortem must provide the final post-mortem report to the Senior Coroner.

c. In the case of a death that has occurred in a correctional centre, the Corrective Services investigator must provide their report to the Senior Coroner.

13.2. A Senior Coroner may extend the timetable set out at [13.1] (and where necessary, the timeframe for the Directions Hearing below in Stage Five) on application where reasonable grounds for a longer period are established. Any such application must be made in writing no less than 14 days prior to the date on which the relevant material is due, and should set out the reasons for delay, as well as the date on which the material will be complete.

13.3. Following receipt of such application in respect of the brief of evidence, the Senior Coroner may request, and the Officer in Charge must provide, a partial brief of evidence consisting of the material available at that time.

13.4. Following receipt of such application in respect of the Corrective Services investigation report, the Senior Coroner may request, and the Corrective Services investigator must provide, any investigation material available at that time, including any witness statements, accounts or incident reports.

13.5. Following receipt of the material referred to in [13.1], [13.3] or [13.4], the solicitor assisting or coronial advocate is to notify any persons who, in the opinion of the Senior Coroner, have a sufficient interest in the subject-matter of the proceedings.

14. STAGE FIVE: DIRECTIONS HEARING

14.1. Within 16 weeks of a determination of jurisdiction, the matter will be listed for a directions hearing before the Senior Coroner to facilitate case management in accordance with section 49 of the Act.

14.2. The Senior Coroner will set a timetable for:

a. The provision of a list of proposed witnesses and proposed issues to be raised in the inquest.

b. The provision of comments by interested parties regarding the proposed witnesses and proposed issues to be raised in the inquest.

c. The provision of any statements including from involved police officers, correctional officers, juvenile justice officers and/ or treating clinicians (as appropriate).

d. The provision of the final post mortem report, if it has not yet been made available.

e. The provision of any other material sought from any parties, including pursuant to a notice to produce or subpoena issued under sections 53 or 66 of the Act.

f. The service of the brief of evidence on the interested parties.

g. Consideration of any protective orders sought or claims for public interest immunity or other objections to material being included in the brief.

h. Any other matters with respect to the conduct of the proceedings as the Senior Coroner considers appropriate.

14.3. If a hearing date cannot be allocated at the directions hearing, the matter will be called over every 12 weeks until a hearing date for the inquest has been allocated.

PART C: SPECIFIC PROCEEDINGS

15. NSW POLICE FORCE CRITICAL INCIDENT INVESTIGATIONS

15.1. This Part applies to a death or suspected death reported to a Senior Coroner where NSW Police Force has declared a Critical Incident in accordance with the NSW Police Force Critical Incident Guidelines (the Guidelines).

15.2. Upon declaration of a Critical Incident by the NSW Police Force, a Senior Critical Incident Investigator is to be assigned to the case without delay in accordance with the Guidelines.

15.3. The matter is to proceed in accordance with Stages One to Five above, with the Senior Critical Incident Investigator responsible for those obligations which are placed on the Officer in Charge.

Judge Peter Johnstone
Chief Magistrate

CHIEF MAGISTRATE OF THE LOCAL COURT
NEW SOUTH WALES

Magistrate Teresa O'Sullivan

State Coroner

ANNEXURE A

PRACTICE NOTE 3 of 2021 - TIMELINE AND OBLIGATIONS

	TIMELINE	OBLIGATION
STAGE 1 – JURISDICTION AND INSTRUCTIONs	Following a determination of jurisdiction	• Senior Coroner to **instruct CSO or DCJ Legal** ('solicitor assisting') • OIC to contact persons identified as involved officers/ employees
STAGE 2 –PRELIMINARY REPORT & EARLY PROVISION OF POLICIES/GUIDELINES	Within 8 weeks of s 23 determination	• **OIC preliminary report** provided to Senior Coroner and solicitor assisting/ coronial advocate • Upon receipt of preliminary report, solicitor assisting/ coronial advocate to liaise with agency regarding provision of **relevant policies/ operational guidelines** and potential protective orders/ public interest immunity claims over this material
STAGE 3 – SENIOR CORONER'S CONFERENCE	Upon receipt of preliminary report	• **Senior Coroner's conference** with OIC and, if appointed, solicitor assisting/ coronial advocate (discretionary)
STAGE 4 – BRIEF AND PM REPORT	Within 12 weeks of s 23 determination	• **OIC brief of evidence, final PM report and CSNSW investigation report** provided to Senior Coroner • If OIC/ CSNSW unable to comply, Senior Coroner may request partial brief/ report

STAGE 5 – DIRECTIONS HEARING	Within 16 weeks of s 23 determination	• **Directions hearing:** Senior Coroner to set procedural timetable and list matter for hearing • If cannot list hearing, call over every 12 weeks thereafter until hearing date allocated