Submission No 12

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Justice Action

Date Received: 25 June 2021

Inquiry into the Coronial Jurisdiction in New South Wales

Contacts
Trades Hall, Suite 204,
4 Goulburn Street,
Sydney NSW 2000, Australia

PO Box 20014, World Square, NSW 2002 Australia

Tel: 612 9283 0123
Fax: 612 9283 0112

Email: ja@justiceaction.org.au
www.justiceaction.org.au

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Executive Summary

Justice Action represents people in institutions and their families who are affected by deaths in custody. We speak on behalf of detainees nationally on the issue of deaths in custody and have been involved in this work for the past decade. The issue of systemic failures leading to deaths in custody is central to our concerns.

This document is Justice Action's submission in response to the inquiry, particularly with respect to points 1(a) and 1(b) in the Terms of Reference to draw attention to the need for changes in the coronial system.

Justice Action was engaged by the Late Mr. David Dungay Jnr's surviving family to assist with navigating the coronial inquest process following his passing in police custody on 29 December 2015. David Dungay's case is one of the most significant inquests to occur in recent times with relation to deaths in custody. The way the case and the coroner's recommendations were handled highlights failures in the system. The responses to the recommendations were not in line with the gravity of the systemic failure to keep David Dungay alive.

The current distribution and feedback mechanisms for coronial recommendations are inadequate. This submission identifies the gaps within the current system and gives suggestions for changes.

Coroners should address their recommendations to all affected authorities regardless of whether they were involved in the inquest. 'Affected authorities' are authorities whose behaviour should be changed in accordance with coronial recommendations to avoid the risk of future death. These should include public statutory authorities, non-profit organisations, and corporations. The recommendations should be distributed to all Australian jurisdictions and all affected authorities should be required to respond to the recommendations.

The authority of the Coroner is central to preventing unnecessary deaths as they are responsible for suggesting reforms. Currently, coronial recommendations are restricted in two dimensions: first, coronial recommendations are only made specific to authorities who are involved in the inquest and second, the dissemination of coronial recommendations are restricted to their jurisdiction. For instance, the recommendations made following the David Dungay inquest were restricted to Long Bay Prison Hospital rather than offered to prisons more broadly. Furthermore, because the recommendations are only made to authorities within their states, the death of Robert Plasto-Lehner in NT in 2009 had no effect on the death of David Dungay in NSW in 2015. A wider range of authorities should be included in the recommendations distributing process to fulfill the Coroner's role.

There is a clear lack of follow through and care from organisations like NCIS who are purportedly responsible for making coronial findings accessible to the public and reporting systemic failures such as those highlighted by recent deaths in custody. This leaves matters such as David Dungay's case falling to Justice Action to review and act upon on behalf of the bereaved families.

Justice Action's proposal to establish the National Database of Coronial Recommendations provides an opportunity to enhance the reach of the system. After examining the weaknesses in the coronial management and lack of follow up on recommended institutional changes on behalf of the Dungay family, we established our proposal which was picked up by AustLII to bring to fruition. The National Database will encourage uniformity amongst such responses, including outlining the reasoning for implementation and explanations for rejection. In some jurisdictions, relevant bodies are 'obliged to respond' to the recommendations. The National Database should raise the need for all Jurisdictions to respond and be held accountable.

This submission presents five main issues and their solutions in which the national database with its inter-jurisdictional scope will be critical:

1. Coroners are to direct their recommendations wider;
2. Recommendations are distributed to affected authorities;
3. All Australian jurisdictions should receive the recommendations;
4. The obligations to respond to recommendations;
5. Essential for coroners to follow the implementation of their responses, and report concerns to parliament where necessary.

The Case of David Dungay

One of the factors that could have prevented David Dungay's death includes the accessibility of coronial data across jurisdictions to limit institutional patterns of police brutality. Allowing coronial data to be accessible to relevant authorities and the public would prevent jurisdictions from implementing similar ineffective strategies and investigative methods. It also facilitates transparency and accountability of authorities within Immediate Action Teams (IAT) and coronial settings.This is particularly important considering the highly disproportionate incarcerations and resulting deaths of Aboriginal and Torres Strait Islander peoples in custody.[1]

Proposal of National Database - Distributing Recommendations

David Dungay's death, along with the hundreds of other Aboriginal and Torres Strait Islander people that have been killed in custody, resulted in a National Database Proposal with the aim of collating coronial findings on deaths in custody and recommendations from all Australian jurisdictions. The National Database is designed to publish State and federal responses to allow relevant authorities to access the data, and to identify and address some institutional patterns that lead to deaths in custody in Australia. The National Database Proposal was taken up by AustLII and is to be funded by the Federal Government. AustLII described the project in their report here.

Petition

To advocate for the establishment of the National Database, Justice Action has started a petition addressed to all Australian authorities with oversight and/or ability to use coercive force. The National Database would allow for coronial recommendations from all jurisdictions to be accessible by the public and all relevant authorities in Australia with coercive power. Over 55,000 signatures were made in support of this petition, highlighting a large consensus for this National Database proposal.

[1] Parliamentary Joint Committee on Law Enforcement, Parliament of Australia, *Summary report of the 24 June 2020 public hearing on the Australian Institute of Criminology's National Deaths in Custody Program* (Report, October 2020) 3, 9.

Coronial Recommendation Coverage

The current coronial systems across all Australian jurisdictions present significant gaps in the collation, accessibility and dissemination of coronial reports. This gap poses a hindrance to the affected authorities and their ability to review and respond to coronial recommendations.The Dungay family, and the wider community stress the urgency of using available information to mitigate future preventable deaths in all jurisdictions.

In discharging their duties, the Coroner bears the obligation to prevent further deaths from occurring. At present, the Coroner makes reform recommendations which are only distributed to the affected authorities in their state. These reports are currently made available on their state coronial database only. This limits the reach of recommended reforms which could be applicable across jurisdictions, and could prevent further deaths.

Coronial recommendations must be given adequate coverage to extend to the relevant affected authorities. The National Database created by AustLII will have the effect of distributing coronial recommendations nationwide. This addresses the issue of accessibility and reach, but will not be sufficient to reduce the occurrence of needless deaths. Coroners should ensure that their recommendations are general enough to apply to a multitude of authorities where their recommendation will be impactful. The application of coronial recommendations should not be limited to those directly involved in a given case. Instead, the recommendations should be applied to other jurisdictions and agencies beyond those involved in the inquest. This is especially significant for findings and recommendations targeting systemic issues and failures to effectively prevent further incidents.

According to many observers, the NSW coronial system is under funded and under-resourced compared to the Victorian coronial system. Unlike Victoria, NSW lacks a dedicated research unit and instead has two specialist researchers who are directed to work only on cases involving domestic violence and murders. Victoria has a dedicated research unit attached to the coroner's office composed of 29 researchers and specialists (allowing for more informed recommendations). The research unit also facilitates the identification of emerging patterns of death. AustLII's National Database gives access to information across all jurisdictions and may aid in alleviating these issues.

Recommendations

1. Coroners should ensure that their recommendations extend beyond the agencies involved. For example, recommendations in response to David Dungay's death in Long Bay Correctional Complex should also apply to other authorities where coercive force is used.

The implementation of more generalised coroners' recommendations across all the jurisdictions reduces the probability of a similar incident occurring in another state.

2. Amendments should be made to the *Coroners Act* 2009 (Cth) to allocate more resources to the Coroners and require Coroners to examine systemic issues and give them power to make recommendations for system wide improvements.
3. The NSW government should allocate more resources to the coronial system such as a dedicated team of expert researchers so that inquests can be carried out in a timely manner. Coronial systems should also recruit interdisciplinary researchers to ensure that investigations are analysed through both legal and multidisciplinary lenses. The establishment of an oversight committee inclusive of people with lived experiences is necessary to establish an appropriate standard of care and accountability for the review and implementation of coronial findings. This consideration speaks to the multi-causal nature of deaths in custody.

Obligation to Respond

Summary of State and Territories Obligation to Coroners

	Mandatory to Respond	Time Frame	Scope of Coroner's Recommendations
NSW	**Y**	Agencies and ministers are required to report to the Attorney General within **6 months** of receiving the recommendations.	Broad - can make recommendations to **any Minister, NSW government agency, non-government organisation and private individual**, and are reported to the Attorney General.
VIC	**Y**	"Any public statutory authority or entity receiving a coroner's recommendations must now respond in writing within **three months**, indicating what action (if any) will be taken in relation to the recommendations"[2]	Broad - can make recommendations to **any Minister, public statutory authority or entity** that may help prevent similar deaths.
QLD	**Y**	The Queensland Government responds to every recommendation directed to them and details if (and how) they plan to implement them but **no clear time frame** stated.	Typically directed to the **Queensland Government**, though they can also be **directed to non-government agencies**. The Coroner is **allowed** to share information to a **corresponding agency**.[3] Prior to the disclosure of coronial information, the board must consult the State Coroner.
NT	**Y**	A Chief Executive Officer or the Commissioner of Police to respond to coronal reports or findings **within 3 months of receipt**; it must be given as a written response to the Attorney General.	Broad - can make recommendations on **any matter connected** with the death/disaster being investigated and that the coroner finds relevant to the **prevention of future deaths in similar circumstances**.

[2] Coroner's Court of Victoria, *Practice Handbook: A legal practitioner's guide to coronial system in Victoria* (2011) 4.
[3] *Coroners Act 2003* (Qld) s 91ZA.

WA	**N**	Currently **no obligation** on parties who are the subject of the coronial recommendation to respond to the coroner and no coherent study on the implementation of coronial recommendations in Western Australia has been undertaken.	Broad - can make recommendations **not restricted in type** and may be **on any matter connected with the death** including 'public health or safety, the death of a person held in care or the administration of justice'.
SA	**Y**	The *Coronial Process and the Coroners Act 2003* states that Chief Executive Officers, SA Ambulance Service and other involved health organisations are responsible for ensuring that the response to the coronial inquest findings address *all* recommendations inclusive of actions undertaken and proposed actions; proposed actions must have time frames for implementation in the response. BUT **no clear time frame** stated.	Can give recommendations that may **prevent or reduce the likelihood of the recurrence** of a similar event and is able to make these recommendations **to public statutory authorities and other entities**.
TAS	**N**	There is **no legislative requirement** in Tasmania for government entities to respond to, or actively implement, coronial recommendations.	Broad - can make recommendations on **any matter** they consider appropriate to prevent further deaths; can be directed towards **any person or organisation**.
ACT	**Y**	The custodial agency to which a report is given must give the Minister responsible for that custodial agency, a written response to the findings contained in the report no later than **3 months** after the date the report was received.	Broad: can report findings to **anyone whom the coroner considers appropriate.**

The lack of obligation to respond both adequately and efficiently to coronial recommendations in some Australian States and Territories highlights the weaknesses of the coronial system. The implementation of a mechanism where feedback from the affected authorities is obligatory ensures that these mechanisms accomplish what they are intended for, particularly by facilitating wider engagement with coronial recommendations. It is paramount that all States and Territories are uniformly obliged to respond to coronial recommendations, including those recommendations from other Australian jurisdictions which would be distributed through the National Database. Government responses to coronial findings are currently not readily available

on the state web pages as standard practice. Queensland is the only state in Australia that specifies on their coronial findings web page whether a response was required.

The NSW Premier's Memorandum 2009-12 'Responding to Coronial Recommendations' mandates Government agencies and public officials to respond to coronial recommendations from 'a coroner' rather than isolating this obligation to respond to the NSW State Coroner.[4] The Memorandum also necessitates that a Minister or NSW government agency should write to the Attorney General within six months of receiving the recommendation to outline any action being taken to implement the recommendation, but does not require non-government organisations or private individuals to respond.

We sent our paper, "Coronial Recommendations: Obligations for Affected Authorities" to the NSW State Coroner who said he "agrees that the way recommendations are dealt with in NSW is an important issue for further discussion". The NSW State Coroner referred to the further select committee and we are actively involved in this process.

In most jurisdictions there is already a requirement to respond to recommendations, as outlined in our paper, "Coronial Recommendations: Obligations for Affected Authorities" (refer pp.6-9). The Minister in NSW responded to our question posed in parliament[5] as below:

> **Question:** Will the Minister's Department respond to interstate coroners' recommendations relevant to its responsibilities, following the Australasian Legal Information Institute's (AUSTLII)'s distribution of recommendations from the new national database?
> 1. Do you regard the Premier's Memorandum as requiring that to happen?
>
> **Answer:** Corrective Services NSW has a well-established process for reviewing and publishing its consideration of coronial recommendations handed down by the NSW State Coroner. Premier's Memorandum M2009-12 Responding to Coronial Recommendations clearly sets out the process for responding to coronial recommendations directed to NSW Ministers and NSW government agencies. Recommendations arising from other interstate jurisdictions may be considered in response to relevant coronial findings.

Similarly in Victoria, coroners can make recommendations to ministers, public statutory authorities or entities that may help prevent similar deaths. Section 72 of the Coroners Act 2008 provides that written responses must be done within 3 months of the making of the

[4] David M Studdert, 'The Modern Coroner as Injury Preventer' (2016) 22(5) *Injury Prevention* 311-313.
[5] https://www.parliament.nsw.gov.au/lc/papers/pages/qanda-tracking-details.aspx?pk=81718

recommendations and be published on the internet for viewing.[6] These two models highlight that by not limiting the obligation to respond to coronial recommendations made in one jurisdiction, states would be able to implement a mandatory-response timeframe that encourages comprehensive and uniform responses. However, we also acknowledge that state institutions across jurisdictions are likely to differ in terms of funding, resourcing and overall organisation. In this case, we suggest a federal commitment to funding state coronial jurisdictions.

Recommendations

1. Amendments should be made to the *Coroners Act 2009* (Cth) to ensure that government departments and correctional centres respond in writing within 6 months of receiving a Coroner's report.
2. Responses are to include what actions will be taken to implement the recommendation or reasons justifying why no action is taken.

[6] *Coroners Act 2008* (Vic) s 72.

Families of Victims, Cultural Sensitivity and Timeliness of Coronial Inquests

- Surviving families experience re-traumatisation during coronial inquests
    - (1) Coronial courts fault to accommodate cultural and religious practices - e.g respectful treatment of evidence/bodies, performing timely burials
    - (2) families are subject to hearing explicit details about injuries and death, are close to the correctional officers that contributed to the death, etc.
- Why does the Coronial system contribute to these problems?
    - (1) There are currently no provisions in the Coroners Act for cultural considerations; NSW and SA are the only jurisdictions that do not make specific provisions in this regard.
    - (2) In NSW, there is no provision that an inquest should not proceed if the deceased's family or their representatives are not in attendance. Failure in notifying family members and the Aboriginal Legal Service surrounding the details of an inquest contribute to this.[7]
- Solution: Integrating culturally sensitive protocols and a largely interdisciplinary approach to coronial investigations
    - First Nations staff and Aboriginal Liaison Officers to be employed by the NSW Coroners Court to help families navigate through the process after the death of their loved one.
    - forensic pathologists should be trained on respecting Aboriginal and Torres Strait Islander peoples' cultural practices related to handling bodies.
    - Syllabus integration rather than supplementary use of force training implemented to ensure cultural sensitivity to be treated as an instituted approach.

Many surviving families inevitably experience re-traumatisation from the coronial process due to the lack of cultural sensitivity and dissonance between the families' demands for justice and the statutory limitations of the courts.[8] Coronial inquests fail to accommodate cultural and religious concerns regarding the respectful treatment of bodies of the deceased. For instance, bodies are often subjected to an autopsy prior to the family having seen the body of the deceased and without consent. This can be particularly traumatising for those Aboriginal and Torres Strait Islander families who seek to uphold religious or cultural practices which require them to refuse an autopsy or deliver a more timely burial.

In addition, families are also subject to hearing the explicit details of fatal injury in disturbing detail, and having to walk by the Correctional Officers that were on duty the night their family

[7] Deloitte Access Economics, Department of the Prime Minister and Cabinet, *Review of the implementation of the Royal Commission into Aboriginal Deaths in Custody* (Final Report, October 2018) 7, 51.
[8] George Newhouse, Daniel Ghezelbash and Alison Whittaker, 'The Experience of Aboriginal and Torres Strait Islander Participants in Australia's Coronial Inquest System: Reflections from the Front Line' (2020) 9(4) *International Journal for Crime, Justice and Social Democracy* 76-89.

member died. There are currently no provisions in the Coroners Act for cultural considerations; NSW and SA are the only jurisdictions that do not make specific provisions in this regard.

The appointment of First Nations staff and Aboriginal Liaison Officers by the NSW Coroners Court can assist families navigate through the process after the death of their loved ones; however there are currently none. The appointment of a First Nations Elders to assist the Coroner would also be necessary.[9] The Dungay family acknowledged that the appointment of First Nations staff would have improved their own experience and builded some trust in the system which is currently low. In this regard, the NSW State Coroner, Magistrate Teresa O'Sullivan, later confirmed that two Aboriginal Liaison Officer roles have recently been created, with recruitment to commence shortly.

Employing Aboriginal liaison officers who are trained in coronial practice to assist the coroner on Indigenous cultural practices, and to guide Aboriginal and Torres Strait Islanders on coronial processes; particularly with a lived experience to undertake inquests into Aboriginal deaths in custody. Moreover, forensic pathologists should be trained on respecting Aboriginal and Torres Strait Islander peoples' cultural practices related to handling bodies.

Solution

Integrating culturally sensitive protocols and a largely interdisciplinary approach to coronial investigations can be enabled through the larger reform of the NSW Police Force Syllabus.[10] This should also be consistent across jurisdictions. This would include integrating culturally competent course units/practical training for police officers, allowing them to study and be examined on strategies that prioritise both conventional police tactics as well as culturally and socially sensitive/safe protocols.[11] These reforms would support the larger reforms required within both custodial and coronial settings regarding cultural sensitivity.

Recommendations

1. First Nations staff and Aboriginal Liaison Officers to be employed by the NSW Coroners Court to help families navigate through the process after the death of their loved one.
2. Integration of culturally sensitive training within a Police force syllabus and law enforcement training across all jurisdictions in Australia.
3. Syllabus integration rather than supplementary use of force training implemented to ensure cultural sensitivity to be treated as an instituted approach.

[9] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *The high level of First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 71.
[10] Randolph T Brooks and Reginald Hopkins, 'Cultural Mistrust and Health Care Utilization: The Effects of a Culturally Responsive Cognitive Intervention' (2017) 48(8) *Journal of Black Studies* 816–836.
[11] Ibid.

National Database: Operational Arrangements

In response to the issue that coronial recommendations are restricted to authorities within their state, a National Database Proposal was created with the aim of collating coronial findings on deaths in custody and recommendations from all Australian jurisdictions. These findings and recommendations are to be distributed nationwide, as well as published responses from state and federal authorities who are affected by the recommendations.

Coroners will ensure that their recommendations extend beyond the area to which they are concerned; such that they apply to organisations and individuals who (are likely to) encounter similar situations. For example, recommendations in response to David Dungay's death in Long Bay Correctional Complex should also apply to other authorities where coercive force is used. Ideally, it then follows that coroners from other jurisdictions should be treated with equal weight as those from within the jurisdiction.

The National Database created by AustLII will then be responsible for collecting and distributing the coronial findings, recommendations and responses nationwide. This National Database will consist of a clearinghouse model which provides a central agency for information collection, classification, and distribution. Accordingly, the data will be collated and automatically distributed to all relevant government authorities, whilst also ensuring free public access.

The National Database will also provide free access to coronial findings with recommendations available in digital form from all Australian jurisdictions in one central location on AustLII.[12] The database will also gather together and link responses made by agencies to coronial recommendations. Where possible and within budgetary constraints, earlier findings and recommendations that only exist in paper form will be digitised and added to the collection. Additionally, findings, recommendations, and responses will be processed and metadata extracted to enable integration with all other primary legal resources on AustLII.[13]

The coroners will be responsible for preparing 'catchwords' for their findings, which can assist with categorising their reports for accessibility in the database. Catchwords will be used to help categorise authorities to receive the recommendations and alert the recipient authorities of the issues to be addressed in their responses. For example, recommendations attached to the catchword 'positional asphyxia' could be distributed by AustLII to the categories 'Corrective Services', 'Police', and 'Health'.

[12] Email from ARDC to Phillip Chung, 14 September 2020 <https://drive.google.com/file/d/1lM55r9X5fdfxi2vrqCQJy0PFJheAm3mb/view>.
[13] Ibid.

In addition to developing a national collection of existing findings and responses, AustLII will develop processes and procedures to allow for the addition of new findings, recommendations, and responses integrated into the workflow procedures of Coroners courts. AustLII already has procedures in place to receive, process, and publish case law decisions from courts and tribunals in Australia. AustLII will thus work with Coroners courts to move towards a more efficient and effective dissemination model. The ongoing maintenance costs of this research infrastructure will primarily be funded by the AustLII Foundation Ltd, which has successfully raised donation funding of over $1M per year for over a decade.[14]

Recommendations

1. Coronial recommendations are to be made general enough by coroners so that they apply to all relevant organisations and institutions nationwide.
2. Collection and distribution of findings, recommendations, and responses is to be conducted by AusLII and held in the centralised National Database. The information will be collated and automatically distributed to all relevant government authorities and available for free public access.
3. Findings, recommendations and responses contain catchwords so that these findings can be easily searched by and distributed to relevant institutions and organisations.
4. Processes are to be developed to allow for the addition of new findings, recommendations and responses.

[14] Ibid.

Institutional Arrangements

Currently findings and recommendations of coronial inquests are largely made available and utilised on a state-by-state basis, with very little collation of jurisdictions undertaken. Previous measures have been taken to address deaths in custody on a national level, yet these have not sustained in recent years. Similarly, current measures are inaccessible to the wider public and do not display the transparency needed to address the public interest of this issue. Each state government retains the ownership and maintenance of either a state coronial website or web page that belongs to a larger government department.

AustLII

The Australasian Legal Information Institute (AustLII) currently provides the most comprehensive assembly of coronial reports, publishing coronial findings and recommendations from four Australian jurisdictions and New Zealand.

The following jurisdictions' reports are made available on AustLII:

- the Coroners Court of Victoria from 2002 onwards,
- the Coroners Court of Australian Capital Territory from 2013 onwards,
- the Magistrates Court of Tasmania from 2002 onwards,
- the Magistrates Court of the Northern Territory from 2002 onwards, and
- the New Zealand Coroners Court from 2007 onwards.

The following Australian jurisdictions produce coronial reports, but are not available on AustLII:

- the Coroners Court of New South Wales,
- the Coroners Court of South Australia,
- the Coroners Court of Queensland, and
- the Coroners Court of Western Australia.

Inquiry has been put to AustLII as to why this inconsistency exists among the jurisdictions.

AustLII also provides a search tool which allows the user to input free text and yield coronial reports as results from either a specific database (jurisdiction), or all databases (jurisdictions). For example, the term 'positional asphyxia' when searched, yields coronial reports as results when using either the all or selected database options (depending on the selected database). Similarly, specific coronial inquests can be searched and found using their catchwords. However, the accuracy to which this is achieved varies depending on the generality of the catchword used and whether one or all selected databases are searched. Catchwords used to search all databases generally will not result in desired/relevant documents.

Australian Institute of Criminology

The Australian Institute of Criminology (AIC) has historically provided the 'National Deaths in Custody Program: Death in Custody in Australia Report'. This report is produced on an annual basis and records the nature and extent of deaths occurring in prison, police custody and youth detention in Australia. The most recent of these reports covers the years 2018 to 2019 (see here).

The AIC also proclaims to compile a National Deaths in Custody Program database, which is composed of data collected by the National Deaths in Custody Program (overseen by the AIC), coronial reports and information collected by the National Coronial Information System (NCIS).

National Coronial Information System

The National Coronial Information System (NCIS) is a database established in 2002 and is currently managed by the Victorian Department of Justice and Community Safety. The database contains a variety of coronial information from findings to legal, medical and scientific reports. Currently, the NCIS does not distribute or make available to the public much of the material in their archives.

Whilst the NCIS allows the user to input free text to search the database, the effectiveness of the search in yielding results is contingent on the use of broad, generalised search terms. For example, the term 'positional asphyxia' does not yield any results, however, the term 'death' yields ample results. As the database is user restricted, only those who have been approved may have full access, thus the volume of results provided in response to a searched term also depends upon whether the NCIS has provided public material related to the term. The application process required to receive full access to the NCIS can only be described as extensive.

Alternatively, the NCIS provides access to a 'Coronial Recommendations: Fatal Facts' search engine. This search engine allows the user to filter their search by selecting from a list of pre-populated criteria, there is no option to input free text to guide the search. Upon attempting to utilise the publicly available search engine, it appears that either the database is not updated regularly or not all coronial recommendations are made available for public access, as the most recent coronial report provided using the criteria of 'Indigenous' and 'Law Enforcement' is from 2015. As more recent reports are not readily available, this undermines the broader value of the findings of cases such as David Dungay's 2019 Coronial Inquest. In order to mitigate the probability of further preventable deaths in custody across the nation, these reports must be easily and promptly accessible to all concerned.

The NCIS publishes Coronial Recommendations: Fatal Facts editions, containing

summaries of available coronial reports and recommendations from all jurisdictions that have taken place within a three-month span.

It is worth noting that the AustLII national coronial database will by no means supersede the NCIS database, and they remain free to update their resources for public use as they see fit.

State Coronial Websites

Each Australian State and Territory maintains its own coronial website or web page, most providing information, coronial reports and recommendations to the public. Each website or web page is unique to its state and provides different levels of functionality. The effectiveness of each State's online offering will be analysed below.

South Australia

The South Australian Coroners Court web page is situated within the South Australian Courts website. Both the general Courts website and coronial findings web page allow the input of free text in order to search, however neither yield results when the term 'positional asphyxia' is entered. The findings of coronial reports are searchable via their content when using the general search bar, the coronial findings search bar only allows the searching of names and the dates that coronial findings were handed down.

On the coronial findings web page, reports are organised by the year the findings were handed down and are identifiable by name only, with an absence of catchwords.

New South Wales

New South Wales offers an entire website dedicated to the Coroners Court, inclusive of a page for coronial findings. All coronial findings from 2012 through to 2021 are listed on the findings page, and only 'major' findings available for cases prior to 2012. Each report is titled by the name of the deceased and accompanied by the name of the relevant coroner, the date the report was handed down and the catchwords for the case. The Coroners Court website allows the input of free text in order to search. The term 'positional asphyxia' yields relevant results, thus coronial reports are searchable via their catchwords.

Queensland

Queensland offers a Coroners Court web page within the Queensland Courts website. Both the general Courts website and the coronial findings web page allow free text input to search. Both yield relevant search results when the term 'positional asphyxia' is searched. All coronial reports from 2004 to 2021 are available on the coronial findings web page. Each report is titled by name of the deceased and accompanied by the date the findings were delivered and the catchwords relevant to the case. For each report it is indicated whether a response from the Queensland Government is required or a link to

the response is provided. After careful assessment of all jurisdictions, Queensland currently offers the most accessible and efficient method of searching and sorting coronial findings.

Western Australia

Western Australia has a dedicated website for the Coroners Court of Western Australia. Coronial findings are arranged by year from 2012 to 2021, with each year having its own page dedicated to the findings delivered that year. Reports prior to 2012 are not available. Findings are listed via a drop down bar alphabetically and provide no further information beyond the name of the deceased. The website's search bar allows the free input of text, and the term 'positional asphyxia' yields one relevant result. It does not appear that Western Australian coronial reports use catchwords, thus catchwords are not searchable, nor are coronial reports searchable via their content.

Victoria

The Coroners Court of Victoria has its own website. All reports are stored on the findings web page and can be accessed via an interactive table. Findings are titled by the name of the deceased, and in descending order of the date that the report was delivered. Reports may be filtered by name, case ID, case type, date, coroner, related rulings and orders and responses to reports. Both the general Court's website and the findings web page allows the input of free text to search, however, neither search yields results in response to the term 'positional asphyxia'. Similarly, it does not appear that content of coronial reports is searchable via the general search bar, but searches of content may yield accurate results when using the findings web page search bar in some cases.

Tasmania

The Coroners Court of Tasmania's web page is situated within the Tasmanian Magistrates Court's website. Coronial reports are arranged into groups of years - pre-2015, 2015 to 2018 and 2019 onwards. Each group has its own page, with corresponding reports listed in a table. Reports are listed in descending order by date of report delivery and each table entry contains the report title (the name of the deceased), the name of the assigned coroner and the relevant catchwords for the case. Both the general Magistrates Court website and the findings web pages allow for the free input of text to search, with both searches yielding relevant results in response to the term 'positional asphyxia'.

Northern Territory

The Northern Territory's coronial findings are available on a web page within the Department of the Attorney-General and Justice's website. Reports are listed in descending order by the year the findings were handed down. The Attorney-General and Justice website has free text search functionality, however the term 'positional asphyxia' yields no relevant results. Similarly, the content of the reports do not yield relevant results.

Australian Capital Territory

The Australian Capital Territory (ACT) offers a web page dedicated to the Coroners Court within the ACT Court's website. Coronial findings are not made available on the website or the web page. Instead it is advised that copies of coronial reports can be requested from the coroner if you are a member of the immediate family of a deceased for whom an inquest (other than an inquest into a death in custody) has been held or if you were the owner of the property damaged or destroyed by the fire the subject of an inquiry. However, coronial reports under the jurisdiction of the Australian Capital Territory Coroners Court are available on AustLII. There is no explanation regarding this discrepancy.

Analysis and recommendations for inquests

The nationally coordinated mechanisms to collate coronial inquests are lacking the necessary support to perform as required. National database mechanisms are inconsistent and demand reform in order to improve centrality and the ease to which users can search causes of death from jurisdiction to jurisdiction.

Inconsistencies in the functionality and features of government databases at both a national and state level restrict user accessibility to public information and raise concerns about the capacity for cross-jurisdiction communication related to deaths in custody.

Recommendations

1. Concerned institutions to facilitate dialogue and information sharing across authorities and jurisdictions (where appropriate) regarding key findings and recommendations which impact that authority's scope of service.
2. The coroner assigned to the case should be held accountable for disseminating findings and recommendations in a transparent and timely manner to ensure the relevant bodies are alerted.

   In choosing between overestimating and underestimating the extent to which all recommendations apply, we believe that it is better to have a broader distribution so that all relevant organisations receive the recommendation. Otherwise the national database as conceived and supported would not be workable. AustLII can assist by sending the recommendations onward to the appropriate authorities for investigation and implementation.

   Any finding or recommendation outside the scope of the coroner's powers to be referred on to the appropriate authority for further investigation and implementation of changes. For example, David Dungay's case could be referred by the NSW coroner to SafeWork NSW for specialised assessment of the application of restraint eventuating in Mr.

Dungay's demise. SafeWork NSW should then share their work with other Work Health Safety authorities nationally. This enables Work Health Safety agencies to implement reforms and standardisation of safe restraint practices, mitigating risk of preventable deaths in custody. Having the coroners' reports easily accessible on a public database makes this crucial information sharing seamless between agencies.

3. Reporting of coronial findings online to be streamlined and standardised across all states and territories. Level of information provided and search functionality should be consistent, clear and user-friendly to empower the public and concerned institutions to access and utilise the coroner's findings as needed.

Inquiry into the coronial jurisdiction in New South Wales

TERMS OF REFERENCE

1. That a select committee be established to inquire into and report on the coronial jurisdiction in New South Wales, and in particular:

   (a) the law, practice and operation of the Coroner's Court of NSW, including:
   - (i) the scope and limits of its jurisdiction,
   - (ii) the adequacy of its resources,
   - (iii) the timeliness of its decisions,
   - (iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
   - (v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,
   - (vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health,

   (b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary,

   (c) the most appropriate institutional arrangements for the coronial jurisdiction in New South Wales, including whether it should be a standalone court, an autonomous division of the Local Court, or some other arrangement, and

   (d) any other related matter.

(2) That the committee report by the end of December 2021.

Committee membership

Hon Adam Searle MLC	Australian Labor Party	*(Chair)*
Mr David Shoebridge MLC	The Greens	*(Deputy Chair)*
Hon Trevor Khan MLC	The Nationals	
Hon Rod Roberts MLC	Pauline Hanson's One Nation	
Hon Penny Sharpe MLC	Australian Labor Party	
Hon Natalie Ward MLC	Liberal Party	