Submission No 27

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: National Justice Project

Date Received: 12 July 2021

National Justice Project

Submission to NSW Select Committee's Inquiry into the Coronial Jurisdiction in New South Wales

July 2021

WARNING: *First Nations readers should be aware that this submission uses the names of deceased persons with permission from their families.*

ABOUT THE AUTHORS

THE NATIONAL JUSTICE PROJECT

The National Justice Project is a not-for-profit human rights legal service that works to eradicate institutional discrimination. Our mission is to fight for justice, fairness and inclusivity by eradicating systemic discrimination. Together with our clients and partners we work to create systemic change and amplify the voices of communities harmed by government inaction, harm and discrimination.

Our key areas of activity include health justice, specifically for persons with disability and First Nations communities; challenging misconduct in police, prisons and youth services; and seeking justice for asylum seekers and refugees. We receive no government funding and intentionally remain independent in order to do our work. We therefore rely on grassroots community, philanthropic and business support.

We create positive change through our key strategic areas:

- **Undertaking strategic legal action** including representing clients in public interest litigation, which leads to law reform, policy change, attitudinal change, improved services and accountability for people who have been harmed by injustice.
- **Delivering world class, practice-inspired and catalytic social justice education** for the community, and for current and future legal professionals and advocates, thus growing the next generation of social justice lawyers in Australia and the Pacific.
- **Supporting grassroots advocacy** built on ethical, rigorous and fact-based research that amplifies the voices of communities harmed by injustice, and leads to law reform and policy change driven by the experience of community.

This submission has been co-authored by staff of the National Justice Project: Mr George Newhouse, Director and Principal Solicitor; Ariane Dozer, Projects Manager and Solicitor; and Rosaleen Jeffries, Legal Clerk, together with the National Justice Project Clinic operating at Monash University under the supervision of Steven Castan. We respectfully acknowledge the contribution and testimony of the Dungay and Kokaua families who have revisited their painful experiences with the view to promote positive change. We too highlight their experiences in hope that much needed reform will be realised.

ACKNOWLEGDEMENT OF FIRST NATIONS PEOPLES' CUSTODIANSHIP

The National Justice Project pays its respects to First Nations Elders, past and present, and extends that respect to all First Nations peoples across the country. We acknowledge the diversity of First Nations cultures and communities and recognises First Nations Peoples as the traditional owners and ongoing custodians of the lands and waters on which we work and live.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The National Justice Project recognises that throughout history the Australian health and legal systems have been used as an instrument of oppression against First Nations Peoples. The National Justice Project seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

Contents

OVERVIEW

EXECUTIVE SUMMARY

In this paper, the National Justice Project examines the fundamental changes required to re-establish the coronial jurisdiction as a vehicle capable of delivering justice through truth, accountability and prevention. We focus on the role of the coronial system in responding to deaths which occur in connection with police or corrective services. To demonstrate the harsh reality of the system as it stands, we draw on the strength of two families who were let down by the system in hope that their truth will be a source of momentum to drive change.

The right to life is one of the most core human rights and yet many avoidable deaths pass through the coronial system each year. An avoidable loss of life causes irreversible effects to families, communities and is a stain on society as whole. When a death occurs at the hands of state institutions, purportedly designed to serve and protect the community, additional scrutiny is required to promote accountability and prevent future deaths from occurring.

The coronial jurisdiction has a unique role in investigating the circumstances that lead to a death. This can be the ultimate opportunity to provide truth, healing, closure and justice to families. The Royal Commission into Aboriginal Deaths in Custody[1] envisaged that post death investigations would lead to systemic change. At present, the current coronial jurisdiction in New South Wales fails to implement those recommendations by generally avoiding addressing systemic issues where deaths are caused by systemic prejudice and racism.

> *The Royal Commission [into Aboriginal Deaths in Custody] recommended an expansion of 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.*[2]

[1] Australia, *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) ('*Royal Commission*')
[2] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 6.

TERMS OF REFERENCE

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, and

(d) any other related matter.

KEY RECOMMENDATIONS

Inspired by guiding principles of justice, accountability, transparency, cultural safety and the sovereign rights of First Nations peoples, we make the following overarching recommendations that apply to all representations made in this submission:

1. Implement the recommendations from the Royal Commission into Aboriginal Deaths in Custody and all relevant subsequent enquiries.
2. The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. The investigative body should have the power to examine the death of a First Nations person under the control of state officials in broad contexts including in police custody, in prisons, any corrective services, during transport, in accessing health services, as well as in the interrelated decisions made by officials in these various bodies and any related death 'close to custody'. Such a body must have real powers to make recommendations, compel responses to recommendations, refer matters for prosecution or disciplinary action and to undertake regular prison and youth detention inspections.
3. Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.
4. First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

DETAILED RECOMMENDATIONS
TO IMPROVE THE CORONIAL JURISDICTION

Scope and limitations of the coronial jurisdiction

5. We recommend that the *Coroner's Act 2009* be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.
6. We recommend that the *Coroner's Act 2009* be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.
7. We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.
8. We recommend that the *Coroner's Act 2009* be amended to:
    a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and
    b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

9. We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.
10. We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

Resources

11. We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.
12. We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

Timeliness of decisions

13. We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

The outcomes and oversight of recommendations

14. We recommend that the *Coroners Act 2009* be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.
15. We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

Responding to cultural needs

16. We recommend that the *Coroners Act 2009* be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.
17. Until complete independence is established, at the very least, a First Nations consultative group must be established and resourced; with powers to liaise with Coroners and to consult with them regarding the scope of coronial investigations of First Nations deaths, to ensure the system is culturally safe at all times and that recommendations are made to address systemic factors that may have caused or contributed to the death of a First Nations individual.

Open Justice

18. We recommend that the *Coroner's Act 2009* be amended to encourage the public release of evidence - with family members' consent where appropriate.
19. We recommend that the *Coroner's Act 2009* be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.

CONTEXT

The National Justice Project ('**NJP**') made a detailed submission to the New South Wales Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody ('**the previous Select Committee Enquiry'**).[3] We stand by the recommendations set out in that submission, which, in our view, remain inextricably linked to the current inquiry. In this submission, we provide additional recommendations that are critical to developing a coronial system that is capable of discharging its obligations in response to deaths which occur in connection with police or corrective services.

Much of our submission focuses on the interaction of the New South Wales ('**NSW**') coronial system with First Nations peoples however we recognise that the systemic failings are not isolated to Australia's First Peoples, and we share a variety of experiences to provide the Committee with a clear understanding of current system's real and devastating impacts on families and communities.

Our submissions must be read together with the many substantive recommendations made to the previous Select Committee Enquiry,[4] together with the recommendations made in numerous other inquiries dating back to the Royal Commission into Aboriginal Deaths in Custody ('**RCIADIC'**),[5]. Throughout this submission, we refer to, and endorse, the recommendations articulated by our sector colleagues including the Jumbunna Institute for Indigenous Education and Research ('**Jumbunna Institute'**), many of which have been made repeatedly to other investigations. All that remains is for the executive and the NSW Parliament to implement them. We implore the Committee to prioritise the implementation of these oft repeated measures.

This submission is informed by the experiences of our clients and their interaction with the NSW coronial system, specifically in circumstances where the death of a family member has occurred in connection with police or corrective services. With permission, we specifically draw on the experiences of two brave families, the Kokaua family and the Dungay family, who despite having lost much loved family members, are willing to share their experiences with the Committee to prevent other families from going through similar experiences. The circumstances of their deaths are briefly set out below:

- Jack Kokaua, a 30-year-old Maori and Cook Islander man, described by his family as "a compassionate, loving guy" and "soft and gentle…despite all he has been through." Jack died on 18 February 2018 after being tasered multiple times by police and the inquest into his death occurred from 2019-2020. Testimony from the Kokaua family is located in Case Study A.

- David Dungay Jr, a 26-year-old Dunghutti man from Kempsey NSW, was very loved by his close-knit family. He enjoyed schooling, music and sports. David died on 29 December 2015 in Long Bay prison hospital when he was restrained and given a sedative after he refused to stop eating a packet of biscuits. Testimony from the Dungay family is located in Case Study B.

---

[3] National Justice Project, Submission No 102 to the *Select Committee into the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Oversight and Review of Deaths in Custody* (August 2020).
[4] Select Committee into the High Level of First Nations People in Custody Oversight and Review of Deaths in Custody, Parliament of New South Wales, *Oversight and Review of Deaths in Custody* (2020) ('*Select Committee Enquiry'*).
[5] *Royal Commission* (n 1).

SUBMISSIONS

We structure the following submissions in accordance with the Terms of Reference as set out by the Committee and we implore the Committee to consider the submissions and recommendations put forward in full.

(a) the law, practice and operation of the Coroner's Court of NSW, including:

(i) the scope and limits of its jurisdiction

1.1 In our view and in the view of our clients, there are significant legislative and cultural factors that limit the NSW coronial jurisdiction and reduce its ability to deliver "justice" to First Nations and Culturally and Linguistically Diverse ('**CALD**') families. The tendency of Coroners to apply a narrow interpretation to the scope of inquests and ultimately the breadth of their findings and recommendations is hindering more meaningful outcomes. The reach of the Coroners Court must be expanded so that Coroners are mandated to consider factors beyond the immediate cause and circumstances of a death.

1.2 Although, the Coroners Act 2009 (NSW) confers significant discretion to each coroner in relation to the scope of the inquiry, in the absence of an express requirement to look more broadly, Coroners routinely narrow the focus of inquests to the exclusion of systemic issues such as discrimination, bias and prejudice. Convincing a Coroner to expand the scope of an inquest is exceptionally difficult for families without legal representation and often for their legal representatives. The result is a missed opportunity to stop further deaths and lack of accountability, which is particularly unacceptable where:

(a) a person dies as a result of state sanctioned violence whilst they are interacting with or under the supervision of the State;
(b) a person dies in police custody, detention or prison or near to or close to custody;
(c) a person's death is the result of failings of procedures or systems; or
(d) where systemic factors have a direct bearing on how they died.

1.3 When investigating deaths related to the actions of police and corrections officers and health practitioners, the scope of the jurisdiction of the NSW Coroner's Courts must be expanded to mandate Coroners to:

- Prioritise protection and prevention of deaths;
- Investigate deaths near to or 'close to' custody;
- Consider the quality of care, treatment and supervision prior to a death;
- Make referrals to disciplinary bodies and prosecution authorities;
- Consider whether systemic discrimination, bias or prejudice caused or contributed to the death; and
- Enhance the substantive participation of families in a trauma informed and culturally safe manner.

Comparable models that demonstrate where the scope of the coronial system has been expanded in other jurisdictions to overcome its limitations is located below in Part B.

Protection and prevention

1.4 NSW coronial laws must be updated to prioritise the prevention of future deaths by formally recognising each Coroner's role in protection and prevention. Almost thirty years ago, RCIADIC noted that 'adequate post death investigations have the potential to save lives'[6]. The coroner's power to prevent unnecessary deaths lies in their ability to make recommendations and referrals at the conclusion of an inquest. These recommendations 'represent the distillation of the preventive potential of the coronial process'.[7]

1.5 The investigation and making of recommendations about deaths that occur in connection with police or corrective services, particularly for First Nations people, must be mandated to ensure similar deaths caused by or contributed to by actions of State agencies are prevented in the future, as was recommended in the RCIADIC.[8]

1.6 The coronial system and oversight of deaths in custody would be enhanced by regular detailed review and analysis of coronial findings to identify common themes and systemic issues, and to inform a coordinated NSW Government policy response designed to prevent unnecessary deaths.[9]

We recommend that the *Coroner's Act 2009* be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.

We also support and endorse the following recommendations made to the previous Select Committee Enquiry:

- Legal Aid NSW recommended the establishment of dedicated units to assist coroners in the development of prevention-focused coronial recommendations and to monitor and inform policy and systemic change in relation to deaths in custody, particularly First Nations deaths.[10]

- The Australian National University recommended that the coroner's office should be resourced and mandated to monitor and report on the implementation of recommendations arising from inquests into deaths in custody.[11]

Deaths 'close to' custody must be considered by the Coroner

1.7 NSW Coroners should to be mandated by legislation to investigate, issue findings and make recommendations relating to deaths that occur near to or 'close to' custody. The scope of the jurisdiction needs to be extended to ensure that all deaths related to any involvement of police or corrections are examined to prevent unnecessary deaths in the future.

---

[6] *Royal Commission* (n 1) vol 1, 170 [4.7.4].
[7] Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: A Lost Opportunity' (2005) 13 Journal of Law and Medicine 173.
[8] *Royal Commission* (n 1) vol 5, Recommendation 13.
[9] An example of such a function in practice is the NSW Domestic Violence Death Review Team (DVDRT).
[10] Legal Aid NSW, Submission no 117 to *Select Committee Enquiry* (n 4) 13 [Recommendation 33].
[11] Australian National University Law Reform and Social Justice Research Hub, Submission no 109 *Select Committee Enquiry* (n 4) 11 [Recommendation 3.4].

1.8 Presently, section 23(1) of the *Coroners Act 2009* (NSW) outlines a number of circumstances in which a coroner can hold an inquest concerning the death or suspected death of a person. The jurisdiction does not extend to cover deaths which occur after, but proximate in time to, or 'close to' a period in custody. As a consequence, in certain cases, police may escape accountability for their actions, and families are denied an independent coronial investigation.

1.9 As an example, in one case, police arrested one of our clients, a First Nations mother and the victim of a vicious assault and took her into custody but they failed to make safe arrangements for her infant son. Hours later, 10-month-old Baby was brutally murdered by the same violent perpetrator who had seriously injured the child's mother. Despite continued advocacy, the role of the police in Baby's death has never been examined.

We recommend that the *Coroner's Act 2009* be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.

Quality of care, treatment and supervision must be in scope

1.10 The RCIADIC recommended that a 'Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death.'[12] This recommendation recognises that inadequate care, treatment and supervision leading up to a death, often caused by bias against First Nations people, may contribute to deaths in custody. However, this recommendation has not been consistently implemented and the *Coroners Act 2009* (NSW) does not require a Coroner presiding over an inquest into a First Nations death in custody to consider the quality of care, treatment and supervision of the deceased before their death – let alone an extensive longitudinal review of their supervision, care and treatment. While NSW Coroner has a discretion to consider matters beyond the 'mere medical cause of death',[13] in practice, this discretion is exercised narrowly, foreclosing an investigation into the wider or systemic circumstances.

1.11 These limitations are particularly concerning in light of the experiences of people with mental health and cognitive conditions which are prevalent among people who come into contact with the criminal justice system.[14] Police and corrections continuously fail to operationalise a health and wellbeing-orientated response to mental health episodes. The coronial jurisdiction urgently needs to examine these failings in order to provoke lifesaving policy reform.

1.12 The frequent limitation by Coroners of the ambit of an inquest to the 'immediate cause and nature of the death', to the exclusion of broader factors is frustrating for First Nations families

[12] *Royal Commission* (n 1) vol 5, [12].
[13] *Lauw v McLean* (High Court of New Zealand, Hardie Boys J, 12 January 1988) cited in Kevin Waller and John Abernethy, *Waller's Coronial Law & Practice in NSW* (LexisNexis, 4th ed, 2010) 26-7 [1.116].
[14] Robert Parker and Helen Milroy, 'Mental Illness in Aboriginal and Torres Strait Islander Peoples' in Patricia Dudgeon, Helen Milroy and Roz Walker (eds.) *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice* (Commonwealth of Australia, 2nd ed, 2014); Baldry et al, *A predictable and preventable path: Aboriginal people with mental and cognitive disabilities in the criminal justice system* (Report, October 2015).

as well as other diverse communities, who 'want the Coroner to examine the wider and related circumstances that contributed to the death'.[15]

1.13 The NJP acknowledges that some Coroners are prepared to expand the scope of an inquest to encompass health care and treatment, as was the case in the inquest into the death of **Naomi Williams**[16] or of **Jack Kokaua**. In the Inquest into the Death of Jack Kokaua, the State Coroner dealt with Mr Kokaua's mental health history and also considered how this affected the police interactions with him, and ultimately made powerful recommendations in respect to the management of individuals with mental health conditions by police and health services.[17] The full testimony of the Kokaua family's experiences with the NSW coronial system can be found in **Case Study A**.

1.14 By way of contrast, during the inquest into the death of **David Dungay Junior** ('**David Jr**'), the Dungay family and NJP raised concerns about the appropriateness of the mental health treatment provided to involuntary patients, who were also inmates in correctional settings.[18] However, the Coroner, on multiple occasions, deemed that 'broader issues relating to management of David's mental health', fell 'outside the parameters of the inquest'.[19]

1.15 In the inquest into David Jr's death the coroner refused to allow any evidence to be heard about the family's calls to consider the systemic question of why NSW prisoners are being detained in a prison hospital ward, instead of a public hospital - when no other State or Territory treat prisoners in need of health care this way. We suggest that the narrow interpretation applied by the Coroner was not in the interest of truth and justice. The full testimony of the Dungay family's experiences with the NSW coronial system is located in **Case Study B**.

1.16 The consideration of all factors that contributed to a person's death cannot be discretionary particularly in the light of the RCIADIC recommendations. Through the examination undertaken in the coronial process, life-threatening healthcare, procedural and capacity deficiencies of police and custodial officers can be properly assessed and addressed.

We recommend that the *Coroner's Act 2009* be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.

Referrals must be made for discipline and prosecution where appropriate

1.17 Coronial decisions not to refer individuals involved in deaths in custody to oversight bodies, and the reluctance to make emphatic, targeted recommendations, perpetuate the injustice of the

[15] 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, 79 ('Newhouse, Ghezelbash, Whittaker') citing Alison Whittaker, 'Dragged 'Like a Dead Kangaroo': Can Australian Justice Systems Do Justice for Indigenous Deaths in Custody?' (LLM Thesis, Harvard University 2018).
[16] *Inquest into the Death of Naomi Williams,* 29 July 2018, 2016/2569.
[17] *Inquest into the Death of Jack Kokaua* (Unreported, Coroner's Court of New South Wales, State Coroner Teresa O'Sullivan, 12 May 2021) ('*Inquest into the Death of Jack Kokaua*').
[18] *Inquest into the Death of David Dungay* (Reported: 2015/381722, Coroner's Court of New South Wales, Magistrate Derek Lee, Deputy State Coroner 22 November 2019, 2015/381722, 17 [11.7] ('*Inquest into the Death of David Dungay*')
[19] Ibid.

deaths that occur as a result of state sanctioned violence or in, or soon after, incarceration. While Coroners have the power to refer individuals to prosecution or to disciplinary bodies, there has been a general reluctance to do so.

1.18 There needs to be accountability to drive change, and without it, the potentially therapeutic value of the coronial system remains unrealised. More than 475 First Nations people have died in custody since the RCIADIC in 1991.[20] Unfortunately in recent months, the number of deaths in custody has continued to grow and yet no police or prison officer has yet been held responsible.

1.19 Following the death of a loved one in custody, many families experience not only strong emotional trauma and grief, but a profound desire for justice and accountability, motivated more than anything else by a yearning to prevent another family from going through the horror of losing a loved one. When someone in the broader community is responsible for taking a life, society expects an expansive investigation and a legal process to bring the perpetrator to justice. However, the despite the coronial process forming a part of the justice system, the outcomes of coronial inquests almost always fail to deliver justice or provide answers for families involved. It is no wonder that First Nations families feel completely disengaged and excluded from the justice system. For First Nations families, the justice system is quick to arrest and incarcerate their people, but is reluctant to hold those responsible for state violence to account. This injustice is stark, sustained and a dark stain on the justice system.

1.20 David Jr lost his life, and the whole world has seen the irrefutable evidence, and yet David Jr and his family have been let down every step of the way and still there has been no accountability. Former USA police officer, Derek Chauvin, was recently sentenced to 22 years in prison for his role in the death of George Floyd, which has been likened to the death of David Jr. We hope that the unprecedented conviction of Derek Chauvin serves as encouragement to the Australian justice system and the coroner's jurisdiction in particular, that appropriate referrals to prosecution bodies, who have the resources and expertise to determine guilt should be engaged in the pursuit of justice.

1.21 A coronial inquiry is not concerned with allocating blame to any party or finding a party guilty of an offence.[21] However, due to the inquisitorial nature of an inquest, it can become clear that an offence may have been committed or that there has been misconduct or a breach of professional standards.[22] As such, it is important that a coroner not only has the power, but is mandated to refer a matter to the DPP or relevant complaint body to ensure that justice and accountability become possible.

1.22 Currently the law in NSW is unclear and does not ensure such just outcomes are achieved. The Coroners Act 2009 (NSW) does require a coroner to forward to the Department of Public Prosecutions ('DPP') the depositions taken at an inquest or inquiry but only when section 78 of

[20] Alexandra Gannoni and Samanthan Bricknell, "Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody," Australian Institute of Criminality (February 2019). <https://www.aic.gov.au/sites/default/files/2020-05/sb17_indigenous_deaths_in_custody_-_25_years_since_the_rciadic_210219.pdf>

[21] Derrick Hand, 'The Office of the State Coroner' (1991) 2(3) *Current Issues in Criminal Justice* 69, 70; *Coroners Act 2009* (NSW) s81(3); *Coroners Act 2008* (Vic) s69(1); *Coroners Act 1993* (NT) s34(3); *Coroners Act 2003* (Qld) s46(3); *Coroners Act 1995* (Tas) s28(4); *Coroners Act 1996* (Tas) s25(5).

[22] Hand (n 72) 70.

the Act applies.[23] Section 78 only applies when the coroner either understands that a person has been charged with an indictable offence that raises the issue of whether they caused the death[24] or if the coroner believes that the evidence is capable of satisfying a jury beyond reasonable doubt that a person has committed an indictable offence and there is a reasonable prospect that a jury would convict the person of the indictable offence that is relevant to whether the person caused the death.[25] Such a threshold, is ambiguous as the Act explicitly states that the Coroner 'must not indicate or in any way suggest that an offence has been committed by any person'[26] and yet to refer a matter to the DPP, the Act requires the Coroner to have contemplated whether a person is capable of being found guilty of an indictable offence. By creating such a high and convoluted threshold, the Act seemingly contradicts itself and creates a barrier for both the deceased and the deceased's family to access any form of genuine justice. In addition, Section 78 does not apply to non-indictable offenses and professional standards complaints. In most cases, without a coronial referral there is no practical pathway for family members to seek justice, particularly as investigatory authorities often hide behind the Coroner's failure to refer a matter to them as a reason to refuse to act.

1.23 Positively in NSW, along with Victoria, the ACT and Queensland, in circumstances where the Coroner meets their respective thresholds for referring a matter to the DPP, they must make the referral.27 Such a model promotes the perception that justice is possible and ensures that the correct processes are instigated in the appropriate circumstances. However, as NSW currently stands, Coroners remain unconfident to make referrals.

1.24 The Dungay family have petitioned and advocated consistently since David Jr's death for justice. The family of David Jr feel completely failed by the coronial system as well as the Commonwealth and the NSW government and their inability not only to protect David's right to life, but to hold anyone accountable. Lawyers and human rights advocates worldwide attest that there is sufficient evidence for charges to be laid by the DPP and SafeWork NSW, and yet the Coroner found that none of the five guards involved in David's death should face any disciplinary action.[28] The Coroner found that the conduct of the guards was 'limited by systemic deficiencies in training' and not motivated by 'malicious intent.'[29]

1.25 The Coroner in the inquest into David Jr's death implied that a lack of 'malicious intent' was a sufficient basis to reject the Dungay family's submission for a referral to the DPP. We suggest that the scope of the Coroner's referral power is misconceived as requiring an implicit perception by Coroner that a 'malice' threshold is met.

"I am going to fight until I live in a country where Black Lives Matter." – Ms Leetona Dungay

1.26 Following numerous unsuccessful attempts to instigate a legal process to cause those responsible for David Jr's death to be held accountable, the Dungay family have taken the

[23] *Coroners Act 2009* (NSW) s78(4)(a).
[24] *Coroners Act 2009* (NSW) s78(1)(a).
[25] *Coroners Act 2009* (NSW) s78(1)(b).
[26] *Coroners Act 2009* (NSW) s81(3).
[27] *Coroners Act 2009* (NSW) s78(4); *Coroners Act 2008* (Vic) s49(1); *Coroners Act 1997* (ACT) s58(3); *Coroners Act 2003* (Qld) s48(2).
[28] *Inquest into the Death of David Dungay* (n 18) 60.
[29] Ibid 60 [18.12].

matter direct to the United Nations30. The Dungay family have been forced to complain to the United Nations because they have no avenues to seek justice in Australia. The full testimony of the Dungay family's experiences with the NSW coronial system is located in **Case Study B**.

1.27 If made, a referral by the Coroner would not amount to a finding of guilt, but would invite the appropriate body to make their own assessment as to whether further disciplinary or criminal sanction is warranted. It must also be acknowledged that Coroners rely heavily on the co-operation of the police and corrective services in conducting their investigations, and this reliance may create a tension, deterring Coroners from referring individuals for discipline or prosecution. These potential reasons for Coroners reluctance to refer matters are best responded to by reducing the threshold for referrals, ensuring the statutory position is clear and setting up an independent body to overcome any potential tension.

We recommend that the *Coroner's Act 2009* be amended to:

a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and

b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

Further, we support and endorse the recommendations provided by the Jumbunna Institute to the previous Select Committee Enquiry that:

- the *Coroners Act 2009 (NSW)* be amended to provide standing to, and require the coroner to consider the views of the families of deceased persons in determining whether to exercise the power of referral to prosecutorial authorities;[31]
- the *Coroners Act 2009 (NSW)* be amended to provide a right of appeal to families of the deceased where the Coroner;[32]
- the Office of Director of Public Prosecutions Guidelines be amended to:
  - require Prosecutors to consult with families about decisions not to prosecute individuals involved in First Nation deaths where there has been a referral by a NSW Coroner; and
  - require Prosecutors to give written reasons to families where it refuses to consider prosecution of, or decides not to prosecute, individuals involved in a First Nation death in custody.[33]

Systemic discrimination must be considered

1.28 First Nations deaths in custody occur against a backdrop of overincarceration, dispossession, intergenerational trauma, and continued oppressive systemic discrimination. Australia's public systems were created and operated as an instrument of colonial control against First Nations people. They have resulted in extreme poverty and disadvantage among First Nations people

[30] National Justice Project, *Leetona Dungay to go to the United Nations for David Dungay Jnr*, Media Release 10 June 2021. <https://justice.org.au/leetona-dungay-to-go-to-united-nations-for-david-dungay-jnr/>
[31] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [10.2].
[32] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4), 52 [10.3].
[33] Jumbunna Institute, Submission No 115 to the *Select Committee Enquiry* (n 4) 52 [Recommendation 11.1-11.2].

and an over-representation in criminal justice system which in too many tragic circumstances leads to the coronial jurisdiction.

"We've got no law to help us Aboriginal people because it's a white man's law."
– Ms Leetona Dungay

1.29 First Nations people encounter discrimination at every stage of the criminal justice process, from police interactions and biased law enforcement, to the application of discretion and sentencing terms. The evidence of a prejudiced system is demonstrated in the well-known statistics, most notably encapsulated in the disturbing reality that Australia's First Nations peoples are the most incarcerated people on the planet.[34] Our First Nations peoples are also the oldest continuing cultures in the world and the well-evidenced systemic oppression that they face needs to be addressed with urgency.

1.30 The evidence of the extensive systemic oppression of First Nations people in the criminal justice system is overwhelming. As at March 2020, First Nations Peoples account for 28% of the national prison population despite only being 3% of the Australian population.[35] In parts of NSW, First Nations people are twice as likely to go to jail as non-Indigenous people for the same offence.[36] In the period from 1991-92 to 2015-16, NSW recorded the highest number of First Nations deaths in custody,[37] and today, First Nations people are still more likely to die in custody than non-Indigenous people.[38] It is within this context that significant numbers of deaths of First Nations people in custody come before the Coroners Courts each year. Yet in spite of the clear linkage between the lived experiences of First Nations people in their interactions with police and corrective services, Coroners routinely refuse to consider the broader circumstances surrounding the deaths of First Nations peoples in custody.

1.31 The former Western Australian State Coroner, Alistair Hope, took an expansive view of the Coroner's powers in the inquest into the death of Mr (Ian) Ward, endorsing the following statement from Watterson, Brown and McKenzie (2008: 6):

> *The Royal Commission [into Aboriginal Deaths in Custody] recommended an expansion of 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*

[34] Thalia Anthony, 'FactCheck Q&A: Are Indigenous Australians the most incarcerated people in Earth?', *The Conversation* (6 June 2017). <https://theconversation.com/factcheck-qanda-are-indigenous-australians-the-most-incarcerated-people-on-earth-78528>
[35] Australian Bureau of Statistics, *Persons in Custody, Australia, March Quarter 2020* (Catalogue No 4512.0, 4 April 2020); Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016* (Catalogue No 3238.0.55.001, 31 August 2018).
[36] Ella Archibald-Binge, Nigel Gladstone & Rhett Wyman, 'Aboriginal people twice as likely to get a jail sentence, data shows', *The Sydney Morning Herald* (17 August 2020).
[37] Alexandra Gannoni and Samanthan Bricknell, "Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody," Australian Institute of Criminality (February 2019), <https://www.aic.gov.au/sites/default/files/2020-05/sb17_indigenous_deaths_in_custody_-_25_years_since_the_rciadic_210219.pdf>
[38] Laura Doherty and Samantha Bricknell, *Deaths in custody in Australia 2018-19* (Statistical Report No 31, Australian Institute of Criminology, December 2020.

its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.[39]

1.32 Unfortunately, Coroner Hope's approach of making findings on broader systemic issues to "identify underlying factors, structures and practices contributing to avoidable deaths"[40] is not being followed by other Coroners. At present, except for exceptional occasions,[41] NSW Coroners do not make findings to redress discriminatory systemic failings that contribute to deaths.

1.33 The NJP considers that the present coronial system is not responsive to the circumstances surrounding First Nations deaths, and does not provide for the adequate contextualisation of First Nations deaths as part of a history of intergenerational trauma, negative police interactions, systemic police discrimination, poor housing, family services, education and inadequate health treatment. The NJP thus considers that a distinct, independent First Nations-led investigatory body, capable of appreciating and responding to systemic issues, is necessary to inquire exclusively into the deaths of First Nations people in custodial and health settings.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

1.34 The adoption of a targeted approach in respect to domestic violence[42] provides some hope that a cultural shift in the coronial jurisdiction is possible in relation to deaths in custody. The Coroners Act 2009 (NSW) directly recognises the need to respond to the specific circumstances surrounding domestic violence deaths with the view to reducing the incidence of domestic violence deaths and facilitate improvements in systems and services[43], including any systemic and procedural failures which may have contributed to domestic violence deaths, and recommendations, legislative or otherwise, to prevent or reduce the likelihood of such deaths.[44] The establishment and functions of the Domestic Violence Death Review Team[45] is discussed further in Part B.

1.35 The same cannot be said of the treatment of the deaths of First Nations people in custody, despite being established as an issue of pivotal concern over 30 years ago.[46] The deaths of First

[39] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 6.
[40] Ibid.
[41] *Inquest into the Death of Tanya Day* (Reported: 2017/2569, Coroner's Court of New South Wales, Magistrate Caitlin English, Deputy State Coroner); *Inquest into the Death of Naomi Williams* (Reported: 2016/6424, Coroner's Court of Victoria, Magistrate Harriet Grahame, Deputy State Coroner).
[42] *Coroners Act 2009* (NSW) s 101A-P.
[43] *Coroners Act 2009* (NSW) s 101A.
[44] *Coroners Act 2009* (NSW) s101J (2)(a)-(b).
[45] *Coroners Act 2009* (NSW) s 101D-F.
[46] *Royal Commission* (n 1).

Nations people in custody also reveal a systemic problem, for which a targeted and holistic response is needed. We do not refer to the example of domestic violence provisions to suggest that an identical approach is appropriate in the context of First Nations deaths in custody, but that this model may serve as inspiration for a targeted and systemic response, in consideration of the broader factors relating to a First Nations death in custody. A coronial jurisdiction that is reaching its potential would mandate such systemic factors to be examined at Inquest and appropriately responded to.

We recommend that the *Coroners Act 2009* be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.

Substantive participation

1.36 The involvement of First Nations people in the coronial system is often significantly restricted to the detriment of the coronial process. Family members are often limited to providing 'narratives about their loved one's life, rather than the cause or circumstances of their death.'[47]

1.37 Given that the chief concern of families is typically seeking answers and accountability, preventing them from meaningfully participating denies them justice:

> *It shuts out Indigenous participation in the storytelling of indigenous death by making families authorities only on sentiment rather than substance, where they most urgently wish to be.*[48]

1.38 The family of **David Dungay Jr** Family felt disempowered by the adversarial nature of the coronial inquest, which provided no real opportunity for open discussion about what happened, nor did it accommodate the participation of the family. The testimony of the Dungay family can be found in **Case Study B**.

We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

(ii) the adequacy of its resources

2.1 The Coroners Court at present is a system which First Nations people regard with distrust, and which lacks adequate resources to ensure family members are properly supported and engaged throughout the process. The very nature of being involved in the Coronial process is the result of a tragic loss. Adequate resources need to be allocated to reduce the barriers that families currently face to participate in the coronial jurisdiction, implement in entirety the recommended reforms, including overhauling the coronial jurisdiction to ensure it is genuinely effective in discharging its functions, is conducted in a transparent way, and is culturally appropriate and responsive to the needs of First Nations people.

[47] Newhouse, Ghezelbash, Whittaker (n 15) 81.
[48] Ibid.

Supporting family engagement

2.2 Resources need to be allocated to implement reforms necessary to ensure that participate in the coronial process with a focus on supporting active participation and reducing the inevitable re-traumatisation of those involved. We refer to the Committee to the reforms outlined in a 2020 article published in the International Journal for Crime, Justice and Social Democracy,[49] including:

- Overcoming financial and geographic barriers to participation, particularly for families from remote and regional communities who face significant transport and accommodation costs, which can be considerable for 'lengthy inquests and often large groups'[50];
- Providing financial support to families to obtain legal representation with specialist knowledge of coronial practice,[51] which is particularly important when facing the often-disproportionate resources and representation that is utilised by the numerous State parties involved;[52]
- Appoint Aboriginal Liaison Officer's with each Coroner's Court to support the engagement of First Nations families throughout the process and ensure they are supported;[53] and
- Funding legal services to represent First Nations families at inquests with specialist skills and prioritisation of ensuring families are kept informed and supported throughout the process. [54]

We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.

Resourcing independence to restore confidence

2.3 There is a common perception among First Nations families that investigatory bodies, including the Coroner, will not provide them with due process, or a just outcome. To restore confidence and ensure that the coronial process is conducted without prejudice, resources need to be dedicated to overhaul the coronial jurisdiction.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

[49] Newhouse, Ghezelbash, Whittaker (n 15).
[50] Newhouse, Ghezelbash, Whittaker (n 15) 83.
[51] Newhouse, Ghezelbash, Whittaker (n 15) 81-2.
[52] Newhouse, Ghezelbash, Whittaker (n 15) 83.
[53] Newhouse, Ghezelbash, Whittaker (n 15) 86.
[54] Ibid.

Resourcing the jurisdiction to expedite matters

2.4 Traumatised families want to know the truth and have some closure as soon as possible. The consequence of an under-resourced coronial jurisdiction is that evidence gathering and investigations are slow and often drawn out over multiple years. The delay in gathering and processing of evidence can be prejudicial and put the integrity of the investigation at risk. The prolonged process is also traumatising and unfair to families who are grieving the loss of a loved one. Additional resources could also enable Coroners to hold a greater number of inquests and may help to encourage Coroners to exercise their discretion to investigate more cases.

We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

(iii) the timeliness of its decisions

3.1 Coronial inquests in NSW are often plagued with lengthy multi-year delays, which only serve to re-traumatise the families and communities involved. Long delays disrupt the grieving process of families and hinders their ability to achieve closure after the death of a loved one. At times, it can be years before an inquest is held, and then a further lengthy wait for findings to be made. Such lengthy delays between the date of death and the final report can prejudice the investigation and findings. The families involved deserve better.

3.2 The family of David Dungay Jr had to wait almost four years to receive answers concerning his death. The answers they did receive left them asking more questions.

***If there's any inquiry into an Aboriginal death in custody, witnesses will take all the time in the world to fix up their statements.* – Ms Leetona Dungay**

The Kokaua family also had to wait over three years, and they too were left with unanswered questions.

I believe the prolonging of Jack's case is a strategy created by the police supported by the system to weaken families in the fight against the police and their system.
– **Ms Pania Kokaua**

We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

(iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented

4.1 Insightful, evidence-based recommendations are a critical source of improved policy, procedure and legislative reforms. However, without any impetus to implement recommendations, the community faces a never-ending cycle of unactioned recommendations for critical changes that have the ability to save lives.

4.2 One of the most significant issues undermining the role of the coronial system in NSW is the lack of administrative and legal mechanisms to mandate responses to coronial recommendations by government and other organisations.[55] There is currently no legislative procedure to monitor and evaluate how recommendations are being responded to or to measure trends.[56] Recommendations have limited utility without implementation. As was noted in the RCIADIC, to realise any meaningful part of its potential a coronial recommendation must be considered and receive a response.[57] The RCIADIC made specific recommendations requiring Coroners to make, publish, distribute, receive responses and monitor the implementation of recommendations.[58] This Inquiry must be the ultimate catalyst for a coronial system that drives meaningful reform.

4.3 People continue to die in custody without accountability, without answers, and without justice. The families and communities of people who have had loved ones die whilst in the care of the state deserve recommendations to be properly responded to and actioned. Notwithstanding a Royal Commission and numerous other related enquiries, the majority of the recommendations have not been implemented, and the coronial system and inquiries continue to produce recurring recommendations. Practical solutions and pathways forward have been provided time and time again, and yet families and communities continue to be left mourning and questioning. As an example, it seems incomprehensible that the RCIADIC recommended 30 years ago to remove all hanging points in cells,[59] and yet today Coroners are still making the same recommendation.[60] The utility of recommendations, and indeed the entire system, is dependent on measures to compel agencies to respond and act on recommendations.

4.4 The Coroners Act 2009 (NSW) empowers coroners to make recommendations that they deem 'necessary or desirable to make in relation to any matter connected with the death'.[61] While the Act provides that the Coroner must ensure that a record of the recommendations are provided to those to whom they are directed, including government authorities, there is no provision that requires a response from the appropriate person, body or authority.[62]

4.5 The value of a recommendation lies in the response it receives, as such, any legislation that does not mandate agencies respond to coronial recommendations is not pursuing just outcomes.[63] The *Coroners Act 2009* (NSW) does not mandate that government agencies respond to recommendations, instead a Premier's Memorandum suggests that the relevant NSW Government department should acknowledge receipt of a recommendation within 21 days and provide a response to the Attorney-General within six months.[64] The NSW Attorney-General must maintain a record of all recommendations and the responses received from government

---

[55] Public Interest Advocacy Centre, *Review of the Coroners Act 2009 (NSW)* (Submission, 2014), 5.
[56] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[57] *Royal Commission* (n 1) vol 1, 155 [4.5.91], 157 [4.5.98].
[58] *Royal Commission* (n 1) vol 1, 172 [4.7.4] (rec 13-15).
[59] *Royal Commission* (n 1) vol 5, Recommendation 165.
[60] Indigenous Social Justice Association (ISIA), Submission No 122 to NSW Legislative Council Select Committee, *Inquiry into high Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (18 September 2020) 6.
[61] *Coroners Act 2009* (NSW), s 82(1).
[62] *Coroners Act 2009* (NSW), s 82(4).
[63] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[64] Department of Premier and Cabinet, 'M2009-12 Responding to Coronial Recommendations', *NSW Government: Premier & Cabinet* (Premier's Memorandum, 31 December 2014). <https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations>

agencies and produce a report collating that information twice a year.[65] However, the Memorandum gives a government agency a discretionary power to decide whether they'll respond to recommendations and thus does not induce public confidence that the circumstances that lead to someone's death have been addressed.[66] It also does not cover non-governmental organisations.

4.6 Without a legislative mandate, it is difficult to effectively measure the trends and impact of recommendations on public health and the prevention of death and importantly, there is no body designed to do so.[67] Without Coroners being made aware of why recommendations are being ignored, they can't better tailor their future recommendations to increase the chance of implementation and actually improve the reform process and achieve their preventive role.[68] There is also a public interest in the disclosure of government agency and non-governmental responses to recommendations.

4.7 The failure to implement recommendations perpetuates the feeling of families among First Nations people that have died in custody, that the coronial process does not provide any measure of assurance that the circumstances surrounding the death of their loved one will not be repeated, let alone offering redress or justice. David Jr's mother, Ms Leetona **Dungay**, acknowledged that while 'some recommendations came out of the inquest to improve the way the gaol operates... there has been no justice for me, my family and my people from the NSW State after the death of my son'.[69] The full testimony of the Dungay family is located in **Case Study B**.

4.8 Following the inquest into the death of **Jack Kokaua**, the NSW State Coroner made a number of recommendations oriented towards reforming police and health staff management of persons in custody with a known mental health illness.[70] However, all of these recommendations were prefaced with the words 'consideration be given'.[71] In circumstances where the Coroner has identified a deficiency in training or procedure as having contributed to the death of a person, the recommendations made must be sufficiently imperative to prevent future deaths from occurring. The full testimony of the Kokaua family is located in **Case Study A**.

Effectiveness of recommendations – related disciplinary issues

4.9 The issues connected with unimplemented recommendations are broader than the *Coroner's Act*[72] or the nature of agency responses. The issues also include the negative interaction of the coronial jurisdiction with the various complaint systems, especially in regard to 'non-fatal

[65] Ibid.
[66] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 355.
[67] Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12 (Special Edition 2) *Australian Indigenous Law Review* 45, 47.
[68] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 353.
[69] National Justice Project, Submission No 102 to the *Select Committee Enquiry* (n 4) 5.
[70] *Inquest into the Death of Jack Kokaua* (n 17) 93-4.
[71] Ibid 94 [528]-[529].
[72] *Coroner's Act 2009* (NSW).

misconduct'. Two legislative schemes, the *Police Act* 1990 (NSW)[73] and the *Health Care Complaints Act* 1993 (NSW)[74], highlight this issue in their respective handling of complaints that may arise following deaths in custody.

4.10 The *Police Act* provides a discretionary power to the Commissioner to choose not to investigate or address police misconduct if the conduct is the subject of a coronial inquest.[75] Similarly, the legislative scheme that manages health care complaints makes it lawful for not only an agency, but an *oversight* agency, to decline to investigate a complaint arising from a coronial inquest.[76] Effectually, disciplinary action and the pursuit of accountability is prohibited by both the coronial system and relevant agencies.

4.11 The Local Court Bench Book[77] correctly outlines that it is not appropriate for a Coroner to make *findings* regarding any disciplinary, criminal or civil liability issues arising from an inquest.[78] This direction however presupposes that another jurisdiction will handle issues arising during an investigation.[79] However, what we have repeatedly found is that government agencies utilise their discretion to do nothing, and without Coroner's referring the matters to the appropriate disciplinary or prosecution body for investigation, no action is taken. When an agency fails to take prosecutorial or disciplinary action, it is left to the family to pursue alternative action themselves. This often means advising a family that an inquest is not nearly the end of their traumatic journey through the legal system, and that they are likely to have further years to go.

We recommend that the *Coroners Act 2009* be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.

We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

We also support and refer the Committee to the recommendations made by the Jumbunna Institute to the previous Select Committee Enquiry including:[80]

- Stronger accountability to ensure recommendations are responded to, addressed and implemented in a timely manner by establishing a specialist unit to monitor and review deaths and track the implementation of recommendations.[81]

[73] *Police Act* 1990 (NSW).
[74] *Health Care Complaints Act* 1993 (NSW).
[75] *Police Act* 1990 (NSW) s 132.
[76] Ibid s 27 (1)(c).
[77] Judicial Commission of New South Wales, Local Court Bench Book (December 2020).
[78] Ibid.
[79] Ibid [44-220].
[80] Jumbunna Institute, Submission No 108 to *Select Committee Enquiry* (n 4).
[81] Jumbunna Institute, Submission No 108 *Select Committee Enquiry* (n 4) 16 [9.1].

- Amend the Coroners Act to embed a mandatory requirement for government departments and private institutions to respond to, and report on the implementation of recommendations made.[82]
- The NSW Government establish an independent merits review process to review decisions of Prosecutors not to investigate and/or prosecute deaths of First Nations people.[83]

We also support and refer the Committee to the recommendations made by the Aboriginal Legal Service (NSW/ACT) to the previous Select Committee Enquiry, including:[84]

- that the Coroners Act 2009 (NSW) be amended so that the Coroner is required to produce a written report to the relevant Minister containing both a summary of the details of the deaths or suspected deaths, and a summary of the recommendations and the responses received; and
- any agency of department to which a recommendation directed must report its response and actions taken to implement recommendations to the relevant Minister.

We similarly endorse the 2009 recommendation that in relation to deaths in custody, that Parliament as well as the Executive should be part of the process that responds to coroners' recommendations.[85] Again, we draw the Committee's attention to another inquiry in which solutions were given and insufficient action was taken.

(v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities

5.1 In its current form, the coronial jurisdiction is unable to respond to the needs of First Nations people and other diverse groups. There is no justice for First Nations people in the justice system. The participation of First Nations peoples within the coronial jurisdiction must be understood in the context of the colonial legal system in which Coroner's Courts operate. What has been described as 'institutional trauma' inflicted on First Nations families by an inquest[86] stem from the systemic oppression inflicted through the operation of public systems including the justice and health systems since colonisation.

Failure to address systemic issues

5.2 The apparent inability of the coronial system, except in irregular cases, to address systemic issues such as discrimination in itself prevents the entire jurisdiction from being able to respond to the needs of systemically oppressed groups. Perpetuating a cycle of power imbalance, prejudice and abuse, the process only serves to re-traumatise families who have spent generations contending with institutions and officials who systematically fail to protect their most basic interests.

---

[82] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.4].
[83] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 12].
[84] Aboriginal Legal Service (NSW/ACT), Submission No 120 to *Select Committee Enquiry* (n 4) 7 [14].
[85] Public Interest Advocacy Centre, *Review of the Coroners Act 2009 (NSW)* (Submission, 2014), 6.
[86] Newhouse, Ghezelbash, Whittaker (n 15) 86.

5.3 An example of the failings of the *Coroner's Act*[87] to address systemic problems is in health care and especially in relation to suicide. By focusing on the manner and cause of death, the Act allows systemic problems in health care to be denied the resources given to mandatory inquests.

5.4 This problem is amplified by the guidance given to regional coroners via the Local Court Bench Book[88] as to the Coroner's discretion to hold an inquest. The Bench Book refers to an example scenario where the evidence clearly indicates a suicide, and there are no additional suspicious circumstances, then this may be sufficient to satisfy a Coroner that an inquest is unnecessary.[89]

5.5 We suggest that this is the wrong approach to take. It suggests that a person died by suicide and that is all we need to know. It sends the message that systemic discrimination and the intergenerational trauma felt by First Nations people is not suspicious - that nothing is wrong. Moreover, it suggests that the Coroner's Court would not have any recommendations to make about preventing similar deaths.

5.6 These are the cases where the lack of resources for the Coroner's Court does its most insidious harm. Suicides should be presumed to be preventable deaths where an inquest would be useful, even where a person has a history of suicidal ideation. In NJP's experience of clients with suicidal ideation, it is regularly a client's response to improper or inhumane treatment, frequently at the hands of government agencies. People who are on Community Treatment Orders under the *Mental Health Act*[90], people on bail or parole, people whose children have been removed by the relevant Department – these are people whose suicides points to systemic failures in the operation of government. With the permission of the families, the actions leading to deaths by suicide should be examined at an inquest.

Cultural Safety

5.7 The concept of cultural safety, originally drawn from the work of Maori nurses in New Zealand has a broad application. Cultural safety can be defined as:

> *An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening*.[91]

5.8 By creating culturally-informed and safe justice systems, access to justice will be increased and First Nations and culturally diverse peoples will be more likely to have their legal needs and expectations met. Many First Nations families feel marginalised and excluded from the coronial process because of a lack of cultural sensitivity, a lack of institutional transparency and dissonance between the families' demands for justice and the statutory limits of the courts.

---

[87] *Coroner's Act 2009* (NSW).
[88] Judicial Commission of New South Wales, Local Court Bench Book (December 2020).
[89] Judicial Commission of New South Wales, Local Court Bench Book (December 2020) [44-160]
[90] *Mental Health Act 2007* (NSW).
[91] Robyn Williams, 'Cultural Safety – what does it mean for our work practice?' (1999) 23(2) *Australian and New Zealand Journal of Public Health* 213.

Inquests ask a lot from family and community members, often without offering much in return for their significant efforts during deep bereavement.[92] Our clients have repeatedly reported to us that they feel their voices are not heard, they are discouraged from speaking up, their concerns are not explored and they are unable to exercise their cultural protocols during the process.

Cultural considerations

5.9 The Coroners Act and coronial process in NSW must specifically accommodate and respect cultural needs and considerations. There are a number of changes that are required in order for the coronial system to adequately respond to the needs of First Nations people.

5.10 The perspectives of First Nations families, and other groups that are over-represented in the justice system, must be central to coronial reform. The NSW Government must listen to the families whose loved ones have died in police or prison custody, and meaningfully and respectfully involve them in all relevant policy and legal reforms.

5.11 Without a specific legislative requirement to accommodate cultural needs, First Nations families as well as others from diverse cultural backgrounds are forced to plead with Coroner's to ensure cultural protocols and other considerations are adhered to.

5.12 The ability to fulfil cultural obligations are important part of the process both for families and to show respect for the deceased. For example, the family of **Jack Kokaua** were extremely appreciative that they were able to perform the Haka during the final tranche of the Inquest. The **Dungay** family organised a smoking ceremony outside of the Coroner's Court.

5.13 Coroners' courts often struggle with the plurality of personal and kinship interests that make up First Nations families.[93] The *Coroners Act 2009* (NSW) must be amended to allow for flexibility and expansion of definitions of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure.

5.14 The appointment of First Nations coroners in every state and territory would significantly improve the cultural appropriateness of the Coronial system. First Nations-led inquests could be held on-country, and the court processes adapted to be more culturally appropriate in consultation with Elders from the community. The coroner could sit with community Elders, and family members participating in the proceedings. Counsel Assisting could work with the family and Elders to both guide and take guidance from them on appropriate practice. In the interim, a First Nations consultative group could assist the coroner in this regard.

Respect for the body of the deceased

5.15 The failure to accommodate cultural and religious protocols related to the treatment of bodies of the deceased is a common concern of many families. Both the **Dungay** and the **Kokaua** families expressed concerns about the treatment of Jack and David Jr's bodies.

[92] Newhouse, Ghezelbash, Whittaker (n 15) 82.
[93] Ibid.

5.16 To ensure respect for cultural protocol, it has been recommended that forensic pathologists be specifically trained on First Nations peoples' cultural practices to do with bodies and how to respect those practices.[94] The RCIAIDC, recommended reforms to the Coroner's Act to ensure that the family of the deceased or their representative have a right to view the body, to view the scene of death, to have an independent observer at any post-mortem that is authorised to be conducted by the coroner, to engage an independent medical practitioner to be present at the post-mortem or to conduct a further post-mortem, and to receive a copy of the post-mortem report.[95]

We recommend that the *Coroners Act 2009* be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.

First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

We support and endorse the recommendations made to the previous Select Committee Enquiry, in particular:

- The Jumbunna Institute's recommendation that in consultation with First Nations people, a number of of First Nations-specific roles, such as Liaison Officers, support staff, Registrar positions and support roles for Elders be created to improve engagement with the coronial system.[96]
- The Jumbunna Institute's recommendation that the *Coroners Act 2009 (NSW)* extend the definition of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure in different cultures (including First Nations).[97]
- The Legal Aid NSW recommendation that the creation of a culturally specific unit within the NSW Coroners Court, developed in consultation with First Nations, employing First Nations staff to act as a point of contact and provide support for First Nations families, and help build trust and informed participation in the system.[98]

[94] Newhouse, Ghezelbash, Whittaker (n 15) 86.
[95] *Royal Commission* (n 1) vol 5, Recommendation 25.
[96] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 51 [Recommendation 3-5].
[97] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.5].
[98] Legal Aid NSW, Submission no 117 to *Select Committee Enquiry* (n 4) 12.

- The Aboriginal Legal Service (NSW/ACT) recommendation that the NSW Government should resource and fund the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.[99]

(vi) the operational arrangements in support of the Coroner's Court with the NSW Police Force and the Ministry of Health

6.1 The integrity of the coronial system is jeopardised by the role of police. The notion of police investigating police is inherently flawed and prevents those who engage with the system from having confidence that the process is not prejudiced. The experience of many First Nations people, including many of our clients, is that the Australian criminal justice system is systemically structured against their interests. It is perceived as a tool for perpetuating the suffering, disadvantage and oppression of their families, while police and corrective services, under the sanction of the State, operate with impunity for the violence and suffering they inflict.

6.2 No Australian jurisdiction has established a system for a completely independent investigation into deaths in police custody.[100] This lack of independence has led to mistrust in the system by First Nations families seeking justice in relation to deaths in custody.[101] These concerns are relevant for all matters that come before the Coroner's Court, but particularly for First Nations people who have a historically unproductive relationship with the police.

Police investigation

6.3 Police retain a significant role in coronial inquests and are generally responsible for the initial fact-finding investigation.[102] Currently, in NSW, all deaths in police or corrective services custody must be reported to the Coroner.[103] NSW Police then conduct an internal investigation on behalf of the Coroner in accordance with the internal Critical Incident Guidelines and prepare a brief of evidence.[104] Once the Coroner is satisfied with the police investigation brief and the medical evidence including the post mortem report, the Coroner can complete their brief and hold an inquest.[105] Where the death concerned was a death in police custody, the use of a police brief may impact the independence and unbiased investigation of the death. The causative factors are explained from the perspective of police in the brief thus the neutrality of the brief is compromised.

6.4 The family of **Jack Kokaua** believe that the Coronial Brief was biased and prepared with a pro-police agenda. The brief detailed the causative factors from the perspective of police, compromising its neutrality. These concerns were reinforced by the selection of photos relied

[99] Aboriginal Legal Service (NSW/ACT), Submission No 120 *Select Committee Enquiry* (n 4) 8 [Recommendation 16].
[100] Human Rights Law Centre, Submission No 68, Australian Law Reform Commission, *Pathways to Justice - Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (4 September 2017).
[101] Ibid.
[102] Ibid [14.68].
[103] *Coroners Act 2009* (NSW) s 35.
[104] NSW Police Force, Critical Incident Guidelines (December 2019). <https://www.police.nsw.gov.au/__data/assets/pdf_file/0020/420392/Critical_Incident_Guidelines_External_Version_updated_23_Dec_2019.pdf>
[105] Judicial Commission of New South Wales, Local Court Bench Book (December 2020) [44-000].

upon to depict the footage. The footage was also not trusted by the family as it was pixelated and failed to show the times that Jack was hit or had fallen down due to tasering. This evidence 'painted Jack in a bad light' and failed to present a complete understanding of the incident and the events that took place. The full testimony from the Kokaua family can be found in **Case Study A**.

6.5 The family of **David Dungay Jr** have concerns about the mismanagement of evidence. They were disturbed to find that a crime scene was not declared in relation to David Jr's cell and that protocols to secure evidence were not adhered to. There is CCTV footage of David Jr on the date of his death that has never been found. The mismanagement of evidence has re-traumatised the family and has left them without closure. The full testimony from the Dungay family can be found in **Case Study B**.

Lack of independence

6.6 To those who are the victims of state violence, the existing investigative procedure appears to lack fairness and independence. An independent investigation requires that those conducting it have no interest in the outcome. Complete independence is the only way to ensure that unconscious bias will not influence the investigation. Because their first contact with the Coroner's office is usually through the police, First Nations people have little faith in a coronial inquest process that appears from the outset to be biased against the interests of the victim and in favour of the State.

6.7 A process in which 'police investigate police' or corrective services guards is far too vulnerable to both deliberate and unintentional perversion by investigators. It has been established in other jurisdictions that an eagerness to protect the reputation and interests of the force may impact on the ability to conduct an unbiased investigation,[106] and it is no different in NSW. This 'culture of loyalty' is well known in the community[107] and places the interests of police and allied officers in preserving their reputations over those of the civilians they are meant to serve and protect, including the First Nations people. To maintain the independence of the coronial process, it is important that the structure of the coronial investigation itself is independent of any involved parties, such as the police, thus removing both any cases of actual bias or perceived bias.

6.8 It is crucial that the primary investigation of the death itself be conducted independently. Although NSW police investigations may be subject to oversight by professional standards and disciplinary boards, this is no substitute for ensuring that initial investigations are properly conducted. It is crucial that critical and specific evidence, including at the location where the death took place, be properly collected and preserved for use in the coronial proceedings.[108] When protocols are not being adhered to, and the investigation is conducted by a party with a vested interest, the integrity of the investigation is automatically questioned, particularly by those who are marginalised by the justice system.

---

[106] Office of Police Integrity, *Review of the Investigative Process Following a Death Associated with Police Contact* (2011) 8.
[107] Royal Commission into the New South Wales Police Service, (Final Report, 1997) vol 1, [2.1]-[2.79].
[108] An example is the investigation on Palm Island of the conduct of Senior Sergeant Christopher Hurley, discussed in Craig Longman, "Police investigators too in-house to probe deaths in custody," *The Conversation* (April 2011). <https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838>

6.9 The *Coroners Act NSW* allows the investigation of coronial scenes to be delegated to 'a police officer or other person'.[109] In the absence of a completely independent body, First Nations investigators should be engaged *in all cases* where there is a death of a First Nations person.

Transparency and Open Justice

6.10 Transparency is a critical component of the justice system. Requests are often made to Coroners during an inquest, for non-publication or suppression orders to be issued in respect to sensitive material, such as the identities of involved persons or evidence of the circumstances leading up to a death.[110] The NJP has contributed to a Submission to the NSW Law Reform Commission's Open Justice review together with the Jumbunna Institute and the Aboriginal Legal Service (NSW/ACT).[111] That submission stressed the importance of open justice in the Coroners Court, and the unique impact on First Nations families when Coroners close courtrooms or impose non-publication orders on evidence. While such orders can fulfil an important role in protecting personal details of the individuals involved, they are disproportionately invoked to protect government agents who were involved in the death, rather than promoting transparency, justice and accountability.

6.11 The increasing use of suppression and non-publication orders, particularly as concerns confronting CCTV footage of deaths in custody hinders the role of the Coroners Court.[112] For example, in the CCTV footage of David Dungay Jr's death only Mr Dungay himself is visible. Comparatively, during the inquest into the death of Aunty Tanya Day in Victoria, the Coroner permitted the unedited viewing of video footage capturing the circumstances of her death, which cumulated in a public campaign and a coronial referral to prosecutorial authorities.[113]

We recommend that the *Coroner's Act 2009* be amended to encourage the public release of evidence - with family members' consent where appropriate.

We recommend that the *Coroner's Act 2009* be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.

Adversarial nature of inquests

6.12 The adversarial nature of the coronial process contributes to the sense of disempowerment experienced by First Nations families. While coronial proceedings are 'ostensibly inquisitorial', they are increasingly conducted in an adversarial manner.[114] One consequence of this is that First Nations families feel 'as if they are on trial and that the process is more about suppressing

[109] *Coroners Act 2009* (NSW) ch 5.
[110] Newhouse, Ghezelbash, Whittaker (n 15) 80.
[111] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project, Submission to NSW Law Reform Commission - Open Justice review, NSW Department of Justice, *Open Justice Review* (March 2021).
[112] Ibid 17.
[113] Ibid 18.
[114] Newhouse, Ghezelbash, Whittaker (n 15) 82.

their voices, defending state actors or blaming their deceased family member, rather than seeking truth or justice.'[115]

6.13 The process can become a blame-shifting exercise which places the blame on the deceased, or their grieving family. As expressed by Caroline Anderson, the mother of Wayne Fella Morrison who died in Yalata prison, 'I feel like I'm on trial. I'm his mum, you know what I mean? I feel pressure. My parenting skills. How I raised him. It's like I'm on trial for their lack of care'.[116]

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

Until such oversight is established, Coroner's should consult with a First Nations Consultative Committee specifically on deaths in custody.

We similarly endorse the recommendations made previously by our sector colleagues regarding the need for an independent body and referrals for prosecution and disciplinary action, including by Deadly Connections Community and Justice Services Limited[117] and the Jumbunna Institute.[118]

(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

In addition to the solutions advanced by NJP and our sector colleagues, we refer the Committee to a number of examples that we hope will inspire improvements to the NSW coronial jurisdiction.

Investigations

7.1 In New Zealand, an Independent Police Conduct Authority has been established as a statutory body to conduct independent investigations and oversight of police conduct, including instances of police detention.[119] The Authority is empowered to investigate complaints and has a

[115] Ibid.
[116] Royce Kurmelovs, 'Three missing minutes, and more questions: Why did Wayne Fella Morrison die in custody?', *NITV News* (online, September 2018) [3] <https://www.sbs.com.au/nitv/feature/three-missing-minutes-and-more-questions-why-did-wayne-fella-morrison-die-custody-1>
[117] Deadly Connections Community and Justice Services Limited, Submission No 126 *Select Committee Enquiry* (n 4) Recommendation 6.
[118] Jumbunna Institute, Submission No 115 to *Select Committee Enquiry* (n 4) 52 [Recommendation 10.4].
[119] *Independent Police Conduct Authority Act 1988* (NZ).

legislative authority to operate completely independently from both the police force and other State agencies.[120]

7.2 In the Northern Territory a failure or refusal of police officers to follow the directions given by a Coroner to investigate elements of a death in custody carries with it criminal liability.[121]

Responding to recommendations

7.3 In Victoria, when the Coroner makes a recommendation to a Minister, public statutory authority or another entity, that body is required to provide a response directly to the Coroner which specifies what action they are taking.[122] Such an approach is preferable as it applies broadly, and requiring responses directly to the Coroner makes it easier for the public to access information and importantly enables Coroners to track their recommendations to inform future recommendations.[123]

7.4 The Northern Territory has a similar system to Victoria and mandates that when a death in custody occurs, any recommendations made to a relevant CEO or Commissioner of Police must provide a written response to the Attorney-General within three months[124] including a statement of the action they are taking.[125]

Enhancing the preventive role

7.5 The Victorian *Coroners Act 2008* introduced significant reforms to the Victorian jurisdiction, in particular enhancing the Coroner's role in the prevention of death.

7.6 The Coroner's Prevention Unit (CPU) in Victoria is a specialist service providing Coroners with expert assistance in developing prevention-focused recommendations. Among the central goals of the CPU is to increase the quality and implementation of recommendations made. The CPU reviews and analyses relevant deaths, and helps to track, publish and monitor the implementation of coronial recommendations.

7.7 A Domestic Violence Death Review Team ('DVDRT') has been established within the NSW coronial jurisdiction, charged with investigating the causes of domestic violence deaths in New South Wales, with the view to reducing the incidence of domestic violence deaths and facilitate improvements in systems and services. The DVDRT is able to review the circumstances of closed cases of domestic violence related deaths,[126] and 'any failures in systems or services that may have contributed to, or failed to prevent, the domestic violence deaths'.[127] The DVDRT must prepare a report every 2 years which is provided to each House of Parliament, and which includes identification of any systemic and procedural failures which may have contributed to

---

[120] *Independent Police Conduct Authority Act 1988* (NZ) s 4AB; *Crown Entities Act 2004* (NZ).
[121] *Coroners Act 1993* (NT) s 25(2).
[122] *Coroners Act 2008* (Vic) s72(3).
[123] Boronia Halstead, 'Implementing Coroners' Deaths in Custody Recommendations: A Victorian Case Study' (1996) 7(3) *Current Issues in Criminal Justice* 340, 353.
[124] *Coroners Act 1993* (NT) s 46B(1).
[125] *Coroners Act 1993* (NT) s 46B(2).
[126] *Coroners Act 2009* (NSW) s 101G(1)(a
[127] *Coroners Act 2009* (NSW) s 101G (1)(d)

domestic violence deaths, and recommendations, legislative or otherwise, to prevent or reduce the likelihood of such deaths.[128]

Deaths in custody mandate

7.8 In the Australian Capital Territory, the Northern Territory, Western Australia and Tasmania, where there is a death in custody, coroners are mandated to make recommendations pertaining to the quality of care, supervision and treatment of the deceased to prevent similar deaths occurring.[129]

7.9 The RCIADIC recommended that a Coroner inquiring into a death in custody should make broad recommendations with the view to prevent further custodial deaths.[130] However, while the Northern Territory and Tasmania have incorporated this recommendation by making such findings mandatory,[131] in NSW, making such findings remains at the Coroner's discretion.[132]

7.10 In Western Australia, regulations can be made that would give effect to the recommendations of the RCADIC.[133]

A culturally responsive jurisdiction

7.11 In Victoria, there is also a culturally specific unit within the Coroners Court. The Coroners Court has recruited a Koori Registrar and a Koori List Engagement Registrar to manage Aboriginal coronial cases to ensure that coronial practices are culturally sensitive and appropriate.[134] Victoria is also in the process of engaging Aboriginal Elders in the Coroners Court to provide cultural advice to ensure that coronial practices are culturally appropriate and safe.[135]

7.12 The Victorian Aboriginal Justice Agreement, developed in response to recommendations from the RCIADIC and subsequent Summit[136] The strategies and opportunities contained in the Agreement are designed to strengthen First Nations oversight and focus on the important roles of family and therapeutic, cultural healing to tackle offending.[137] The Agreement aims to improve Aboriginal justice outcomes, family and community safety, and reduce over-representation in the Victorian criminal justice system.

---

[128] *Coroners Act 2009* (NSW) s101J (2)(a)-(b).
[129] *Coroners Act 1993* (NT) s26(2); *Coroners Act 1996* (WA) s25(3); *Coroners Act 1995* (Tas) s28(5); *Coroners Act 1997* (ACT) s74.
[130] *Royal Commission* (n 1) vol 5, [13].
[131] *Coroners Act 1993* (NT) ss 26(2), 34(2), 124; *Coroners Act 1995* (Tas) s 28.
[132] *Coroners Act 2009* (NSW) s 82.
[133] *Legal Aid NSW, Submission no 117 Select Committee Enquiry* (n 4) 81.
[134] Victoria State Government, 'Goal 3.1: The needs of Aboriginal people are met through a more culturally informed and safe system', *Victorian Aboriginal Justice Agreement* (Webpage, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-met>
[135] Victoria State Government, 'Cultural advice in the Coroners Court', *Victorian Aboriginal Justice Agreement* (Web Page, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-outcomes-framework/goal-31-the-needs-of-aboriginal-people-are-9>
[136] Ministerial Summit on Indigenous Deaths in Custody, *Speeches and papers from the Summit / Ministerial Summit on Indigenous Deaths in Custody* (Compiled by the Commonwealth Attorney-General's Department and ATSIC, 1997).
[137] Victorian State Government, *Victorian Aboriginal Justice Agreement* (Webpage, 2021). <https://www.aboriginaljustice.vic.gov.au/the-agreement/aboriginal-justice-caucus-co-chairs-foreword>

7.13 In Tasmania, the engagement of a First Nations organisation in mandatory where the Coroner suspects that a death involves human remains of a First Nations person.[138] This direction ensures the treatment of a First Nations person's body post-death can be conducted respectfully and that cultural protocols are adhered to.

Referrals to the Director of Public Prosecutions (DPP) and other disciplinary bodies

7.14 In most Australian jurisdictions, the threshold to allow a Coroner to refer a matter to the DPP is much lower than in NSW. Importantly, a Coroner is not required to make any implication or suggestion of guilt, as this is the role of the DPP following their investigation and independent decision to lay charges. A coroner may make a referral to the DPP if they:

- believe that an indictable offence may have been committed (Victoria, Northern Territory and Western Australia);[139]
- have reasonable grounds to believe an indictable offence has been committed (ACT);[140] or
- have a reasonable suspicion a person has committed an offence (Queensland).[141]

7.15 Queensland goes further in promoting accountability by mandating that coroners must refer any other matter, not prosecutable by the DPP, to the CEO of the relevant department who administers the legislation which creates the offence.[142] It also allows for the coroner to give information about corrupt conduct or police misconduct to the Crime and Corruption Commission.[143]

(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

8.1 In light of all of the matters, we stand by our principal recommendations, in line with those made to the previous Select Committee Enquiry that in relation to First Nations deaths in custody, that independent oversight needs to be established.

First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system.

[138] *Coroners Act 1995* (Tas), s 23.
[139] *Coroners Act 2008* (Vic) s49(1); *Coroners Act 1996* (WA) s27(5)(a); *Coroners Act 1993* (NT) s35(3).
[140] *Coroners Act 1997* (ACT) s58(1).
[141] *Coroners Act 2003* (Qld) s48(2).
[142] *Coroners Act 2003* (Qld) s48(2).
[143] *Coroners Act 2003* (QLD) s48(3).

Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.

We endorse and support the recommendations put forward by the Jumbunna Institute that an independent body could operate as a specialised stream within the coronial system and draw on the existing models of the Koori Court and circle sentencing to promote First Nations self-determination.[144]

(d) any other related matter

Irrespective of any legislative changes and specific improvements to the form and operation of the NSW coronial system, the *culture* of the coronial system as a whole requires a dramatic shift. It cannot be the responsibility for individual Coroner's to establish the necessary system-wide changes. The impetus must be embedded at a system-wide level through policy, statutory amendments and the Executive. A renewed coronial system framework must embed substantive principles of truth, accountability, protection and prevention to enable the coronial jurisdiction to discharge its obligations.

Case Study A: From our case files - Inquest into the Death of Jack Kokaua

Background

Jack Kokaua was a 30-year-old Maori and Cook Islander man, described by his family as "a compassionate, loving guy" and "soft and gentle…despite all he has been through." He had a long history of mental illness dating from his adolescence.

The coronial process is an important vehicle to elicit the true circumstances surrounding a death and an opportunity to identify important changes to prevent future deaths from occurring. The circumstances surrounding Jack's death raised a number of important questions about police restraint techniques, taser use, gaps in mental health training and culturally safe care. There were many occasions in which a different intervention by police, mental health practitioners or his parole officer might have prevented Jack's ultimate fate.

On the morning of 18 February 2018, multiple witnesses called police expressing concern for Jack's safety after witnessing him struggling to ride a rental bike.[145] The responding police called an ambulance and Jack was transported to Royal Prince Alfred Hospital (RPA).[146] Jack subsequently absconded from RPA and was located by police. Jack was capsicum sprayed, tasered on three occasions and held down by multiple officers in the prone position.

[144] Jumbunna Institute, Submission No 108 to *Select Committee Enquiry* (n 4) Recommendation 6.
[145] *Inquest into the Death of Jack Kokaua* (n 17) 17 [92].
[146] Ibid 31 [173].

It was only after additional officers arrived at the scene that Jack's lips were observed as changing colour and an officer was instructed to check whether he was breathing.[147] Unfortunately, Jack had stopped breathing and could not be revived.

The Coroner's Findings

The Coroner found that the actions of police were inconsistent with NSW Police Policies. The officers did not seek the prompt attendance of an ambulance despite the fact that he was tasered three times.[148] The officers did not communicate with Jack for the purposes of reassurance and de-escalation, did not monitor his breathing and did not consider whether force was necessary during his restraint.[149]

The Coroner found that the police restraint techniques which lead to positional asphyxia and exertion as well as the uses of the taser, superimposed upon Jack's underlying occult coronary heart disease, ultimately resulted in Jack's death.[150]

Despite such findings and concerns surrounding the circumstances of Jack's death, jurisdictional limitations and system failures have left the Kokaua family with unsatisfactory information, unanswered questions and a distrust of the coronial process.

Kokaua family concerns with the coronial process:

The family of Jack Kokaua has expressed concerns in relation to their experience and their interaction with the coronial system in NSW.

Lack of resources and communication

The level of support and resources available to families of deceased persons throughout coronial investigations is inadequate. Inadequate lines of communication and limited access to information left the Kokaua family in the dark and waiting for extended periods for the truth to come out. These gaps in communication and support for families can create barriers for families' involvement in the investigation process such as a lack of knowledge of status of the police investigation, preparation of coronial brief and expectations around timeframes and the outcomes of an inquest.

Delayed investigation, communication and findings

Media reports wrongfully claimed that Jack was under the influence at the time of his death. It was later found that this was false, causing great harm and upset to the family for having to wait so long for answers and for the record to be set straight.

[147] Ibid 43 [250].
[148] Ibid 58 [344].
[149] Ibid 74 [421].
[150] Ibid 3.

Further, such failings are evidenced by the fact that the family had to wait for 19-months to hear the account of the involved officers. Pania, Jack's sister, believes that this delay was a strategy to 'wear us out' and allowed the police ample opportunity to cover their tracks and obstruct access to the truth. Most importantly, the delay prevented the family from being able to seek closure and grieve for their kin. The police claimed to have no notes and claimed that no discussions took place before the hearing however, such claims are not believed by the family.

The Kokaua family were greatly affected by the lack of timeliness in the findings being handed down. Two days before the findings were due to be handed down, the family was advised that there may be a delay, which did eventuate and the findings were finally handed down 6-weeks later. The family, though understanding the substantial evidence needed to be reviewed, were not prepared for such a significant delay. Jack's mother, Queenie Kokaua, had travelled from New Zealand to be present when the findings were due to be handed down and was not able to travel to and from Australia again. The postponement caused great stress to the family.

The Kokaua family also had to sit through 3 tranches and wait over two years after the first Directions hearing (2 May 2019) to hear the findings (12 May 2021). Reflecting on the more than 3-year gap in time between the date of Jack's death (18 February 2018) and the release of the findings, Pania states '**I believe the prolonging of Jack's case is a strategy created by the police supported by the system to weaken families in the fight against the police and their system**.'

Police Conduct

The police conduct during the proceedings was of great concern to the Kokaua family. The police received certificates under s 61 of the *Coroners Act 2009* (NSW)[151] which permitted them to testify without prejudice. While giving evidence, the police showed great disrespect for both Jack and his family. Officers said that they would not change anything in hindsight and made rude remarks which included a reference that likened Jack to a cockroach. The police lawyers were also seen to be disrespectful in Court. These interactions exacerbated the already existing unease of the family with the police, whose conduct contributed to Jack's death.

Investigation and evidence

The Kokaua family believe that a more thorough investigation should have taken place. The family believe that the Coronial Brief was biased and prepared with a pro-police agenda. As the police briefs play a key role in the finalisation of the Coroner's Brief, it is reasonable for the family to hold such concerns. Where the death concerned was a death in police custody, as it was in Jack's case, the use of a police brief may impact the independence and unbiased investigation of the death. The brief detailed the causative factors from the perspective of police, compromising its neutrality. These concerns were reinforced by the selection of photos relied upon to depict the footage. The footage was also not trusted by the family as it was pixelated and failed to show the times that Jack was injured or had fallen down due to tasering. This evidence 'painted Jack in a bad light' and failed to present a complete understanding of the incident and the events that took place.

[151] *Coroners Act 2009* (NSW) s 61.

Condition of the Jack's body and cultural protocol

The Kokaua family was upset about the condition of Jack's body when it was returned to them. The condition of Jack's body was left unaddressed at the Inquest. The family's embalmer identified that there was substantial decay to the body and stated that it was in the 'worst condition they had seen'. Such factors have led to great distrust of the autopsy process, concern as to how the body was kept and uncertainty as to whether the condition was tied to the police or the post-mortem process. Due to the condition of the body, the family were unable to have a 3-day viewing as part of their funeral customs.

Positive Experiences

Although the above-mentioned circumstances were extremely harmful to the Kokaua family, the respect shown by Counsel Assisting (Kristina Stern SC) and the Coroner (Magistrate Teresa O'Sullivan) was the first sight of hope for justice in the whole ordeal. The Counsel Assisting and the Coroner acted with dignity, integrity and respect at all times. Queenie Kokaua stated they "actually tried to make us feel comfortable in the most uncomfortable situation a family could find themselves in". In addition, the family appreciated that they were allowed to perform the Haka at the final tranche of the Inquest.

Case Study B: From our case files - Inquest into the David Dungay Junior

Background

David Dungay Jr ('**David Jr'**) was a 26-year-old proud Dunghutti man from Kempsey NSW. He was very loved by his close-knit family and was a mentor to his family members. He enjoyed schooling, music and was an excellent sportsman.

David Jr suffered from mental health issues and had a history of recurring psychosis. He was diagnosed with type 1 diabetes when he was just six years old and had been managing his insulin independently since then.

David Jr was being detained in Long Bay Prison and was receiving involuntary treatment in the sub-acute ward at Long Bay prison hospital as a mental health patient.[152] David Jr was in lawful custody at the time of his death on the 29th of December, only three weeks away from parole.

The Coroner stated that the events of 29 December 2015 and the circumstances surrounding David Jr's death raised a number of questions about the manner of his death.[153] The Inquest sought to explore key issues relating restraint techniques, appropriate use of force, compliance with policies and procedures, cultural sensitivity and appropriateness of steps taken following David Jr's death.

[152] *Inquest into the Death of David Dungay* (n 18) [1.1].
[153] Ibid [2.3].

On the day David Jr died, he was eating biscuits in his prison cell.[154] Despite David Jr always having self-managed his diabetes, concerns were raised about risk to his health posed by his eating of the biscuits. Prison guards asked David Jr to stop eating the biscuits, but he refused. No adequate attempt was made by the prison officers to remove the biscuits from David Jr or negotiate with him.[155] Instead, the officers called in the Immediate Action Team (IAT), which specialises in prisoner removals, to forcibly move David Jr from his cell.[156]

One of the six IAT officers stormed David Jr's cell with a riot shield, which David Jr collided with.[157] The other officers entered and restrained him by manoeuvring him face-down and handcuffed him behind his back.[158] David Jr was held in a prone position with at least one officer lying on top of him and three others holding him down, each with their knees on top of him. Then, they dragged him to another cell[159] and held him face down underneath their full weight.[160]

Under the weight of the guards, David Jr was spitting blood and was injected with a sedative while being held down.[161] David Jr called out "I can't breathe"[162] more than a dozen times in the final minutes before he passed. Despite these calls for help, David Jr continued to be restrained by multiple officers in a position that compromised his breathing.[163] By the time the guards realised he had stopped breathing, it was too late. Still, only two resuscitation attempts were undertaken.[164] It was less than 10 minutes after the cell move began that David Jr became unresponsive whilst restrained, and tragically died.

The Coroner's Findings

The Coroner found that David Jr died whilst being restrained in the prone position by prison officers. The consequent hypoxia, prolonged restraint and extreme stress and agitation as a result of the use of force and restraint contributed to David Jr's death.[165] However, the Coroner made no recommendation regarding charges or sanctions against the prison officers involved nor the medical staff assigned to David Jr's care.

It has been almost six years since the death of David Dungay Jr, and no-one has ever been referred for discipline or prosecution for David Jr's death. Despite an abundance of both testimonial and video evidence, and Findings of the circumstances surrounding David Jr's death, no justice has been afforded to David Jr's loving family.

---

[154] Ibid [1.2].
[155] Ibid [1.2].
[156] Ibid [9.9].
[157] Ibid [9.13].
[158] Ibid [9.15].
[159] Ibid [9.16].
[160] Ibid [9.17].
[161] Ibid [9.18].
[162] Ibid [9.20].
[163] Ibid [9.20].
[164] Ibid [9.22].
[165] Ibid [24.23].

Dungay family concerns with the coronial process:

David Jr's family feel that the coronial system completely failed them as it provided no accountability, the coroner found 'systemic deficiencies in training' but did not make a referral to SafeWork NSW despite the admissions and apologies made by the Department of Corrective Services NSW and Justice Health. Since the findings, the family have criticized the Commonwealth and NSW governments for failing to protect David Jr's right to life or hold any individual or organisation accountable for his death.

Investigation and evidence

The Dungay family have raised concerns about the mismanagement of evidence. They were disturbed to find that a crime scene was not declared over David Jr's cell and that protocols to secure evidence were not adhered to, including that blood and DNA in David Jr's cell was cleaned against protocol. Although the destruction of evidence and government records may be a criminal offence, no one was held responsible for the breaches of those protocols and for breaches of the law. Rather, the Coroner underplayed those breaches and an *internal* corrective services investigation found that there was no criminal negligence.[166] Further, the polices' initial investigation found that his death was not suspicious which seemingly ignores the abundance of evidence regarding the prison officer's involvement in David Jr's eventual death.

Ms Christine Dungay, David Jr's sister, noted her frustration and heartbreak that a forensic and criminal investigation was not possible following David Jr's death, as all the physical evidence was cleaned up. David Jr's clothes and some of his belongings were never returned to his family which only added to the family's suspicions of improper conduct. Further, there is CCTV footage of David Jr on the date of his death that was destroyed and once again the Coroner made no adverse finding in that regard. The mismanagement of evidence, which may be a crime under NSW law, has re-traumatised the family and has left them without closure as has the failure of the Coroner to take issue with it or make recommendations to hold individuals or organisations accountable for their mismanagement or criminality.

Failure to refer anyone for discipline or prosecution

The Inquest held in 2019 found that David Jr died from cardiac arrhythmia, with contributing factors including the actions of the guards in restraining David Jr with significant physical pressure in a position which compromised his breathing, and extreme stress and agitation as a result of the use of force and restraint.[167] Despite such findings, the Coroner found that none of the guards involved in David Jr's death should face any disciplinary action.[168] The Coroner found that the conduct of the guards was 'limited by systemic deficiencies in training'[169] and not motivated by 'malicious intent'.[170]

---

[166] Helen Davidson, 'The story of David Dungay and an Indigenous death in custody', *The Guardian* (11 June 2020) <https://www.theguardian.com/australia-news/2020/jun/11/the-story-of-david-dungay-and-an-indigenous-death-in-custody>.
[167] *Inquest into the Death of David Dungay* (n 18) [24.23].
[168] Ibid [18.12].
[169] Ibid [18.12].
[170] Ibid [18.12].

Lack of accountability

The family of David Jr believe that they have been unheard and denied justice by the coronial process. The family continue to organise protests and mount public campaigns to persuade the government to take long overdue action and hold the officers who stormed David Jr's cell, Justice Health or Correctional Services NSW accountable for their actions. Following continued advocacy and various unsuccessful attempts to convince authorities that someone must be held accountable, the Dungay family, led by Ms Leetona Dungay, have taken their call for justice to the United Nations.

"I am going to fight until I live in a country where black lives matter." – Ms Leetona Dungay

Timeliness of decisions

The Dungay family had to wait almost four years to receive answers concerning David Jr's death. The prolonged process was traumatising, particularly given the findings and recommendations delivered by the coronial process left the family dissatisfied.

Cultural responsiveness

The Dungay family have shared their concern about a lack of involvement of First Nations people and values throughout the coronial process, which reinforced their existing distrust in the justice system and re-traumatised their family. The Dungay family vocalise and advocate that there needs to be a First Nations Coroner and Investigators in NSW, alongside better First Nations representation in employment throughout the entire criminal justice system. The Dungay family acknowledge that this would have improved their own experience in the coronial system and would help them to build some level of trust in the system, which is currently diminished.

Notification

The Dungay family have expressed their disappointment in the insensitive notification of David Jr's death by NSW police. Their experience was far from RCIADIC recommended procedure for notifying families of those who have died in custody.[171]

> **"It wasn't very nice. They should have come to where I was directly. I'm his mum, I should have been told first." – Ms Leetona Dungay**

NSW Police communications with the Dungay family caused confusion, distress and anger for a family on top of their grief. Mr Dungay Jr's mother was not the first person to be notified of her son's death. Ms Leetona Dungay's eldest son, Ernest, was the person to inform her of David Jr's death. The police later contacted Ms Leetona Dungay to let her know over the phone.

David Jr's sister, Ms Christine Dungay, was notified of David Jr's death by the police coming to her house. Christine met the police officer at the fence of her yard in fear, noting that whenever the police had attended her residence prior to this occasion, the interactions were unproductive and

[171] *Royal Commission* (n 1) vol 1, Recommendation 19.

disrespectful. In this context of distrust, the NSW Police were not the best means by which to notify the Dungay family of their tragic loss. The inherent feeling of distrust in the system was only aggravated by these encounters.

The nature of the Inquest

The Dungay family felt disempowered by the adversarial nature of the coronial inquest, which provided no real opportunity for open discussion about what happened to David Jr, nor did it accommodate the participation of the family. David Jr's sister, Ms Christine Dungay, expressed that the lack of First Nations representation in the Coronial system, compounded by the amount of legal representation provided to the IAT guards, portrayed the image that the guards were victims, rather than her brother David Jr, who lost his life.

Transparency and Open Justice

To compound the hurt to the family, the pleas by Ms Leetona Dungay for all CCTV footage of the death of her son to be released publicly were refused after a protracted dispute. Even when the extracts were released the identities of guards were anonymised through pixilation. The family were left feeling that their requests were ignored or diminished and those of the guards who held David Jr down until he died were promoted.

Condition of David Jr's body

The Dungay family were extremely upset by the condition of David Jr's body when it was delivered to them. Ms Leetona Dungay and her eldest son Ernest, visited the morgue and took pictures of David Jr's body as they did not trust the investigation was conducted. The Dungay family believe that the circumstances of David Jr's death are suspicious and they did not trust the investigation that was being undertaken.

KEY RECOMMENDATIONS

Inspired by guiding principles of justice, accountability, transparency, cultural safety and the sovereign rights of First Nations peoples, we make the following overarching recommendations that apply to all representations made in this submission:

1. Implement the recommendations from the Royal Commission into Aboriginal Deaths in Custody and all relevant subsequent enquiries.
2. The NSW Government must establish and properly fund a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. The investigative body should have the power to examine the death of a First Nations person under the control of state officials in broad contexts including in police custody, in prisons, any corrective services, during transport, in accessing health services, as well as in the interrelated decisions made by officials in these various bodies and any related death 'close to custody'. Such a body must have real powers to make recommendations, compel responses to recommendations, refer matters for prosecution or disciplinary action and to undertake regular prison and youth detention inspections.
3. Until an independent oversight body is established, First Nations Coroners and Investigators need to be appointed to investigate and make recommendations about the deaths of First Nations people in custody with a mandate to examine and make recommendations on systemic issues including but not limited to prejudice, bias and racism.
4. First Nations communities need to involved in and lead all relevant reforms in the overhaul of the coronial and criminal justice systems insofar as they affect First Nations Peoples.

DETAILED RECOMMENDATIONS
TO IMPROVE THE CORONIAL JURISDICTION

Scope and limitations of the coronial jurisdiction

5. We recommend that the Coroner's Act 2009 be amended to prioritise the protection of lives and the prevention of death and injury by including a statutory recognition of prevention as part of the role of the Coroner.
6. We recommend that the Coroner's Act 2009 be amended to mandate an Inquest be conducted for deaths that occur near to or 'close to' custody.
7. We recommend that the Coroner's Act 2009 be amended to require the Coroner to consider and comment on the quality of care, treatment and supervision of an individual prior to their death.
8. We recommend that the Coroner's Act 2009 be amended to:
    a. require a coroner to refer an individual or organisation to the DPP, SafeWork NSW or a relevant disciplinary or complaint body when a Coroner has a reasonable belief or suspicion that an offence or misconduct may have been committed which may have caused or contributed to a death; and
    b. require a coroner to refer relevant matters relating to potential misconduct or corruption to the relevant corruption or disciplinary body.

9. We recommend that the Coroner's Act 2009 be amended to require the Coroner to consider and comment on systemic factors, discrimination and bias, including by police, corrective services and health services.

10. We recommend that the Coroners' Court encourage the substantive participation of families in the coronial process by developing and implementing trauma informed and culturally safe practices and policies in conjunction with a First Nations Consultative Committee.

Resources

11. We recommend that significant resources be dedicated to ensure that First Nations families are fully supported (including but not limited to, travel costs, accommodation, legal and psychological support) to facilitate engagement with the coronial system in an informed and culturally safe way.

12. We recommend that significant resources be dedicated to the Coroners Court to expedite coronial investigations and inquests and allow for more investigations.

Timeliness of decisions

13. We recommend that the coronial jurisdiction set and adhere to reasonable timeframes for investigations and inquests.

The outcomes and oversight of recommendations

14. We recommend that the Coroners Act 2009 be amended to require Coroners to make broad recommendations at Inquests into a death in custody (including 'close' to custody) and to mandate that recommendations are published, disseminated, responded to, monitored and implemented in a timely manner.

15. We recommend that an independent body be established to monitor and evaluate responses to and implementation of recommendations.

Responding to cultural needs

16. We recommend that the Coroners Act 2009 be amended to allow for cultural needs and practices, as determined by First Nations or culturally and linguistically diverse communities, to be met and respected at all stages of the coronial process. This includes respect for cultural practices in the Court, in relation to the bodies of deceased persons, specialist training for forensic pathologists and respect for kinship interests.

17. Until complete independence is established, at the very least, a First Nations consultative group must be established and resourced; with powers to liaise with Coroners and to consult with them regarding the scope of coronial investigations of First Nations deaths, to ensure the system is culturally safe at all times and that recommendations are made to address systemic factors that may have caused or contributed to the death of a First Nations individual.

Open Justice

18. We recommend that the Coroner's Act 2009 be amended to encourage the public release of evidence - with family members' consent where appropriate.

19. We recommend that the Coroner's Act 2009 be amended to require Coroners to publish reasons for making suppression or non-publication orders, and provide legislative clarification of the right of families to make submissions in opposition of such orders.