Submission No 6

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Australian Lawyers Alliance

Date Received: 25 June 2021

Coronial Jurisdiction in New South Wales

Submission to the NSW Legislative Council Select Committee on the Coronial Jurisdiction in New South Wales

25 June 2021

Suite 5 Level 7, 189 Kent Street, Sydney NSW 2000 | GPO Box 7052, Sydney NSW 2001 | **ABN** 96 086 880 499
T +61 2 (02) 9258 7700 | **F** +61 2 9258 7777 | **E** enquiries@lawyersalliance.com.au | **W** www.lawyersalliance.com.au
Protecting and promoting justice, freedom and the rights of the individual.

Contents

Who we are

The Australian Lawyers Alliance (ALA) is a national association of lawyers, academics and other professionals dedicated to protecting and promoting justice, freedom and the rights of the individual.

We estimate that our 1,500 members represent up to 200,000 people each year in Australia. We promote access to justice and equality before the law for all individuals regardless of their wealth, position, gender, age, race or religious belief.

The ALA is represented in every state and territory in Australia. More information about us is available on our website.[1]

The ALA office is located on the land of the Gadigal of the Eora Nation.

[1] www.lawyersalliance.com.au.

Introduction

1. The ALA welcomes the opportunity to have input into the Select Committee inquiry into the coronial jurisdiction in New South Wales.

2. This submission will focus on the following issues:

    - The structure of the Coroner's Court of New South Wales ("NSW Coroner's Court");
    - The lack of funding and resourcing of the NSW Coroner's Court;
    - Delays in commencing and completing coronial inquests;
    - The need for a trauma-informed, culturally appropriate approach within the conduct of the coronial processes;
    - The capacity of the NSW Coroner's Court to examine systemic issues; and
    - The need for greater accountability for implementing recommendations made by NSW Coroners.

Structure of the NSW Coroner's Court

3. The ALA submits that the NSW Coroner's Court should be a stand-alone, specialist Coroners Court, similar to the specialist Coroner's Courts in Victoria, Queensland, South Australia and Western Australia.

4. At present, NSW does not have a stand-alone, specialist Coroners Court. Instead it has adopted a "hybrid" model, administered by the Local Court, where five full-time coroners are employed in Sydney and about 36 country and regional magistrates act as part-time coroners across the rest of the state.

5. Tasmania and NSW are the only state jurisdictions that do not have a stand-alone, specialist Coroner's Court. In 2006 a Parliamentary inquiry in Victoria,[2] as well as a 2012 report by the

[2] Law Reform Committee, Parliament of Victoria, *Coroners Act 1985* (Parliamentary Paper No 229, September 2006).

Law Reform Commission of Western Australia,[3] were both highly critical of arrangements in those states which mirrored the current NSW system at that time. As a result of the 2006 inquiry, Victoria established a standalone specialist Coroners Court in 2008, separate from the Victorian magistracy.

Lack of funding and resourcing of the NSW Coroner's Court

6. The ALA agrees with the NSW Select Committee into the high level of First Nations People in custody and oversight and review of deaths in custody ('the Select Committee') which concluded that funding and resourcing of the NSW Coroner's Court needs to be improved.[4] The Select Committee noted that the inadequate resourcing significantly contributes to delays in the coronial system and compromises its efficacy. Any benefits for families are also greatly compromised by the significant delays.[5]

7. The ALA notes the Productivity Commission's finding that in 2019-20 NSW's recurrent expenditure on coronial services was $6.9 million, compared with $21.5 million in Victoria and $12.4 million in Queensland.[6] Victoria has nine full-time coronial positions and Queensland has eight, compared with the five in NSW.

8. The ALA supports the Select Committee's recommendation that the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroner's Court can effectively undertake its role in investigating deaths in custody in a timely manner.[7]

[3] Law Reform Commission of Western Australia, *Review of Coronial Practice in Western Australia – Final Report* (Project No. 100, January 2012) 14.

[4] Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, NSW Parliament Legislative Council, *The high level of First Nations people in custody and oversight and review of deaths in custody* (Report, April 2021) [6.125].

[5] Ibid [6.5].

[6] Productivity Commission, Report on Government Services 2020, Table 7.3 - Court's recurrent expenditure, 2019-20 dollars by criminal and civil jurisdictions, by jurisdiction, 2020.

[7] Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (n 4) Recommendation 31.

Inquest timeframes

9. Related to the issue of lack of resourcing, the ALA shares the concerns of several stakeholders, who also had input into the Select Committee inquiry, regarding the significant delays in terms of progress and completion of inquests.[8]

10. The ALA has had similar experiences to those reported before the Select Committee by the Jumbunna Institute of Indigenous Education and Research and by Legal Aid NSW, in which coronial inquests commence two or three years after death and can take several years to resolve.[9]

11. In one example reported by an ALA member, involving the death of 18-year old Thomas Redman in Barrington (near Gloucester) in December 2015, the inquest process took 5 years to be finalised. The inquest was heard by LCM Hudson with the first hearing dates being 16 and 17 May 2018. Further dates were not available until 12 and 13 June 2019. The findings were delivered on 24 January 2020 – five years after the death.

12. The ALA is concerned that these delays cause significant distress and trauma to grieving families. In addition, the ALA agrees with Legal Aid NSW that these delays can detract from the quality of the evidence and can diminish the utility of any recommendations.[10]

The need for a trauma-informed, culturally appropriate approach

13. The ALA submits that there is a need for the NSW coronial system to adopt a more therapeutic, trauma-informed care approach within the conduct of the coronial processes so that these processes do not further traumatise grieving families and communities. In particular, the ALA recommends that the *Coroners Act 2009* (NSW) ('the Act') is amended to include provisions to ensure that coronial processes specifically accommodate cultural needs and considerations, particularly in relation to Aboriginal and Torres Strait Islander people.

14. The ALA is concerned that NSW and South Australia are the only jurisdictions that do not make provisions for cultural considerations in relation to Aboriginal and Torres Strait

[8] Ibid [6.11], [6.14–6.15].

[9] Ibid.

[10] Ibid [6.15].

Islander people in relation to dealing with investigation directions and exhumations, and with the exercise of post-mortem investigative functions, as well as considerations of the definition of 'relative' and 'senior next of kin'. The ALA submits that given the scandalous level of Aboriginal and Torres Strait Islander deaths in custody, this should be addressed as a matter of urgency.

15. The ALA welcomes the comments from Magistrate Teresa O'Sullivan, a NSW State Coroner, that two Aboriginal Liaison Officer roles have recently been created within the NSW Coroner's Court.[11] The ALA considers that this will assist in the court employing culturally appropriate engagement with First Nations communities and families. It is hoped that these roles will provide culturally appropriate support to families during coronial processes and help build trust and informed participation in those processes.

Capacity to examine systemic issues

16. The ALA submits that it is essential that the capacity of NSW Coroners to examine systemic issues is further enhanced and resourced. The ALA agrees with the NSW Bar Association that the NSW Coroner's Court should establish a Coroners Prevention Unit similar to that which exists in Victoria. According to the NSW Bar Association, such a unit could strengthen the coroners' prevention role and could provide them with expert assistance in reviewing deaths, collecting and analysing data, and developing prevention-focused recommendations. The effectiveness of such a unit would be reliant on adequate funding for it to undertake these functions.[12]

17. The ALA also supports the establishment of a specialist death review team with a statutory basis, to monitor and inform policy and systemic change for all deaths in custody, particularly Aboriginal and Torres Strait Islander deaths.[13]

18. The ALA also agrees with the suggestion from the NSW Ombudsman that consideration could be given to conferring an express statutory function on the Coroner to undertake systemic research and reviews of deaths in custody. This could enhance the role of the Coroner in monitoring deaths in custody. According to the NSW Ombudsman this would

[11] Ibid [6.64].

[12] Ibid [6.111].

[13] Ibid [6.112].

include establishing and maintaining a public register of deaths and a role to track trends and identify systemic issues. This may enhance the Coroner's ability to make recommendations in a report to Parliament, including progress on implementation of previous recommendations.[14]

Accountability for recommendations

19. The ALA agrees with the Select Committee's finding that that the system lacks concrete mechanisms to hold the relevant government departments and correctional centres to account in implementing recommendations that are made by the Coroner in relation to deaths in custody. The ALA shares the concerns that there does not seem to be sufficient oversight, monitoring and follow-up of actions and responses from government departments and correctional centres following a death, to improve their policies and procedures.[15]

20. The ALA supports the recommendation from the Select Committee for the Act to be amended to ensure that the relevant government department and correctional centre respond in writing within six months of receiving a Coroner's report, detailing the action being taken to implement the recommendations, or if no action is taken, the reasons why, with this response tabled in the NSW Parliament.[16]

21. The ALA also supports the recommendation that the Act be amended to stipulate that the Coroner is required to examine whether there are systemic issues in relation to a death in custody, in particular for First Nations people, with the Coroner provided with the power to make recommendations for system wide improvements.[17]

22. The ALA also supports the recommendation proposed by the Jumbunna Institute of Indigenous Education and Research that the Act be amended to mandate Coroners to make findings on whether the implementation of any, some or all of the recommendations of the

[14] Ibid [6.113].

[15] Ibid [6.127].

[16] Ibid Recommendation 32.

[17] Ibid Recommendation 33.

Royal Commission into Aboriginal Deaths in Custody's report could have reduced the risk of death in all cases where a First Nations person has died in custody.[18]

Conclusion

23. The Australian Lawyers Alliance (ALA) welcomes the opportunity to provide this submission to the Select Committee inquiry into the coronial jurisdiction in New South Wales. The ALA is willing to further assist the Committee in its deliberations.

Joshua Dale
NSW President
Australian Lawyers Alliance

[18] Ibid Recommendation 34.