CORONERS COURT
OF NEW SOUTH WALES

CORONIAL PRACTICE NOTE No 2 of 2018

Part 1: Case management of mandatory inquests involving Critical Incident Investigations

1.1 The Practice Note will commence on 19 November 2018

Part 2: Purpose and objects of this Practice Note.

2.1 This Practice Note is issued pursuant to s 52 of the *Coroners Act* 2009.

2.2 This Practice Note relates to a death or suspected death reported to a senior Coroner where the person has died in any of the following circumstances:

- While in custody of a police officer, s 23(1)(a) of the *Coroners Act* 2009
- While escaping or attempting to escape from the custody of a police officer s 23(1)(b)
- As a result of police operations, s 23(1)(c)

2.3 The object of this Practice Note is to ensure that all coronial investigations and mandatory inquests into deaths or suspected deaths where a Critical Incident has been declared in accordance with the NSW Police Force Critical Incident Guidelines ("Guidelines") are conducted in a timely and proper manner.

2.4 This Practice Note sets out the procedural requirements for the early listing and case management of reported deaths in the above categories.

2.5 Mandatory Inquests into the death or suspected death of a person under s 23 of the *Coroners Act* 2009 may only be conducted by the State Coroner or a Deputy State Coroner (a senior Coroner as defined under s 22 of the Act).

Part 3: Stage One

3.1 Upon the report of a death or suspected death of a person in the categories outlined in [2.2] **and** following a determination by a senior Coroner of jurisdiction under s 23 of the *Coroners Act* 2009, the senior Coroner will instruct the Crown Solicitor's Office to assist in relation to the conduct of the coronial proceedings.

3.2 Upon the 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.

3.3 In circumstances where a determination under s 23 has been made by a senior Coroner and a Critical Incident is not declared by the NSW Police Force, Stages Two and Three do not apply. The matter is to proceed in accordance with Stage Four.

Part 4: Stage Two

4.1 No later than eight weeks after a senior Coroner has determined jurisdiction under s 23 in accordance with Stage One, the senior Critical Incident Investigator is to provide a preliminary report of no more than five pages to the senior Coroner and the Crown Solicitor's Office. This report is to outline and address the following:

- The background of the reported death (the known circumstances based on information currently available at the time of the report)
- The current status of the investigation
- Identified issues arising from the investigation
- Identified New South Wales Police Force policies or operational guidelines relating to the investigation
- The status of the brief of evidence including items outstanding and

- The proposed date when the brief of evidence will be complete.

Part 5: Stage Three

5.1 Upon receipt of the preliminary report the senior Coroner will conduct a conference with the solicitor with carriage of the matter from the Crown Solicitor's Office and the Senior Critical Incident Investigator.

Part 6: Stage Four

6.1 The case is to be listed in Court no later than 12 weeks from Stage One for a directions hearing before the senior Coroner. The case will then be case managed in accordance with s 49 of *Coroners Act* 2009.

6.2 At the first directions hearing, the representative for the Commissioner of Police is to advise the senior Coroner of any objections raised regarding police interviews or other material contained in the brief of evidence.

6.3 In circumstances where a Critical Incident has not been declared pursuant to the Guidelines, but the matter is otherwise a mandatory inquest as set out in [2.2] above, the Officer in Charge is to provide a written summary of the current status of the police investigation.

6.4 Following the first directions hearing, the case is to be called over in Court every three months until a hearing date for the inquest has been allocated.

Chief Magistrate

State Coroner