Submission No 108

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

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Date Received: 7 September 2020

Submission to the Select Committee on First Nations People in Custody in New South Wales

Inquiry into First Nations people in custody in New South Wales

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1. Background: First Nations Access to Justice Project

We are a team of researchers based at Jumbunna UTS and UNSW Law, currently undertaking an Australian Research Council Discovery project related to First Nations Access to Justice.[1] The project is looking at how First Nations peoples in Australia can achieve better justice outcomes in priority areas of legal need in civil/family law. These areas of law are: tenancy (housing), discrimination, child protection, social security and credit & debt/consumer law.

The current project follows earlier research into First Nations civil and family law legal need.[2] This earlier work identified that legal disputes and problems in the above five areas of law are frequently experienced by First Nations peoples, with significant negative impacts. First Nations peoples are also generally not achieving positive justice outcomes in these areas through the mainstream legal system. They do not commonly engage with the legal system to either assert or defend their rights. Additionally, the legal system does not adequately respond to First Nations perspectives and needs when they do interact with it.

Through this research, and with a view to improving First Nations access to justice in the above five key areas of law, we are seeking answers to the following questions.[3]

[1] Australian Research Council DP180101152, 'Reconceptualising Indigenous access to justice in civil law'.
[2] More information on this project is available at: https://www.jcu.edu.au/indigenous-legal-needs-project
[3] More information about the current project is available at: https://www.uts.edu.au/research-and-teaching/our-research/jumbunna-institute-indigenous-education-and-research/our-research/indigenous-law-and-justice-hub/rethinking-indigenous-access-civil-law-justice

a) What are good justice outcomes for First Nations peoples in these areas of law and can these outcomes be achieved through the mainstream legal system?
b) What reforms or adaptations to the legal system might be required to deliver these outcomes?
c) Access to justice is generally defined as legal processes and outcomes used to resolve a legal problem or dispute after it arises. Is access to justice defined differently by First Nations peoples? Do justice processes and outcomes sit outside of the legal system, involving political or collective action, for e.g., or initiatives that strengthen community (and avert the emergence of legal issues)?
d) What core principles (such as protection of culture, self-determination) ought to inform First Nations definitions of access to justice and how?

2. Our submission: institutional racism in the coronial system in NSW and potential solutions

To answer the above questions, the project is investigating major and minor case studies in each of the above five areas of law. These studies examine existing strategies and initiatives that are meeting the justice needs of First Nations peoples, and what they tell us about First Nations definitions of access to justice in these areas.

Our major case study in the area of discrimination focuses on coronial systems in Australia, with a particular focus on NSW. The mainstream legal system in general may be identified as institutionally racist where it fails, for structural or other reasons, to respond to First Nations peoples' justice needs. These needs relate to what 'justice' looks like and how this form of 'justice' might be attained. Where these justice needs fail to be met by virtue of a person's Indigeneity, it can be understood as discrimination (see also [3] below). Our case study enquires into institutional racism within a particular part of the legal system – the coronial system. It will consider how such racism occurs and might be responded to through reforms or adaptations to mainstream legal processes and outcomes.[4]

To gather information for the coronial system case study we conducted interviews with those working in the system – coroners and other court staff, legal practitioners, and advocates and activists working with families engaging with the system. This material will be drawn together in a broader project report focused on First Nations access to justice with respect to race discrimination, to be published in coming weeks. This report will include detailed comments provided by these interview participants on racism within the coronial system and potential responses to it. In this submission we will share some of the interview material collected to date, in abbreviated form only. Our interviewees are referred to as 'participants' throughout this submission.

The focus of our submission is responding to TOR 1 (b) – (d), looking at institutional racism within the coronial system as it responds to First Nations deaths in custody, and adaptation of that system in NSW to better respond to First Nations needs and perspectives.

[4] A further area of inquiry within the current project is looking at alternative methods of attaining justice, including in the wake of the passing of a First Nations person where the death in question requires a legal response (investigation, prosecution etc.). As seen recently with the Black Lives Matter (BLM) movement, deaths in custody and legal system responses to such deaths galvanizes First Nations peoples, leading at times to direct action or protest. The project is exploring protest as a First Nations access to justice strategy in this context, identifying the type of justice outcomes it might deliver and how these align with or are different to those produced by the legal system. This area of inquiry will not be a focus of this submission.

We will focus, in particular, on the following questions:

[a] The coronial system is part of the mainstream legal system. Does this impact on its capacity to respond effectively to First Nations justice needs arising in the context of a death in custody?

[b] What can be done to reform or adapt the coronial system in its responses to a death in custody to ensure it better responds to First Nations justice needs in this context? What is already working well in this regard?

In thinking about adaptation of the current system, two initial points are as follows.

Firstly, we refer at various points below to recommendations of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). These recommendations provide an important framework through which reform of current legal responses to deaths in custody should be developed.[5] We note that these recommendations also point to multi-layered responses to First Nations deaths in custody aimed at reform of the justice system, but also at reduction of Indigenous over-criminalization (by addressing 'social' drivers of contact with the justice system) and strengthening all-important self-determination. We understand that these are also essential components of strategies designed to reduce and respond to First Nations deaths in custody.

Secondly, some participants we spoke to believed that the coronial system needed to be completely overhauled by and for First Nations peoples, rather than attempting to adapt its current way of working. One participant felt that a whole new 'forum' is required 'that is explicitly about finding responsibility'. This would be 'a body that's tasked with the investigation and carrying it through to potential criminal prosecution, which is a new body, independent of police, and has First Nations representation central to it'. This point is considered further below, though in the context of setting up a forum that draws from the Koori Court model [10].

3. Institutional racism within the coronial system

We have identified four outcomes associated with the coronial system, based on our interviews with those working in this area.

[1] To fact find or to conduct a search for the truth through identification of the manner and cause of a death in custody.
[2] To prevent deaths through the identification of any relevant public interest lesson to be learned and of systemic problems or deficiencies, which can then be addressed by way of findings or recommendations of the coroner.
[3] To ensure accountability for those responsible for a death, including by way of criminal prosecution.
[4] To deliver more therapeutic outcomes, providing closure and healing for families impacted by a death through the process of investigation.

[5] Coroner English recently noted in the Inquiry into the Death of Ms Day, that the recommendations 'provide a framework for relevant standards and a template of best practice [and] a useful comprehensive accountability structure against which to assess aspects of the evidence'. English, C. (2020) *Finding into Death with Inquest. Ms Tanya Louise Day*, Coroners Court of Victoria, Melbourne at para 63.

The consensus amongst our participants is that the coronial system in NSW and elsewhere can oftentimes not only be ineffective for First Nations families, it may re-traumatise them. Where First Nations perspectives and needs are neither acknowledged nor responded to by the coronial system, *institutional racism* is also evident.

Though to some extent all families interacting with the coronial system after a death of a relative want the same or similar things, a First Nations death in custody is *not* the same as, and ought not to be responded to in the same way as other deaths in custody. Firstly, a First Nations death in custody occurs within our long history of colonial violence (encompassing both physical violence and the denial of culture), in which the legal (and justice) system has played a significant role. Secondly, First Nations peoples have their own cultural ways of understanding and responding to a death. Whilst all cultural groups need a response to their cultural difference within the coronial system, disregarding First Nations' cultural ways is particularly problematic, given the historical experiences of racism and colonization, contemporary experiences of over-policing and the very high level of over-representation in the courts, prisons and juvenile detention centres.

Formal equality means treating all persons the same, regardless of their differences. Substantive equality, on the other hand, recognises and responds to difference, including that associated with First Nations people. It delivers different but equitable outcomes, as opposed to the same (and potentially discriminatory) outcomes generally produced by formal equality. The coronial system must consider how it can ensure substantive equality for First Nations peoples. Thinking through each of the four outcomes identified above, various adaptations to the coronial system are required to ensure that these are attained through mechanisms and with end-results that accord with First Nations perspectives and needs. For example, ensuring that coronial processes are therapeutic for First Nations peoples means creating a culturally safe and respectful process in which families have a sufficient degree of input and control. Further, in order to prevent future deaths, racism and colonization and their contemporary effects and consequences should be included in the exploration of 'systemic problems' that have contributed to a First Nations death in custody.

We also note the importance of the principles underpinning the United Nations *Declaration on the Rights of Indigenous Peoples* to reforming the coronial system. The four key principles underpinning the rights contained in the Declaration are **self-determination, respect for and protection of culture, participation in decision-making and equality and non-discrimination**. These principles ought to be applied to development and implementation of reforms of the coronial system to ensure that the human rights of Aboriginal and Torres Strait Islander peoples are respected.

4. Coronial system: inconsistency in practice

There are coroners investigating First Nations and other deaths in custody that understand and respond to First Nations justice needs, but this good practice is not applied consistently across the jurisdiction.

Coroners are exercising discretion in determining processes to be used at an inquest and the type of issues they are willing to consider as relevant to the manner and cause of death, and in making findings and recommendations. This discretion gives rise to often quite different responses to First Nations justice needs. Some coroners do very well, for example, in adapting the coronial process to accommodate First Nations culture - providing space for smoking ceremonies and ensuring there is a Welcome to Country at commencement of proceedings. Others do not do so well, exercising this

discretion in (likely to be unconsciously) discriminatory ways, including where they do nothing differently for First Nations peoples: that is, they maintain the status quo.[6]

This inconsistency is, in part, due to the respective levels of experience coroners have in running inquests, and into a First Nations person's death in custody, as well as their understanding of First Nations peoples' cultural differences and experiences of colonization. Where coroners do not have sufficient expertise or understanding, training is one option. In Victoria, for example, all coronial staff are undergoing Sorry Business and cultural awareness training. However, well-thought out appointment of coroners with sufficient cultural and other competencies, including an awareness of our national history and its ongoing impacts, is also key.

RCIADIC recommendations may guide development and implementation of best practice in investigating a death in custody of a First Nations person. Best practice may also be informed by First Nations staff employed by Coroner's Courts (see below [6.3]). We are aware, as an example, that the Victorian Coroner's Court is developing a practice direction that draws on the RCIADIC recommendations and the expertise of staff within its Koori Engagement Unit. We also understand that the NSW Coroner's Court is considering formalising best practice for First Nations coronial hearings and investigations. **Publishing practice directions is a good way to ensure uniform practice between coroners**.

It is noted too that some coroners may know they need to - and wish to - run an investigation differently for First Nations peoples. They do not have the requisite resources to respond appropriately, however. This points to the importance of better resourcing of coronial services, including to provide for appointment of First Nations staff.

5. Pre-court investigation, police investigation

Delay in pre-court investigation and court processes (including due to lack of resourcing) is identified as an issue for all who have experienced a death, not just First Nations families and communities. However, problems of significant delay in the NSW coronial system may be exacerbated for First Nations peoples for a number of reasons, including the prevalence of deaths in custody hearings in First Nations communities, and community members' perceptions of being locked out of, feeling distrustful of, and/or being treated differently (in a negative sense) within the coronial system. These delays also have real impacts on court proceedings and outcomes. The impracticality of bringing evidence to court some years after a death has occurred was highlighted by those we spoke to; a problem made worse if there is no or inadequate evidence gathered at the time of the death (for example, a witness statement is not taken from a particular witness). Suggestions to address delay include better resourcing of investigation processes, as well as early conferencing of matters (see below [6.4]).

This point highlights the importance of a thorough, effective pre-court investigation. A significant concern raised in relation to pre-court investigations pertains to the lack of independence arising

[6] In a US context, academics have suggested that coroners 'represent a neutral component in the criminal justice system', however they may be in a 'compromising position' because they are public servants passing judgment on other public servants'. Walsh, T and Counter, A (2019) 'Deaths in custody in Australia: a quantitative analysis of coroners' reports', *Current Issues in Criminal Justice*, 31:2, 143-163, DOI: 10.1080/10345329.2019.160383, 150, citing Pelfrey, W and Covington, M (2007), Deaths in custody: The utility of data collected from county coroners, *Criminal Justice Studies*, 20(1), 65–78, 67-8.

where police prepare a brief for the coroner, particularly where the death also occurred in police custody. Research conducted into publicly available coroners' reports (1991-2016) across all jurisdictions indicates that 58% of the deaths investigated occurred in a prison or in youth detention; 31% during a police operation; and 9% in a police cell, watch house or police vehicle. In NSW, these statistics were 51% in prison or youth detention, 38% during a police operation, and 4% in a police cell, watch house or police vehicle. As such, a significant number of deaths in custody occurred in police custody. Moreover, First Nations persons, in particular, were more likely to die in police custody than in the corrections system.[7] These statistics point to the importance of investigation functions being removed from police services.

Police investigations are not legislatively mandated in NSW. Rather, this practice has emerged because of the way coronial services are resourced, according to participants. Many international jurisdictions do not engage police to investigate a death, ensuring a higher level of independence.[8] This independence is especially crucial when a First Nations person has died in police or other custody. Police investigations of First Nations deaths in custody are, however, identified as discriminatory, regardless of whether police are directly involved in the death in question, given their 'strong role in the historic oppression of Indigenous communities'. First Nations experiences of colonization and racism, including at the hands of police, are identified as impacting both on First Nations' perspectives of bias in police investigations and on the capacity of police to carry out impartial investigations. First Nations peoples are likely to struggle with trusting police evidence. Police may also be unaware of and therefore unable to respond appropriately to the broader contexts of colonization and racism in which the investigation is being conducted.

The participants we interviewed had various views on police investigations of deaths. Some participants identified that police adopt investigation techniques they would ordinarily use in investigating a criminal offence for which individual perpetrators are criminally liable. 'The police mindset may be, "is one person responsible?" And, if one person is not responsible, then nobody is.' This means that broader contexts remain unexamined, such as systemic racism as a contributing factor to a death. Police are 'very good usually at taking witness statements from everyone who was involved in the immediate event but very poor at taking witness statements from anyone who might be able to shed some light on, "Well, what is the culture that facilitated this event to take place in the way it did?"'

In terms of ensuring accountability, including through prosecution of individuals, some participants also noted that police will never be able to identify persons who may be criminally liable because they do not set out with this goal in mind. Deaths are investigated as 'procedural' failings rather than as potential homicides. One participant stated that, 'maybe you won't be able to find a perpetrator'. However, 'the outlook and the attitude going in [should have the] same level of commitment to finding who is responsible for the death and bringing them to justice as you would see if a group of black men killed a police officer'.

[7] Walsh and Counter (2019), 152, 158

[8] See discussion of independent models overseas in Office of Police Integrity (VIC) (2011) *Review of the investigative process following a death associated with police contact*, VIC. https://www.ibac.vic.gov.au/docs/default-source/reviews/opi/review-of-the-investigative-process-following-a-death-associated-with-police-contact---tabled-june-2011.pdf?sfvrsn=e6586175_8

A common view among participants was that having independent investigators 'empowered to work with families' and ready to identify individual perpetrators is essential. Investigations should not be conducted by organisations involved in a death in custody. Investigations should be conducted by a specialized (civil) unit situated within the Coroner's Court, rather than being police-run.

6. Family and community participation

The coronial process is identified as generally deeply disempowering for First Nations families and communities. This is due to the lack of cultural safety afforded to them throughout the investigation process, immediately after a death, during and in the aftermath of coronial court proceedings. It is also evident in the limited degree to which they are able to participate, to be seen and heard in these processes. Silencing of families affected by a death is referred to as an act of racism in itself, as is disregard for culture. These deficiencies also have real impacts on those outcomes identified above [2], both in terms of findings and recommendations made by the court, but also on the potentially positive therapeutic outcomes of investigation processes.

6.1 Ensuring families are heard

A two-way flow of information is required to ensure families are able to effectively participate in investigations of a death in custody. Families may wish to share perspectives on what their loved one meant to them, on the manner and cause of death, and on potential findings/recommendations. Families also need access to information as early as possible to help alleviate their inevitably high levels of grief and distress and to ensure appropriate levels of participation throughout the investigation process. This includes information about processes and about potential outcomes in advance of court proceedings. They ought also to be advised of a death in custody in a culturally safe and timely fashion.

Examples of problems arising for families in relation to access to and sharing of information *pre-court* are as follows.

- Families are not always aware of what coronial processes are to be implemented when there is a death in custody, and/or how they can participate in them.
- There may be delays in advising a family about a death. This locks them out of important decision-making such as whether or not there an autopsy should be conducted. As one participant points out, delays are not uncommon, and there is no equivalent to the Custody Notification Service (CNS) in NSW when an Aboriginal person dies in custody.
- The pre-court investigative process also gathers evidence that goes into the brief to the coroner. Families generally have insufficient input into what is included in the brief. A loved one may be described very clinically (as body parts) in this brief by way of pathology reports, identified by Aboriginal people we spoke to as a further process of colonization. Without being involved in pre-court processes, family may only hear about the cause of death of a loved one at court. What they find out may be 'shocking or contrary to what they thought they knew or what they've been told' previously. 'Going in' to proceedings, they may want to 'get a very particular form of justice', but to 'effectively be told that that might not be on the cards and that the whole story that's being told about their loved one is quite different' is extremely confronting. Families need to be able to express their loss, to describe their loved one or to

present them to the court both within the brief and during court proceedings other than solely through engagement with the existing legally and medically clinical coronial processes.[9]

Examples of problems arising for families in relation to access to and sharing of information *during court* are as follows.

- Family statements provided in court do not constitute evidence in NSW. These statements may therefore appear to be only an 'afterthought', heard at the conclusion of or outside of formal proceedings, after all other witnesses for the state (police, corrections, health services, etc.) have been heard. The inquest into the death of Mr Dungay is cited as an example of this, where after proceedings were closed the family was invited to give a statement, at which point many at the bar table had left. Their statements weren't part of the substantive proceedings, and as such it felt like they 'weren't being paid attention to'.
- Families may have information and perspectives to share about the manner and cause of death, raising the possibility of criminal liability of individuals or racism as a contributing factor. For example, First Nations participants felt that statements of families may either be 'curated' or 'watered down' by their legal counsel to fit within a particular legal strategy; or disregarded by the court, including through rules of evidence such as hearsay, though Coroner's Courts are not bound by such rules.

6.2 Balance of power in the coronial system

There are power imbalances evident throughout the coronial process, including in court. The disproportionately high level of resources available to the state during investigations, in contrast to those to families, and the space or speaking time allotted to families and communities (as noted above) are examples of this power imbalance.

Lack of cultural safety contributes to this imbalance. The extent to which cultural practice and awareness informs court proceedings is variable, dependent on a coroner's discretion and available resourcing, discussed above in [4]. Some proceedings commence with an Acknowledgement or Welcome to Country, as noted, and some do not. One participant pointed to 'simple things' the NSW Coroner's Court 'already will try to do.' 'Aboriginal people have brought artwork into the court room. If you can't be on country at least bring something. Small things like that, they're small things', but symbolically significant. Other examples cited include opening an inquest with a cultural dance, smoking ceremonies, and placing a possum pelt on the bar table.

A further example of lack of cultural safety is provided by participants, who discuss suppression of evidence where it appears to implicate the state or individual police or correctional officers. This includes footage of a death or names of individual officers involved in that death – sometimes to protect these officers. This may occur even if against the family's wishes, as release of the footage is perceived by the court to be culturally insensitive. As one participant states 'There's a fine line between what's called cultural competency and an excuse for paternalism.'

One additional issue raised in this context is the limited degree of physical separation of families who have lost a loved one and those involved in the death, who are also quite likely to outnumber family members. This impacts on the sense of safety families have, and 'make[s] the inquest process seem

[9] For example, one participant spoke of how moving it was when the Dungay family read out a poem in court which David Dungay had written in his cell.

like a hopeless project for a lot of families who go through it', 'just deeply culturally inappropriate practices that border on retraumatising them.'

It is important to be aware of this power imbalance and how to address it, at all times. Suggested strategies to respond to this imbalance include having sufficiently experienced and culturally competent legal representation (see below [7]), embedding culturally responsive processes into the coronial system, including by way of practice notes, and ensuring all coroners are aware of the cultural and colonial context in which a First Nations death in custody occurs (discussed above [4]). Building cultural safety into coronial processes should be the norm, and requires often relatively simple adaptations, including those set out immediately above. **A significant process to respect culture, ensure cultural safety, make sure that good evidence is collected and to redress power imbalances is to hear inquests on country.**

6.3 First Nations Liaison role: 'It's like having a domestic violence service and not employing any women'.

Many of the problems identified above can be resolved, to a significant degree, through employment of First Nations liaison persons within the coronial system, including at the Coroner's Court. It is worth describing the Koori Family Engagement Coordinator role within the Koori Engagement Unit in the Victorian Coroner's Court, a role that as far as we know is only in place in Australia. We suggest that a similar role ought to be created and filled by one or more Koori people in NSW as a priority. As one participant notes 'I don't think we can justify having this jurisdiction with no Aboriginal staff when Aboriginal people are over-represented in almost every category of reported deaths. It's like having a domestic violence service and not employing any women.' The more positions of this kind that are created and filled, the better things will be for families and communities, for those working in the system, but also for those working in the role, since they might then 'pick up the phone, talk, share experiences' with their counterparts in other jurisdictions.

The Victorian role was developed through the Aboriginal Justice Caucus, a leadership structure established through the Victorian Aboriginal Justice Agreement (VAJA).[10] Significantly (and as is essential) the role is Koori designed and implemented: 'To really drive change and remove some of the systemic barriers - most of all, Aboriginal people do need to have a seat at the table.'

The role is focused on 'managing First Peoples' passings and Sorry Business', with Sorry Business described in this context as 'a cultural strength', 'how it brings our communities together.' The coordinator is tasked with building understanding across all Coroner's Court staff of Sorry Business and other cultural practices, and building understanding for Koori people of the coronial system. This helps to address and meet expectations of Koori families interacting with the court, which are identified as 'engagement to information, shared knowledge of what's happening, a culturally safe environment and most of all, a non-judgmental environment.'

[10] Important to note is that NSW does not have a current Aboriginal Justice Agreement through which structural reforms to the coronial system may be developed, and is dependent on individual coroners to develop and implement adaptations.

Specific tasks of the Koori Engagement Unit include the following:

- The Koori Engagement Unit is notified of a death within 10-20 minutes of all calls that come through to coronial admissions and enquiries to notify a reportable death where the person who has passed identifies as Aboriginal. The Unit is then able to contact families within the first 24 hours of this passing and start providing support straight away. This helps to address issues of delay highlighted above, and ensures that families understand and are involved in the process as early as possible.
- The Unit also compiles cultural briefs for the coroner about the person who has passed away, another important method of respecting culture, ensuring cultural safety, building trust and ensuring First Nations input into processes. The brief is about 'painting out kinship models, who the individual is, their connections, their totems'. This helps the court to 'really understand the deceased.' The brief also 'flips' the deficit narrative, presenting to the court an account of the person who has passed as a whole individual, who was loved by their family and connected to their community. It also 'gives the family a strong connection point. They establish very quickly that there' is 'buy-in on a cultural brief to support the coroner in their process, and this builds that strong relationship.'
- The Unit identifies where Koori and mainstream understandings may diverge, and discusses these with families to alleviate concerns and distress. An example was provided of different definitions of next of kin in the *Coroners Act 2008* (VIC) and within the Koori community (which has impacts on who plays what role in proceedings).
- The Unit creates a culturally safe space, which allows for healing. This is informed by what individual families want. One specific positive example includes opening up a spill-over court 'so that people wouldn't have to be in the same room as the people who were giving evidence if they didn't want to, or where they could be a bit noisier and react more to what was being said'. Another is the embedding of cultural practice into court processes. One participant noted that 'even though Victoria has had this capacity within the legislation, it has needed people from within the community like [the Engagement Liaison person] to be able to make it happen, to give a voice in a way the legislation intends to families.'

6.4 Restorative justice approaches

Also raised during our interviews is the potential for restorative justice conferencing as a means of ensuring a more therapeutic experience during coronial processes. We understand that consideration is underway in NSW for establishing an early conference with the family where there is an Aboriginal death in custody. Conferences would commence from when a death is reported and continue at least until commencement of an inquest. It would involve bringing together the 'person who's being wronged and the person who's done the wrong' to engage in 'full and frank discussion', and would allow for 'healing' through the 'process of saying what's been lost'.

Through conferencing, the family could express their concerns freely, 'instead of waiting for years until they're in court and having to give evidence in a very scary and often hostile environment'. This removes this important process out of the 'colonizing' space of court. It also enables fast-tracking of investigation of Aboriginal deaths, so the court is not waiting for a full brief and autopsy report. 'You have early report from police' for deaths in custody where police are involved. Then the officer in charge and the team assisting the coroner and the family come together - but also essential is that Aboriginal staff are facilitating this' (see discussion of the Koori Engagement Unit above [6.3]).

It is noted that certain matters would be appropriate for a conference but others would not (where tensions are particularly high, for instance). Families must therefore be able to opt-in to conferences rather than it being a mandatory process. One First Nations participant also pointed to challenges. Firstly, 'there's just a huge imbalance of power there that makes something like a restorative justice process really tricky.' And secondly, families may see accountability in terms of retribution and deterrence rather than restorative justice.

It is our view that a **First Nations Engagement Unit ought to be established in NSW, as a priority. This will help to address issues of cultural safety and imbalance of power within the coronial system. The Unit will also assist with development and implementation of the suggested strategies that follow immediately below.**
Consideration should be given to how restorative justice processes, such as a conference between families and those involved in a death in custody, might improve First Nations experiences of the coronial system. Such processes ought not to be mandatory, and should have a high level of First Nations input in terms of how they are run and who facilitates them.

Family and community participation must be a priority throughout every stage of coronial processes. This means ensuring that the family has access to information and (at least equal) opportunity to inform coronial processes and outcomes and to share perspectives and understandings. Specific examples of what is needed include:

- advising the family of a death at the earliest opportunity, and of next step processes and how they might participate in the same;
- consulting with family as early as possible about what might go into the brief of evidence, and potentially establishing model rules to guide construction of the brief;
- consulting with them (well in advance) about how a coronial inquest might be run, including so as to ensure cultural safety (see below);
- prioritising family statements in court, perhaps by re-ordering who gives evidence at what stage of the proceedings and whether statements are identified as formal evidence;
- respecting the family's wishes with respect to release of footage; and
- respecting the family's wishes with respect to how to honour their loved one and express their loss, including during proceedings.

Respect for culture and ensuring cultural safety must be a priority within the coronial system. This may be assisted through:

- preparation of a cultural brief;
- ensuring court processes and the physical space of the court is culturally safe and respectful;
- embedding best practice in this context within a practice note;
- ensuring all involved in the coronial process are sufficiently experienced and aware; and
- running inquests on country.

7. Lawyers in the coronial system

This section considers the role of lawyers in the coronial system: both those representing families and those assisting the coroner.

Participants, including legal practitioners who have represented families, pointed out that lawyers may be distrusted by families and perceived to be just another arm of the state. They may also lack expertise in terms of understanding culture and historical contexts and/or in running coronial inquests. As an example, the issue of expertise arose in discussion of the type of issues raised as relevant to manner and cause of death and in lack of accountability in coronial inquests. Some felt that inexperienced lawyers are unreasonably raising expectations of families that criminal charges could be laid, for instance. Others felt that lawyers are not calling for a referral to the DPP in instances where this should be occurring (see below [8.2]).

Counsel Assisting play an important role in determining whether families feel that the coronial process has provided a just outcome. However, there is a perception among some participants that Counsel Assisting have a 'muddled and contradictory role', which may lead to distrust from families. On the one hand, they provide 'a critical voice in the courtroom' and are ready to cross-examine state witnesses. However, as one participant stated, they can also present as: '"we're just here to get to the bottom of it and we're all cooperating to find the truth"'. They may 'shy away at times from a more adversarial attitude', conveying to families that, '"this isn't the forum for it, keep those issues of criminal responsibility aside, this isn't where we're supposed to do that"'.

Counsel Assisting also appear to families to source a lot of the information used to assist the coroner in running the inquest from police statements, which also increases distrust. One participant questioned if Counsel Assisting were sufficiently impartial, as at times they appear to be protecting the interests of the State over those of families impacted by a death. Yet, 'representing the state's interest, this means looking after interests of *all* its subjects, including Aboriginal people. They're not teasing out the questions … with an open, curious mind, with the interests of justice at heart.'

It is clear that families need access to experienced, culturally competent lawyers to ensure effective processes and outcomes (see discussion of resourcing of the Aboriginal Legal Service at [8.2]). We suggest that First Nation barristers should be preferred for Counsel Assisting where there is a First Nations death in custody. Model rules might also be established for Counsel Assisting to reiterate that their role in assisting the coroner ought to encompass acknowledgement and representation of the perspectives and needs of families.

8. Considering racism and colonization, ensuring accountability

In the identification of the manner and cause of death and the prevention of deaths, First Nations peoples seek recognition of and appropriate responses to racism, colonization and criminal culpability.

8.1 Racism and colonization

For First Nations peoples, the role racism plays in a First Nations death in custody – both individual and systemic racism – may appear completely obvious. Yet, 'to suggest racism is like beyond the pale'. Whereas for Aboriginal people, 'when you're actually in the criminal justice system it's bland as you like. Of course, there's racism!' Links between racism, colonization and a death in custody is

not, however, easily established during an inquest.[11] In fact, there is a perception that the coronial process 'in a lot of ways' seems to 'mask' racism. To unmask racism requires that a coroner will (a) accept that these issues are relevant to and ought to be included in their inquiry and (b) based on the evidence presented, make relevant findings and recommendations to respond to the links identified. Implementation of such findings and recommendations is a further issue (see [9]).

Coroners can pick and choose issues of relevance to proceedings, including what falls within scope when seeking to identify manner and cause of death, with Counsel Assisting also playing some role in this selection. Coroners are, according to one participant, 'uniquely positioned to [deal] with the totality' of circumstances that have led to a death. They can 'broaden-out that idea of manner and cause of death to encapsulate something like history or the culture of a particular geographic area where something occurred, or the culture of the organisation in which the death occurred'.

Some coroners are, however, more willing than others to look at issues of racism and colonization and whether these issues played into, for example, whether someone was arrested or the kind of healthcare or other treatment they received. This is a further example of the inconsistency referred to above: two courts may sit simultaneously, and one will consider systemic racism and another will not. As one participant notes, 'Up until the last decade, those questions were roundly considered by coroners as being just too remote from the question of the medical cause of death, so they weren't even raised.' Some recent inquests have made findings and recommendations related to racism, including the Ms Williams and Ms Day inquests– with Ms Day's inquest referred to as the 'high watermark case' in this context.

Problems related to discussion of racism and colonisation are identified as follows.

- There can be a lack of understanding for some coroners of the nature of systemic racism and its consequences - a problem that is not exclusive neither to coroners nor the legal system. This is a much broader societal issue.
- In general, the coronial system, as one participant states, appears to have limited capacity 'to bring about systemic change' as it has 're-narrativised a lot of these deaths in a medical way.' [12] The jurisdictional focus, according to this same participant, is on the medical cause of death, rather than on how racism may have played a role in the death in question, with a further note that 'We've got to start doing it more, calling [it] out more. This is the context, the systemic background.' For instance, examination of the part that racism plays in provision of care to those in custody is a reasonable line of inquiry, even where the cause of death is identified as medical.[13]

[11] Significantly, in this context, the research conducted by academics Walsh and Counter into publicly available coroners' reports published around Australia (505 reports in total) indicates that the race or First Nations status of the person who has passed away was not recorded in 71% of these reports. Walsh and Counter (2019), 150.
[12] We note that medical cause of death accounts for a significant proportion of causes of death identified by coroners investigating deaths in custody. Walsh and Counter (2019) found that in 44% of coroners' reports (1991-2016) medical cause was identified by coroners as the primary cause of death (most frequently heart failure), followed by suicide (26%). Medical cause is more likely to be identified as the cause of death for First Nations persons than non-Indigenous persons, and suicide is more likely to be identified as the cause of death for non-Indigenous than First Nations persons. Ibid, 154-5.
[13] Lack of medical and mental health care in custodial facilities is identified by the United Nations' Universal Periodic Review as contributing to Australia's relatively high rate of mortality in prisons. Other concerns raised by the UPR in an Australian death in custody context include excessive use of police force and Indigenous over-

- There is a tendency to exclude issues of systemic racism and to focus on individuals, both as victim and in terms of responsibility for a death. This may involve inquiry into the health issues of a deceased person, described 'as diseased or weak', with their death a 'tragic' accident. Alternatively, the culpability of certain individuals may also be a focus, with all court players comfortable examining the evidence of a particular witness, but less comfortable unpacking 'systemic discrimination in the context of how a series of decisions are made, particularly among a collective.'
- Coroners may find that practices and policies contributed to a death, or that a person did not carry out their duty of care to a prisoner. Though these types of findings may help to prevent deaths, which is something First Nations communities want, naming racism where it exists is also an incredibly important outcome. Divorcing such findings from racism means that 'blackfellas can't get justice because the truth-telling is never done'.
- It was also suggested that findings of 'unconscious' or 'implicit bias' may be unhelpful to First Nations peoples. Such findings give 'rise to a feeling that it wasn't their fault.' 'The system isn't intentionally racist and no-one's really to blame for it.'
- Also noted are the difficulties of proving discrimination. It was suggested that academic experts might be called upon to give evidence to a greater degree, particularly First Nations academics. 'We [need to] keep on putting forward Aboriginal expert evidence because the system is so comfortable to put forward non-Aboriginal experts when actually this is not a nation that lacks Aboriginal expertise.' It was noted that evidence from First Nations families and communities on racism and on colonisation ought *also* to be drawn up and given the weight it deserves. The evidence of other types of 'experts' on racism (state witnesses) may be prioritized, including where it refutes the evidence of family and community.

It has also been suggested that legislation could be reformed to mandate consideration of racism in coronial inquiries and we make a recommendation of legislative amendment in this regard. Other strategies require training of coroners to ensure sufficient awareness of issues such as racism and colonization, and selection of sufficiently knowledgeable and experienced coroners. For this reason, we have recommended both improved training and the appointment First Nations Coroners. This should help to ensure that issues are aired by coroners, and appropriately inform findings and recommendations.

Expert evidence on racism and on cultural safety as a response to racism provided by family and community must be given the weight it deserves. Bringing community experts in to talk about racism and colonization and how it relates to a death and statistical evidence on systemic racism (for example, racial profiling in police) is also essential.

8.2 Accountability

> *My son's life was taken over a packet of biscuits. I've heard from guards and nurses who let my son David die because they failed in their duty of care. I want to see change throughout the whole corrective system and justice health, so no mother or family have to watch their loved one die the way I have had to repeatedly watch over these past two weeks here at the coroner's inquiry. I want all parties and people responsible to be fully accountable and*

incarceration. United Nations General Assembly (UNGA) (2016), Report of the Working Group on the Universal Periodic Review, UNDoc A/HRC/31/14, Thirty-first session.

> *charges laid for my sons' homicide.* [Leetona Dungay, speaking about the death of her son David][14]

This comment by Leetona Dungay expresses her desire to ensure criminal accountability for the death of her son. Many First Nations peoples experiencing the death of a loved one in custody may want accountability, but this rarely occurs through the inquest process. Though coroners may identify wrongdoing during an inquest, prosecution is not an inevitability, including because (commonly) coroners do not refer matters to the DPP (NSW). The Coroner's Court assesses legal evidence to meet a particular legal threshold for prosecution, and a referral in NSW requires a higher threshold, compared to (for example) Victoria. However, for the families, all the evidence points to criminal liability.

This situation gives rise to two very different sets of expectations. Advocates report having to continually manage family expectations of what an inquest will deliver, given the unlikelihood that a matter will be referred for prosecution. '[N]o one's going to be held accountable'. 'That's my advice to people always - you're not going to get anything out of this court.' As noted above, families may feel they have to 'fight' their 'own lawyers' to have the issue of criminal liability raised in court. Families may experience this as a failure of justice, with coronial inquests seen as providing a lower 'second tier of justice'; that is, an inquest rather than a criminal trial. On the other hand, others feel that lawyers and advocates may be lifting family expectations around prosecution unreasonably and unfairly, as this leads to further pain for families when the court finds that there is insufficient evidence that an offence has been committed.

The Victorian Koori Engagement Unit helps to manage expectations of families in relation to the coronial process. The role of the coordinator of this Unit is described as having 'three pillars, one being family support, two being coronial support inhouse, and three, community engagement.' Engagement involves, in part, 'engaging community so community understands the role of the coroner and understands the outcomes that may be presented through a coronial investigation.' It is made clear that 'this isn't about saying somebody's guilty, that's not what this process is about.' It aims to prevent 'another family going through the traumatic experience that … this family [is going through] and that resonates.'

In our view it is important that families have access to suitably qualified lawyers who know when and when not to call for prosecution, and to be able to advise the family on the reasons for this decision. Providing greater resourcing to the Aboriginal Legal Service to allow for the development of specialist lawyers would assist with this.

Further strategies to assist with management of expectations of families are also important, and we see the establishment of a First Nations Engagement Unit as important in this regard.

In addition, we recommend amendment to the NSW Coroners Act to allow family to be heard on whether or not someone should be referred to prosecution. In matters where the DPP refuses to

[14] 'Winning justice for David Dungay', Rachel Evans, August 3 2018, Green Left Weekly, https://www.greenleft.org.au/content/winning-justice-david-dungay

consider prosecution or makes a determination not to prosecute, then prosecutors must be required to give written reasons to families.

9. Responses to and implementation of recommendations, reporting of deaths in custody

9.1 Responding to coronial commendations

Implementation of recommendations is essential to ensuring that the coronial system delivers real, positive justice outcomes to First Nations peoples. 'Even in great coronial inquests that are well-executed… where you get a great result, the families will feel more heard and they will feel like they got closer to the truth', however what you 'end up with is a series of recommendations. There's no mandatory obligation to enact any of those recommendations.'

Recommendations may be unimplemented, including by government, because there is insufficient political will: 'I've certainly never felt that any political party in Australia has ever been concerned about Aboriginal people dying in custody. Certainly, not concerned enough to use any political capital to try and address it.' There can be 'push back, a lot of push back' to the implementation of recommendations. It was noted by some participants that now is a good time to call for and bring about reform of the coronial system, given perhaps a higher level of political will to see change, evidenced by the establishment of the current inquiry.

It is important that there is tracking of what happens with the implementation of recommendations: not just the RCIADIC recommendations, but recommendations from individual coronial inquiries too. This is another important component of ensuring accountability, discussed above in the context of criminal liability. Also important is ensuring some enforceability in terms of implementation.

In our view **there needs to be stronger accountability measures in place to ensure that coronial recommendations are firstly formally responded to by those to whom they are addressed and secondly implemented, including mandating periods in which responses and implementation should occur**. **Government ought to be providing resources and other capability to monitor and follow up on implementation of recommendations.** The Coroner's Prevention Unit in Victoria has a death review role, as well as helping with tracking and monitoring of implementation of coronial recommendations. This type of unit should be introduced in NSW, including for deaths in custody.

9.2 Access to data and other information on First Nations deaths in custody

Ensuring information on deaths in custody is more accessible, particularly to First Nations communities, is also a key issue. During the Black Lives Matter movement protests a number of NSW communities sought information on the number of deaths in custody of local community members or in particular locations, including so as to inform their efforts to push for better First Nations justice outcomes in the wake of a death in custody. This data, however, is very difficult, if not impossible, to access.

Enhanced and more accessible public reporting mechanisms on deaths in custody are required, including so as to enable First Nations communities to access data. This information increases capability of First Nations families and communities to be informed about, and to be seen and heard on issues related to legal responses to First Nations deaths in custody.

10. Koori Court model

As noted above, some have called for something other than an adaptation of or a 'tinkering around' with the existing coronial system. According to this view, a whole new First Nations system of inquiring into a death is required, developed from the ground up, by and with First Nations peoples' input. As such, this model ought to be informed by speaking 'to the families that have appeared in front of [coroners] over the last 10 years and ask[ing] how they experienced this.' The model would have less of what is referred to by one participant as a public health focus and be more centred around how deaths are experienced from First Nations' perspectives.

As an alternative to an entirely reconceptualised coronial system, adaptations that go much further in terms of First Nations self-determination, respect for culture and participation in decision-making may be drawn from models like the Koori Court in Victoria, or circle sentencing in NSW. One participant pointed out that in some respects some coroners are already borrowing from the Koori Court in the processes and ceremonies they bring into the Coroner's Court. For instance, having in court 'traditional artefacts, such as digeridoos and other cultural symbols, the possum skin cloak, the Aboriginal flag, having a smoking ceremony, … Acknowledgements of Country.' A significant step further has occurred in Victoria with the establishment of the Koori Engagement Unit.

It was also suggested by participants that these changes could go much further. First Nations peoples, for example, could (and should) be making contributions to decision-making (in both findings and recommendations). 'You could borrow from some of the ideas around circle sentencing – having Elders sitting with coroners, particularly Elders from the communities, to help the coroner navigate the culturally-appropriate way.' In comparison to such initiatives, however, there would be no 'hurdles' to bypass to access this model (for example, the guilty plea which determines access to the Koori court or Circle Sentencing court). It would be available to any First Nations person. This type of model would enable First Nations understandings of racism or the importance of criminal liability, for instance, to be at the centre of processes and outcomes (findings/recommendations).

Other First Nations participants were more cautious because coronial investigations of First Nations deaths were an area of such trauma that it would be inappropriate to involve Elders: 'It's exposing our Elders, who have seen so much trauma already, to a new level of trauma.'

In our view, consideration should be given to establishing a separate specialised stream within the coronial system to respond to First Nations deaths. This could draw on and potentially expand upon the Koori Court, circle sentencing and similar models to promote First Nations participation in decision-making.

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RECOMMENDATIONS

1. The NSW Government should prioritise the appointment of First Nation Coroners and Counsel Assisting when conducting investigations and inquests into deaths of First Nations people, and, in particular, First Nation deaths in custody. In addition, the NSW Government should:

- Appoint coroners with sufficient cultural and other competencies in working with First Nations peoples;
- Provide cultural competency training for all individuals working in the coronial system;
- Provide resources and support for coroners to develop specific First Nations protocols and practice directions to address current deficiencies;
- Address delays through better resourcing of the coronial process and other reforms identified in this submission, including the use of conferences early in the coronial process.

2. The NSW Government should establish a specialised (civil, independent) investigation unit that accords with best-practice guidelines of independence, adequacy, public scrutiny and involvement with the victim's families. The Unit should have specific capacities to investigate First Nation deaths following protocols developed and directed by First Nations communities and their culture and traditions surrounding death.

3. As a priority, the NSW Government should establish a First Nations Engagement Unit in the Coroners Court. As part of the work of the Unit, consideration should be given to:

- how restorative justice processes, such as a conference between families and those involved in a death in custody, including where held at an early stage in terms of coronial processes, might improve First Nations experiences of the coronial system;
- processes through which family and community participation can be prioritised through every stage of the coronial process;
- developing processes through which respect for culture and ensuring cultural safety is prioritised within the coronial system.

Specific strategies for developing these processes are outlined in the submission.

4. In addition to the First Nations Engagement Unit, consideration should be given to establishing a separate specialised stream within the coronial system along the lines of the Koori Court/ Circle Sentencing models to facilitate First Nations participation in decision-making.

5. The NSW Coroners Act should be amended to:

- explicitly broaden the scope of the Coroner to consider issues of systemic discrimination and/or racism where those issues relate to the circumstances of the death; and
- allow family to be heard on whether or not someone should be referred to prosecution.

6. The Guidelines of the Office of Director of Public Prosecutions should be amended to:

- require consultation with families about decisions not to prosecute in matters where there has been a referral by an NSW Coroner;
- require the DPP to provide written reasons to families where it refuses to consider prosecution, or makes a determination not to prosecute.

7. To ensure stronger accountability measures for the implementation of coronial recommendations, the NSW Government must establish a Coroner's Prevention Unit, similar to that which exists in Victoria. Accessible and timely information (including data) on First Nations deaths in custody must be made available, particularly to First Nations communities.

8. The NSW Government should provide additional funding to the Aboriginal Legal Service to enable the establishment of a specific unit to represent families in matters involving First Nations deaths.