NEW SOUTH WALES STATE CORONER

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Coroners Court

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The Hon. Adam Searle MLC
Chair
Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

By email: Sarah Dunn, Principal Council Officer
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24 March 2021

Dear Chair

Aboriginal and Torres Strait Islander people continue to be overrepresented in almost every category of death reported to the coroner each year in New South Wales, a confronting and disturbing trend that must be considered and understood in the context of the ongoing effects of colonisation and dispossession experienced by First Nations people.

Since being appointed State Coroner, I have sought to better understand how the coronial system can be improved for First Nations people and families. While this work is ongoing and will continue to evolve, a number of initiatives are currently being implemented to better ensure that the court's processes and practices are culturally safe and respectful. These reforms also aim to promote positive engagement with and participation by First Nations people and families, acknowledging that the coronial system has been described by some as inaccessible, disempowering and one that can contribute to or compound feelings of grief, loss and frustration.

Investigating deaths thoroughly so as to prevent future loss of life is a central tenet that underpins the work of the Coronial jurisdiction and one of my key priorities as State Coroner is to prevent Indigenous deaths in custody. This is complex work that requires us to work in close co-operation with the family to ensure that all relevant issues are ventilated and relevant material put before the inquiry. I am pleased to advise that two Aboriginal Family Liaison officer roles have recently been created with recruitment to commence shortly to assist the coronial jurisdiction in this work.

The Local Court has also been undertaking a review of the case management of matters in the coronial jurisdiction involving deaths in custody, including deaths of First Nations persons in custody and I have been working with the Chief Magistrate to develop a new Practice Note for deaths in Corrective Services custody the aim of which is to ensure that coronial investigations and mandatory inquests into such deaths are conducted in a timely and proper manner. This new Practice Note will sit alongside existing Practice Note 2 of 2018 which applies to deaths as a result of Police operations.

I am also developing a Protocol for the case management of mandatory inquests involving deaths of First Nations people in custody, which will sit underneath and apply to matters covered by both of these Practice Notes. Targeted consultations on the Practice Note and Protocol are being undertaken with key legal and First Nations stakeholders.

The Court has also undertaken a focused review of deaths in custody of all First Nations people in NSW between 2008 and 2018. I present the findings of that review as a contribution towards the important work being undertaken by the Committee. The report is scheduled to be tabled next month alongside my annual report into all deaths in custody and is, accordingly, not to be distributed beyond the Committee members or otherwise made public until such time as it has been tabled.

Yours sincerely,

Magistrate Teresa O'Sullivan
State Coroner