Terms Of Reference

Corrective Services NSW - Management of Deaths in Custody Committee

To oversight the overall management of Deaths in Custody to ensure that Corrective Services NSW (CSNSW) takes a proactive approach to duty of care responsibilities and, in particular, proactively manages contributions to inquiries by the Coroner and responses to Coroner's recommendations by:

1. Formalising the coordinated recording, tracking, management and management response to all deaths in custody including provision of management reports through a single source of coordinated truth within CSNSW Corporate Information Management System;

2. Ensuring that the internal investigation of deaths in custody are subject to protocols which reflect CSNSW proactive management response and respects the role and requirements of the Coroner;

3. Ensuring that all findings listed in investigation reports into deaths in custody, are assessed by an appropriate person or committee prior to the investigation report being submitted to the NSW Coroner.

4. In instances where urgent consideration of the Investigation Report is required towards ensuring the timely submission of the report to the Coroner, the report will be submitted to the Committee out of session to ensure that it can be provided to the Coroner at least 28 days prior to a coronial inquest.

   If required, the Chair of the Committee is empowered to forward the Investigation Report to the Coroner, if submitting the report to the Committee will prevent it from being forwarded at least 28 days before an inquest.

5. Ensuring the person or committee responsible for assessing any finding listed in an investigation report, appropriately endorses or rejects the investigative findings and transparently records their associated decision making process.

6. Ensuring the NSW Coroner is kept appraised of the implementation of any endorsed recommendation prior to the inquest into the subject death in custody.

7. Ensuring that all requirements of the Coroner are met and that in particular recommendations by the Coroner are subject to proactive management consideration, implementation (where so identified) and reporting following any inquest into a death in custody;

8. Ensuring that the various organisational areas of CSNSW are working collaboratively and in tandem to ensure that CSNSW appropriately responds to deaths in custody and ultimately Coroner's recommendations.

9. Ensuring that CSNSW complies with Premier & Cabinet Memorandum 2009-12 issued on 4 June 2009. This directive requires Ministers and Government agencies to respond to the NSW Attorney General within set deadlines in relation to the consideration and implementation of recommendations arising from coronial inquests.

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