Submission No 125

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

Organisation: Associate Professor Rebecca Scott Bray and Emeritus Professor Phil Scraton

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Associate Professor Rebecca Scott Bray
School of Social and Political Sciences
University of Sydney

Emeritus Professor Phil Scraton
School of Law
Queen's University, Belfast

28 September 2020

The Hon. Adam Searle MLC
Chair, Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody
Legislative Council, Parliament of NSW
6 Macquarie Street
SYDNEY NSW 2000

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

Dear Chairman, the Hon. Adam Searle,

Submission to the Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

Thank you for the opportunity to provide a submission to the Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody. Please find attached our submission.

Yours sincerely

Rebecca Scott Bray and Phil Scraton

Department of Soc o ogy and Soc a Po cy
Facu ty of Arts and Soc a Sc ences
Soc a Sc ences B dg A02
The Un vers ty of Sydney
NSW 2006 Austra a

ABN 15 211 513 464
CR COS 00026A

Submission to the The Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

Rebecca Scott Bray and Phil Scraton[1]

We welcome the opportunity to provide this submission to the Select Committee. We are academic researchers who have worked both separately and together on the issue of contested deaths and coronial inquiries.

This submission is in four distinct but related parts summarising our recent shared and collective work. First, we provide a summary of recommendations derived in the range of primary and secondary research we have conducted including consultations and workshops. This is followed by our observations on coronial courts, followed by a section on our commitment to situating the bereaved and their interests at the centre of the inquest process, concluding with a summary of the international workshop we co-directed at the University of Sydney in late 2018.

1. Summary of Recommendations

- Undertake a substantive legislative review of the NSW coronial jurisdiction, akin to the 2006 Victorian Parliamentary Law Reform Committee review and the 2010 Law Reform Commission of Western Australia review.[2]
- Establish the NSW Coroners Court as a specialist court of inquisitorial jurisdiction with clear legislative purposes and objectives that signal the significance of prevention, the rights of the bereaved, respect for diverse cultures and Indigenous self-determination.
- Develop a Charter for the bereaved.
- Implement the recommendations of the Royal Commission into Aboriginal Deaths in Custody.
- Improve resourcing of the NSW coronial system to realise its core justice work in death prevention.
- Adopt processes and practices from notification of death through to post-finding conduct whereby the bereaved's desire for truth, their demands for accountability and their need for acknowledgement are recognised and respected following a death in custody.
- Widen the scope of inquest, where necessary, to address the deaths in custody of First Nations people in the context of settler colonialism and systemic racism, dispossession, and structural inequality, and hear evidence in that respect.
- Develop formal coronial guidance around inquest hearing practice and procedure.[3]
- Reiterate the independence of the coronial office and coronial investigations by ensuring that police are not investigating police.
- Ensure the priority listing by the Coroners Court of all State-related deaths.

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[1] See Appendix for author profiles.
[2] Victorian Parliamentary Law Reform Committee, *Coroners Act 1985: Final Report* (2006); Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia, Final Report Project No 100* (2012).
[3] See JUSTICE, *When Things Go Wrong: The Response of the Justice System* (London, 2020) Chair: Sir Robert Owen; Rt Hon Dame Elish Angiolini DBE QC, *Report of the Independent Review of Deaths and Serious Incidents in Police Custody* (2017) Home Office UK.

- Acknowledge Indigenous culture and rituals, including at inquest, and fund Aboriginal family liaison.[4]
- Give public interest organisations/human rights interveners regular standing as interested parties at inquest to promote compliance with Human Rights obligations.
- Develop specialist accountability measures for deaths in custody, that draw on multi-disciplinary teams of expertise to work with coroners, including community, such as an Independent Panel with the capacity to perform investigative work, or a Special Procedure Inquest.[5]
- Establish specialist deaths in custody review processes (such as that for Family Violence Death Review).
- Develop alternative justice processes involving culturally competent investigators, coroners, and lawyers, which are held on country.
- Establish a coronial research unit to inform coroners, and to assist in the development of targeted and relevant coronial recommendations.
- Require mandatory responses to coronial recommendations.
- Create a publicly accessible centralised database of deaths in custody coronial findings, including recommendations made, and responses to recommendations, to enable accountability, oversight and review.
- Introduce NSW and national oversight mechanisms to ensure effective monitoring of coronial recommendations, responses to recommendations and implementation issues.
- Fund research that assesses coronial findings and recommendations into deaths in custody and deaths after police contact, and organisational responses to them, to understand the coronial role and its contribution to death prevention following the deaths of First Nations people in custody.

Further expansion of these recommendations is to be found in the following sections of this submission.

2. Background Observations Regarding Coronial Courts

Coronial inquests are routinely described as independent, inquisitorial, public, fact-finding hearings directed towards ascertaining the identity of the deceased, the time and place of death, and the cause and circumstances of death; often referred to as the 'who, when, where, what and how'. However, it is a key submission of ours that inquests can, and do, reveal and examine much more than these 'facts'. Our cross-jurisdictional research shows that when death occurs in contested circumstances the inquest becomes a site of contestation, an adversarial process in an inquisitorial arena. Often it is the only public examination of the circumstances of a death, or multiple deaths, in which bereaved families and communities have the opportunity to have the facts and circumstances examined.

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[4] See Lindsay McCabe, 'An Aboriginal Liaison in the Coroner's Court is Just the Start, But We Need to Start Somewhere' (2019) *IndigenousX* (7 November) at: https://indigenousx.com.au/an-aboriginal-liaison-in-the-coroners-court-is-just-the-start-but-we-need-to-start-somewhere/. See also Victorian State Coroner, *Practice Direction 6 of 2020: Indigenous Deaths in Custody*; but see Calla Wahlquist, 'Victorian Coroner Changes How Indigenous Deaths in Custody are Investigated' (2020) *The Guardian* (22 September) at: https://www.theguardian.com/australia-news/2020/sep/22/victorian-coroner-changes-how-indigenous-deaths-in-custody-are-investigated.

[5] See JUSTICE, above n 3.

Commentators have noted the therapeutic potential of coronial inquests to get to the truth of death through a process of public scrutiny, which has at its heart the prevention of avoidable death through the making of recommendations, a coronial power which has been described as representing 'the distillation of the preventive potential of the coronial process'.[6] On this view, on a personal level, inquests have the therapeutic potential to contribute to bereavement, often in the most difficult circumstances, experienced by families and friends of the deceased; on a societal level to inform public health and safety policy and agencies' practice preventing further avoidable deaths through open scrutiny allaying suspicion and ensuring the open, accountable administration of justice. This potential is tempered, however, by the persistent reality that inquests have been arenas of deep disappointment and distress, exacting damage instead of justice. It is a reality that has been well-documented in cross-jurisdictional research and includes: delays in the holding of inquests; restricted documentary disclosure; adversarial contexts and process; and inequality of arms in legal representation and funding.[7]

This tension explains why, for some commentators, 'inquests have long been a poor medium for revealing important information surrounding controversial deaths',[8] while others assert that: 'imperfect and variable as the coroner system is in helping relatives to understand the events leading up to the death of a family member, it is, in many cases, the only mechanism which even attempts to do this. There are other forums in which a death may be discussed or investigated, but . . . *[i]t is only in the inquest that the deceased is the focus of proceedings, rather than being a shadowy figure in somebody else's story'*.[9] In other words, 'death features in the work of civil and criminal courts as well as often being the motivation for the establishment of a public inquiry. But the inquest is the only formal state tribunal whose exclusive concern is death'.[10]

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[6] Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody' in Hugh Selby (ed) *The Inquest Handbook* (Federation Press, 1998), 186, 187. See also Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives* (Edward Elgar, 2016); Ray Watterson, Penny Brown and John McKenzie, 'Coronial Reform and the Prevention of Indigenous Death' (2008) 12(SE2) *Australian Indigenous Law Review* 4; Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(SE2) *Australian Indigenous Law Review* 45.

[7] Phil Scraton and Kathyrn Chadwick, *In the Arms of the Law: Coroner's Inquests and Deaths in Custody* (Pluto Press, 1987); Phil Scraton and Kathyrn Chadwick, 'Speaking Ill of the Dead: Institutionalised Responses to Deaths in Custody' (1986) 13(1) *Journal of Law and Society* 93; Phil Scraton, *Hillsborough: The Truth* (2016) Mainstream Publishing; Phil Scraton, 'The Legacy of Hillsborough: Liberating Truth, Challenging Power', (2013) 55(2) *Race & Class* 1; Phil Scraton, ''They'd All Love Me Dead …": The Investigation, Inquest, and Implications of the Death of Annie Kelly' (2006) 33(4) *Social Justice* 118; Phil Scraton, 'Lost Lives, Hidden Voices: 'Truth' and Controversial Deaths' (2002) 44(1) *Race & Class* 107; Phil Scraton, 'Policing with Contempt: The Degrading of Truth and Denial of Justice in the Aftermath of the Hillsborough Disaster' (1999) 26(3) *Journal of Law and Society* 273; INQUEST, *How the Inquest System Fails Bereaved People: INQUEST's Response to the Fundamental Review of Coroner Services* (2002); Ethan Blue, 'Seeing Ms Dhu: Inquest, Conquest and (In)visibility in Black Women's Deaths in Custody' (2017) 7(3) *Settler Colonial Studies* 299; Deborah Coles and Helen Shaw, '*Deaths in Custody: Truth, Justice and Accountability? The Work of INQUEST*' (2006) 33(4) *Social Justice* 136; Frances Gibson, 'Legal Aid for Coroner's Inquests' (2008) 15(4) *Journal of Law and Medicine* 587; Sherene Razack, *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody* (University of Toronto Press, 2015); Rebecca Scott Bray and Greg Martin, 'Exploring Fatal Facts: Current Issues in Coronial Law, Policy and Practice' (2016) 12(2) *International Journal of Law in Context* 115; Craig Longman, 'Police Silence and Aboriginal Deaths in Custody' (2020) 68 *Law Society Journal* 66; Rebecca Scott Bray, 'Paradoxical Justice: The Case of Ian Tomlinson' (2013) 21 *Journal of Law and Medicine* 447; Federation of Community Legal Services/ Australian Inquest Alliance, *Issues Paper: Saving Lives by Joining Up Justice* (March 2013).

[8] Tim Newburn, 'The Hillsborough Report Once and for all Lays Bare the Lies', *The Guardian* (12 September 2012) at: https://www.theguardian.com/commentisfree/2012/sep/12/hillsborough-report-lays-bare-the-lies.

[9] Gwynn Davis et al, United Kingdom Home Office Research, Development and Statistics Directorate *Experiencing Inquests, Home Office Research Study 241I* (2002), 77 (emphasis added). See also INQUEST, *How the Inquest System Fails Bereaved People*, above n 7.

[10] Celia Wells, 'Disasters: The Role of Institutional Responses in Shaping Public Perceptions of Death' in Robert Lee and Derek Morgan (eds), *Death Rites: Law and Ethics at the End of Life* (Routledge, 1996) 197.

This 'exclusive concern' is strongly aligned with a focus on 'truth-telling', publicly revealing 'what happened', thus encouraging the expansion and refinement of coronial powers through law reform and appellate review. Such reform reflects bereaved people's expectation that coronial inquiries should be sites of truth-telling, distinct from the adversarial context and process of criminal or civil courts. To discover the 'truth' of a person's death, coroners have wide powers of investigation and inquiry that are anomalous in adversarial legal landscapes, and they are not bound by the usual rules of evidence. In Australia, coronial death investigation has seen tranches of law and policy reform which, since the 1980s Norris reform agenda,[11] has deflected jurisdictional purpose away from criminalisation towards a remedial death prevention role. Gradual clause-by-clause reforms have been supported by significant legislative reform: the end of coronial juries; introduction and appointment of state coroners; and the cessation of many coronial powers with respect to the criminal jurisdiction. The latter includes committal powers, and preclusions from making findings or statements that persons may be guilty of an offence.

These changes are responsible for shifting the coronial role away from the commission of crime and criminal liability to a public health context. Thus its primary social purpose is the prevention of avoidable deaths; a role which is now characterised by a strong preventative principle embodied in coronial recommendatory functions.[12] Additionally, appellate decisions have clarified the jurisdictional ambit of investigation[13] and inquest,[14] the recommendatory power,[15] and findings with respect to causation and contribution to death.[16] Implicit in these reforms is the recognition that modern coronial law is distinct from criminal law, its processes and procedures. Rather, as an inquisitorial process it aims to establish the circumstances and context in which death/s occurred, establishing for the deceased and public record 'what happened' and to prevent recurrence through its findings and recommendations.

2.1 The Significance of the Royal Commission into Aboriginal Deaths in Custody

The evolution of the coronial role in Australia regarding deaths in custody investigations owes much to the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). Established in 1987 to investigate the high number of Aboriginal deaths in custody, the RCIADIC's 1991 *National Report* revealed 'the pervasive and troubling failure' of the coronial system in every Australian State and

[11] The 1981 Victorian Norris Report identified prevention as a key organising principle of modern coronial practice and was the foundation for the *Coroners Act 1985* (Vic). In 2009, Victoria enshrined prevention as a part of the Coroners Court function and coroners' core duties. John Gerald Norris, State of Victoria Law Department, *The Coroners Act 1958: A General Review* (1981) 4; Justin Malbon, 'Institutional Responses to Coronial Recommendations' (1998) 6 *Journal of Law and Medicine* 35, 38; Ian Freckelton, 'Coronial Law Reform: The New Wave' (2006) 14 *Journal of Law and Medicine* 151, 151.

[12] *Coroners Act 2008* (Vic) s 72(2); *Coroners Act 1997* (ACT) s 52(4); *Coroners Act 1993* (NT) s 26(1)(b), 34(2); *Coroners Act 1996* (WA) s 25(2); *Coroners Act 2009* (NSW) s 82; *Coroners Act 2003* (Qld) s 46(1)(a)–(b). In addition, in Queensland coroners hold the power to make comments on 'ways to prevent deaths from happening in similar circumstances in the future': see *Coroners Act 2003* (Qld) s 46(1)(c). In South Australia a similar power exists with respect to making recommendations that 'might, in the opinion of the court, prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest', *Coroners Act 2003* (SA) s 25(2). In Tasmania, coroners must, where appropriate, make preventative recommendations, *Coroners Act 1995* (Tas) s 28(2), (3).

[13] *Grace v Saines* [2004] VSC 229.

[14] *Fire Rescue Authority (Qld) v Hall* [1998] 98 2 Qd R 162; *Atkinson v Morrow* [2005] QCA 353; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1; *Conway v Jerram* (2010) 78 NSWLR 371.

[15] *Harmsworth v State Coroner* [1989] VR 989; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; *Grace v Saines* [2004] VSC 229; *R v Coroner Doogan; Ex parte Lucas- Smith* (2005) 158 ACTR 1; *Doomadgee v Clements* [2005] QSC 357 [2006]; *Doomadgee v Deputy State Coroner Clements* [2006] 2 Qd R 352.

[16] *Anderson v Blashki* [1993] 2 VR 89; *Keown v Kahn* [1999] 1 VR 69; *Chief Commissioner of Police v Hallenstein* [1996] 2 VR 1; Secretary, *Department of Health and Community Services v Gurvich* [1995] 2 VR 69; *Perre v Chivell* (2000) 77 SASR 282; *R v Coroner Doogan; Ex parte Lucas-Smith* (2005) 158 ACTR 1.

Territory to uncover the circumstances of Aboriginal deaths in custody and to make appropriate coronial recommendations.[17] The RCIADIC drew attention to issues with the independence of coronial investigations.[18] It also highlighted the then limitations of coronial legislation and the exercise of coronial powers, particularly that the prescribed coronial fact-finding task in deaths in custody had 'narrow focus'. This 'tunnel vision' meant that coronial investigations into deaths in custody excluded a consideration of wider issues, such as the quality of custodial care, treatment and supervision of the deceased prior to death.[19]

The RCIADIC also noted the inadequacy of statutory provisions around coronial recommendations, otherwise known as 'riders'. For example, it cited the then *Coroners Act 1958* (Qld), s 43(5), which, in limited circumstances, allowed coroners to deliver a 'rider' that expressed their informed conclusion based on the facts of the case that would 'prevent the recurrence of similar occurrences'. The diminished priority given to riders under the Act was emphasised by s 43(5A), which further provided that a 'rider shall not be deemed to be part of the Coroner's findings but it may be recorded if the Coroner thinks fit'. Considering the limits of such legislative provisions regarding recommendations, the RCIADIC noted that:

> Such a statutory provision tends to marginalise what … should be a major consideration for all coroners on inquest. Far from requiring that recommendations be made, it tends to suggest that they will only be made in exceptional circumstances. The inhibition which some coroners have shown in cases examined by the Commission is reinforced by the provision of a power couched in such terms.[20]

Correspondingly, the RCIADIC recommended that a more 'positive duty' should be imposed on coroners, sponsoring an upgrading of coroners' recommendatory powers from discretionary to obligatory.[21] The RCIADIC added that the value of coronial powers with respect to making recommendations lies in their implementation, and that statutory provisions should be enacted to enable a circuit of accountability, from the distribution of coronial findings and recommendations to government departments and agencies, through to agencies' operational policies and practices.[22] The RCIADIC thus brought considerable attention to the Australian coronial process, specifically and importantly to Indigenous death prevention. It affirmed the vital role of the office of coroner and delivered 34 recommendations aimed at modernising the system and enhancing its preventative potential. However, unlike larger legislative inquiries both prior and subsequent to the RCIADIC, a key criticism of post-RCIADIC coronial law reform has been its *ad hoc* and piecemeal application, with recommendations interpreted and implemented differently across Australia – including in NSW – an issue that re-emerged in 2016 with the 25th anniversary of the RCIADIC's *National Report.*[23] In NSW, s 22A *Coroners Act 1980* was enacted in response to Recommendation 13 of the RCIADIC relating to a more positive coronial duty to make recommendations, now reflected in the *Coroners Act*

[17] Watterson, Brown and McKenzie, above n 6, 6.
[18] See also https://www.policeaccountability.org.au/.
[19] Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 1* (1991) [4.5.83]-[4.5.84].
[20] Ibid [4.5.87]–[4.5.89]. Recommendation 13.
[21] Ibid [4.5.89].
[22] Ibid [4.5.91]-[4.5.98].
[23] See Amnesty International, 'The Adequacy of Post Death Investigations (Recommendations 6-40)' in Amnesty International, *Review of the Implementation of RCIADIC* (2015) Chapter 3; Prue Vines and Olivia McFarlane, 'Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody' (2000) 4(27) *Indigenous Law Bulletin* (2000) 8; Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner/ Aboriginal and Torres Strait Islander Commission, *Indigenous Deaths in Custody 1989-1996* (October 1996).

2009 s82 (NSW).[24] Yet, the statutory expression of this positive duty remains discretionary; coroners '*may*' make recommendations, and the circuit of accountability in NSW is not as strong as that recommended by the RCIADIC, a point expanded on below.

The RCIADIC marked a key development in contemporary Australian coronial law: the legislative recognition of, and expectations for, the coroner's role in death prevention following Indigenous deaths in custody.[25] Unlike other legal processes that consider matters of death and injury, albeit with different focus and purpose, the coronial inquest has a substantive remedial aspect that is forward looking, now firmly woven into the purpose and practice of NSW coroners and arguably signalling the jurisdiction as proactive rather than reactive. Nevertheless, we contend that there are issues specific to the deaths of First Nations people in custody which highlight limitations within the coronial truth-telling and fact-finding role. Two important matters we wish to highlight are issues of scope and the recommendatory role.

2.2 Inquest Scope

How the facts of death are investigated, revealed and registered in coronial courts and subsequently documented in official findings is important. In-depth research has revealed how a 'truth-telling' process such as the coroners' inquest focuses on contestation in 'weighing and weighting' evidence, exposing 'the myth of absolute truth' thus revealing a process which offers an aggregation of truth.[26] This process does not happen in a vacuum.[27] Ostensibly, while the fact-finding task of the coroner may appear to be focused on the 'who, when, where, what and how' of death, researchers have demonstrated how death's 'facts' have an extra-legal life, where the call for justice is influenced by the reconstruction of circumstances in the context of particular histories and their interpretation. This is especially notable when considering Indigenous deaths in custody, which have distinct socio-legal legacies, particularly institutionalised racism directed against Indigenous peoples in policing practice and incarceration.[28] In NSW for example, this history and its legacy has been documented by Chris Cunneen.[29] In reviewing Australia's – and NSW's – social and legal past, key historical facts, such as the policing of Indigenous people, and conditions of custody, provide the context for understanding contemporary Indigenous death. When the facts of death reflect specific histories of Indigenous life and death, coronial inquiries have implications well beyond fact-finding in individual cases, and coronial process has reflected and reinforced the discriminatory marginalisation of Indigenous people by State institutions.[30] The point being that this history must not be ignored when interpreting official versions of coronial fact-finding when considering Indigenous deaths in custody or during arrest.

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[24] John Abernethy et al, *Waller's Coronial Law and Practice in NSW* (Lexis Nexis Butterworths, 2010), 222 [82.1].

[25] Geraldine Mackenzie, Nigel Stobbs and Mark Thomas, '"What Really Happened" Versus "What We Can Prove": Tension Between the Roles of Coroner and DPP in Queensland' (2007) 6(24) *Indigenous Law Bulletin* 6, 7.

[26] Scraton, *Policing with Contempt*, above n 7, 274.

[27] Ibid.

[28] Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567; Chris Cunneen, 'Aboriginal Deaths in Custody: A Continuing Systematic Abuse' (2006) 33(4) *Social Justice* 37, 42; Jennifer Corrin and Heather Douglas, 'Another Aboriginal Death in Custody: Uneasy Alliances and Tensions in the Mulrunji Case' (2008) 28(4) *Legal Studies* 531; Janet Ransley and Elena Marchetti, 'Justice Talk: Legal Processes and Conflicting Perceptions of Justice About a Palm Island Death in Custody' (2008) 12(2) *Australian Indigenous Law Review* 41; Paula Morreau Policing Public Nuisance: The Legacy of Recent Events on Palm Island' (2006) 6(28) *Indigenous Law Bulletin* 9.

[29] Cunneen, above n 28, 42. See also Chris Cunneen, *Conflict, Politics and Crime: Aboriginal Communities and the Police*, (Allen and Unwin, 2001).

[30] Scott Bray, above n 28, 587; Alison Whittaker, 'The Unbearable Witness, Seeing: A Case for Indigenous Methodologies in Australian Soft Law' (2018) 25 *Pandora's Box* 23.

The strength of these determining contexts are gradually receiving greater recognition in Australian coronial courts, including in NSW, yet progress is slow. As recently as August 2020 NSW Coroners have commented on important background factors regarding the deaths in custody of Indigenous people in the wider political and social context. They cite research findings which demonstrate the high incarceration rate of First Nations people, their over-representation in prison, the underlying factors and structural disadvantage underpinning disproportionate incarceration, and the need for diversion from the criminal justice system. Coroners also refer to the findings of the RCIADIC, and the much-cited observation that 'if Aboriginal people were not in custody, they would not be dying in custody'.[31] It appears that coroners recognise the significance of settler colonialist legacy and its ongoing violence against Indigenous peoples. Yet, relegating this history to 'relevant background factors' deflects attention 'away from the strength of determining contexts' and their relevance to the scope of inquests and the facts of death.[32] As Coles and Shaw argue in the UK context regarding the disproportionate numbers of Black people in police and prison custody, 'understanding why these deaths occur requires an examination of their broader social and political contexts'.[33]

A key factor in how the coronial jurisdiction manages both the scope and parameters of inquiry is through applying the subjective notion of 'relevance'. Coroners are cautioned that their inquiries should be limited to factors relevant to the death. This nexus ensures that coronial power is not free-ranging, yet is sufficiently broad to permit coroners to contextualise the causes of deaths by examining their circumstances. Nevertheless, the capacity exists to elevate, when necessary, underlying factors to the foreground through widening the scope of inquiry, and is being tested in coronial courts. For example, in her findings into the death in custody of Yamatji woman Ms Dhu, the Western Australia (WA) State Coroner emphasised the importance of historical context and its relationship to the inquest's scope. She referred to the findings of the RCIADIC, and cited the following academic research reiterating the RCIADIC's unequivocal recommendations regarding coronial investigations of deaths in custody. They include:

> … an expansion of a coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.[34]

However, the intention to assess underlying causes of death and the structural context of Indigenous disadvantage ultimately was interpreted differently by the WA State Coroner. In Ms Dhu's case, it was considered by the coroner as only a very brief history – her medical and drug history, her *personal* history. Relegated to the conclusion of her 165-page findings the State Coroner comments on institutional racism, yet fails to contextualise its origins and persistence. For, it is the legacy of Australian settler colonial history and its contemporary manifestation that underpin what the coroner

[31] David McDonald and Chris Cunneen, 'Aboriginal Incarceration and Deaths in Custody: Looking Back and Looking Forward' (1997) 9(1) *Current Issues in Criminal Justice* 5, 18.
[32] Scraton, *Policing with Contempt*, above n 7, 274.
[33] Coles and Shaw, above n 7, 139.
[34] Watterson, Brown John McKenzie, above n 6, 6; Western Australia Coroners Court, *Inquest into the death of Ms Dhu*, *Inquest 11020-14* (2016), 8.

termed 'the social determinants of ill health'.[35] The State Coroner detailed 'a story of Aboriginal difference',[36] instead of the legacy of settler colonialism, which should form an essential element of the inquest's scope. Indigenous scholars repeatedly have identified that settler colonial history is not confined to the past, but is the recent historical context to the present,[37] a point which coroners are increasingly recognising. Such findings by the WA State Coroner fall short of addressing the prevention of avoidable death – which is the declared role of the coroner. While clearly coronial work is developing greater recognition of determining contexts in inquest scope, it has been families and their advocates who have campaigned for coronial change to ensure that the scope of inquests reflects the factual circumstances of death for First Nations peoples. A pertinent example is Yorta-Yorta woman Tanya Day's family in Victoria, who succeeded in arguing that the inquest scope should include consideration of the significance of systemic racism in her death.[38] This means there exists a need to better account for determining contexts in an instrumental way at inquest. While the examples quoted above are from WA and Victoria, they are directly relevant to other coronial jurisdictions, including NSW.

When coroners find facts by weighing evidence and delivering findings, they produce official determinations about death which remain on the record. They are manifestations of State power.[39] As Halstead has also noted, a coronial finding is 'the key vehicle through which the public interest in the coronial process is conveyed'.[40] The language used is important in recognising how coroners delimit scope but also how they determine causation. Despite increasing attempts by coroners to respect and 'humanise' the deceased, coronial researchers continue to reveal how Indigenous deaths in custody regularly are characterised as 'timely' or 'tragic' and, therefore, 'naturalised'.[41] Gomeroi scholar Alison Whittaker has analysed coronial findings following Indigenous deaths in custody revealing how the conduct of police or prison guards is described by coroners as 'unnecessary', the use of force

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[35] Western Australia Coroners Court, above n 34, 161; see also Pauline Klippmark and Karen Crawley, 'Justice for Ms Dhu: Accounting for Indigenous Deaths in Custody in Australia' (2018) 27(6) *Social and Legal Studies* 695.

[36] Sherene Razack, 'Reframing *Two Worlds Colliding*: A conversation between Tasha Hubbard and Sherene Razack' (2011) 33 *The Review of Education, Pedagogy, and Cultural Studies* 318, 329. See also Sherene Razack, 'The Space of Difference in Law: Inquests into Aboriginal Deaths in Custody' (2011) 1(1) *Somatechnics* 87; Klippmark and Crawley, above n 35; Travis Hay, 'Foreclosing Accountability: The Limited Scope of the Seven Youth Inquest in Thunder Bay, Ontario' (2019) 78 *Canadian Review of Social Policy* 1; Blue, above n 7; Latoya Aroha Rule, 'Sovereign Debt' (2018) *The Lifted Brow* (21 December) at: https://www.theliftedbrow.com/liftedbrow/2018/12/19/blak-brow-sovereign-debt-by-latoya-rule; Alison Whittaker, "'Dragged Like a Dead Kangaroo': Why Language Matters for Deaths in Custody' (2018) *The Guardian* (8 September) at: https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody; Amanda Porter, 'On Death and Indifference' (2016) *NITV* (15 April) at https://www.sbs.com.au/nitv/nitv-news/article/2016/04/15/amanda-porter-death-and-indifference; Mandi Gray, 'Pathologizing Indigenous Suicide: Examining the Inquest into the Deaths of C.J and C.B at the Manitoba Youth Centre. (2016) 10(1) *Studies in Social Justice* 80.

[37] Judy Atkinson, *Trauma Trails: Recreating Song Lines* (Spinifex, 2002); Larissa Behrendt 'Consent in a (Neo)Colonial Society: Aboriginal Women as Sexual and Legal 'Other' (2000) 15(3) *Australian Feminist Studies* 353; Aileen Moreton-Robinson, *The White Possessive: Property, Power and Indigenous Sovereignty* (University of Minnesota Press, 2015); Aileen Moreton-Robinson (ed) *Sovereign Subjects* (Allen & Unwin, 2007); Irene Watson, 'Sovereign Spaces, Caring for Country and the Homeless Position of Aboriginal Peoples' (2009) 180 *South Atlantic Quarterly* 27.

[38] See https://www hrlc.org.au/tanya-day-overview. See the family's submissions in the inquest into the death of Tanya Day, available at: https://www hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability. See also Monique Hurley, 'The Beginnings of Justice for Aboriginal Deaths in Custody?' 159 (July/August) *Precedent* 4. In NSW an example is the inquest into the death of Wiradjuri woman Naomi Williams, which considered whether the medical care provided to her was affected or compromised by unconscious, implicit bias or racism. See Coroners Court of NSW, *Inquest into the Death of Naomi Williams* (2016/2569).

[39] Scraton, *Policing with Contempt*, above n 7, 278.

[40] Boronia Halstead, 'Coroners' Recommendations and the Prevention of Deaths in Custody', Australian Deaths in Custody, No. 10. Canberra: Australian Institute of Criminology (November 1995), 7.

[41] See Sherene Razack, 'Timely deaths: Medicalizing the Deaths of Aboriginal People in Police Custody (2011) 9(2) *Law, Culture and the Humanities* 352; Razack, above, n 7; Whittaker, above n 36; Aroha Rule, above n 36.

'unfortunate' but 'never causative'.[42] She concludes that, ultimately, coronial findings represent 'the same blameless fatalism that has long underscored Australia's Indigenous policy'.[43] It is important to consider family submissions at inquests into deaths of First Nations people in custody to demonstrate the importance of language and its effects, such as the submission of Tanya Day's family in the Victorian jurisdiction.[44] The family clearly outlined the significance of language and how it makes meaning of death.[45] These critical submissions and research highlight the importance and impact of coroners' findings and how they are written. Significantly, they also spotlight the coronial lens through which the deaths of First Nations people in custody are interpreted.[46] Language that glosses over conduct, diminishes its place in the causative chain, and buries causative actions within a range of 'naturalised' factors rather than State violence has devastating consequences for families; it also has devastating consequences for accountability following the deaths of First Nations people in custody, with coroners rarely referring matters to the Director of Public Prosecutions.[47]

In England and Wales, European human rights jurisprudence has steered coronial law and practice in a more preventative direction, emphasising the importance of 'lessons learned',[48] and broadening the scope of inquests that engage Article 2 of the European Convention of Human Rights. Thus, the coronial investigation of 'how' the deceased came by their death is not confined to 'by what means',[49] but 'by what means and in what circumstances' as ruled in *Middleton*.[50] These changes have led to the important introduction of narrative conclusions supplementary to short-form verdicts, delivered by the coroner or, where applicable, by juries. Narrative verdicts are more probing than short-form verdicts, giving greater scope to contextualising the circumstances of a death. Despite jurisdictional differences,[51] NSW coronial fact-finding nevertheless echoes the *Middleton* approach to context. *Conway v Jerram* affirmed that the expression 'how the death occurred' should be given the broad construction of 'by what means and in what circumstances the death occurred'.[52] In NSW the narrative form of coronial findings is a strong element of inquest findings. Coroners commonly deliver their findings of fact through discursive statements of circumstances enabling in their findings the inclusion of contextual background factors.[53] This contextual narrative seeks to offer a comprehensive understanding of the context and circumstances of death, reinforcing the significance of language in Australian coronial findings.

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[42] Whittaker, above n 36.
[43] Ibid.
[44] Available at: https://www hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability.
[45] *Inquest into the Death of Tanya Day: Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberly Watson, the Children of Tanya Day* (2019), 6, available at: https://www hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability.
[46] See Whittaker, above n 36.
[47] A key example here is the death of Dunghutti man David Dungay Jr: Coroners Court of NSW, *Inquest into the Death of David Dungay* (2015/381722). See Alison Whittaker, 'Despite 432 Indigenous Deaths in Custody Since 1991, No One Has Ever Been Convicted. Racist Silence and Complicity Are to Blame' (2020) *The Conversation* (3 June) at: https://theconversation.com/despite-432-indigenous-deaths-in-custody-since-1991-no-one-has-ever-been-convicted-racist-silence-and-complicity-are-to-blame-139873; see also Whittaker, above n 36.
[48] *R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653 [31].
[49] As stated in *R v Coroner for North Humberside and Scunthorpe; Ex parte Jamieson* [1995] QB 1.
[50] *R (Middleton) v HM Coroner for West Somerset* [2004] 2 AC 182.
[51] A point expanded on below in terms of human rights.
[52] See *Conway v Jerram* (2010) 78 NSWLR 371; *Atkinson v Morrow* [2005] QSC 92; *Atkinson v Morrow* [2005] QCA 353.
[53] Scott Bray, above n 28.

2.3 Coronial Recommendations

The challenge for many coronial jurisdictions – including NSW – lies in realising the preventative potential of coronial findings via their recommendations. The RCIADIC noted the importance of coroners' using their powers to make recommendations and for institutions to respond appropriately.[54] Victoria legislated for mandatory responses to coronial recommendations in addition to greater visibility of coronial decisions via internet publication of coronial findings and subsequent responses.[55] Regarding responses to coronial recommendations, NSW adopted a policy directive. In 2009 the NSW Premier issued the *Responding to Coronial Recommendations* memorandum to Ministers and agencies, directing that 'within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney-General outlining any action being taken to implement the recommendation'.[56] The Memorandum stipulates that a record of all recommendations made and responses received would be maintained, and information would be summarised in a report posted on the Attorney General's website.[57] The Memorandum does not capture recommendations directed to private sector agencies or regulatory feedback. Coronial recommendations are just that: solely recommendatory, with Australian coroners possessing no power to make orders enforceable. Potentially, this limitation forfeits the preventative power of coroners.[58] However, the debates concerning mandatory responses and enforceability raise important questions about the suitability and development of relevant, targeted recommendations and coronial expertise. Victoria sought to boost the preventative capacity of coroners commissioning research via the Coroners Prevention Unit, yet there is a case for wider appreciation of death research beyond epidemiological models.[59]

The ongoing issue of making and responding to recommendations also raises the issue of coroners potentially trespassing on government policy. In June 2009, while recognising the importance of coronial recommendations, the NSW Attorney-General noted they are 'not directives', adding that '[a]ny system which enabled a coroner, who is a judicial officer, to direct or determine government policy would not only be a serious breach of the separation of powers, but would also be contrary to the principles of democratic governance'.[60] Nevertheless, as highlighted by two recent NSW deaths in custody decisions, coroners still are recommending the removal of hanging points in cells,[61] an issue raised three decades ago by the RCIADIC in its 1991 report.[62] Just as importantly as Halstead notes, 'the action taken in response to such recommendations carries the promise of lives saved and injuries averted. It should be noted that every single death represents the tip of the iceberg of injuries and other high-risk circumstances'.[63]

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[54] Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 1* (1991) [4.5.85]-[4.5.98].
[55] *Coroners Act 2008* (Vic) s 72, s 73 and s 72(5)(a) respectively.
[56] NSW Premier, Memorandum, *M2009-12 Responding to Coronial Recommendations* (2009) at: https://arp nsw.gov.au/m2009-12-responding-coronial-recommendations/.
[57] Ibid. To view the summaries of responses to coronial recommendations made pursuant to s 82 of the *Coroners Act 2009* (NSW) see: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.
[58] Rebecca Scott Bray 'Why this Law?': Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(2) *Australian Indigenous Law Review* (2008) 27.
[59] See also Hugh Dillon, 'A Three-Cavity Autopsy of the NSW Coronial System: What's Going on Inside?' (2019) *Journal of the NSW Bar Association* (Autumn) 9.
[60] New South Wales, *Parliamentary Debates,* Legislative Assembly, 4 June 2009, 15781 (The Hon John Hatzistergos, Attorney General, and Minister for Industrial Relations).
[61] Coroners Court of NSW, *Inquest into the Death of Tane Chatfield* (2017/288854); Coroners Court of NSW, *Inquest into the Death of Jonathon Hogan* (2018/37983).
[62] Cunneen, above n 28.
[63] Halstead, above n 6, 187.

With the increase in 'narrative verdicts' (or 'narrative conclusions') in the England and Wales, together with the making of preventative reports, UK campaigners remain concerned about their impact on institutional policies and practices. Advocacy group INQUEST has published numerous reports addressing institutional deaths, arguing for auditing, follow-up and compliance monitoring of coronial recommendations, and has cited Australia's ability in this respect.[64] In Australia, however, these issues have been an ongoing concern since coronial recommendations signalled the preventative evolution of coronial law,[65] leading researchers to question the effect of coronial recommendations on death prevention.[66] In 2000, Australia established the National Coronial Information System, a database of coronial information on all Australian deaths reported to the coroner, subsequently extended to New Zealand deaths.[67] In addition, NSW reports annually to parliament on deaths in custody and during police operations,[68] and responses to NSW coronial recommendations are archived online in response to the 2009 NSW Memorandum.[69] NSW publishes detailed biannual report summaries of government responses on the Justice Department's website, not full agency responses.[70]

Despite these established databases and activities of archiving and audit, there is no effective public oversight or monitoring of coronial recommendations following deaths in custody or official responses to them. No published research study has analysed the uptake of coronial recommendations following deaths in custody since Boronia Halstead's Victorian research[71] which examined the pathway of implementation as recommended by the RCIADIC.[72] Halstead's analysis highlighted concerns regarding interagency accountability and communication in the implementation pathway. While the RCIADIC recommendations for post-death investigations and implementation pathways in part have been implemented in Australian states and territories, including NSW,[73] it is significant that since the RCIADIC and Halstead's research there has been increased awareness of the coronial recommendatory role and responses to recommendations. However, there is an urgent need to think beyond the 1991 RCIADIC implementation pathway recommendations, not least because Indigenous people 'now die

[64] INQUEST, *Deaths in Mental Health Detention: An Investigation Framework Fit for Purpose?* (London, 2015); INQUEST, *Stolen Lives and Missed Opportunities: The Deaths of Young Adults and Children in Prison* (London, 2015); INQUEST/ Barrow Cadbury Trust/ Prison Reform Trust, *Fatally Flawed: Has the State Learned Lessons from the Deaths of Children and Young People in Prison?* (London, 2012).

[65] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2003) 10(4) *Journal of Law and Medicine* 399.

[66] Scott Bray, above n 58, 36; Watterson, Brown and McKenzie, above n 6; Raymond Brazil, 'The Coroner's Recommendation: Fulfilling its Potential? A Perspective from the Aboriginal Legal Service' (NSW/ACT) (2011) 15(1) *Australian Indigenous Law Review* 94; Rory Downey, 'When Will People Read the Recommendations?' (2008) 12(2) *Australian Indigenous Law Review* 95.

[67] Jessica Pearse and Leanne Daking, 'The National Coroners Information System: Contributing to Death and Injury Prevention' (2007) 36(2) *Health Information Management Journal* 54.

[68] The reports are available online at: https://www.coroners nsw.gov.au/coroners-court/resources/publications/deaths-in-custody-and-police-operations-annual-reports.html. See also the Australian Institute of Criminology: *Deaths in Custody National Monitoring Program*, established in response to Recommendation 41 of the RCIADIC at: https://aic.gov.au/publications/mr/mr20/national-deaths-custody-program.

[69] See https://www.justice nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

[70] Ibid.

[71] Halstead, *Coroners' Recommendations Following Deaths in Custody*, above n 6; Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340; Halstead, *Coroners' Recommendations and the Prevention of Deaths in Custody*, above n 40.

[72] See RCIADIC recommendations 13-18, Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 5* (1991).

[73] See Amnesty International, above n 23; Vines and McFarlane, above n 23; Office of the Aboriginal and Torres Strait Islander Social Justice Commissioner, above n 23; Victorian Aboriginal Legal Service (2008) 'The Centrality of the Royal Commission into Aboriginal Deaths in Custody When Discussing Potential Reform to the Victorian Coronial System' *Australian Indigenous Law Review* 12(SE12): 55-63.

in custody at a greater rate than before the RCIADIC handed down its report in 1991'.[74] The RCIADIC focused on potential pathways to implementation of coronial recommendations. In addition to full and comprehensive adherence to the RCIADIC recommendations, a review of oversight mechanisms is necessary.

This is highlighted in part by Halstead's research, which also explored the intermediary role of the Attorney-General, interposed between coroners and agencies to whom coronial recommendations are addressed.[75] While there is no requirement for the NSW State Coroner to submit findings and recommendations to the Attorney-General (as is the case in other jurisdictions, such as the Northern Territory),[76] the intermediary role is evident is section 37 of the *Coroners Act 2009* (NSW), stipulating that the State Coroner should provide an annual report to the Attorney-General detailing all deaths in custody and in the course of a police operation. This action was to give effect to Recommendation 17 of the RCIADIC,[77] and 'create a mechanism which can strengthen accountability for the implementation of recommendations, and to place on the public record recommendations made and response to same'.[78] Halstead notes that through this action, 'Recommendation 17 would be interpreted as the final and critical link in a carefully crafted chain of accountability, tying together the responses of a range of agencies'.[79] In NSW, the intermediary role of the Attorney-General is boosted by the 2009 NSW Premier's Memorandum, *Responding to Coronial Recommendations*, referred to above, which details the process for responding to all coronial recommendations. Directed at Ministers and NSW government agencies, it includes a record of coronial recommendations and responses.[80] Halstead questions this intermediary role, which she argues is 'passive and undefined'.[81] Notwithstanding the separation it enacts between the coroner's investigatory role and the government's decision-making role, Halstead states it has 'blurred accountability and provided a false sense of security for the preventive functioning of the coroner'.[82]

A quarter of a century on from Halstead's case study and conclusions, it is important to record that there have been 21 annual reports into deaths in custody and police operations made by the NSW State Coroner to the NSW Attorney-General in 23 years.[83] Halstead offered a clear vision for coronial accountability via the Attorney-General, given that the Department of Justice possesses sufficient resources to monitor effectively the implementation of recommendations, and have a 'wider understanding of the inter-agency implications of particular recommendations'.[84] Also, she raised the

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[74] Kirrily Jordan, Thalia Anthony, Tamara Walsh and Francis Markham, *Joint Response to the Deloitte Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*. Centre for Aboriginal Economic Policy Research, ANU College of Arts and Social Sciences, CAEPR Topical Issue No.4/2018 (2018), 1.

[75] Halstead, *Implementing Coroners' Deaths in Custody Recommendations*, above n 71.

[76] See *Coroners Act 1993* (NT) s 27.

[77] Recommendation 17: 'That the State Coroner be required to report annually in writing to the Attorney-General or Minister for Justice, (such report to be tabled in Parliament), as to deaths in custody generally within the jurisdiction and, in particular, as to findings and recommendations made by Coroners pursuant to the terms of Recommendation 13 above and as to the responses to such findings and recommendations provided pursuant to the terms of Recommendation 16 above'.

[78] Halstead, *Implementing Coroners' Deaths in Custody Recommendations*, above n 71, 351.

[79] Ibid.

[80] NSW Premier, Memorandum, *M2009-12 Responding to Coronial Recommendations* (2009) at: https://arp nsw.gov.au/m2009-12-responding-coronial-recommendations/. See the summaries: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

[81] Halstead, *Implementing Coroners' Deaths in Custody Recommendations*, above n 71, 352.

[82] Ibid.

[83] Available online at: https://www.coroners.nsw.gov.au/coroners-court/resources/publications/deaths-in-custody-and-police-operations-annual-reports html.

[84] Halstead, *Implementing Coroners' Deaths in Custody Recommendations*, above n 71, 352.

potential of a 'watch-dog role', through which the Attorney-General could 'report annually to Parliament or the relevant Minister on the extent to which agencies have implemented coronial recommendations' and any follow-up required.[85] For, without greater oversight of coronial recommendations, a key intermediary role such as that of the Attorney-General is reduced to a 'non-interventionist post-box function'.[86] Thus, concern regarding realisation of the coronial preventative role is that it is reduced to 'a disinterested intermediary which has an unspecified purpose and no defined responsibilities is actually likely to blunt the remedial effectiveness of coronial recommendations'.[87] What is required, therefore, is effective monitoring of coronial recommendations and responses.

However, the lack of research into the context and construction of coronial recommendations leaves a significant gap in realising a key concern noted by the RCIADIC, with significant and persistent implications for the deaths of First Nations people and recommendatory outcomes. Indeed, there is limited research into the broader uptake of coronial recommendations. There are few Australian studies assessing the significance of coronial investigations and minimal recommendations for policy change. Watterson et al[88] conducted a broad national study and established several significant factors affecting the implementation of coronial recommendations, including the feasibility of recommendations, whether a mandatory system of reporting responses had been established, and how recommendations were formulated and expressed.[89]

Sutherland et al's Victorian-based research[90] confirmed Watterson et al's data, although they surveyed recipient organisations regarding actions taken in relation to public health and safety coronial recommendations and factors influencing their decision. Their study revealed only a third of coroners' recommendations were implemented. Sutherland et al also differentiate between actions taken by organisations before and after recommendations are made (supplanted recommendations), raising important issues regarding inquest delays, organisational input into recommendations, and organisations acting in anticipation of coronial findings. Their research demonstrated that reasons for the rejection of coronial recommendations include logistical and economic considerations of viability.[91]

A more probing analysis by Sutherland et al was limited by project design which precluded in-depth investigation of organisational behaviour. They note that 'more in-depth qualitative study of action taken and views held within recipient organisations would be a valuable complement' to their findings.[92] This limitation was also addressed by Moore and Henaghan[93] and Moore,[94] who have provided the most comprehensive study of coronial recommendations in New Zealand (NZ). They developed Sutherland et al's methodological approach, to provide an in-depth qualitative assessment of the uptake of coronial recommendations by recipient organisations in NZ. They interviewed coroners and other stakeholders, and surveyed recipient organisations, collecting and analysing

[85] Ibid.
[86] Ibid 353.
[87] Ibid.
[88] Watterson, Brown and McKenzie, above n 6.
[89] Ibid 6.
[90] Georgina Sutherland et al 'What Happens to Coroners' Recommendations for Improving Public Health and Safety? Organisational Responses Under a Mandatory Response Regime in Victoria, Australia' (2014) 14 *BMC Public Health* 732.
[91] Ibid.
[92] Ibid 738.
[93] Jennifer Moore and Mark Henaghan, *New Zealand Coroners' Recommendations, 2007-2012*. The Law Foundation of New Zealand/Faculty of Law, University of Otago (2014).
[94] Moore, above n 6.

complex data to provide a quantitative and qualitative assessment of the nature, frequency and responses to coronial recommendations. They focus on improving the preventative potential of coronial recommendations, including the need for oversight mechanisms.[95] In Victoria Sutherland et al[96] conducted in-depth content analyses of mandatory responses to coroners' public health and safety recommendations, more fully considering the composition and adequacy of organisational responses. They found Victoria's mandatory response regime to be compromised by the opacity of many response letters, in addition to concerns regarding 'soft' coronial recommendations including requests to review, consideration or continuance of a certain course of action, where a compliance response is 'relatively effortless'.[97] Other small-scale, focused studies augment these larger research initiatives.[98] These studies highlight the complexity and diversity of issues involved in the formulation, expression, and implementation of coronial recommendations.

Examining the characteristics of coronial findings and recommendations into deaths in custody and deaths after police contact, and organisational responses, is an important step to understanding the coronial role and contribution to prevention following First Nations deaths in custody. *Crucially and instructively, we do not know when, whether and to what extent coroners' investigations into deaths in custody precipitate action, when recommendations are made, accepted and acted on, or why they are rejected.* Analysing the circuit between coronial investigations, recommendations, and relevant agencies is essential in establishing current limitations and best practices. It would also document prevention success stories. For example, Victorian research into coronial recommendations has highlighted coroners' contribution to avoidable drowning deaths of children in swimming pools, tractor-related deaths, and railway level-crossing related deaths.[99] Research is imperative to examine the intersection of coronial work and criminal justice reform to document death prevention in custodial environments. Without this information, the effectiveness or suitability of the coroner as an oversight agency of deaths in custody cannot be ascertained.

These issues are not restricted to NSW, but relate to coronial audit Australia-wide. In light of these limitations, initiatives such as The Guardian's *Deaths Inside* database,[100] and the *UQ Deaths in Custody Project*,[101] have emerged to interrogate and make deaths in custody data publicly accessible and intelligible. They are joined by other initiatives such as *Deathscapes*,[102] a database of Indigenous and racialised custodial deaths in settler states, including Australia. These initiatives enable the distillation and oversight work that should be a routine part of accountability mechanisms following deaths in custody.[103] This is not satisfactory in a state – or country – that espouses death prevention at the heart of its death investigation system. For example, an important question is that if three decades on from

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[95] Ibid 286-287.

[96] Georgina Sutherland, Celia Kemp and David M. Studdert, 'Mandatory Responses to Public Health and Safety Recommendations Issued by Coroners: A Content Analysis' (2016) 40(5) *ANZJ Public Health* 451.

[97] Ibid 455.

[98] See Elena Mok, 'Harnessing the Full Potential of Coroners' Recommendations' (2014) 45(2) *Victoria University of Wellington Law Review* 321; Rose Mackie, 'The Implementation of Coronial Recommendations in Tasmania: Two Case Studies on Child Deaths' (2018) 25(2) *Journal of Law and Medicine* 503.

[99] See Moore and Henaghan, above n 93, 252-255; Bugeja and Ranson, above n 65. Added to this is the issue of whether recommendations are made at all, see Lyndal Bugeja et al, 'Application of a Public Health Framework to Examine the Characteristics of Coroners' Recommendations for Injury Prevention' (2012) 18 *Injury Prevention* 326.

[100] A database of Indigenous deaths in custody. See https://www.theguardian.com/australia-news/series/deaths-inside.

[101] A database of deaths in custody from publicly available information. See https://deaths-in-custody.project.uq.edu.au/; Tamara Walsh and Angelene Counter, 'Deaths in Custody in Australia: A Quantitative Analysis of Coroners' Reports' (2019) 31(2) *Current Issues in Criminal Justice* 143.

[102] See https://www.deathscapes.org/.

[103] Rebecca Scott Bray, 'Death Justice: Navigating Contested Death in the Digital Age' in Michael Hviid Jacobsen and Sandra Walklate (eds) *Emotions and Crime: Towards a Criminology of Emotions* (Routledge, 2019), 169.

the RCIADIC coroners still are making recommendations regarding hanging points in cells, what exactly is preventative about the coronial role following deaths in custody?[104]

Coronial death investigation, including the holding of inquests, is a considerable and necessary justice investment. NSW spends less on coronial death investigation than other comparable jurisdictions. In 2017-18, NSW spent $6.6m on coronial matters; Victoria $16.7m and Queensland $11.3m.[105] Nevertheless, expenditure is justified in part because coroners contribute to death prevention goals within communities.[106] For deaths in custody or during police operations, inquests are mandatory, and the independent scrutiny coroners provide is an invaluable in unpacking the facts of individual deaths while, ideally, directing remedial attention towards systemic issues.[107] The cost, however, is also felt in other areas. People who have lost loved ones often report that they do not wish other families to suffer the loss of a loved one in similar circumstances, and that the coronial process has the potential to achieve that objective.[108]

Post-RCIADIC coronial reform sought to recognise the particular circumstances of deaths during arrest or in custody. Reforms addressed definitions of deaths in custody, in addition to requirements of investigation, inquiry, inquest[109] and, in some States and Territories, findings and recommendations and subsequent responses.[110] Further coronial reforms must reflect and reiterate that 'from a social perspective the investigation of deaths in custody is perhaps one of the most important types of investigation undertaken by coroners … a person who is being involuntarily detained has lost his or her freedom of action and the ability to take specific steps to protect himself or herself from harm'.[111] More broadly these matters raise the question of human rights. Australia is a signatory to a number of human rights treaties, including the *International Covenant on Civil and Political Rights* (ICCPR). The right to life is provided for by Article 6(1) of the ICCPR which states that 'Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life'. The right to life infers two substantive obligations on the State: a negative obligation to refrain from taking life without justification, and a positive obligation to protect it by establishing a framework of laws, precautions, procedures and means of enforcement.[112] Both Victoria, by way of its *Charter of Human Rights and Responsibilities Act 2006* (Vic), and the ACT by virtue of its *Human Rights Act*

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[104] See Inga Ting (2011) 'Deaths in custody: authorities ignore warnings on hanging points', *Crikey* (15 June 2011), where she writes: 'Between 2001 and 2009, NSW coroners commented on the Department's failure to remove or screen obvious hanging points – in breach of Recommendation 165 of the Royal Commission into Aboriginal Deaths in Custody – at more than 20 inquests and made formal recommendations urging the elimination of hanging points in 2002, 2004, 2005, 2006 and 2009'. See Inga Ting's series of reports on deaths in custody for *Crikey* from April-December 2011.

[105] Australia Government, *Report on Government Services*, Productivity Commission: Canberra (2019), 7.4. See also Hugh Dillon, 'Why NSW Needs a Specialist Coroners Court' (2018) 48 *Law Society Journal* 26.

[106] Moore and Henaghan, above n 93, 20. See also Michael S King, 'Non-Adversarial Justice and the Coroner's Court: A Proposed Therapeutic, Restorative, Problem-Solving Model' (2008) 16 *Journal of Law and Medicine* 442; Hugh Dillon, *Raising Coronial Standards of Performance: Lessons from Canada, Germany and England,* Winston Churchill Memorial Trust (2014) available at: https://www.churchilltrust.com.au/project/to-develop-guidelines-for-best-practice-in-australian-coroners-courts-especially-the-training-of-coroners---canada-uk-germany/.

[107] Halstead, *Coroners' Recommendations and the Prevention of Deaths in Custody*, above n 40, 3.

[108] Moore and Henaghan, above n 93, 14.

[109] See Vines and McFarlane, above n 23.

[110] See recommendations 12–18 of the RCIADIC: Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 1* (1991) [4.7.4]. See also *Coroners Act 1997* (ACT), ss 75(1), 76; *Coroners Act* (NT), ss 26(1)(a), 26(2), 27(1), 35, 46A, 46B; *Coroners Act 2003* (SA), s 25.

[111] Ian Freckelton and David Ranson, *Death Investigation and the Coroner's* Inquest (Oxford University Press, 2006), 224.

[112] International obligations under these conventions do not provide for domestically enforceable rights in the absence of legislation implementing those rights in local laws, although aggrieved individuals can communicate their claim in respect of a breach of the ICCPR to the United Nations Human Rights Committee (UNHRC).

2004 (ACT), give some effect to human rights in the local context, providing for rights-protecting legislative scrutiny and the requirement that public authorities act consistently with human rights.[113]

Legislative scrutiny on recent UK coronial reform framed it as a 'human rights enhancing measure'.[114] Australian coroners should not, and in fact, do not ignore human rights considerations in discharging their investigative duty,[115] however this consideration requires enhancement, including in NSW. In 2011 the Australian government released its draft Baseline Study for consultation as part of the process of implementing a National Human Rights Action Plan.[116] In their submission, the advocacy group Australian Inquest Alliance (AIA) outlined the relevance of the coronial system to Australia's human rights obligations. The AIA documented a number of areas that highlight the coronial capacity to protect human rights, including its truth-telling and fact-finding role, and its preventative function. The AIA additionally outlined the shortcomings of the coronial jurisdiction that frustrate and potentially breach these rights, such as delays in inquest, lack of resources for coroners, and limitations with respect to coronial recommendations. The result is that the Australian coronial jurisdiction broadly is now out of step with international human rights jurisprudential developments following deaths in custody.[117]

3. The Centrality of the Bereaved and the Community

> The bereaved and survivors continually reiterate their desire for truth, their demands for accountability and their need for acknowledgement. This should not be perceived as vengeful or punitive. Nor should it be interpreted as an abandonment of due process or just deserts. Reconciliation, as truth commissions have shown, can be achieved only if ethical responsibility is established in the context of recognisable due process.[118]

Coroners' courts are routinely described as 'the people's court', where the dead and the interests of the bereaved are central to proceedings; where publicity is an important component of scrutinising death and securing open justice. Such claims do not hint at the complexities behind the investigation of deaths in custody, nor do they tackle the differential experiences of families who come into contact with the coronial system. Attending an inquest into the death of a person in custody reveals many other issues at the heart of inquests: the adversarial life of the inquisitorial process; the words and techniques of lawyers; the demeanour of State witnesses, some of whom cannot offer contrition or compassion in the face of avoidable death. From our extensive research, inquests are regularly insensitive to the presence and needs of the bereaved. Technology often delivers overwhelming, sensitive visual evidence to the

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[113] Ian Freckelton and Simon McGregor, 'Coronial Law and Practice: A Human Rights Perspective' (2014) 21 *Journal of Law and Medicine* 584, 587.

[114] UK Joint Committee on Human Rights House of Lords, *Legislative Scrutiny: Coroners and Justice Bill*. Eighth Report of Session 2008-09, HC 362 HL Paper 57 (2009), 25.

[115] See the (then) Australian Human Rights and Equal Opportunity Commission's submissions to the inquest into the death in custody of Mulrunji Doomadgee in 2004 on Palm Island, and the inquest into the death of Elder Ward during prison transportation in Western Australia in 2008 at: https://www humanrights.gov.au/right-life. See also the Human Rights Law Centre submissions to the inquest into the police shooting of 15-year-old Tyler Cassidy in 2008: Human Rights Law Centre, *In the Coroners Court of Victoria, Inquest into the Death of Tyler Cassidy, Submissions of the Human Rights Law Resource Centre* (2008). See Jonathon Hunyor, 'Disgrace: The Death of Mr Ward' (2009) 7(15) *Indigenous Law Bulletin* 3; Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12(2) *Australian Indigenous Law Review* 64; Rebecca Scott Bray, 'Death Investigation, Inquests and Human Rights' in Leanne Weber, Elaine Fishwick and Marinella Marmo (eds), *Routledge International Handbook of Criminology and Human Rights* (Routledge, 2017) 146; Freckelton and McGregor, above n 113, 585.

[116] Australian Inquest Alliance, *Submission to the National Human Rights Action Plan Baseline Study Consultation* (2011).

[117] Scott Bray, above n 115; Freckelton and McGregor, above n 113, 585.

[118] Scraton, *Lost Lives, Hidden Voices*, above n 7, 117.

court when projecting death scene images and sounds. Lawyers, seemingly inured to the presence of bereaved families and their communities casually laugh, grin, and exchange in-house jokes. The explicit detail of fatal injury is delivered via often terrifying pieces and disturbing detail. The violence of inquiry becomes visceral as the bereaved are subjected to repeated audio and visual evidence of the last moments of their loved one's life, are subjected to different iterations of that evidence, and consistently, staunchly, attend court. Disconcertingly, uniformed rank and file police or corrections officers directly involved in the death sit close to family members in the public gallery. While the inquisitorial process claims that it is non-adversarial regarding deaths in contested circumstances, lawyers adopt often aggressive tactics, including the demonisation of the deceased, to deflect accountability from those they represent. It can be a hurtful, damaging process for the bereaved, not least when those involved in the death offer condolences to families. The 'adversarial wolf in inquisitorial sheep's clothing' is absent from coronial findings, but it has lasting, destructive impact on the lives of the bereaved and on the communities in which they live.

Minimal academic research has been conducted into bereaved families' and friends' experiences of the coronial system, including the racial dimensions of those encounters. Academic research addresses bereaved people's experiences of coronial process in terms of specific issues, such as post-mortem practices,[119] or particular contexts of death, such as workplace death,[120] suicide,[121] missing persons,[122] or other critical events such as disasters.[123] Signal research has examined contested deaths and inquest processes, including the impact of coronial processes on families.[124] Important but intermittent insights also come from submissions informing coronial law reform,[125] or reviews, such as those of the Coronial Council of Victoria's (2017) review of rights to appeal coronial decisions and findings.[126]

Notable international research is conducted by campaign organisations such as the UK Institute for Race Relations, and the UK charity INQUEST, which supports people bereaved through a death in custody or other contested circumstances. These organisations provide invaluable insights due to their close working relationships with the bereaved, as do case notes and reflections written by legal

[119] John Drayton, 'Bodies-in-Life/ Bodies-in-Death: Social Work, Coronial Autopsies and the Bonds of Identity' (2013) 43 *British Journal of Social Work* 264; Jane Mowll, Elizabeth A Lobb and Michael Wearing, 'The Transformative Meanings of Viewing or Not Viewing the Body After Sudden Death' (2016) 40(1) *Death Studies* 46.

[120] Lynda Matthews et al, *Death at Work: Improving Support for Families* (Final Report, 2017) available at: http://sydney.edu.au/health-sciences/research/workplace-death/; Mark Ngo et al, 'Bereaved Family Members' Views of the Value of Coronial Inquests into Fatal Work Incidents' (2018) *OMEGA - Journal of Death and Dying*; Katy Snell and Steve Tombs, 'How Do You Get Your Voice Heard When No-One Will Let You?' Victimization at Work' (2011) 11(3) *Criminology & Criminal Justice* 207.

[121] Lucy Biddle, 'Public Hazards or Private Tragedies? An Exploratory Study of the Effects of Coroners' Procedures on those Bereaved by Suicide' (2003) 56 *Social Science & Medicine* 1033; Ailbhe Spillane et al, 'How Suicide-Bereaved Family Members Experience the Inquest Process: A Qualitative Study Using Thematic Analysis' (2019) 14(1) *International Journal of Qualitative Studies on Health and Well-being*; Alison Chapple, Sue Ziebland and Keith Hawton, 'A Proper, Fitting Explanation? Suicide Bereavement and Perceptions of the Coroner's Verdict (2012) 33(4) *Crisis* 230; Alison Wertheimer, *A Special Scar: The Experiences of People Bereaved by Suicide* (Routledge, 2013).

[122] Stephanie Dartnall, Jane Goodman Delahunty and Judith Gulliver, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322.

[123] Scraton, *Lost Lives, Hidden Voices*, above n 7; Scraton, *Policing with Contempt*, above n 7; Howard Davis and Phil Scraton, 'Institutionalised Conflict and the Subordination of 'Loss' in the Immediate Aftermath of UK Mass Fatality Disasters' (1999) 7(2) *Journal of Contingencies and Crisis Management* 86.

[124] Razack, above n 7; Scraton and Chadwick, *In the Arms of the Law*, above n 7; Scraton, *Hillsborough: The Truth*, above n 7.

[125] Law Reform Commission of Western Australia, above n 2; Victorian Parliamentary Law Reform Committee, above n 2; New Zealand Law Commission, *Coroners*, Report 62 (August 2000); Coronial Reform Group, *Submission from the Coronial Reform Group (CRG) to the Productivity Commission Inquiry into the Social and Economic Benefits to Improving Mental Health* (2019). See also Ian Freckelton, 'Minimising the Counter-Therapeutic Effects of Coronial Investigations: In Search of Balance' (2016) 16(3) *QUT Law Review* 4.

[126] Coronial Council of Victoria, *Reference 4 - Coronial Council Appeals Review* (29 November 2017).

advocates, which offer practitioner reflections on issues such as race.[127] It is clear that, despite few academic studies, information exists regarding bereaved people's experiences of the coronial process following deaths in custody. Significantly, following the deaths in custody of First Nations people, it is the ongoing work by families, activists, advocates, campaigners, charities and practitioners which highlight the expertise of everyday knowledge and lived experience of affected communities, and these experiences find expression in many places and take different forms.[128]

Respectfully, we submit that as its first priority, the Select Committee listens closely to the experiences and views of those directly affected by coronial inquests into First Nations deaths in custody. Their experiences and voices should have priority. They are not difficult to access. Families and their communities possess authoritative knowledge about the numerous issues the inquiry is concerned with and speak to what is at stake in its outcomes. The knowledge embedded in community experience is also available to the committee through reviewing media commentary and advocacy reports produced in the aftermath of First Nations deaths in custody. Following inquests into the deaths in custody of First Nations people, many Indigenous researchers, advocates, commentators and journalists survey coronial processes and provide incisive, pointed reflections on the issues within the remit and review of the Committee.[129] We would urge the Committee to prioritise these invaluable, and publicly available insights.

4. Critical Research into Deaths in Contested Circumstances

In 2018 we organised the *Critical Research into Deaths in Contested Circumstances* Research Lab at the University of Sydney, Sydney Social Sciences and Humanities Advanced Research Centre (SSSHARC). The Lab ran from November 2018 to January 2019, bringing together over 115 national and international participants including bereaved families, researchers, campaigners, coroners, advocates, lawyers, social workers and others. Its key aim was to gather and collectivise expertise concerning deaths in contested circumstances.

The following brief summary of findings from the Lab are relevant to the Select Committee's inquiry into the suitability of oversight and review of deaths in custody in NSW.

4.1. Pre-Inquest Process

Issues relating to pre-inquest processes, include: when and how bereaved families learn of the death of their loved one; knowing where the body of their loved one is held at any time (eg. when being transported); being appraised of the truth of the circumstances of the death; the ability for families to seek a second opinion on autopsy; provision of safe spaces for viewing the body and any

[127] In NSW, key advocacy work with First Nations families is undertaken by the Jumbunna Institute for Indigenous Education and Research at UTS, the National Justice Project and the Indigenous Social Justice Association. See Whittaker, above n 47. See also Shannon Chapman, 'The Coroner's Exercise of Discretion: Are Guidelines Needed?' (2008) 12(2) *Australian Indigenous Law Review* 103; Federation of Community Legal Services/ Australian Inquest Alliance, *Joining Up Justice*, above n 7;

[128] See Amanda Porter, 'Aboriginal Sovereignty, 'Crime' and Criminology' (2019) 31(1) *Current Issues in Criminal Justice* 122. Porter details the contributions of filmmakers, poets and others that bring awareness to the issue of deaths in custody. Podcasts such as *The Guardian* and *Radio 2SER*'s podcast *Breathless,* about the NSW death in custody of Dunghutti man David Dungay Jr and the inquest, provide insight into families' experiences of coronial processes. Further examples include the panels and interviews on the Radio National program *Speaking Out* with Larissa Behrendt, available as a podcast.

[129] For example, via *IndigenousX*; National Indigenous Television (NITV); Let's Talk, 98.9FM; and across other media including *The Guardian* and its integrated reporting on deaths in custody, such as Carly Earl's 'Photo Essay: David Dungay Jr Dies in Custody, and his Family are Changed Forever (2018) *The Guardian* (13 July) at www.theguardian.com/australia-news/2018/jul/13/david-dungay-jr-dies-in-custody-and-his-family-are-changed-forever-photo-essay.

documents/evidence; timely information disclosure, and the necessity of trauma-informed care and support of the bereaved. In addition, families need early engagement with legal representatives and advocates.

There is a consistent need for family representatives to have the opportunity to gather material before an inquest or raise lines of enquiry to be pursued. There can also be a need to pursue Freedom of Information requests should there be concerns regarding the adequacy of the investigation. The toll of these activities on families and advocates is significant.

4.2 Inquest Process

The inquest process raises challenging issues for families and their advocates. Families are intimidated, marginalised and sometimes directly offended by the way inquests are conducted, highlighting the need to humanise the process and recognise that the deceased was a person, not another 'Aboriginal death in custody' or the 'deceased'. Families possess unique and incomparable knowledge of a person, and should be addressed inclusively and directly by coroners. Many of these issues occur in the context of significant delays in inquest, placing a significant burden on families expected to retain their dignity and bide their time while the coronial process proceeds.

Defining the scope of the inquest is essential, and relates not only how, and to what extent, State institutions may have contributed to death, but also in relation to the information canvassed in relation to the person who has died. Families consistently report the tendency to attribute blame to the deceased for their own death. In light of the role of the State in deaths in custody, it is crucial to reappraise policies, procedures and training and question the conditions that contribute to death, in addition to ensuring accountability measures are used (eg. referrals to the DPP).

In many cases, there is more than one interested party for specific organisations at inquest, resulting in inequality of arms. Correspondingly, there can be purposeful, institutional blocking of access to knowledge and understanding about the circumstances of death and the protection of organisational interests. At its worst this has been described as collusion between State agencies, operating on a range of levels; from objections to lines of enquiry, to aggressive questioning tactics and the organisational representation of families which can contribute to their negative treatment.

A disproportionate police, correctional officer and security presence at court invariably is intimidating for bereaved families and community supporters, particularly when it reflects negative, stereotypical assumptions about how specific groups are likely to react. It is imperative that families do not feel that they or their loved one are under scrutiny and are being held responsible for the death. Further, the significance of institutional apologies and the importance of institutional reforms to prevent deaths in similar circumstances from occurring are of paramount importance. Bereaved families and their legal representatives consistently raised these issues.

There was a consistent, identified need to reduce the disconnect between legal representatives and bereaved families. This involves: careful consideration of the presentation and management of sensitive evidence in court; communication with families in and around courts; and recognising the role and rights of the bereaved in coronial investigation. It extends to the location of and preparation for the inquest, attendance at and accommodation in the court including seating and consultation rooms.

4.3 Coronial Findings

There should be appropriate and accessible access to coroners' findings and recommendations, made available to bereaved families and communities, lawyers, advocates, campaigners and academics. This should be matched by a better understanding of the impact of coroners' findings and recommendations.

There are numerous areas of custodial and policing practice that coroners consider in making their recommendations. A comprehensive monitoring of recommendations is required to ascertain the practical impact of coroners' comments on issues as diverse as training and education, organisational policy and practice, legislation, and previous coronial findings. Central to this is the requirement of an oversight and monitoring mechanism to determine 'lessons learned'.

4.5 Post-Inquest Process

Bereaved families often are advised that they should 'move on' after an inquest, that it will bring 'closure' by investigating and presenting the full context of deaths. The reality is, however, that inquests often raise more questions than they answer, that key issues regarding the circumstances in which the death occurred remain unaddressed. In the aftermath, families need ongoing support (including follow-up discussions, support groups), access to compensation, advice on determinations of liability/culpability through criminal and civil processes. Often they require further information regarding recommendations and their implementation years after the inquest has concluded.

4.6 A Critical Analysis of the Inquest Process

The Lab gathered critical insights into the analysis of deaths in contested circumstances. Derived in extensive research into deaths in contested circumstances, it revealed how State institutions, particularly police and custodial bodies, approach inquests to avoid and deflect institutional or operational responsibility for deaths during arrest or in custody. Creating the court as a site of contestation undermines the truth-telling role of coronial investigation, even with skilled and sensitive coroners presiding. However, families play an important role in ensuring that their voices are heard and the reluctance to allow their full participation exacerbates the trauma of sudden bereavement.

The Lab drew on the work of interdisciplinary researchers, human rights lawyers, campaigners, family members and those with extensive experience of coronial practice. It demonstrated the diversity and complexity of familial and community relationships and cultural contexts. It was clear from the testimonies presented that understanding the complexity of community relations includes addressing the role of State institutions in perpetuating historical institutionalised racism and its consequences for inquests.

The inquest process was identified as a key site where the deceased should be humanised, their life recognised in a non-objectified manner, as a relative, a community member. Further, central to that recognition is the placing of the deceased in relation to the bereaved, their circumstances and complexities.

To address these matters, the Lab discussed options for change, such as: acknowledging and including Indigenous culture and rituals in coronial processes; providing Aboriginal family liaison; the development of alternative justice processes involving culturally competent investigators, coroners and lawyers, which are held on country; the importance of independent investigations where police are not investigating police; priority listing by courts of all State-related deaths; improved resourcing of the coronial system, including research for coroners; the use of public interest organisations at inquest; specialist deaths in custody review processes; practical support for families travelling to inquests; funded research into the formulation and implementation of coronial recommendations; the development of specialist accountability measures for contested deaths, drawing on the expertise of multi-disciplinary teams to work with coroners, including community, such as an Independent Panel with the capacity to perform investigative work, or a process such as a Special Procedure Inquest.[130]

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[130] See JUSTICE, above n 3.

Appendix

Author Profiles

Rebecca Scott Bray PhD, is Associate Professor of Criminology and Socio-Legal Studies in the School of Social and Political Sciences at the University of Sydney, Australia, and has been Visiting Scholar at New York University, New York, UNSW Sydney, and Humboldt University, Berlin, Germany. From 2012-2016 she was Director of the Sydney Institute of Criminology, Sydney Law School, University of Sydney. Together with Professor Phil Scraton, she co-convened the *Critical Death Investigation Research Lab* on contested deaths and the coronial system funded by the Sydney Social Sciences and Humanities Advanced Research Centre (SSSHARC), which included comparative research in London, Dublin, Belfast and Derry. In 2018 she was awarded a Thompson Fellowship at the University of Sydney to research the coronial system and contested deaths. She has published widely on coronial process and practice, including on diverse issues such as digital justice, policing and contentious deaths, human rights, open justice and coronial reform. She is co-editor of *Secrecy, Law and Society* (2015 Routledge).

Phil Scraton PhD, DLaws (Hon), DPhil (Hon) is Professor Emeritus in the School of Law, Queen's University, Belfast. He has held recent visiting professorships at Amherst College, USA, the Universities of Auckland, Monash, New South Wales and Sydney. Widely published on critical theory, incarceration and children/ young people his books include: *In the Arms of the Law: Coroners' Inquests and Deaths in Custody; No Last Rights: The Promotion of Myth and the Denial of Justice in the Aftermath of the Hillsborough Disaster; Identifying and Resolving Inter-Agency Conflict in the Aftermath of Disaster; Hillsborough: The Truth*. A member of the Liberty Advisory Committee on deaths in custody, he led the Hillsborough Independent Panel's research team and was principal author of its 2012 Report*, Hillsborough,* and its 153 key findings. He was seconded to the families' legal teams throughout the 2014-2016 inquests. A revised edition of *Hillsborough: The Truth* was published in 2016. Consultant on, and contributor to, the 2017 BAFTA winning ESPN/BBC documentary *Hillsborough*, he holds a Leverhulme Fellowship to research the unique work of the Hillsborough Independent Panel and all that followed. In 2018 he was Visiting Fellow at the University of Sydney co-convening a two-month funded research programme on coroners' inquests into deaths in custody and during arrest. It includes comparative research in London, Dublin, Belfast and Derry. He is co-investigator for the Irish Council of Civil Liberties' research project *Deaths in Contested Circumstances and Coroners' Inquests* and was a member of the JUSTICE Working Party Inquiry, *When Things Go Wrong*, into inconsistencies in coroners' inquests and public inquiries, 2019-2020. He was awarded the Freedom of the City of Liverpool in recognition of his Hillsborough research.