Submission No 31

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Jumbunna Institute of Indigenous Education and Research, Research Unit

Date Received: 12 July 2021

Submission to the Select Committee on the NSW coronial jurisdiction

Jumbunna Institute of Indigenous Education
and Research, Research Unit

12 July 2021

UTS UNIVERSITY OF TECHNOLOGY SYDNEY

Jumbunna Institute
15 Broadway, Ultimo NSW 2007

T: +61 2 9514 9655
IndigenousResearch@uts.edu.au

PO Box 123
Broadway
NSW 2007 Australia
www.uts.edu.au

UTS CRICOS PROVIDER CODE 00099F

By email:

coronial.jurisdiction@parliament.nsw.gov.au

12 July 2021

To the Select Committee on the coronial jurisdiction in New South Wales -

The Jumbunna Institute's submission to this inquiry is enclosed.

This submission is from the Research Unit of the Jumbunna Institute for Indigenous Education and Research at the University of Technology Sydney. Our members are committed interdisciplinary scholars and practitioners. We work from one key guiding principle, that our work should be driven by Aboriginal and Torres Strait Islander people, and contribute to their strength, self-determination, sustainability and wellbeing. In the course of this work, we have close contact with systems that review deaths in custody and walk with families and communities who have lost loved ones through this process.

The following Jumbunna Institute staff principally authored this submission - Craig Longman (Snr Researcher, Legal Strategies Hub), Alison Whittaker (Senior Researcher, Indigenous Policy), Katie Lowe (Intern, Legal Strategies Hub) and Paddy Gibson (Senior Researcher, Indigenous Child Protection).

We are happy to provide further information on any of the matters raised within this submission.

Regards,

Dist. Prof. Larissa Behrent AO Prof. Lindon Coombes Mr Craig Longman

We are the Jumbunna Institute for Indigenous Education and Research (**Jumbunna Institute**).

We thank the Committee for the opportunity to make submissions to the current Legislative Council's Select Committee on the coronial jurisdiction in New South Wales (**the Committee**).

Introduction

At the outset, we direct the Committee's attention to two submissions made by the Jumbunna Institute last year that relate to issues covered in this Committee's Terms of Reference (**TORs**): the first to the NSW Parliament's Legislative Council's *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Link) (**FN Sub**) and the second to the NSW Law Reform Commission's *Open Justice Review* (alongside the Aboriginal Legal Service (NSW/ACT), and the National Justice Project) (Link) (**OJ Sub**).

We reiterate our prior observations that First Nations Death in Custody (**FNDIC**) uniquely trouble investigations and inquests and consequently unique arrangements are required to ensure justice is afforded to First Nation families of those who have died in care or custody.

We restate our belief that FNDIC inquests and investigations require First Nations leadership and self-determination. They must be truly independent, impartial and transparent. By extension, we also submit that FNDIC require specific coronial inquest arrangements to ensure justice under current institutional arrangements. Those are detailed in the FN Sub.

The bulk of our FN Sub addresses structural and procedural concerns with the Coroners Court in NSW and its supporting legal, regulatory and logistical architecture. While that submission was focussed on deaths in custody, this submission can provide insight into arrangements for other inquests into deaths that occur outside of custody.

Finally, we note that the Jumbunna Institute is also assisting with community-led organisations and families in making their submissions to this inquiry.

Table of contents

Scope and limitations of the Coroners Jurisdiction (TOR 1(a)(i))

1. The Coronial jurisdiction has a long history on this continent, even though the recent attention following deaths in custody and institutional innovations around inquests in the 1980s may make the jurisdiction and its relationships seem new.

2. The first NSW Coroner was appointed by Admiral Arthur Phillip. This history and others are not forgotten by First Nations in NSW who, while turning (sometimes voluntarily, sometimes by mandatory referral) to inquests for answers and justice, remain sceptical of what the Coroners Court can offer them. This is especially the case for the role that the Coroners Court has played in deaths in custody before the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) and to date.

Scope of the coronial jurisdiction

3. We have previously addressed the importance of Coroners adopting a wide scope of investigation in our FN Sub.[1] There we draw attention to the importance of Coroners inquiring broadly into not just the biomedical cause of death, but also those circumstances that are consistent with known systemic discriminatory outcomes in the legal, criminal justice, health and corrective services areas. The adoption of a broad scope is essential in fulfilling two of the Coroner's functions: first, to satisfy '*the legitimate concerns of relatives, the concern of the public in the proper administration of institutions, gaols and the care of persons in custody and the like*'[2] and second, its preventative function.[3]

4. In our experience, the boundaries of an Inquest's scope is one of the predominant questions that inform First Nation experiences of the quality of justice that is achieved through coronial investigations and inquests. A narrow determination of scope curtails the capacity of the Coroner to inquire into the circumstances of death, focusing instead upon a solely biomedical model of mortality. The scope of inquest is also a central question for many families, who may wish to raise systemic issues such as discrimination and racism as factors contributing to the death of their loved one.

5. Although inquests are informal by design, they are growing more adversarial. We are concerned that an increasing threat of judicial review directed to determinations of scope may lead Coroners in NSW to determine scope and relevance narrowly. This context leaves little room for families to draw the Coroner's attention to their concerns.

6. Whilst in our recent experience some Coroners seem to be more willing to examine systemic issues, (as detailed in our FN Sub),[4] in our experience the practice generally in the Coroner's Court is to take a narrow rather than broad approach to the question of scope, often accompanied with a reference to the inquiry not becoming a 'royal commission'. Usually this approach not only preferences biomedical issues within the scope of investigation and inquest, but also subordinates many of the concerns of First Nation families who have lived experiences of how systemic issues impacted on how their loved one came to both be in custody and to have died.

---

[1] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 19-20, paras [56] to [60].
[2] *Bilbao v Farquhar* [1974] 1 NSWLR 377 at 388 per Bowen J.
[3] See Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), *National Report,* Vol 1, AGPS, Canberra 1991, at para 4.7.4 and *Ex parte Minister of Justice; Re Malcom; Re Inglis* [1965] NSWR 1598 at 1602 per McClemens J.
[4] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 19-20, paras [56] to [60].

This includes, for example, discretionary policing practices or sentencing practices that disproportionately affect First Nations people. The oft-quoted statements to the effect that Coroner's Courts are inquisitional and designed to investigate the 'truth' about the circumstances of a death (when compared with adversarial or accusatorial jurisdictions), has a profound and cruel impact on families when their interest in highlighting possible discrimination is declared to be outside the scope of the inquiry. Such a narrow scope confirms the experience of First Nation people that the Australian legal system is not interested in analysing its contribution to the discrimination that contributes to FNDIC.

7. We support the recommendation made by the Select Committee for the immediate and comprehensive implementation of the RCIADIC recommendations[5], and the requirement of the Coroner to make findings on whether the implementation of the RCIADIC could have reduced the risks of death in cases of First Nations death in custody.[6]

8. We support that recommendation as going somewhat to addressing such systemic issues, however we suggest it be broadened by this inquiry. Currently, that recommendation limits Coroner's to consider those issues identified 30 years ago by a series of commissions of inquiry into specific cases. Increasingly, research is providing a basis for expert evidence on the way in which discriminatory practices in a range of areas of society impact upon First Nation peoples and we see no reason why Coroners should not be directed to consider contemporary evidence of systemic discrimination.

9. If the Coroner is to properly fulfill their mandate to inquire into the circumstances of a death, then they must be both empowered and trained to recognise and remedy (through the recommendation power) how systems of power have contributed to the circumstances in which a First Nations person has died. Such deaths happen in a fundamentally different context or 'world' than non-First Nations deaths, because First Nations people are born into, and live their lives within, a legal system that has a role in the colonisation of First Nations people. That role involves in many cases, the killing of First Nations people, and a disproportionate death rate of First Nations people in public institutions, including police watch houses, hospitals, schools and prisons.

Limitations of the coronial jurisdiction

Use of powers to refer for consideration for criminal prosecution

10. The Coroner's power to refer suspected persons for consideration for criminal prosecution,[7] has previously been addressed in our FN Sub.[8] Historically, Coroners had the power to commit a person for trial. Over time, that power has been removed and the distinction between coronial and criminal jurisdictions emphasised. As it stands currently, Coroners are required to suspend a coronial investigation where charges have been or are to be laid[9] and Coroners are prohibited from '*indicat[ing] or in any way suggest[ing]' that an offence has been committed by any person*'[10] in their findings.

[5] Legislative Council, Parliament of New South Wales, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Report No 1, April 2021) xi, Recommendation 1.
[6] Legislative Council, Parliament of New South Wales, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Report No 1, April 2021) xiv, Recommendation 34.
[7] *Coroners Act 2009* (NSW), s78
[8] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 23-24, paras [71] to [81].
[9] *Coroners Act 2009* (NSW), s78.
[10] *Coroners Act 2009* (NSW), Ss 81(3) and 82(3).

11. One area in which the current Act is concerning is the view formed by some Coroners that families have no right to seek referral, or indeed, be heard on the question of whether a matter should be referred to prosecutors.[11] By contrast, we have seen many First Nations families seek these referrals (often as their principal goal in an inquest) — in circumstances where those responsible for criminal prosecution (being the Police and the Office of the Director of Public Prosecutions) have not independently done so.

12. There are also some tensions on whether the referral power is performed on the record and delivered alongside findings, or whether it requires an off-the record referral. This is a crucial transparency concern given growing public scrutiny of post-FNDIC review systems.

13. In our OJ Sub, we discussed the lack of transparency of the Coroners Court, in failing to keep a central repository for suppression and non-publication orders.[12] The same logistical failings exist, for keeping track of persons referred by Coroners to the ODPP for consideration of criminal investigation. There is no national comparative consensus position on this, with other states and territories taking their own approaches. That is, short of newspaper reportage, in circumstances where a suspected person is referred to the ODPP during the course of an inquest, such a referral is not consistently documented in Coroners' findings or publicly recorded elsewhere.[13] We submit that it is preferable that a consistent practice be introduced that decisions on such referrals, and the reasons for those decisions, are made on the public record either at the end of the inquest or as a separate notice in the event of referral.

Manner of death classifications

14. The preference of the coronial jurisdiction to narrowly focus on the biomedical questions of a death in custody was recognised in our FN Sub and discussed above.[14] In making findings on the cause and manner of death, we are troubled by how Coroners come to describe the cause and manner of some deaths as 'natural' in circumstances where this is patently inappropriate.

15. In the recent report by the NSW State Coroner into FNDIC,[15] the Court helpfully collates this data — with 19 described as natural causes deaths.[16] It is not, however, a neutral classification.

16. From our reading of findings in the period captured by the report, the following FNDICs were recorded as involving a 'natural' cause of death —

    - The death of David Dungay Jr — who died after being pinned down by multiple officers after he would not stop eating a packet of biscuits. His cause of death was described as cardiac arrhythmia. The manner of death was, the Coroner found, contributed to by 'poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to

[11] See our reference to the *Inquest into the Death of David Dungay* at Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 23, para [75].
[12] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021)15, 16, paras 56] to [62].
[13] For example, in the course of the Inquest into the Death of Dwayne Johnstone, the DPP stopped the inquest to refer a suspected person to the ODPP for consideration of criminal prosecution. Whilst this was reported in the media, there exists no record of the Inquest Findings or such a referral on the publicly accessible Coroners website or repository of Coronial Findings. (see as example of media reportage – Keira Jenkins, 'Dwayne Johnstone's death referred to DPP to consider prosecution', *NITV News* (Online, 29 October 2020) < https://www.sbs.com.au/nitv/article/2020/10/29/dwayne-johnstones-death-referred-dpp-consider-prosecution>
[14] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 18, para [49].
[15] NSW Coroners Court, *Report by the NSW State Coroner into First Nations People's Deaths in Custody in NSW 2008-2018,* (NSW Office of the State Coroner, 2021).
[16] NSW Coroners Court, *Report by the NSW State Coroner into First Nations People's Deaths in Custody in NSW 2008-2018,* (NSW Office of the State Coroner, 2021) 9.

prolong the QT interval, elevated body mass index, likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint.'[17]

- The death of Nathan Reynolds — who died after being provided with sub-standard and insufficient medical care for his chronic condition on an ongoing basis, and who was denied acute emergency care for an hour when his airway closed. None of the corrective services officers who did attend provided CPR or emergency care, and none instigated a call for an ambulance. His cause of death was described as bronchial asthma,[18] with the manner of death recognising the contributory role of the lack of acute and chronic care.

17. We do not regard these deaths as appropriately classified as 'natural causes', and we think that painting them as such disguises the significant state contribution to those deaths. We were encouraged by the recent findings in the inquest into the death of Nathan Reynolds, that noted the contribution of '*deficiencies in management of his severe asthma by the JHFMHN, and deficiencies in the immediate response to his medical emergency by Corrective Services NSW'* to his death — but we do not think this goes far enough.[19]

18. These deficiencies arise from the governing legislation and coronial practice which emphasises a biomedical mandate of the Coroners Court that makes it difficult for it to confront state violence and mistreatment in carceral and colonial contexts. Along with the structural conditions outlined above, it inevitably focusses on the pathology of the victim, implicitly blaming First Nations peoples inside for their deaths, which can be extremely traumatising for families to hear. We outline the structural causes of this in FN Sub. Whilst such distinctions might appear reasonable for non-FNDIC in that they arguably reflect a distinction between potential homicide and non-homicide deaths, they are inappropriate for FNDICs which occur in a historical context of state narratives that have long utilised racist stereotypes about FN people (including the idea of biological inferiority) as justifications for state acts of genocide.

19. This biomedical focus, along with the structural capture we describe in FN Sub,[20] has the consequence of making it difficult to meet the required evidentiary standard to prompt the Coroner to refer a matter to prosecutors. Where Coroners see only inevitability and Indigenous illness, they cannot see state negligence or violence. This results in perverse outcomes like those currently subject to an international human rights complaint in the manner of David Dungay Jr.

[17] Inquest into the Death of David Dungay (Unreported, Coroners Court of New South Wales, Coroner Lee, 22 November 2019) 89, para [26.1].
[18] Inquest into the Death of Nathan Reynolds (Unreported, Coroners Court of New South Wales, Coroner Ryan, 11 March 2021) 33.
[19] Inquest into the Death of Nathan Reynolds (Unreported, Coroners Court of New South Wales, Coroner Ryan, 11 March 2021) 33.
[20] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 10, paras [28] to [29].

Adequacy of its resources and timeliness of its decisions (TOR 1(a)(ii) and (iii))

20. It remains our view that the NSW Coroners Court is under-resourced, leading to delays in both investigation and inquest which can result in delays to families learning about the circumstances of the death of their loved ones. These delays are obscene and brutal to many families, cutting off opportunities to mourn and delaying answers to critical questions about how their loved one died. These delays damage trust and faith in the coronial system (see our FN Sub). [21]

21. For example, we are aware of one FNDIC inquest in which the inquest was not conducted until five years after the death.[22] The delay in answers can only be described as cruel and traumatising to this young man's family — especially when the latency period resulted in poor recollection from individual and institutional witnesses, frustrating both his family and the inquiry itself. The impacts of delay on the quality of evidence (and therefore answers) received during the Inquest is well understood, and inevitable in legal proceedings (particularly those that that rely on eyewitness accounts). In extreme cases, the fact that substantial delays have persisted for so long in the jurisdiction can reinforce FN families beliefs that the devastating impact of such delays on the quality of answers the families receive is in fact the goal of the State.

22. Equally, as we have previously addressed, we believe the Coroners Court and services such as the Aboriginal Legal Service are under-funded and strained in their capacity to offer inquest support to bereaving families.[23] The responsibilities of legal advice, emotional and psychological support, as well as fundraising for travel, accommodation and food expenses currently fall to family and community members as well as organisations like the ALSNSW/ACT, Legal Aid, the Jumbunna Institute, the National Justice Project and activists organisations.

[21] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 25-28, paras [82] to [89].
[22] Aboriginal Legal Service (NSW/ACT), 'Family demand answers at death in custody inquest for Aboriginal man Danny Witton', (Media Release, 22 February 2021).
[23] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 15, 46, paras [46], [169] to [171].

The outcomes of recommendations made, including the mechanisms for oversight whether recommendations are implemented (TOR 1(a)(iv))

23. We have previously addressed the question of the implementations of recommendations. In 2020, Distinguished Professor Larissa Behrendt said to the Select Committee —

> "*our key concerns are that many deaths when investigated, repeat recommendations that are consistent with those of the Royal Commission into Aboriginal Deaths in Custody. This not only highlights that the blueprint for reform have long been in place but not acted upon, but also that many of those deaths are preventable – a conclusion coroners themselves have come to*".[24]

24. In our prior submissions, we have previously advocated for a more robust implementation of both the recommendations made by the Royal Commission into Aboriginal Deaths in Custody[25] and recommendations made by Coroners, directed at state and private institutions in the course of coronial investigations and inquests.[26] It remains our view that the current *Premier's Memorandum M2009-12,*[27] is inadequate in ensuring the complete and timely implementation of coronial recommendations.[28] The continual failure to implement recommendations not only weakens the credibility of the coroners court, but fails to prevent future deaths of a similar nature.[29]

25. We also note that the law of negligence would traditionally provide a vehicle for some oversight of the implementation of recommendations. Effectively, coronial recommendations would form part of the evidence base for proving both what the defendant in a case should have known about a particular area of risk, and, potentially, the standards accepted as reasonable practice. Those remedies are limited for First Nations families given the limitations on bringing compensation for relatives claims and the limited damages available.

26. As a result, there is little political or commercial consequences for government departments who fail to implement recommendations (even when such implementation could have prevented a subsequent death in custody). The justice system is predicated on the idea that deterrence plays a core role in changing future behaviour. For families used to seeing that idea imposed through the criminal justice system, the absence of any consequences for failing to implement coronial

[24] Transcript of Proceedings, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Legislative Council of New South Wales, 27 October 2020) 41. Evidence of Distinguished Professor Larissa Behrendt.
[25] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 51, Recommendation 1; Transcript of Proceedings, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Legislative Council of New South Wales, 27 October 2020) 41. Evidence of Distinguished Professor Larissa Behrendt.
[26] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 44-46, paras [161] to [164]; [172].
[27] Premiers Memorandum, Responding to Coronial Recommendations 2009 (NSW) available at https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.
[28] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 21-22, paras [65] to [67].
[29] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 22, paras [68] to [70].

recommendations suggests the State does not care about deterring behaviours that continue to contribute to FNDICs.

The ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities (TOR (1)(a)(v))

27. The appropriateness and ability of the Court to respond to the needs of bereaved First Nations families in the course of a coronial investigation and inquest was a central theme present throughout our FN Sub.[30]

28. In addition to addressing trust deficits arising from a lack of transparency, independence and delay, we discussed the potential applicability of therapeutic jurisprudential practices as a means of enhancing the ability of the court to respond to needs of bereaved First Nations families in a culturally sensitive and respectful manner.[31] Throughout that submission we spoke specifically to the current cultural insensitivity in the manner in which notifications of deaths in custody are done,[32] the use of damaging language in the courtroom, so as to minimise the accountability of individuals and the state,[33] the exacerbation of grief and trauma associated with extraneous delays (see above TOR (1)(a)(iii)), the inadequate space provided to grieving families at the courtroom[34]), the inappropriateness of police involvement in First Nations deaths in custody (discussed below (TOR 1(a)(vi)) and the reliance on the media and external bodies for legal assistance and social, emotional and psychological support throughout the coronial process.[35] Similarly, in our OJ Sub, we raised the perception of FN families that the use of non-publication and suppression orders by the Court prioritises the reputation, or protection, of state agents over truth-telling and public accountability.[36] Such factors demonstrate the inappropriateness of the existing coronial jurisdiction and practice in potentially exacerbating the trauma of First Nations families.

29. Additionally, there remains an unclear standing for families throughout the coronial death investigation process. At an inquest, there are no parties as of right in an inquest. Rather, individuals with a 'sufficient interest', appearing as parties to an inquest, have a prima-facie right to leave. The family of a deceased are prima facie granted such leave. However, that standing does not usually translate as a matter of practice to an engagement with the investigation phase, and often the investigation phase is central to the determination of the scope of an inquest.[37]

---

[30] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 9-46, paras [20] to [172].
[31] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 42-44, paras [152] to [160].
[32] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 18-19, paras [50] to [55].
[33] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 18, para [49].
[34] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 43, 51, para [158], Recommendation 9.
[35] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 37-38, paras [129] to [133].
[36] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021) 8-11, paras [20] to [31].
[37] See the example of the question of the death of Naomi Williams: Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 37-38, paras [60].

30. We have previously noted that the traditional role of families in the investigation and Inquest has been restricted to that of memorialising the deceased (in providing a victim-impact style statement at the cessation of the inquest) rather than being actively invited to engage in the investigation and inquest process. [38] In such circumstances, families have unclear standing on a number of matters before the Coroners Court, including and especially on the power of referral for prosecution,[39] and the power to challenge suppression and non-publication orders.[40]

31. The prohibition on publication within the Coroners Court is also troubling to us. In many cases in which we have worked, families have sought to draw public attention to information that comes to light through the inquest process, a strategy that is curtailed by such prohibitions. These strategies represent a key part of the involvement of families.

32. First Nations families who face an inquest after their loved ones have died in custody are involved in coronial proceedings where they are just one or two parties. At a death in custody inquest, families can often expect to see many of the following parties represented:
    - Police and/or Corrective Services
    - Private prison operators
    - Counsel for numerous individual nurses and doctors
    - Counsel for non-state individuals involved in circumstances surrounding the death
    - Counsel for numerous state actors or employees, and
    - A Counsel Assisting who works off a brief usually compiled by NSW Police under instruction from the appointed Coroner.

33. In most First Nations death in custody inquests, the assigned space for the legal representatives often overflows and solicitors and junior counsel are forced into the public gallery — where families sit. All of this takes place in a context of increasingly adversarial advocacy in an inquest that is not designed to anticipate or accommodate it, especially where homicide is a suspected or live issue, regardless of which parties hold that suspicion. Each of these parties is representing a live legal interest of a living client. Some of these clients, such as the police, may also have links to the investigation process. This may not only be intimidating to families but also seen as unjust, where families have no formal role or legal interest in the investigation process.

34. In these circumstances, First Nations families, and the interests of their loved ones are often left vulnerable to multiple, often state-funded parties whose interests all coincide with shifting the focus of the inquiry onto the actions of the deceased for their. Families, and the interests of their loved one, specifically in cases of First Nations deaths in custody, do not benefit from inquisitorial protections afforded to parties with something to lose from an adverse finding — like certificates, or the Briginshaw standard. As previously discussed, we reiterate our support for investigations conducted independent of the police, and with the involvement of families, so as to minimise some of these existing experiences. We detail this concern further in our FN Sub.[41]

35. Suppression and non-publication orders and protections have a role in the coronial jurisdiction, and can also be used to the benefit of families, such as in circumstances in which families wish to

[38] George Newhouse, Daniel Ghezelbash & 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, 82-83.

[39] See our reference to the *Inquest into the Death of David Dungay* at Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 23, para [75].

[40] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021) 18, para [70].

[41] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 39, paras [134] to [144].

protect personal details of the deceased,[42] or families seek protection when providing evidence at an inquest on an unrelated criminal matter. But, in many First Nations deaths in custody inquests, such orders and protections can have the impact of hiding the adverse findings, actions or identities of state parties potentially involved in First Nations deaths. This directly impedes families' capacity to campaign in relation to their loved one's deaths — and goes against the transparency function of the Coroner in relation to deaths in custody.

[42] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021) 8, para [20].

The operational arrangements in support of the Coroners Court with the NSW Police Force and the Ministry of Health (TOR 1(a)(vi))

36. We reiterate our view that investigations into FNDIC must be institutionally, practically, culturally and politically independent of the Police.[43] Such independence is essential if families are to trust in the coronial process, to ensure the rule of law, and to meet Australia's international law obligations.[44] Given the historic and present relationship between NSW Police and First Nations communities, plagued by distrust and perceptions of bias,[45] we believe the current role of police to be unsuitable in investigating FNDICs.

37. It is not only the relationship between NSW Police and the First Nations community in this State that is cause for concern. NSW Police commonly appear before the Coroner on a range of matters other than deaths in custody, as do (albeit less frequently) other state bodies like Corrective Services NSW and hospitals or healthcare institutions. Indeed, Police appear as prosecutors in the vast majority of criminal cases in NSW and are often responsible for the arrest and prosecution of First Nations people who end up in custody. They appear together over long periods of time, in a niche judicial setting. While our experience is limited, we understand the same to be true for the Ministry of Health.

38. In our FN Sub, we discussed the risks of 'regulatory capture' and 'structural spillover'.[46] In the context of the coronial jurisdiction, regulatory capture can be understood as the reliance on NSW Police (whether for training, research, forensic capacity, investigation, briefs, the running of an inquest). Equally, the Coroner or their Counsel Assisting, for instance, may be a former police officer, prosecutor or related professional — because of the unique combination of biomedical, forensic and legal expertise required to be a specialist in this space. They may have institutional relationships with those organisations appearing before them, but more importantly, they may think similarly or make similar assumptions and decisions.

39. Given the unique context in which First Nations peoples are incarcerated and die in custody, we recommend that the entire investigation process into FNDIC (from the notification of death, collection of evidence and persons acting as counsel assisting) be independent of NSW Police.

[43] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 39-40, paras [134] to [140]; Transcript of Proceedings, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Legislative Council of New South Wales, 27 October 2020) 43, 44. Evidence of Distinguished Professor Larissa Behrendt and Mr Craig Longman.

[44] Craig Longman, 'Ensuring accountability form First Nations deaths in custody' (2021) 79 (NAIDOC Edition) *Law Society Journal* 70, 70.

[45] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 12-15, paras [32] to [44]; Transcript of Proceedings, *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (Legislative Council of New South Wales, 27 October 2020) 49. Evidence of Distinguished Professor Larissa Behrendt.

[46] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 10-11, paras [25] to [31].

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 (TOR 1(b))

40. As discussed in our previous submissions, many of the deficiencies and concerns arising within the coronial jurisdiction, law and practice in NSW addressed here – from the scope of inquiry, poor communication and distrust regarding police involvement in investigations, the rising use of suppression and non-publication orders and delays — similarly exist in other Australian coronial jurisdictions. [47] Rather than adopting amendments for the NSW coronial jurisdiction from other Australian jurisdiction, we support the recommendation made by the Australian Law Reform Commission (ALRC) for the review and consideration of international models of police accountability, police complaint and investigating deaths in custody.[48]

41. In their 2017 Pathways to Justice report, the ALRC reviewed five international models of police accountability currently in operation in New Zealand, Canada, Northern Ireland, the Republic of Ireland and England and Wales.[49] Integral to these models, and notably absent from the current NSW Coroners Court, is the independent nature of investigations. Despite an exploration of these alternatives some four years ago, no progress has been made in NSW towards the establishment of a like system for investigating deaths in custody. Along with this ALRC report,[50] Annexure 1 of this submission provides detail of each of these models. As the ALRC recommended, we encourage the Committee to review these models for serious consideration as a means of investigating future First Nations deaths in custody.

[47] The key issues of the coronial jurisdiction pertaining to distrust and poor communication regarding police involvement in investigations, scope of investigation and delays were analysed through case studies existing across Australian coronial jurisdictions. See Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 13-17, 25-26, paras [36] to [44]; [46] to [47]; [82] to [85].
[48] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 467-468.
[49] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 467-468. See also Annexure 1 for more detail on these models.
[50] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 467-468.

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 arrangements (TOR (1)(c))

42. One consistent theme that arises from both the FN Sub and the OJ Sub is our view that First Nations deaths in custody require a separate, tailored approach to coronial investigation.[51] In our view, a similar approach should be adopted to the conduct of inquests into First Nations deaths in custody. We hold this view because of the incomparable historical and contemporary position that First Nations peoples hold. In many cases, the discriminatory disadvantage experienced by First Nations people is reflected in individual circumstances of a particular First Nations deaths in custody.

43. The short time frame for the making of submissions that has been provided means that we are limited in the amount of detail that we are able to provide as to how an alternative structure might operate. However, one option might be to create a new Part in the current Act that relates to First Nation deaths in custody or care only, and that addresses many of the concerns raised by family members. That Part, for example, could provide for —

- A requirement that only specialist coroners preside over such investigations and inquests (for example, as is currently the case, only senior coroners). Nominated Coroners could, for example, either be First Nation Coroners or sit in conjunction with Elders;
- A requirement that investigations be conducted by a nominated investigatory body that is independent of NSW Police and with the involvement of the family of the deceased, and provisions that ensure such investigations accord with international law obligations, including investigations are conducted promptly, independently and impartially;
- A provision requiring the Coroner to consider whether, and how, systemic discriminatory practices are consistent with the circumstances of a particular death;
- The recommendation previously made in the FN Inquiry that Coroners be required to consider the implementation of RCIADIC recommendations;
- A new right of standing that requires Coroners to engage with families in relation to the investigation phase, a right of families to seek referral for prosecution and a requirement that the Coroner provide reasons for the same;
- A new right of standing that requires Coroners to engage with families in relation to suppression and non-publication orders, and a requirement that the Coroner provide reasons for the same; and
- A provision requiring notifications of death to be communicated to families in a culturally sensitive and considerate manner, by the Aboriginal Legal Service, a First Nations liaison officer, or agency independent of NSW Police.

[51] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 40, paras [134] to [140].

Any other related matters (TOR 1(d))

44. In the course of our work at the Coroners Court, we have observed sources of distress and indignity that First Nations families face at deaths in custody inquests. Some come from places that may surprise this Select Committee. On multiple occasions, we have witnessed solicitors and solicitor-advocates acting with some callousness to these families outside of formal proceedings. These incidents include —

    - Before lawyers have realised that family are in the room, they have joked about proceedings (including prior witnesses and evidence), how much they are charging for particular matters, comparisons to other matters, or offer disrespectful descriptions of the person who has died;
    - Horseplay in common areas and cafes that includes re-enacting restraint techniques with Corrections Officers giving evidence; and
    - Generalised remarks about Aboriginal people as a group.

Recommendations

We are aware that the NSW Coroner will issue a protocol for FNDIC under consultation. We do not consider that adequate to address these fundamental issues we have discussed here and in our previous submissions. We urge that First Nations deaths in custody before the Coroners Court are not treated as a special cultural group issue, but as an issue fundamental to justice for uses of fatal state power on a colonised people.

We reiterate the recommendations made in our previous submissions and the above provisions suggested.[52] Additionally we recommend the following —

1. We recommend a process of formal guidance from the Coroner to participating counsel about the dignity and social and emotional wellbeing of families, and the requirement for their conduct outside of formal proceedings to respect that dignity and wellbeing;
2. The Select Committee recommend the return of directly-initiated coronial prosecutions in FNDIC matters;
3. The Select Committee recommend a change to *Coroners Act 2009* (NSW) to provide families standing on the question of referral;
4. The Select Committee recommend the omission of *Coroners Act 2009* (NSW), s76(d) which prevents publication of submissions in proceedings where Coroners consider referral to prosecutorial bodies.
5. The Select Committee recommend significant funding be allocated to the Aboriginal Legal Service NSW/ACT to offer advocacy to any First Nations family who has lost someone in custody and is facing an inquest. Further, we ask the Select Committee recommend funding offered to families to meet the logistical expenses associated with participating in an inquest.

[52] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 51-53; Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021) 21, paras [84.1] to [84.2]

Annexure 1: Comparative models

In addressing the above terms of reference, we believe there is a significant need for both statutory and structural reform to the existing systems of investigating deaths in custody. Whilst amendments to the existing coronial death investigation process, such as an enhancement of pro-therapeutic practices that are considerate to the social and emotional wellbeing of bereaved families engaging in this system, would be of benefit,[53] a more radical and rigorous reform is needed for specifically investigating FNDIC.

International models of police accountability, which could be used as a framework for the establishment of an independent review body responsible for investigating deaths in custody in NSW, have been previously presented to the government. In 2017, the ALRC Pathways to Justice report explored five international models of police accountability, recommending that 'these international models should be reviewed and considered as part of reforms to police complaints handling mechanism in Australia.[54]

Despite an exploration of these alternatives three years ago, no progress has been made in NSW, towards the establishment of a like system for investigating deaths in custody. Again in 2020, the Aboriginal Legal Service submission to the Select Committee urged the committee to look to such models for guidance when creating an independent body for police accountability in deaths in custody.[55]

The five international models identified by the ALRC will be briefly summarised below. Whilst there exists variation in these models, all such examples are recognised for their best practice in upholding police accountability.

The Police Ombudsman of Northern Ireland (PONI)

The PONI has been described as the "golden standard in police investigations"[56]. The non-departmental public body is responsible for providing independent and impartial investigations into complaints against police officers and officials in Northern Ireland. The PONI is financially and institutionally independent of the police. [57]

The PONI has been in operation since November 2000, three years after the initial blueprints for the independent body were established.[58] The PONI has exclusive legal jurisdiction over investigations into police misconduct. Such investigations encompass various forms of police misconduct – from complaints pertaining to traffic incidents, religious and socio-economic profiling

[53] Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 42, 43, paras [150] to [160].
[54] Australian Law Reform Commission, *Pathways to Justice - An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) 467-468.
[55] Aboriginal Legal Service (NSW/ACT), Submission 120 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (17 September 2020) 45-48.
[56] Sinead O'Brien Butler, 'Policing the Police: Independent Investigations for Victoria' (2018) 41 (3) University of New South Wales Journal, 732; Tamar Hopkins, 'An Effective System for Investigating Complaints Against Police', Victoria Law Foundation Grants Publication Education, (2008-2009) 43.
[57] Police Ombudsman for Northern Ireland, *Annual Report and Accounts for the year end 31 March 2017* (2017)
[58] Police Ombudsman, About Us, History of the Office, available at https://www.policeombudsman.org/About-Us/History-of-the-Office

to serious criminal conduct and deaths in custody.[59]

Where the PONI has investigated a police officer for any criminal activity, a file of evidence will be sent to the Public Prosecution Service (PPS). While the PONI can make recommendations as to disciplinary or criminal proceedings, ultimately the final decisions rests with the PPS.[60]

The Independent Police Conduct Authority of New Zealand (IPCA)

The IPCA is a statutory independent body in New Zealand led by a District Court Judge. The IPCA is responsible for receiving and acting on complaints alleging misconduct or neglect by the police, and investigating incidents involving death or serious bodily harm cause or appearing to have been caused by the police.[61] Where a police officer causes, or appears to have caused, the death of a civilian, the Commissioner of Police is obliged to notify the IPCA in writing, as soon as practicable. [62]

As an independent investigatory authority, the IPCA has the power to compel any information and/or documents, as well as summoning and examining persons under oath, where relevant to the investigation. [63] The IPCA also has the scope to hear or obtain information from persons, pertaining to cultural matters that may be a factor relevant to a complaint or investigation.[64]

Whilst the IPCA is the primary body for conducting independent investigations against serious misconduct or death, the IPCA cannot generate is own investigations (i.e. relies on civilian complaints or notification from the Commissioner of Police) nor can it prosecute or take disciplinary action against police.[65] The IPCA may notify the Commissioner of Police, as to any findings pertaining to illegal, unjustified or unreasonable conduct, and of recommendations for disciplinary or criminal proceedings, however such recommendations are not mandatory.[66] In circumstances where the Commissioner of Police departs from the recommendations made by the IPCA, reasons must be provided as to that departure. [67] Equally, if the IPCA is not satisfied with such a response, they must submit a copy of its opinion and recommendations to the Commissioner, Attorney-General and Minister of Police. [68]

The Independent Office for Police Conduct of England and Wales (IOPC)

The Independent Office for Police Conduct was established in 2018 and is responsible for conducting investigations into the most serious and sensitive incidents and allegations involving the police. [69] These include investigations into deaths or serious injuries of persons in police custody, police shootings and allegations of use of excessive force. [70]

Police are statutorily bound to refer such serious incidents to the IOPC for investigation, whether a civilian complaint has been made or not. The IOPC however can also consider incidents that have not been referred to them by the police, exercising discretion in determining how they will investigate. [71]

---

[59] Sinead O'Brien Butler, 'Policing the Police: Independent Investigations for Victoria' (2018) 41 (3) University of New South Wales Journal, 732; Tamar Hopkins, 'An Effective System for Investigating Complaints Against Police', Victoria Law Foundation Grants Publication Education, (2008-2009) 43; ; Office of the Police Ombudsman of Northern Ireland, 'The Police Complaint System in Northern Ireland', 2014, 14.
[60] Office of the Police Ombudsman of Northern Ireland, 'The Police Complaint System in Northern Ireland', 2014, 21
[61] *Independent Police Conduct Authority Act* 1988
[62] *Independent Police Conduct Authority Act 1988* (NZ), s13
[63] *Independent Police Conduct Authority Act 1988* (NZ), s24
[64] *Independent Police Conduct Authority Act 1988* (NZ), s23(3)(a)
[65] Independent Police Conduct Authority, Outcomes, available at https://www.ipca.govt.nz/Site/Outcomes/; *Independent Police Conduct Authority 1988* (NZ) s29 (1)(2)
[66] Independent Police Conduct Authority Annual Report 2015-2016, 8
[67] *Independent Police Conduct Authority Act 1988* (NZ) s29 (1)
[68] *Independent Police Conduct Authority Act 1988* (NZ) s29 (2)
[69] IOPC, Becoming the IOPC, available at https://policeconduct.gov.uk/becoming-iopc
[70] IOPC, Investigations, available at https://www.policeconduct.gov.uk/investigations
[71] IOPC, Investigations, Our Investigations, available at https://policeconduct.gov.uk/investigations/our-investigations

At the completion of an investigation, the IOPC produces a report setting out the facts, how the investigation was conducted, evidence and analysis. A report of this investigation is sent to the relevant police force, as well as the person who made the complaint or was injured, the family of the deceased (in cases of deaths in custody), the Coroner (in cases where someone has died) and the Crown Prosecution Service (CPS) (in cases where there is the belief that a police officer may have committed a criminal offence. Much like the other international models of police accountability, the IOPC does not have the power to mandate prosecution. In cases where there is the belief that a criminal offence has been committed, it is the CPS who will decide whether to prosecute.[72]

Alternatively, the IOPC does make the final decision with reference to the appropriate disciplinary action or outcome for individuals. Any disciplinary action deemed appropriate by the IOPC will be carried out by the police force. Such disciplinary action can include; disciplinary hearings or meetings (for misconduct or gross misconduct), a written warning, a final written warning, reduction on rank or dismissal without notice. [73]

The Special Investigations Unit of Ontario, Canada (SIU)

The SIU is the independent civilian agency in the province of Ontario Canada, responsible for both investigating and charging police officers with a criminal offence. The aim of the SIU is to 'nurture confidence in Ontario's police services…by assuring the public that the actions of these officials resulting in serious injury, death, the discharge of a firearm or an allegation of sexual assault, are subjected to rigorous, independent investigations'.[74] The objective of the SIU is to determine whether an official of the police force has committed criminal wrongdoing. In circumstances in which such grounds exist, the SIU Director has the power to charge such officers or police personnel.[75] Where such grounds do not exist for the SIU to charge a police officer, the SIU Director will issue a public report summarising the investigation, findings, and reasoning for the decision not to charge the individual(s) in question.[76] A common criticism of the SIC is rate with which it employs former police officers, as SIC investigators, calling into question the impartiality and independence of the body.[77]

Garda Siochana Ombudsman of the Republic of Ireland

The GSOC in the Republic of Ireland is responsible for conducting independent investigations into police conduct, in circumstances where such conduct may have resulted in death of or serious harm to, a person.[78] The GSOC may also investigate any police policies or procedures, with the view of reducing incidence of related complaints. [79]The GSOC was established under the Garda Siochana Act 2005 (Republic of Ireland), coming into force in May 2007.[80]

The role of the GSOC is to investigate complaints made against the police. However for the purpose of public interest, the GSOC can also initiate investigations into certain matters without receiving a complaint from the general public.[81] Complaints made to the GSOC must be made within 12 months of the incident, although the GSOC has the discretion to extend the time limit if

[72] IOPC, Investigations, What We Investigate and Next Steps, available at https://policeconduct.gov.uk/investigations/what-we-investigate-and-next-steps
[73] IOPC, Investigations, What We Investigate and Next Steps, available at https://policeconduct.gov.uk/investigations/what-we-investigate-and-next-steps
[74] SIU, What We Can Investigate, Mandate, available at https://www.siu.on.ca/en/investigate_what.php
[75] *Special Investigations Unit Act 2019* (Ontario, Canada), s15, s33 (1)
[76] *Special Investigations Unit Act 2019* (Ontario, Canada) s34(1)
[77] Adam Carter, 'Cops policing cops and their duty to talk: The questions surrounding Ontario's police watchdog' (online, 10 July 2020) https://www.cbc.ca/news/canada/toronto/special-investigations-unit-1.5642604
[78] *Garda Siochana Act 2005* (Republic of Ireland),
[79] *Garda Siochana Act 2005* (Republic of Ireland), s106
[80] Garda Ombudsman Commission, available at http://www.justice.ie/en/JELR/Pages/garda_ombudsman_commission
[81] Garda Ombudsman Commission, available at http://www.justice.ie/en/JELR/Pages/garda_ombudsman_commission

there are good reasons.[82] The independent investigations conducted by the GSOC aim to ensure public confidence in the police.

If directed by the Ombudsman Commission to investigate a complaint, the GSOC investigators have all the powers, immunities and privileges afforded to the police, to effectively conduct their investigations.[83] Once an investigation has been completed, in circumstances where the GSOC believes a criminal offence has been committed, the GSOC is to send a copy of the report to the Director of Public Prosecution[84]. The decision lies with the DPP as to whether an prosecution with initiated. The DPP is to keep the GSOC appraised as to their decision, and any progress if a prosecution begins.[85]

[82] Garda Siochana Ombudsman, available at https://www.citizensinformation.ie/en/justice/law_enforcement/garda_siochana_ombudsman_commission.html#
[83] *Garda Siochana Act 2005* (Republic of Ireland), s98.
[84] *Garda Siochana Act 2005* (Republic of Ireland), s 101 (2)
[85] *Garda Siochana Act 2005* (Republic of Ireland), s101 (3)