Submission No 100

INQUIRY INTO HIGH LEVEL OF FIRST NATIONS PEOPLE IN CUSTODY AND OVERSIGHT AND REVIEW OF DEATHS IN CUSTODY

Organisation: Chief Magistrate of the Local Court of New South Wales

Date Received: 26 August 2020

NEW SOUTH WALES

THE CHIEF MAGISTRATE OF THE LOCAL COURT

26 August 2020

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

By email: First.Nations@parliament.nsw.gov.au

Dear Mr Searle,

RE: Invitation for Submissions – Inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody

1. I write in response to your invitation to make a submission to the '*Inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody*'. Please find below the NSW Local Court's comments on the matters outlined in the Inquiry's Terms of Reference, which have been prepared with the assistance and advice of the State Coroner, Her Honour Magistrate O'Sullivan.

2. The below comments go towards:

   - The Court's acknowledgement of the over-representation of First Nations people[1] in custody and the importance of criminal justice diversions;
   - The oversight functions performed by the NSW Coroners Court in undertaking mandatory inquests into all deaths in custody;
   - The State Coroner's oversight function providing an annual report to the Attorney General in relation to all deaths in custody (and police operations) pursuant to section 37 of the *Coroners Act 2009* (NSW); and
   - The suitability of the NSW Coroners Court and the State Coroner to undertake the above roles, as well as possible avenues for enhancing their responsibilities and functions.

[1] For the purpose of this submission, the term 'Aboriginal' is used interchangeably with 'First Nations people' to describe persons identifying as Aboriginal and Torres Strait Islander.

The high level of First Nations people in custody in NSW

Rates of Aboriginal incarceration

3. It is not appropriate for the Chief Magistrate, on behalf of the Local Court of NSW, to comment in detail in relation to the number of First Nations people in custody. There are others more qualified and less constrained by the nature of their office to address the historical, criminological and social factors that feed into this area of sensitivity.

4. The Court does however recognise over-representation is not a recent phenomenon. As far back as 1991, the Royal Commission into Aboriginal Deaths in Custody (the Royal Commission) found that Aboriginal people were grossly over-represented in custody and noted that this over-representation in both police and prison custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody".[2] The Royal Commission made a clear statement that until we do something about over-representation, we will certainly continue to record a disproportionate level of Aboriginal deaths in custody.

5. To this end, the Court acknowledges the more recent findings of the Australian Law Reform Commission's (ALRC) in its' 2017 report '*Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*':

   - Aboriginal and Torres Strait Islander adults make up around 2% of the national population, however they constitute around 27% of the national prison population; and

   - In the period 2006 -2016, rates of indigenous incarceration increased by 41% nationally and the gap between Aboriginal and Torres Strait Islander and non-Indigenous rates widened.[3]

6. The most recent figures available from the NSW Bureau of Crimes Statistics and Research (BOSCAR) indicate that as at June 2020, 25.1% of the adult prison population across NSW was identified as Aboriginal.[4]

7. While these figures demonstrate ongoing high rates of Aboriginal incarceration, from a judicial perspective it is important to note the above outcomes exist in a judicial system with a series of checks and balances within its appellate arrangements to ensure that outcomes of courts of lesser jurisdiction are appropriate to the objective seriousness of the particular case, both in terms of the question of guilt and the appropriateness of the particular sentence.

8. The Royal Commission made clear findings that the causes of over-representation of Aboriginal persons in custody which need to be addressed are located in the historical and social framework of this country. It went as far as to identify indicators of disadvantage that contribute to disproportionate incarceration including:

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[2] *Royal Commission in Aboriginal Deaths in Custody* (Final Report, April 1991) vol 1, [9.4.1]
[3] Australian Law Reform Commission, *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 21-22.
[4] NSW Bureau of Crime Statistics and Research, *NSW Custody Statistics*, Quarterly Update (June 2020)

"the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education, the part played by alcohol and other drugs - and its effects".[5]

9. Although significant resources have been dedicated to remedying the factors identified by the Royal Commission in the 30 years which have since passed, there has been little or no impact on the disproportionate rate of Aboriginal incarceration. Yet it remains clear that if the number of First Nation deaths in custody is to be reduced, governments need to grapple both with the underlying causes of over-representation. The Local Court is hopeful the submissions provided below will assist this Inquiry in reporting and making recommendations to the NSW Government which do towards overcoming these issues.

The Local Court's experience and observations in relation to Aboriginal offenders

10. As the largest criminal court in NSW, the Local Court encounters majority of the Aboriginal defendants with charges finalised by NSW criminal courts. In 2019 BOSCAR reported that the Local Court dealt with 26,074 Aboriginal defendants in its summary criminal jurisdiction out of a total of 29,767 Aboriginal defendants with charges finalised by NSW criminal courts (approximately 87.6%). Of the 26,074 Aboriginal defendants dealt with in the Local Court, 23,495 or 90.1% were found guilty or pleaded guilty to at least one charge. A total of 4,119 received a sentence of imprisonment (with a mean duration of 5.7 months), with the remainder receiving fines or non-custodial sentences.[6]

11. Magistrates sentencing these offenders would have observed a common thread of factors as underlying the offending behaviour of the Aboriginal defendants before them – social and economic disadvantage, physical and mental health issues, alcohol and substance abuse problems, and lack of access to services in regional and remote locations are all too regularly at play in relation to the Aboriginal defendants who appear before this Court. I note the statements of principle regarding the relevance of an offenders' severe social deprivation to the sentencing exercise are set out in the High Court decision of *Bugmy v The Queen* [2013] HCA 37 and the Court of Criminal Appeal decision in *R v Fernando* (1992) 76 A Crim R 58. These judgements are widely known and understood within the Local Court and are regularly reinforced through its judicial education programs.

12. Sentencing principles to one side, the Court wishes to highlight the importance of therapeutic jurisprudence as an effective mechanism for assisting individual offenders to address some of the issues underlying their offending behaviour. In this jurisdiction, therapeutic jurisprudence is delivered via 'criminal justice diversion programs' whereby criminal matters are adjourned by the judicial officer while the defendant participates in rehabilitative programs targeted at addressing criminogenic needs and the causes of offending behaviour. Participation in such

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[5] Royal Commission (above n 2) vol 1, [1.3.6]

[6] NSW Bureau of Crime Statistics and Research, *NSW Criminal Court Statistics* (December 2019)

programs may then be taken into account by the court on sentence, with the aim of potentially reducing the sentence imposed, and ultimately, reducing recidivism.

13. While there are a number of diversion programs currently available in the Local Court,[7] the Circle Sentencing program is specifically targeted at Aboriginal offenders. Circle Sentencing is an alternative sentencing court for adult Aboriginal offenders who plead guilty or are found guilty in this jurisdiction. The Circle Sentencing program allows for input from the victim and offender, and directly involves Aboriginal people in the sentencing process, with the goal of empowering Aboriginal communities through their involvement. The 'sentencing circle' sits with the magistrate to determine the appropriate sentence, with contributions from local Aboriginal elders, victims, respected members of the community and the offender's family. As an alternative sentencing tool for magistrates, Circle Sentencing promotes the sharing of responsibility between the community and the criminal justice system. It attempts to address the causes of criminal behaviour, to develop solutions to issues raised, and also actively involves the community in solving its problems.

14. In April 2020, BOCSAR released an evaluation of Circle Sentencing which compared offenders participating in this program to similar Aboriginal offenders participating in the traditional sentencing process during the period 1 March 2005 to 31 August 2018. The study found that when compared to Aboriginal offenders sentenced in the traditional way, offenders participating in Circle Sentencing:

    - Are 9.3 percentage points less likely to receive a prison sentence;
    - Are 3.9 percentage points less likely to reoffend within 12 months; and
    - Take 55 days longer to reoffend if and when they do.[8]

15. The study provides clear evidence that Aboriginal sentencing courts are associated with lower rates of incarceration and recidivism.

16. These results present an opportunity to consider the expansion the program– currently Circle Sentencing is only available in 12 regional/ remote Local Court locations. The Local Court would welcome a decision by NSW Government to invest further funding in this program to increase its availability and effectiveness. Such investment may go towards increasing the number of Aboriginal offenders who are diverted away from the criminal justice system and ultimately reduce the rate of Aboriginal incarceration in NSW.

17. In addition to program-based diversionary interventions, there is also capacity for further exploration and development of legislative interventions to assist in the rehabilitation of repeat

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[7] These include the Magistrates Early Referral Into Treatment Program (MERIT) (drug and alcohol treatment and rehabilitation program), ReINVEST (repeat-violent adult male offenders), ENGAGE (domestic violence offenders) and the Traffic Offender Intervention Program (TOIP) (traffic offenders). Further information about these programs is available in the Local Court's Annual Review (available here).

[8] NSW Bureau of Crime Statistics and Research, *Circle Sentencing, incarceration and recidivism* (April 2020)

young offenders generally, which would include young Aboriginal offenedrs. Experience has shown the cumulative effect of regular convictions for offences that are relatively minor in nature prolongs the impact of previous records of offending. As the High Court stated in *Veen v The Queen (No.2)* (1998) 164 CLR 465 at [14], a prior record is relevant:

> "to show whether the instant offence is an uncharacteristic aberration or whether the offender has manifested in his commission of the instant offence a continuing attitude of disobedience of the law. In the latter case retribution, deterrence and protection of society may all indicate a more severe penalty is warranted".

18. It is noted a record of offending in the NSW Children's Court has no impact where the last offence in that jurisdiction occurs more than 2 years prior to the matter which is before the Local Court pursuant to section 15 of the *Children's (Criminal Proceedings) Act 1987* (NSW). In this way, the Local Court can deal with adult offences more leniently and with an emphasis on rehabilitation for young offenders with a prior juvenile record than otherwise. As part of this Inquiry, consideration might be given to extending provisions akin to section 15 into the adult jurisdiction of offenders under 25 years of age. The Court makes this suggestion on the basis of the observation that restorative or therapeutic justice remains an important consideration when dealing with relatively young offenders whose maturity as adults does not necessarily arrive when they become adults in the eyes of the law.

19. In addition to the above, this Inquiry presents an opportunity to seriously consider the lack of flexibility within the judicial process in relation to young offenders, whether of Aboriginal background or in general. Some years ago this Court proposed to government that consideration might be given to extending the operation of the *Young Offenders Act 1997* (NSW) to adults under the age of 25 for certain minor offences. Such an approach would see the extension of diversionary options available under this legislation for particular offences, such as Police cautions and warnings, and participation in youth justice conferences.

20. The capacity to divert young, immature people out of the criminal justice system should be seen as an opportunity to make a difference in their lives rather than to perpetuate the disconnect between crime and punishment and its potential for cumulative impact on the lives of young Aboriginal members of the community, and young offenders in general.

The oversight function performed by the NSW Coroners Court

The NSW Coroners Court and deaths in custody

21. In NSW, the coronial jurisdiction and the NSW Coroners Court forms part of the NSW Local Court and all magistrates, by virtue of their office, are coroners. The Coroners Court in Lidcombe is the state headquarters for the coronial jurisdiction and the State Coroner is responsible for the oversight and coordination of coronial services across the State, with the assistance of those magistrates who are appointed as Deputy State Coroners.

22. The *Coroners Act 2009* (NSW) provides the legislative framework within which coroners operate, including the central requirements for:

1) a person who has reasonable grounds to believe that a reportable death has taken place to report such a death to the coroner;[9] and

2) coroners to examine reportable deaths.[10]

23. A reportable death includes unnatural, unexpected, sudden and suspicious deaths, and suspected deaths (in the case of missing persons). Coroners are provided with broad powers to undertake the examination of these deaths, including post-mortem and general investigative powers, as well as the discretion to determine whether to hold an inquest into the circumstances of a death.

24. The Act sets out certain categories of deaths which must be reported to the coroner and vests exclusive jurisdiction in Deputy State Coroners and the State Coroner (also referred to as 'senior coroners') to undertake a mandatory inquest into the circumstances of these deaths. Deaths in custody are explicitly identified as one of these categories.[11] In the context of these submissions, this means the death of every Aboriginal person in custody must be reported and an inquest held by a Deputy State Coroner or the State Coroner.

What is a 'death in custody'?

25. It was agreed by all mainland State and Territory governments in their responses to recommendations of the Royal Commission that a definition of a 'death in custody' should include:

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the *Migration Act 1958* (Cth);
- the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper care whilst in such custody or detention;
- the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and
- the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

26. Section 23 of the *Coroners Act 2009* expands this definition to include circumstances where the death occurred:

- while temporarily absent from a detention centre, a prison or a lock-up; and
- while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

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[9] *Coroners Act 2009* (NSW) ss 6, 35
[10] *Coroners Act 2009* (NSW) Part 3.2
[11] *Coroners Act 2009* (NSW) ss 23, 35

27. Where the death of a person occurs whilst that person is serving an Intensive Correction Order (i.e. a sentence of imprisonment to be served in the community, as opposed to full-time custody), such a death will also be regarded as a death in custody pursuant to section 23 of the Act.

28. It is important to note that in relation to those cases where an inquest is yet to be heard and completed, no conclusion can be drawn that the death necessarily occurred in custody or during the course of police operations. This is a matter for determination by the coroner after all the evidence and submissions have been presented at the inquest hearing.

29. It is also noted Corrective Services NSW has a policy of releasing prisoners from custody prior to death, in certain circumstances. This generally occurs where such prisoners are hospitalised and will remain hospitalised for the rest of their lives. While this is not a matter of criticism, it does result in a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of section 23, such prisoners are simply not "in custody" at the time of death. Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

NSW Coronial Protocol for deaths in custody

30. There is a Coronial Protocol in place for the reporting and coronial investigation of deaths in custody which sets the clear expectation that all investigations are to be carried out to the highest standard and are to be approached on the basis that the death may be a homicide; suicide is never to be presumed.

31. In achieving this, the Protocol outlines:

- Mechanisms for such deaths to be reported promptly by NSW Police to the State Coroner or a Deputy State Coroner, who are rostered on call 24 hours a day, 7 days a week.

- The responsibility assumed by the coroner so informed for overseeing the initial investigation into the death, including giving directions for experienced detectives from the Crime Scene Unit, other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death. The coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where Aboriginality is identified, the Aboriginal Legal Service is contacted by NSW Police.

- Arrangements regarding the body of deceased and inspection of the death scene, including the requirement that the post mortem be conducted by experienced forensic pathologists at the forensic facilities located at Lidcombe or Newcastle.

- Arrangements for a request to be made the Crown Solicitor to instruct independent Counsel to assist the coroner with the investigation into the deaths involving NSW Police, such as in the case of a death in police custody. This course of action is considered necessary to ensure that justice is done and seen to be done.

The responsibility of the coroner and the role of the inquest

32. As indicated above, inquests into all deaths in custody are mandatory and are exclusively undertaken by a Deputy State Coroner or the State Coroner (a senior coroner). These inquests (and inquests generally) are inquisitorial in nature, as opposed to adversarial criminal or civil litigation. This means the coroner is actively aiming to seek the truth surrounding the circumstances of the death.

33. The coroner controls the inquests' agenda and is assisted by a solicitor from the Crown Solicitor's Office and a barrister appointed as counsel assisting. The coroner is able to give directions regarding the investigations to be undertaken by police, [12] a power which makes clear the police investigations are undertaken to assist the coroner in undertaking their coronial functions. The coroner also chooses which witnesses to call (or not to call) and is vested with powers to subpoena certain witnesses to attend to give evidence and to compel the production of documents.

34. The coroner exercises these inquisitorial powers to investigate and establish the identity of the deceased, the time and place of the death, and the cause and manner of the death (i.e. how the person died, what happened and why). In addition, a coroner inquiring into a death in custody is required to investigate the quality of the care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

35. Counsel assisting the coroner plays a significant role in the conduct of the mandatory inquest. Prior to the inquest, counsel will have overseen the preparation of the brief of evidence, reviewed the conduct of the investigation, and conferred with relatives of the deceased and witnesses. Prior to the inquest hearing, conferences and direction hearings will often take place between the coroner, counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed. Counsel then appears at the inquest, ensuring that all relevant evidence is brought to the attention of the coroner and is appropriately tested so as to enable the coroner to make a proper finding and appropriate recommendations. This includes information provided in a police brief of evidence and various other written materials, as well as expert evidence provided by general medical practitioners, specialist forensic pathologists, and other specialist physicians and experts.

36. At the conclusion of the inquest, the coroner is required to record their findings in relation to these matters in writing.[13] These findings are published on the Coroners Court website here. In some cases, the coroner may not be able to answer all of the questions and instead may make what is referred to as an open finding. If there is doubt about some of the circumstances of the death, the coroner may also make a finding based on what was most likely to have occurred (i.e. on the balance of probabilities). However, when making a finding of death by suicide, the

[12] *Coroners Act 2009* (NSW) s 51
[13] *Coroners Act 2009* (NSW) s 81

coroner must be satisfied to the *Briginshaw* standard that the deceased intended to take his or her own life. [14]

Coronial recommendations

37. In undertaking their functions, coroners are also charged with protecting lives and wellbeing by bringing to the notice of relevant agencies and authorities any practices, policies or laws which could be changed to prevent similar deaths in the future. Consequently, during the inquest the coroner will consider whether there is anything that can be done to prevent similar deaths in the future and their findings may contain recommendations to improve issues of public health and safety, including those which are directed at NSW Government agencies.

38. In recent times, coroners have identified a number of health related issues specific to Aboriginal inmates that require urgent action. These include the employment of Aboriginal Health Workers,[15] the use of Aboriginal Welfare Officers or Aboriginal Inmate Delegates at Long Bay Hospital (where appropriate),[16] and further protections for intoxicated Aboriginal persons in police custody.[17] Other issues which relate to all prisoners, but which are relevant to First Nation prisoners, have also been examined, including the continued existence of hanging points, and the quality of psychiatric and medical care.[18]

39. There is no statutory requirement for the NSW Government or the agencies at which they are directed to respond to the recommendations made by coroners in their coronial findings. Instead, NSW Premier's Memorandum M2009-12 'Responding to Coronial Recommendations' sets out the process for responding to coronial recommendations directed at Ministers and NSW Government agencies. This includes the process for a copy of the recommendation to be provided by a coroner to the State Coroner, the relevant Minister or agency, and the Attorney General. It states within 6 months of receiving the recommendation:

> "the Minister or NSW Government agency should write to the Attorney General outlining any action being taken to implement the recommendation. If it is not proposed to implement the recommendation, reasons should be given... Ministers and agencies are encouraged to provide updates to the Attorney General on any further action taken to implement recommendations following their initial advice".

40. In addition to the Memorandum, details of all recommendations made by coroners are also recorded in a database kept by the Office of the General Counsel at the Department of Communities and Justice.

41. Given the time and resources invested in undertaking coronial investigations and inquests, it seems illogical that there is no statutory requirement for NSW Government to officially respond to these recommendations, particularly in those scenarios, such as deaths in custody, where the

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[14] *Briginshaw v Briginshaw* [1938] HCA 34; (1938) 60 CLR 336 at 361-362
[15] Inquest into the death of Jonathon Hogan (6 May 2020)
[16] Inquest into the death of David Dungay (22 November 2019)
[17] Inquest into the death of Rebecca Maher (5 July 2019)
[18] Inquest into the death of Jonathon Hogan (6 May 2020)

inquest which assisted in forming the recommendations was mandatory. Further development in this area appears to be sensible.

The suitability of the NSW Coroners Court as an oversight body

42. Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered coronial recommendations. As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. The suitability of the NSW Coroners Court as a vehicle for undertaking the function of an oversight body for Aboriginal deaths in custody is tied to the necessary independence and judicial expertise of the magistrates charged with undertaking coronial functions.

43. As indicated above, there is a statutory requirement for any death in police or corrective services custody to be investigated by a Deputy State Coroner or State Coroner.[19] Magistrates hold these positions. Magistrates who undertake a judicial oath as to the proper, impartial and independent exercise of their judicial power, to do right by all persons, without fear or favour, affection or ill-will. Magistrates who employ expert judicial skills to independently and critically assess complex coronial evidence. Magistrates who have tenure, form part of a separate third arm of government, and are protected from whatever criticisms they are required to make in exercising their powers, including in relation to government agencies and policies.

44. With that said, the Coroners Court is an under-resourced jurisdiction. An examination of the resources allocated to equivalent jurisdictions in other States, for example Victoria, provides ample supporting evidence for this statement. Not only do these resourcing issues affect the timeliness of the completion of coronial inquests and the provision associated findings, they affect the level of support provided by the surrounding administrative structure. While the coroners and administrative support staff who undertake coronial functions in NSW do so in a highly commendable and empathetic manner, they are stretched and they have the potential to do more with better funding and resources.

45. I have made requests for additional resources from government in recent years. My request to the Attorney General in April 2019 for additional magistrates included three who would be allocated to the coronial jurisdiction as additional Deputy State Coroners. Feedback provided to the Attorney General and the Department of Communities and Justice as part of the (yet to finalised) statutory review of the *Coroners Act 2009* again drew attention to what the State Coroner and I perceive as deficits in the current resourcing arrangements. We are yet to be advised of an outcome in response to either of these matters.

46. At present the State Coroner is also working in collaboration with the Department of Communities and Justice to identify options to provide support to Aboriginal families throughout the coronial process, including the possible establishment of Aboriginal Liaison Officer positions in the Coroners Court. Such a role would be of substantial value and assistance in relation to the deaths of all Aboriginal persons, but particularly deaths in custody, and would

go towards implementing the Royal Commission's recommendations aimed at making the coronial process more culturally appropriate. I cannot stress too highly the years of insensitivity visited upon members of the Aboriginal community through either a failure to comprehend or unwillingness to apply a culturally sensitive outcome to a persistent cause of criticism of both the Court and the government.

47. By contrast, the establishment of Circle Sentencing within the general criminal environment of the Local Court depends upon the interface between Aboriginal Client and Community Support Officers and Aboriginal communities. Circle Sentencing cannot function effectively without the members of the Aboriginal community who occupy these roles. Objectively, it makes little sense to recognise the need for a role performing these functions in the criminal jurisdiction but not to establish one or more such position within the coronial jurisdiction. In the latter jurisdiction, such a role would provide a link with grieving immediate and extended families and Aboriginal communities which would be both vital and fundamental in establishing a greater degree of trust within such communities and breaking down suspicions regarding the nature of the coronial jurisdiction.

48. It is noted similar roles exist in the coronial jurisdiction in Victoria, providing assistance with the identification of Aboriginality, supporting the families of deceased Aboriginal persons throughout the coronial process, including during inquests, and implementing initiatives which demonstrate appropriate cultural sensitivity and respect for Indigenous traditions and beliefs.

The oversight function of the NSW State Coroner

The role of the State Coroner

49. As indicated above, the State Coroner is responsible for the oversight and co-ordination of coronial services throughout NSW, including supervising and providing guidance and assistance to all NSW coroners, receiving details of all NSW coronial cases and their ultimate conclusion, providing coronial education to various bodies, and undertaking consultative functions in relation to forensic health.

50. The State Coroner also exercises statutory powers to issue practice notes in relation to the practice and procedure to be followed in coronial proceedings[20] and is currently developing a practice note specific to the management of all Aboriginal deaths in custody. The objectives of this Practice Note will be to ensure:

    - coronial investigations and mandatory inquests in these matters are conducted in a timely and proper manner; and

    - the family of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a culturally appropriate, timely and proper manner.

[20] *Coroners Act 2009* (NSW) s 52

51. As part of this Practice Note, the State Coroner is concerned to ensure that clear timeframes regarding the completion of steps in the investigative process are provided, particularly in relation to the undertaking of investigative steps at an earlier stage so the senior coroner appointed to the case will have oversight of the police investigation much earlier. Another important feature of the Practice Note is the requirement for an early conference between the counsel assisting team and the family of the deceased (and their legal representatives, if represented) to hear from them in detail and at length as to what issues they would like to be investigated immediately and explored at inquest.

52. The Practice Note is currently in the consultation phase. Once finalised, it will be gazetted and made publicly available on the Coroners Court website.

Statutory functions in relation to deaths in custody

53. Pursuant to section 37 of the *Coroners Act* the State Coroner is required to provide the Attorney General with an annual summary of all deaths in custody and deaths in a police operation which were reported to a coroner in the previous year. The current report is available on the Coroners Court website here.

54. Undertaking this statutory role provides the State Coroner with oversight into all deaths in custody in NSW, as well as the subset of Aboriginal deaths in custody. In the period January to December 2019, 47 deaths in custody were reported to the State Coroner, compared to 27 in the 2018 calendar year. Of the 47 deaths in custody reported during 2019, 5 identified as Aboriginal or Torres Strait Islander, with findings that 3 of these deaths were from non-natural causes and 2 were from natural causes.[21] For comparison, of the total 27 deaths in custody reported in 2018, 3 were identified as Aboriginal or Torres Strait Islander, with findings that 1 of these deaths was from non-natural causes and 2 were from natural causes. Further historical data in relation to Aboriginal deaths in custody is provided in Table 1 below.

55. On receipt from the State Coroner, the Attorney General is required to table the report into deaths in custody and police operations in Parliament. However, there is currently no legislative requirement for the NSW Government to respond to the report.

[21] A natural cause death is a death resulting from a medical condition or a disease as opposed to a death from external factors like trauma or self-harm. Ordinarily, a natural cause death would not be reported to the coroner if the cause of death is known and a medical practitioner signs a Medical Certificate Cause of Death (MCCD). When someone in custody dies from natural causes, their death must be reported to the coroner, even if the medical cause of death is clear, and an inquest is mandatory.

Table 1: Deaths in custody reported to the NSW State Coroner from 1995-2019

Year	Total deaths	Aboriginal deaths
1995	23	7
1996	26	2
1997	41	6
1998	29	2
1999	27	3
2000	19	4
2001	21	5
2002	18	3
2003	17	1
2004	13	2
2005	11	1
2006	16	4
2007	17	3
2008	14	0
2009	12	1
2010	23	3
2011	20	2
2012	20	1
2013	26	3
2014	14	1
2015	26	6
2016	16	1
2017	28	4
2018	27	3
2019	47	5

Thank you for the opportunity to make submissions in response to this inquiry. Should you wish to discuss any of the above further, please do not hesitate to contact my policy officer, Brooke Delbridge

Yours sincerely,

Judge Graeme Henson AM
Chief Magistrate
Local Court of New South Wales