10 February 2022

Select Committee on the Coronial Jurisdiction in NSW

Dear Committee,

Re: Inquiry into the Coronial Jurisdiction in New South Wales

The Aboriginal Legal Service (NSW/ACT) Limited ("the ALS") provided evidence at the Inquiry into the Coronial Jurisdiction in New South Wales, which took place on Tuesday 30 November 2021. We write in response to the Committee's request that we respond to five identified questions on notice.

Our responses to these questions on notice are outlined below.

Please don't hesitate to contact us should the Committee require further explanation or clarification on our responses below.

Sincerely,

Sarah Crellin
A/Principal Legal Officer
Aboriginal Legal Service (NSW/ACT) Limited

10 February 2022

Inquiry into the Coronial Jurisdiction in New South Wales

QUESTIONS ON NOTICE

QUESTION ONE

Mr DAVID SHOEBRIDGE: It is not necessarily a drafting error in the legislation, because the phrase "manner and cause" does not necessarily have a legislative ambit, it is the interpretation that has been taken by coroners and when it has been tested by the Supreme Court on a very narrow view about cause. Is that right?

Ms CRELLIN: It is, and we are seeing coroners lately in the last couple of years certainly expand that definition. You would have seen the findings in the last couple of years go deeper into what Mr Searle refers to as the health causes. We are seeing a lot of focus on the health system in Corrective Services' Justice Health system. But broader still, I think the coroners have capacity, and certainly they should have capacity, to go further than that.

Mr DAVID SHOEBRIDGE: Could you take on notice whether or not the Victorian formulation would be adequate? I fundamentally support the direction of your submission, but is there a boundary on it? Should there be a legislative boundary on it, or should there just be a broader definition of cause and allow the coroners on a case-by-case basis to work out where the inquiry should cease, for example, chronic overcrowding, systemic poverty, intergenerational trauma? Many of these are factors that are relevant to the manner and cause of death of a First Nations person at the hands of police, for example. Is there a legislative boundary or is it just a broader definition and you allow the coroners to police the boundary?

Ms CRELLIN: I will take that on notice. But I will say also I think you could link it into the Royal Commission into Aboriginal Deaths in Custody and the recommendations that came out of that.

ANSWER

The NSW legislation identifies at s3(c) that one of the objects of the *Coroners Act 2009* is to enable coroners to determine the manner and cause of the death of a deceased person. The ALS asserts that given the coronial jurisdiction is not one able to determine guilt or liability, the efficacy of enabling a court to determine the manner and cause of death must be for two primary purposes;

1. To provide a level of understanding of the death to the families of the deceased person; and
2. to consider the prevention of further deaths

The Victorian *Coroners Act* 2008 identifies that one of the purposes of their Act is

> *1(c) to contribute to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners;*

This wording encourages coroners in Victoria to actively conduct inquests and make recommendations in circumstances where they could contribute to the reduction of the number of preventable deaths. This

The ALS believes that adopting phrasing within the NSW legislation like the Victorian formulation would make explicit that the Coroner's key role is to actively consider the prevention of further deaths and consequently, any required amendments to systems and process that could facilitate the prevention of further deaths. By explicitly identifying 'prevention of future deaths' as an object of the Act and of the function of the coroner, we envisage coroners being able to make any recommendations that they believe will result in the goal of death prevention, including recommendations that consider systemic causes and factors behind incarceration and interaction with police. This is consistent with the recommendations from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC); in particular recommendation 13 which said:

> *13. That a Coroner inquiring into a death in custody be required to make findings as to the matters which the Coroner is required to investigate and to make such recommendations as are deemed appropriate with a view to preventing further custodial deaths. The Coroner should be empowered, further, to make such recommendations on other matters as he or she deems appropriate. (1:172)*

The ALS does not support a legislative boundary on these considerations and believe Coroners should be empowered and encouraged to make findings purposed to prevent future deaths. Coroners are specialist legal officers who are constantly developing an understanding of the failures and gaps in our systems and with government agencies and departments. It is they who should be tasked with determining the boundaries of their recommendations and findings given a purpose of death prevention.

In addition, the ALS would welcome a legislative amendment that requires coroners to comment on what, if any, systemic issues are at play for every Aboriginal and Torres Strait Islander death in custody or in police operations before the coroner, including recommendations to address the identified systemic issue. This amendment, in combination with the adoption of the Victorian formulation on purpose would contribute to some robust change and improve accountability mechanisms.

QUESTION TWO

Mr DAVID SHOEBRIDGE: Your submission talks about the coroner needing to be empowered to call for such further explanations or information as they consider necessary, including reports as to further action taken in relation to the recommendations. Is that the kind of jurisdiction there?

Ms CRELLIN: It is. I think you would have to ask the coroner to do that before the findings were handed down. So perhaps it is a matter of the coroner indicating to the parties what the recommendations will be and allowing the parties to have an opportunity to respond.

The CHAIR: A bit like an Ombudsman's report?

Mr DAVID SHOEBRIDGE: You might want to take this question on notice. I read recommendation 6 (c) in your submission as that happening very much after the findings had been handed down, waiting for the response and, if there had been an inadequate response, enlivening the coroner's jurisdiction afterwards.

Ms CRELLIN: I will take that on notice.

ANSWER

Recommendation 6(c) of the ALS Submission argues that after the coroner makes final recommendations, they need to be empowered to call for further explanation or information from relevant agencies or departments. The difficulty is that once the coroner's findings have been made, the matter is finalised, and the coroner has no agency to follow up on whether their recommendation have been accepted and enacted by the relevant agency.

What the ALS recommends is that the process be amended whereby matters aren't finalised until a time after the coroner's preliminary findings have been made, the relevant agency or department have responded in writing to the findings, and the coroner has been empowered to call for further explanation where required. To limit the impact on Aboriginal families, we suggest that the Coroner's delivery of preliminary findings finalises the court process but does not finalise the matter entirely.

One possible iteration of the process could be as follows:

1. The Coroner, following the investigation, delivers its preliminary findings and recommendations to the relevant parties.
2. The court process remains open.
3. The relevant agencies and departments are given a certain amount of time to respond to the coroner's recommendations in writing. Those recommendations are provided to the relevant family members, the coroner as well as the relevant Minister – as noted in Recommendation 15 and 16 of RCIADIC.
4. The coroner is given the power to call for further explanation or information where required.

5. Following a predetermined amount of time, the matter is finalised, and the coroner releases their final recommendations and findings.

The benefit of this process is that the family of the deceased will be aware of the timeline and the dates by which the response from the agencies is required. This process also increases the level of accountability and places more pressure on the relevant agencies and departments to implement the recommendations of the Coroner.

QUESTION THREE

The CHAIR: Recommendation 13 of your submission talks about recognition mentioned as an alternative to holding a full inquest. Can you step us through as to what that entails, what it might look like?

Ms CRELLIN: Often a loved one might die in a police operation that does not, perhaps, strictly fall, in that they were not in custody or there might be some debate about the technicality around whether the deceased was in custody or not. To go through that sort of legal debate, technicality debate, in a Coroners Court is extremely traumatic. Often what the family would like is some sort of recognition within a courtroom with a Coroner explaining to them why the matter does not fall within the ambit of a full inquest but that it is a matter that the Coroner has looked at, that the brief has been read to acknowledge that the death happened in a police operation but not strictly falling within the legal definition in the Coroner's Act of a section 23 death to allow the family to have that day in court, I guess. The idea of the Coroners Court is that it should be a therapeutic model; it should allow families to be able to grieve, to understand and that is why we would submit a recognition mention would be beneficial for some parties.

The Hon. TREVOR KHAN: On the basis of the First Nations inquiry, and some of what you could describe as case studies that we saw there, I am concerned that even when people have been through the full process, they leave entirely disheartened and dissatisfied by the process—I am not being critical of them in any way. Taking that into account, if a full hearing does not bring resolution how does a short, sharp mention or explanation provide a degree of satisfaction?

Ms CRELLIN: I think there is a difference between a lawyer telling you over the phone, explaining that legal technicality to you, saying the Coroner has read the brief and actually having a day in court where there is a bit of ceremony to it; you can come in, you can sit down, the Coroner looks at you and apologises for your loss, and there is an acknowledgement of your loved one and that they died in a way that is unusual, could be really beneficial. I am not saying in all cases.

The CHAIR: Is that done elsewhere?

Ms CRELLIN: I am not sure of that. I will take that on notice.

ANSWER

Upon research, it does not appear that Recognition hearings occur in other jurisdictions.

The ALS acknowledges that this may not be sufficient or appropriate for all families involved in the Coroners Court. However, our clients and communities have expressed a desire to be more involved with the process. We assert that providing those that want it, an opportunity in court is a much more therapeutic and trauma informed way to dispense with an inquest.

QUESTION FOUR

The CHAIR: I know that primarily your funding comes from Federal sources. Have you had any discussions with the State Government about providing some of that additional funding because the coronial process is really a state process? Have you had any discussions with the State Government?

Ms CRELLIN: I will take that on notice. Not to my knowledge.

ANSWER

The ALS has not had any discussions with the NSW state government about funding for coronial inquiries. We have recently had funding confirmed through the Commonwealth.

QUESTION FIVE

Mr DAVID SHOEBRIDGE: What I would suggest is we are talking here about additional funding. Clearly, Legal Aid is already stretched for its resources. But it is not just legal assistance; it is that wraparound support and advocacy you want. Is that right?

Ms CRELLIN: Yes, we rely very heavily on organisations like Jumbunna as well, who provide the wraparound support that we are sometimes not able to. So we do rely very heavily on other community organisations to assist us in that process.

Mr DAVID SHOEBRIDGE: On notice, will you give us some details about what those additional wraparound services would, in a perfect world, look like?

Ms CRELLIN: Certainly.

ANSWER

On top of legal representation throughout the process, wraparound services in an ALS Coronial Unit would include;

- Assistance with funeral arrangements – navigating the process of the autopsy and then seeking the release of the body is a very daunting process whilst going through the initial shock and grief.
- Assistance with travel arrangements – the Inquests are invariably dealt with in Lidcombe. Most of the families we represent live in regional or remote NSW. The Inquests are usually 5- 10 days long. Even if the families reside in Sydney, the Coroner's Court is almost inaccessible by public transport. There are a few charities who provide financial assistance to Families the cost of travel and accommodation. It would be helpful to have someone who could assist with this process (other than a solicitor)
- Advocacy support throughout the process – assistance with understanding the process and communication with lawyers.
- Assistance with referrals to counsellors and other trauma specialists.