Submission No 33

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Name: Katie Lowe

Date Received: 12 July 2021

Submission to the Select Committee on the coronial jurisdiction in New South Wales

12TH JULY 2021

PREPARED BY: KATIE LOWE

By email:
coronial.jurisdiction@parliament.nsw.gov.au

12th July 2021

To Members of the Select Committee,

The submission of Katie Lowe to the Select Committee on the coronial jurisdiction in New South Wales is enclosed

My name is Katie Lowe and I am a recent graduate, having completed my Criminology Honours thesis at UNSW in April 2021. Titled 'Exploring the Coronial Jurisdiction: First Nations Experiences and the Potential for Therapeutic Jurisprudence', this thesis sought to examine the current coronial death investigation process, and the way in which bereaved First Nations families experience such processes. The experiences explored throughout this thesis were informed first and foremost by the experiences voiced by families, particularly during the Black Lives Matter movement, and in the course of enduring coronial inquests into the death of their loved ones.

I am also an intern at the Jumbunna Institute of Indigenous Education and Research based at UTS. In my time at the Jumbunna Institute, I have worked collaboratively with their team of experienced researchers, assisting in the preparation of their submission to the 2020 *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*, their submission to NSW Law Reform Commission's *Open Justice Review* (alongside the Aboriginal Legal Service (NSW/ACT), and the National Justice Project) and their most recent submission to this Committee.

I thank the Committee for taking the time to read this submission to the current Legislative Council's Select Committee on the coronial jurisdiction in New South Wales

Regards,

Katie Lowe

Introduction

The disproportionately high rate of First Nations deaths in custody has been well-established. [1] The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) brought into question the circumstances of First Nations overrepresentation at each stage of the criminal legal process, the circumstances of deaths in custody and the processes employed to investigate such deaths.[2] Recognising the contribution of disadvantage, differential treatment and the unequal position of First Nations people to their overrepresentation in custody, the Commission made 339 recommendations pertaining to the disproportionate apprehension and incarceration of First Nations people for summary offences, the incidences of deaths in custody, and the way in which the state had investigated such deaths.[3] Of those recommendations, 34 recommendations specifically pertained to the post death investigation process – from how such investigations were conducted, reported and recommendations implemented. Thirty years since those recommendations were handed down, they remain largely unimplemented. [4] The trauma and grief associated with the loss of a loved one in custody is often exacerbated for bereaved families, enduring a coronial investigation and inquest.

The Black Lives Matter movement of May 2020 reignited discussion of the over-incarceration and disproportionate deaths of First Nations people in custody in Australia and the manner in which such deaths are investigated. This movement not only sparked mass movements and demonstration, it also inspired the 2020 Select Committee.

In 2020, the NSW Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in custody was presented with statistics and stories of the continuing instances of First Nations death in custody.[5] Of significance to this inquiry was hearing from many First Nations families who have lost a loved one in custody. The families of Nathan Reynolds, David Dungay Jnr, Tane Chatfield and TJ Hickey were extremely generous and vulnerable, speaking on their experience of losing a loved one in custody and their experience engaging in the coronial death investigation process.[6] I urge this Committee to again reflect and listen to their voices, perspectives and experiences when reforming the death investigation process. Whilst the Committee did explore the coronial jurisdiction to an extent, as evident by virtue of this inquiry, the limitations of this jurisdiction, in investigating First Nations deaths in custody in a timely, effective and just manner, remain.

This submission will apply my recent research and findings of the coronial jurisdiction, to the relevant terms to be investigated by the Committee -

> ***(1)(a)(i)*** *the scope and limits of its jurisdiction,*
> ***(1)(a)(iii)*** *the timeliness of its decisions,*
> ***(1)(a)(iv)*** *the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,*
> ***(1)(a)(v)*** *the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities,*
> ***(1)(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,*[7]

---

[1] See generally 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).
[2] See generally, *Royal Commission into Aboriginal Deaths in Custody* (National and Regional Reports, 1991),
[3] Royal Commission into Aboriginal Deaths in Custody (National and Regional Reports, 1991) Vol 5 Recommendations
[4]Change the Record, Amnesty International Australia, and Clayton Utz 2015, Review of the Implementation of RCIADIC, Change the Record, May, viewed 10 January 2019, https://changetherecord.org.au/review-of-the-implementation-of-rciadic-may-2015; Kirrily Jordan, Thalia Anthony, Tamara Walsh and Francis Markham, 'Joint Response to the Deloitte Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody', Centre for Aboriginal Economic Policy Research Topical Issues, no. 4, 2018, pp. 3-10. Raymond Brazil, 'The Coroner's Recommendation: Fulfilling Its Potential? A Perspective from the Aboriginal Legal Service' (2011) 15(1) 94.
[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).
[6] 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, 26 October 2020; 27 October 2020; 3 December 2020; 7 December 2020)
[7] Legislative Council, Parliament of New South Wales, *Select Committee on the coronial jurisdiction in New South Wales* (Terms of Reference, 6 May 2021).

With a background in criminology, this submission will not be exhaustive in its discussion of detailed legal reform, nor will it address the question of government funding and the resourcing of the coronial jurisdiction in depth. However, these issues remain extremely relevant, evident by virtue of their inclusion in the TOR.

Table of Contents

1- A (i) scope and limitations of its jurisdiction; 1 - A (iii) the timeliness of its decisions; 1- A (iv) the outcomes of recommendations made, including the mechanisms for oversight whether recommendations are implemented

Overview

1. Several submissions made to the previous inquiry portrayed the failings of the current inquisitorial coronial jurisdiction, as not fit-for-purpose of investigating First Nations deaths. Given the socio-historical nature of First Nations deaths in custody, many submissions pointed to the history and continuation of colonisation, the relationship between the police and First Nations communities as problematic. Equally, the lack of accountability and justice provided to First Nations families mourning the loss of a loved one in custody remains a constant point of trauma. This section will identifying the existing scope and limitations of the jurisdiction.

Scope of jurisdiction

2. The New South Wales coronial jurisdiction is governed by the *Coroners Act 2009* (NSW). In contrast to the criminal and civil adversarial systems, the coronial jurisdiction engages in an inquisitorial, fact finding exercise. [8] The focal scope of the coronial jurisdiction is to answer the question of 'what happened', through determining the identity of the deceased, the times and dates of their death and the manner and cause of their death. [9]

3. Pursuant of s3(c) of the Coroners Act 2009 (NSW), the coronial investigation and inquest are narrowly focused on the cause and manner of certain kinds of deaths or suspected deaths. [10] The classes of death stipulated as suitable (or 'reportable') for coronial investigation include when a person has died a violent or unnatural [11], sudden[12], suspicious or unusual death,[13] when the death was not a reasonably expected outcome of a health-related procedure[14], or where a person has died in custody.[15]

4. Pursuant of s23 of the Coroners Act, the most senior coroner is required to hold an inquest into a death in custody or suspected death, when the person has died whilst, during the course of or shortly after a period of incarceration or police operation.[16] The ensures deaths in settings of incarceration are mandatorily investigated.

5. The power to make recommendations falls within the scope and power of the modern-day coroner.[17] Coronial recommendations have been recognised as enhancing the coroners ability to fulfil their role in preventing future avoidable deaths, particularly in institutional or custodial settings.[18] At the completion of an inquest, the coroner may make recommendations to the relevant ministers or state agencies, as to measures, reforms or actions relating to the circumstances which may have influenced the cause and manner of death, so as to prevent future deaths. However, given the coronial jurisdiction is not bound by the same rules of evidence as the adversarial system, the Coroner is limited in the extent to which they can make enforceable findings – namely a determination of criminal culpability, guilt or blame and the imposition of disciplinary action.[19] This limitation will be expanded upon below.

Limitations of the coronial jurisdiction

---

[8] Michael King, Arie Freiberg, Becky Batagol and Ross Hyams, 'Coroners' in Michael King, Arie Freiberg, Becky Batagol and Ross Hyams (eds) *Non-adversarial justice* (Federation Press: Leichardt) 201, 201.
[9] *Coroners Act 2009* (NSW) s3(c).
[10] *Coroners Act 2009* (NSW) s3(c).
[11] *Coroners Act 2009* (NSW) s6(1)(a)
[12] *Coroners Act 2009* (NSW) s6(1)(b)
[13] *Coroners Act 2009* (NSW) s6(1)(c)
[14] *Coroners Act 2009* (NSW) s6(1)(d)
[15] *Coroners Act 2009* (NSW) s6.
[16] *Coroners Act 2009* (NSW) s23.
[17] *Coroners Act 2009* (NSW) s82
[18] *Coroners Act 2009* (NSW) s82
[19] Rebecca Scott Bray, ''Why This Law?': Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(SE2) *Australian Indigenous Law Review* 27, 31; Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567, 577; *Coroners Act NSW 2009*: s81(3).

6. By virtue of this inquiry, and the experiences presented to the 2020 Committee by families with lived experience[20], it can be accepted that there exists significant limitations of the current coronial law, practice and operation. The limitations of this jurisdiction can be categorised by (a) general concerns and (b) specific concerns voiced First Nations families.

A. General limitations/concerns

7. **Inquisitorial nature and referral power of the Coroner:** Whilst the inquisitorial nature of the jurisdiction is important in enabling Coroners to compel evidence to determine the manner and cause of death,[21] it remains a point of contention for families in their pursuit for justice. That is, specifically in circumstances in which an individual has died in a setting of incarceration or under the care and protection of the state, it can be difficult for families to accept that individuals or institutions will not be held criminally liable or otherwise accountable for their potential involvement in the death of their loved one (be it of medical negligence or failure to provide an adequate and humane level of care and protection).

8. Pursuant of s78(4) of the *Coroners Act 2009* (NSW),[22] in circumstances where it does appear that an indictable criminal offence may have been committed, in relation to the death, a Coroner has the power to refer (during or at the completion of the inquest) suspected persons to the Director of Public Prosecution for investigation. This remains the only avenue for criminal accountability in coronial investigations. Once referred, the decision lays with the DPP, to determine whether there is substantial information to commence criminal proceedings.

9. In the contemporary landscape, specifically with reference to First Nations deaths in custody inquests, such referrals are rare. Even in instances in which persons have been referred to the DPP for investigation, criminal convictions are equally extremely rare.[23] Despite the at least 474 First Nations deaths in custody since the RCIAIC, there have been zero instances in which a police officer, corrective services officer or personnel have been held criminally accountable under the general criminal law in Australia.[24]

10. It must be noted that in the last year, since the global and domestic Black Lives Matter movement, there have been five referrals made to the DPP, for police or corrective services officers being involved in First Nations deaths in custody across the country, one of which was made in the NSW Coroners Court.[25] The public pressure for criminal accountability in First Nations deaths in custody, along with the increasing wider scope of investigations cannot be ignored.

11. Similarly, whilst the jurisdiction is classified as inquisitorial, observations have been made to the increasing adversarial nature of this domain. [26]Whilst the focal scope of the inquest is said to be on providing answers as to the manner and cause of death, families are increasingly faced by several camps of lawyers for interested parties – from the police, correctives services, justice health. Many of these parties may have competing interests to the family, seeking to shift blame

---

[20] 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, 26 October 2020; 27 October 2020; 3 December 2020; 7 December 2020) See the evidence of the families of David Dungay Jr, Nathan Reynolds, Tane Chatfield and TJ Hickey

[21] *Coroners Act 2009* (NSW) s3(c)

[22] *Coroners Act 2009* (NSW) s78

[23] For example, in 2020 the DPP in Victoria dismissed the recommendations made by Coroner English for the investigation of suspected persons related in the death of Tanya Day. See more at https://www.hrlc.org.au/news/2020/8/26/police-officers-involved-in-tanya-days-death-avoid-prosecution

[24] Craig Longman, 'Where is the accountability for Aboriginal deaths in custody?' (2016) 25 (3) *Human Rights Defender* 5; Alison Whittaker, 'Despite 432 Indigenous deaths in custody since 1991, no one has ever been convicted. Racist silence and complicity are to blame', *The Conversation* (online 3 June 2020) https://theconversation.com/despite-432-indigenous-deathsin-custody-since-1991-no-one-has-ever-been-convicted-racist-silence-and-complicity-are-to-blame-139873; Lorena Allam, Calla Wahlquist, Nick Evershed and Miles Herbert, 'The 474 deaths inside: tragic toll of Indigenous deaths in custody revealed, *The Guardian (Australian Edition)* (online 9 April 2021) https://www.theguardian.com/australia-news/2021/apr/09/the-474-deaths-inside-rising-number-of-indigenous-deaths-in-custody-revealed

[25] 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>

[26] 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.

or resolve themselves from involvement circumstances of death.[27] This can be recognised as not only intimidating for families, but has the potential for the life of the deceased to become lost amongst the bureaucratic blame game amongst state institutions.

12. **Narrow scope of inquiry:** A common criticism of the inquisitorial coronial scope of investigation, identified within the scholarship surrounding the, is the difficulty associated with balancing the socio-political public commitments of the jurisdictions (i.e. making recommendations to prevent future deaths of a similar nature), making findings of the medical cause of death, whilst also recognising the extra-legal and socio-historical factors associated with the death.[28] One of the key questions that has arisen within coronial inquests into First Nations deaths in custody specifically, is the extent to which the narrow scope of 'manner and cause of death', engages with the historical context of colonialism and its intergenerational impacts, the relationship between First Nations communities and the state, the continued disadvantage and unequal position in the social, economic and cultural domains, and the presence of racism and unconscious bias. [29]

13. In the context of First Nations deaths in custody, such factors include but are not limited to understanding the death within the context of drivers of high rates of mortality (i.e. rates of suicide), the appropriateness of arrest,[30] examining the relationship between First Nations people and the police,[31] the presence of stereotyping, racism and unconscious bias in state institutions[32] and the quality and adequacy of care and protection whilst under state custody.[33] Despite a changing coronial landscape in which particular Coroners are encompassing the discussion of systemic and institutional failings into their scope of investigation, there remains a dissonance in which such findings are translated into meaningful recommendations, or disciplinary action against those involved [34]

14. Recently, Coroners in NSW and across other Australian states and territories have acted on their discretionary power to engage with these wider issues and scope of investigations.[35] Whilst these cases act as an example of this shift present amongst the perspective and practice of some Coroners, more should be done so as to bound Coroners statutorily to examine these factors.

15. **Investigations by police**: Whilst the coronial jurisdiction is positioned as an independent oversight body, all deaths in police or corrective services custody subject to a coronial inquest, are investigated by police on behalf of the state Coroner. The issue of police acting as the primary body for investigating deaths, on behalf of the Coroner, was well documented in submissions to the 2020 Select Committee.[36] Whilst police investigate deaths in custody on behalf of the

---

[27] 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, 83.

[28] Rebecca Scott Bray, ''Why This Law?': Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(SE2) *Australian Indigenous Law Review* 27, 31; Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567, 577.

[29] 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, 84-85.

[30] Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567, 578; The Children of Tanya Day, 'Submissions by Belinda Day/ Stevens, Warren Stevens, Apryl Watson and Kimberly Watson, The Children of Tanya Day', Submissions in Inquest into the Death of Tanya Day, COR 2017/6424, 15 October 2019,: 14),

[31] Rebecca Scott Bray, ''Why This Law?': Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention' (2008) 12(SE2) *Australian Indigenous Law Review* 27, 33.

[32] Inquest into the Death of Naomi Williams (Unreported, New South Wales, Coroner Grahame, 29 July 2019) 46, 52; Inquest into the Death of Tanya Day (Unreported, Coroners Court of Victoria, Coroner Caitlin English, 9 April 2020); Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567, 578.

[33] Thalia Anthony and Harry Blagg 'Biopower of Colonialism in Carceral Contexts: Implications for Aboriginal Deaths in Custody',(2021) 18(1) *Journal of Bioethical Inquiry*, 71, 79; 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, 84.

[34] Thalia Anthony and Harry Blagg 'Biopower of Colonialism in Carceral Contexts: Implications for Aboriginal Deaths in Custody',(2021) 18(1) *Journal of Bioethical Inquiry*, 71, 79; 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, 85.

[35] Inquest into the Death of Naomi Williams (Unreported, New South Wales, Coroner Grahame, 29 July 2019); Inquest into the Death of Tanya Day (Unreported, Coroners Court of Victoria, Coroner Caitlin English, 9 April 2020)

[36] 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), 9-10, 39-40.

Coroner, and are bound by the directives of the Coroner, such a role not only risks the impartiality and independence of the jurisdiction, but also diminishes the public confidence in the system of investigation. The negative relationship of distrust and indifference between First Nations communities and the police has been well documented, stemming from colonial violence, oppression and control. [37] The experiences of bereaved First Nations families interacting with the police during the death investigation process have been described as an exacerbation of trauma.[38]

16. **Delays:** Delays associated with coronial investigations and inquest processes have been well documented in Australia for their duration and adverse effects on the wellbeing of family.[39] On average, nearly a quarter of all inquests in Australia run for more than three years .[40] Earlier this year, NSW Coroners Court began an inquest into the death in custody of Danny Witton.[41] This inquest began some five years after the death of Witton[42]. Delays in coronial investigations not only prolong the period of uncertainty and complicate the experience of grief, bereavement and trauma,[43] it also has the potential to diminish families hope for justice and accountability, as the quality and credibility of witnesses and evidence can be seen to weaken over time.[44]

17. **Unclear voice and role of family throughout process:** The role of families throughout the coronial death investigation process is insufficient and unclear at times. Whilst families are recognised as 'interested parties' in the coronial inquest process, their standing as such, is equal to that of other parties (such as the state institutions who may be involved in the circumstances of death). Equally, the guidance as to the way in which families can engage with the inquest remain ad hoc, with families reliant on guidance from their legal representation, support networks and at times the court.

18. For example, Newhouse, Whittaker and Ghezelbash speak to the way in which there is a false sense of encouragement for family participation by the court throughout the coronial process.[45] In NSW, the Coroners Act does not stipulate the role of families at an inquest, beyond the medico-legal rights of next of kin, or their entitlement to leave as an 'interested party'. Whilst there exists some additional guidance in practice directions and coronial pamphlets,[46] the voices of families are often left to be heard at the cessation of the inquest, providing a moralising image of the deceased and their lives.

19. **Implementation of recommendations:** In NSW, the implementation of coronial recommendations are ad hoc and not statutorily mandated. Whilst the duty of the Coroner to make recommendations and notify the relevant ministers and government agencies of said recommendations is bound by statute, their response and implementation is not. The inadequacy of the existing policy pertaining to the implementation of coronial recommendations was noted in

---

[37] Chris Cunneen and Juan Tauri, ''Policing, Indigenous peoples and social order' in C. Cunneen and J. Tauri (eds) *Indigenous criminology* (Policy Press, 2016)
[38] Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 20200) 5
[39] Lorena Allam, "Why does it take so long?' The desperate wait for answers after a death in custody', *The Guardian (Australia Edition),* (online, 25 August 2019) https://www.theguardian.com/australia-news/2019/aug/25/why-does-it-take-so-long-the-desperatewait-for-answers-after-a-death-in-custody. Tatum Hands, 'Under the Microscope: Reforming Western Australia's Coronial System' (2012) *Brief* 12; David M. Studdert, Simon J Walter, Celia Kemp and Georgina Sutherland, 'Duration of death investigations that proceed to inquest in Australia' (2016) *Injury prevention* 22(5) 314, 316.
[40] David M. Studdert, Simon J Walter, Celia Kemp and Georgina Sutherland, 'Duration of death investigations that proceed to inquest in Australia' (2016) *Injury prevention* 22(5) 314, 316.
[41] Aboriginal Legal Service (NSW/ACT), 'Family demand answers at death in custody inquest for Aboriginal man Danny Witton', (Media Release, 22 February 2021).
[42] Aboriginal Legal Service (NSW/ACT), 'Family demand answers at death in custody inquest for Aboriginal man Danny Witton', (Media Release, 22 February 2021).
[43] Ian Freckelton, 'Death Investigation, the coroner and therapeutic jurisprudence', (2007) 15(2) *Journal of law and medicine*, 242, 250.
[44] Joseph Pugliese 'Dispatch Sydney: A series of daily dispatches from the coronial inquest currently underway in Sydney for Mr David Dungay, Dunghutti Warrior', Deathscapes (Web Page, 16 July 2018-14 August 2018) <https://www.deathscapes.org/engagements/dispatch-sydney/>.
[45] 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, 81.
[46] NSW Government, 'Initial steps after a death is reported to the Coroner' (Brochure) available at https://www.coroners.nsw.gov.au/coroners-court/the-coronial-process/what-to-expect-during-the-coronial-process.html

submissions to the 2020 Select Committee.[47] In NSW, the M2009 Premiers Memorandum, encourages state agencies and ministers to respond to recommendations 'within six months of receiving a coronial recommendation'. [48]However given the lack of enforceability and monitoring of such recommendations and responses, coronial recommendations often go unimplemented.

20. **Non-publication and suppression orders – used for the protection of police and CSO:** The rising use of suppression and non-publication orders by state parties and employees, has recently been identified as a concern of the coronial jurisdiction.[49] Whilst it must be recognised that such orders have a legitimate purpose and use in this jurisdiction, in protecting personal information of the deceased, or information deemed culturally inappropriate to share, such orders are increasingly used in favour of protecting state agents and employees. Not only do these orders risk hiding the violent actions or identities of state employees, they inhibit the ability for truth-telling and accountability in the inquisitorial jurisdiction. [50]

B. Specific experiences and concerns for First Nations families

21. Whilst First Nations families are subject to the negative effects of the general failings of the functioning of the coronial jurisdiction discussed above, they may also be faced with further concerns or negative experiences when interacting with the Coroners Court. This list is not exhaustive of the experiences of First Nations people within the coronial jurisdiction, however these foreground the limitations of the coronial experience for bereaved families. As noted above, for a greater understanding of the true experience, pain and trauma associated with enduring the coronial death investigation process, I would urge this Committee to reflect upon the verbal and written submissions made by families to the 2020 Select Committee, and those which I am sure will again make submissions to this Committee.

22. Perceptions of racial prejudice: First Nations families who have engaged with the coronial process have expressed feelings of racial prejudice, indifference and hostility from both police, coronial staff and counsel in coronial inquests.[51] Concerns have been raised about the behaviour of police in notifying families of the death and the attentiveness of police in investigating deaths or disappearances on behalf of the coroner.[52] Speaking to these experiences, several families have often drawn comparison with investigations into cases of non-Indigenous people, which they feel have been addressed with greater seriousness and speed. [53]

23. **Unwelcoming court processes:** The coronial inquest and court environment has been described by Apryl Day, the daughter of Yorta Yorta woman Tanya Day, as "not a kind process". [54] Aspects of the coronial process have been criticised as cold and alienating, in which families

---

[47] 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, 34.

[48] Premiers Memorandum, Responding to Coronial Recommendations 2009 (NSW) available at arp.nsw.gov.au/m2009-12-responding-coronial-recommendations

[49] 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].

[50] 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) 9.; Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 20200) 8.

[51] George Newhouse, Daniel Gheze bash & 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, 83; Sherene Razack, '*Dying from improvement: Inquests and inquiries into Indigenous deaths in custody*', (2015) Toronto: University of Toronto Press, 113, 133)

[52] National Justice Project, Submission 102 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (31 August 2020) 17

[53] Standing Committee on Law and Justice, Legislative Council of New South Wales, The family response to the murders in Bowraville (2014) 16, 20, 21; 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, 83; Jane Bardon and Stephanie Zillman, 'Sasha Green's parents accuse NT Police of discrimination over Indigenous cold case' *ABC News* (online 24 November 2017) https://www.abc.net.au/news/2017-11-24/inquest-after-sasha-green-fatal-stabbing-at-tennant-creek/9184770; Steven Schubert, ''Eerily similar' suspected Indigenous murder cases go cold as police explain away truth', *ABC News* (online, 23 June 2018) https://www.abc.net.au/news/2018-06-23/indigenous-murder-cases-go-cold-as-coroner-lashes-nt-police/9899946

[54] Lorena Allam and Calla Wahlquist, ''I want to break that cycle': the relatices still fighting for justice over deaths in custody', The Guardian (Australian Edition) (online 15 April 2021) https://www.theguardian.com/australia-news/2021/apr/15/i-want-to-break-that-cycle-the-relatives-still-fighting-for-justice-over-deaths-in-custody

have told of experiences in which they have been told to hide their grief and shock in the courtroom.[55] For example, at the inquest into the death of Ms Dhu, spectators reported being told they could not gasp, make noise or show shock during the court proceedings.[56] That is, despite the fact that for some families, the inquest involves the viewing of gruelling CCTV footage which details the final moments of their loved one's life. In these instances, the coronial environment can be recognised as a completely unsympathetic environment to the First Nations experiences. In his attendance at the inquest into the death of Ms Dhu, Ethan Blue describes a similar experience, in which there was a "demand for silent and emotionless viewing" and an apparent prioritisation of court proceedings over the emotional state of the bereaved First Nations family. [57]

24. **Focus on behaviour of the deceased:** Whilst the coronial inquest is concerned with the deceased, and manner and cause of their death, it has been observed that coronial inquests can unjustly focus on the behaviour of the deceased – for example, a criminal record or a history (or stereotype) of alcohol or drug problems – in a manner that can fuel negative racial stereotypes and exacerbate trauma for the deceased's family by depicting the death as "timely" rather than "untimely", and the life and body of the deceased as "damaged" and a "discredited Aboriginal subject".[58] Such portrayals not only delegitimise the deceased as a victim of police and institutional violence, but so too diminish the accountability of the state for their neglect and inhumane treatment of the imprisoned persons and the First Nations deceased[59]

1 – A (v) the ability of the Coroners Court to respond to the needs of culturally and linguistically diverse and First Nations families and communities.

25. The aforementioned limitations can be recognised as experiences that are extremely difficult and traumatic for bereaved families. The points raise questions as to the extent to which the Coroners Court currently meets the cultural, linguistically diverse and First Nations needs of families and communities in the coronial arena.

26. In addressing these existing concerns, and poor ability of the Coroners Court to respond to such ranging needs, several submissions to the 2020 Select Committee spoke of the potential applicability of therapeutic jurisprudence to the coronial jurisdiction. At the outset it must be recognised that whilst this approach has potential in this jurisdiction, it does not go far enough to address the issues of lack of accountability and the need for investigations independent of the state, in investigating First Nations deaths in custody. However, what it does seek to achieve is minimising the trauma associated with the existing death investigation process and promoting practices that are sensitive to the wellbeing of bereaved families and court participants. As such, a novel body which is led by First Nations people is ideal for the investigations of First Nations deaths in custody.

27. Whilst this submission will focus on therapeutic jurisprudence, I want to convey my support f the discussions and recommendations made by First Nations families with lived experience in the coronial jurisdiction and organisations [60], for the establishment of an independent body

---

[55] Lorena Allam and Calla Wahlquist, ''I want to break that cycle': the relatices still fighting for justice over deaths in custody', The Guardian (Australian Edition) (online 15 April 2021) https://www.theguardian.com/australia-news/2021/apr/15/i-want-to-break-that-cycle-the-relatives-still-fighting-for-justice-over-deaths-in-custody

[56] Ethan Blue, 'Seeing Ms. Dhu: Inquest, conquest and (in)visibility in black women's death in custody' (2017) 7(3) *Settler Colonial Studies* 299; Pauline Klippmark and Karen Crawley, 'Justice for Ms Dhu: Accounting for Indigenous deaths in custody in Australia' (2018) 27(6) *Social & Legal Studies* 695.2018; Amanda Porter, 'Reflections on the Coronial Inquest of Ms Dhu', (2016) 25(3) *Human Rights Defender* 8.

[57] Ethan Blue, 'Seeing Ms. Dhu: Inquest, conquest and (in)visibility in black women's death in custody' (2017) 7(3) *Settler Colonial Studies* 299, 306

[58] Sherene Razack, '*Dying from improvement: Inquests and inquiries into Indigenous deaths in custody*', (2015) Toronto: University of Toronto Press, 113, 116.

[59] Amanda Porter, 'Reflections on the Coronial Inquest of Ms Dhu', (2016) 25(3) *Human Rights Defender* 8, 11; Sherene Razack, '*Dying from improvement: Inquests and inquiries into Indigenous deaths in custody*', (2015) Toronto: University of Toronto Press, 116, 117.

[60] 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]; 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, 26 October 2020;

responsible for investigating death in custody. First Nations leadership and self-determination in this process is also integral. Their work with families and communities in navigating this domain has equipped them to provide insight as to what does and does not work in this domain. For real, significant change, and in order to achieve some form of justice and peace for First Nations families engaging with this system, I strongly urge the Committee to listen and act on the recommendations made by these organisations.

Engaging with therapeutic jurisprudence

28. The concept of therapeutic jurisprudence can be understood as exploring the potential role of the law and legal processes as a therapeutic agent. [61]That is, therapeutic jurisprudence explores the way in which legal processes, can recognised as traumatic or negatively impacting the emotional and psychological wellbeing of its participants.[62] Therapeutic jurisprudence aims to promote reflective practices within legal settings and emphasises consideration for the wellbeing of legal participants. What must be recognised is that therapeutic jurisprudence does not seek to undermine other legal principles, rather suggests they are not the only one's of value when considering the pursuit of justice. [63]

29. The potential application of therapeutic jurisprudence in the coronial jurisdiction has been recognised by several legal scholars within the last decade, amongst those Ian Freckelton QC and former WA Coroner Michael King.[64] According to those scholars, the inquisitorial nature of the Coroners Court allows for greater flexibility than the criminal justice system, including enhanced communication, interaction and promotion of trauma-informed measures with family and participants of the court.[65]

30. In recent times, some Coroners have demonstrated an engagement with positive therapeutic jurisprudential practices in the course of coronial investigations. For example, one can observe greater consideration of cultural and religious practices surrounding autopsies and utilising the correct terminology when referring to the deceased. [66] In his research, Michael King stresses the importance of the Coroner in recognising and validating the concerns raised by bereaved families, expressing empathy, whilst exhibiting a reflective stance on their role in investigating deaths and making recommendations.[67]

31. As noted above, several organisations and academics made submissions to the 2020 Select Committee, which engaged with the principles of therapeutic jurisprudence. A handful of

---

27 October 2020; 3 December 2020; 7 December 2020) See the evidence of the families of David Dungay Jr, Nathan Reynolds, Tane Chatfield and TJ Hickey

[61] Bruce J Winick, ''The jurisprudence of therapeutic jurisprudence', (1997) 3(1) *Psychology, Public Policy and Law* 184,185-187.

[62] Bruce J Winick, 'Foreword: Therapeutic Jurisprudence Perspectives of Dealing with Victims of Crime' (2009) 33(3) *Nova Law Review* 535, 536; David B Wexler and Bruce J Winick 'Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research', (1991) 45(5) *University of Miami Law Review* 979, 982.

[63] Bruce J Winick, 'Foreword: Therapeutic Jurisprudence Perspectives of Dealing with Victims of Crime' (2009) 33(3) *Nova Law Review* 535, 536; David B Wexler and Bruce J Winick 'Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research', (1991) 45(5) *University of Miami Law Review* 979, 982.

[64] Ian Freckelton QC, 'Minimising the counter-therapeutic effects of coronial investigations in search of balance' (2016) 16(3) QUT Law Review 4; Ian Freckelton, 'Death Investigation and the Evolving Role of the Coroner', (2007) 11(4) *Otago Law Review* 565; Ian Freckelton, 'Reforming coronership: international perspective and contemporary developments', (2008) 16(3) *Journal of Law and Medicine,* 379; Michael King, 'Restorative Justice, Therapeutic Jurisprudence and the Rise of Emotionally Intelligent Justice', (2008) 32(3) *Melbourne University Law Review,* 1096.Michael King, 'Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model' (2009) 16(3) Journal of Law and Medicine 442

[65] Ian Freckelton QC, 'Minimising the counter-therapeutic effects of coronial investigations in search of balance' (2016) 16(3) QUT Law Review 4, 5, 9, 10, 23; Michael King, Arie Freiberg, Becky Batagol and Ross Hyams, 'Coroners' in Michael King, Arie Freiberg, Becky Batagol and Ross Hyams (eds) *Non-adversarial justice* (Federation Press: Leichardt) 201; Isabel Roper and Vivien Holmes, 'Therapeutic jurisprudence in the coronial jurisdiction', (2016) 25(3) *Journal of Judicial Administration* 134; . 2016; Gordon Tait and Belinda Carpenter, 'Suicide and the Therapeutic Coroner: Inquests, Governance and Grieving Family', (2013) 2(3) *International Journal of Crime, Justice and Social Democracy* 2(3): 92.

[66] Michael King, Arie Fre berg, Becky Batagol and Ross Hyams, 'Coroners' in Michael King, Arie Freiberg, Becky Batagol and Ross Hyams (eds) *Non-adversarial justice* (Federation Press: Leichardt) 201; 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

[67] Michael King, 'Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model' (2009) 16(3) Journal of Law and Medicine 442.

submissions spoke specifically and in-depth to the pro-therapeutic considerations for First Nations people within the coronial arena so as to meet the needs of First Nations participants.

32. Below are just some practices or sensitivities that were proposed within these submissions, for their incorporation in the coronial jurisdiction. Whilst this list is not exhaustive of all of the therapeutic measures that have the potential to be incorporated into this jurisdiction to meaningfully aid families, they certainly represent significant progress in the ability of the Coroners Court, to meet the needs of First Nations families in the coronial investigation and inquest process.

    a. **Greater presence of First Nations personnel within the Coroners Court – from Aboriginal Liaison Officers, to investigators, Coroners, and counsel assisting with lived experience:** Many of the submissions to the 2020 inquiry encouraged greater representation of First Nations staff within the coronial jurisdiction.[68] The inclusion of First Nations liaison officers, Coroners, counsel assisting, lawyers and investigators would not only enhance a sense of trust and support in the system, but would also allow bereaved First Nations families to engage with court personnel who may have a greater understanding of their grief, and the socio-historical context of intergenerational trauma and bereavement, stemming from the ongoing impacts of invasion.

    Whilst such roles would likely enhance the therapeutic potential of the jurisdiction, Distinguished Professor Larissa Behrendt made a significant point to the Committee, on the need for amending the coronial system as a whole, beyond solely the front facing personnel -

    "That is perhaps part of the scepticism that many First Nations people have about the idea that systems can be improved simply by that participation increasing—the structure and institutional racism is much deeper than that. That I why there is a firm view from Indigenous people—and I share this view myself—that the ability to design the institution is an opportunity to ensure that you are not just trying to change a structure and a culture that already exists, and you instead bring a different framework, mindset and perspective."[69]

    I recognise and support the recommendation made by the Select Committee in 2020 for the employment of First Nations staff across the coronial and criminal jurisdictions.[70] However, I urge this Committee to consider the evidence given by Distinguished Professor Behrendt, for structural and institutional change.

    b. **Greater engagement with First Nations psychologists and counselling personnel to offer culturally safe and appropriate psychological and emotional support:** The exacerbation of trauma and bereavement as a result of engaging in a coronial investigation has been well established above. In order to meet the cultural needs of bereaved First Nations families, several submissions encouraged the government to fund and establish, in consultation with First Nations communities, a First Nations led counselling service, offering support to surviving families of deaths in custody and other deaths investigated by the Coroner. First Nations leadership in this service would ensure the cultural traditions and

[68] Legal Aid, Submission 117 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (11 September 2020) 12; 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;The Reynolds Family, Submission 124 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (30 September 2020) 7; Ngalaya Indigenous Corporation, Submission 84 to to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (24 August 2020)* 11 ; National Justice Project, Submission 102 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (31 August 2020) 8, 15, 19; Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 20200) 9

[69] 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

[70] 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) xv, Recommendation 37.

protocols surrounding death and mourning are protected and empowered.[71] This can include the incorporation of traditional practices, symbols and protocols surrounding death and mourning as well as the appropriate notification of death. The role of identified and/or culturally trained social workers cannot be ignored in this domain as well.

Whilst I support the aforementioned recommendation made by the 2020 Select Committee for the employment of First Nations staff across the legal system, I urge this Committee to go further, listening to the voices of experts and families with lived experience, all of whom identified a need for greater emotional, psychological and therapeutic support to meet the specific cultural and bereavement needs of First Nations families.

c. **Greater platform for First Nations families to voice their experience, beyond a memorialising role – from raising issues of scope of investigation to coronial recommendations:** The unclear role of family in the coronial process was discussed above, in which it has been observed that families often feel excluded from participating in the coronial investigation. The sense of disempowerment associated with preventing families from actively engaging with the coronial death investigation process was discussed at length throughout submissions to the 2020 Select Committee. For example Alison, Cunneen and Schwartz note the "silencing of families affected by a death is referred to as an act of racism in itself, as is disregard for culture. These deficiencies also have real impacts … findings and recommendations made by the court, but also on the potentially positive therapeutic outcomes of investigation processes". [72]

I note the 2020 Select Committee Recommendations did not specifically speak to the role of families within the coronial jurisdiction. I urge this Committee to consider how such rights and participation can be cemented into coronial processes in a way that meaningfully engages with families, empowers their voices and acknowledges their grief.

d. **Adequate space for families during the coronial inquest – a safe environment recognising the plurality of personal and kinship relations that may be in attendance**: The limited space for First Nations families at the Coroners Court was a common thread throughout the 2020 submissions.[73] The Jumbunna Institute observe that often the space provided to families and their supporters in the Coroners Court are outnumbered by an overwhelming amount of legal representation for the police, corrective services and other interested parties. [74] Equally, they note that the Coroners Court does not provide adequate space for extended family networks and supporters. Providing adequate space for families during the inquest is just one way of improving the pro-therapeutic consequences of the coronial experience.

Equally, whilst the coronial inquest is traditionally informal, it is becoming increasingly adversarial. Several submissions made to the 2020 Select Committee spoke to the potential applicability of restorative justice principles and practice of circle sentencing, to the coronial death investigation process. [75] Such conferences would allow for not only 'full and frank

[71] 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, 43, 51.
[72] Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 12; 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) 33
[73] Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 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) 43.
[74] 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
[75] 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

discussion', but would enhance the potential for 'healing' through the 'process of saying what's been lost'.[76]

e. **Exploration of systemic issues within the scope of investigation: The need for** addressing systemic issues relating to death was discussed above with reference to the scope of coronial investigation. An exploration of such issues within the context of a death in custody not only has the potential to provide greater truth as to the manner and cause of death, but it is also likely to validate the voices and perspectives of bereaved First Nations families and those with lived experience of racism, discrimination and prejudice when engaging with the state and with settings of incarceration.

I recognise and support the recommendation made by the 2020 Select Committee in mandating Coroners to examine whether systemic issues are present in relation to First Nations deaths in custody.[77] I would recommend this Committee to expand upon on this, to engage with First Nations communities with lived experience to understand such systemic issues that have arisen in deaths in custody and to train Coroners in investigating such issues appropriately.

f. **Greater power of the Coroner or government in the implementation of coronial recommendations:** Whilst the poor implementation of recommendations were addressed above, from the perspective of structural and statutory insufficiencies, several submissions spoke to the impact of coronial recommendations, on families who have spent many years engaging with the Coroners Court following the death of a loved one. In their submission to the 2020 Select Committee, the Aborginal Legal Service (NSW/ACT) noted -

" For many families, a fundamental aspect of the process is to ensure that similar incidents do not happen again, which would cause harm to other families that could have been avoided. Yet families may not be able to see how recommendations are being monitored or implemented, and communities may feel that systemic issues have not been addressed despite the length and complexity of the coronial process which was designed to consider the issues."[78]

I recognise the recommendation made by the 2020 Select Committee for the implementation of the recommendations made to the RCIADIC (Recommendation 1, 34) and the recommendation for prompt responses to coronial recommendations (Recommendation 32).[79] However, I would urge this Committee to expand upon such recommendations, enhancing the implementation and review of coronial recommendations, where such recommendations may have been made in previous First Nations inquests.

1- B whether, having regard to coronial law, practice and operation in other Australia and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary

33. Whilst the foundations of the coronial process remains relatively similar across the states and territories (by virtue of the RCIADIC recommendations which spoke to the post-death investigation process), there does exist some slight variation. Of interest to this submission is the way in which different jurisdictions engage with First Nations families engaging in the coronial process.

34. At the outset, I will recognise that the coronial policies and practices to be discussed are just that – practice direction and guidelines. Whilst they do offer some guidance as to the way in which court participants engage in the process, as well as an enhanced cultural consideration, they do

[76] Fiona Allison, Chris Cunneen and Melanie Schwartz, Submission 108 *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) 10
[77] 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 33
[78] 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) 33.
[79] 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) Recommendations

not address the overarching issue of independence with the coronial jurisdiction as it exists today in NSW. As a long term approach, I continue to support the recommendations discussed above for an independent investigative jurisdiction or body. Similarly, the comparative international models of police accountability to be discussed below align with this recommendation, as an ideal model for First Nations death in custody investigations.

35. However, the below serve only as short-term beneficial reforms to existing practices that speak to the experiences engaging with the coronial death investigation process in its current state. While these short-term reforms aim to minimise the exacerbation of the already existing grief, harm and trauma associated with the loss of a loved one, a more rounded, long term approach is required for addressing the wider systemic issues of the coronial jurisdiction that have been discussed throughout this submission.

Comparative Models – Australian Jurisdictions

36. In terms of coronial policy and practice, both the Victorian jurisdiction and Queensland jurisdiction go further than the NSW jurisdiction in providing policy or practice details specifically relating to the experience of First Nations deaths in custody investigations and the inquest process for families and supporters.

    A. Victoria: In 2019, the Coroners Court of Victoria established the Koori Engagement Unit as a part of their Aboriginal Justice Initiatives. The Koori Engagement Unit was established to 'better serve Aboriginal and Torres Strait Islander families involved in coronial investigations'.[80] This unit provides a range of services to support families through their grief and navigation of the coronial process, ensuring culturally safe practices are embedded within the court process.[81] Supplementary to this unit, the Coroners Court issued a practice direction detailing some of the specific actions and sensitivities taken when engaging with bereaved families navigating the coronial process, following the death of a loved one in custody.[82] These will be discussed below.

    B. Queensland: The Queensland 'Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people (2019) (The Guide)' [83] was created by the Coroners Court of Queensland in collaboration with First Nations families with lived experience in the coronial jurisdiction. The Guide is multilayered, speaking to the cultural considerations and protocols surrounding death in First Nations communities, next of kin responsibilities, and issues arising for First Nations people, when engaging with the Western coronial investigation and inquest process. The Guide provides a considerable balance of both advice to Coroners and coronial proceedings, as well as background information and presented clear reasoning for engaging in a manner considerate to First Nations cultures.

    The full guide is attached as an appendix. I encourage the Committee to consider ways in which such a similar guide may be of use in the NSW jurisdiction. Yet beyond that, I still urge the Committee to do more than simply create a guide or practice direction, but engage with First Nations families in reforming the death investigation process.

37. The below examples portray key therapeutic features existing across the Victorian and Queensland coronial jurisdictions through the existing policies and practices discussed below. These are to be considered, supplementary to the proposed practices and sensitives discussed above.

    a. **Cultural practices, protocols and sensitivities**: Both guides promote the incorporation of practices related to First Nations mourning and Sorry Business protocols. At the discretion of the family, and guidance and control of the community, both documents encourage the

[80] Coroners Court of Victoria, *Annual Report 2018-2019* (November 2019) 6, 17.
[81] Coroners Court of Victoria, *Annual Report 2018-2019* (November 2019) 6, 17.
[82] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 4.
[83] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019), found at *Inquest into the death of Master Carr and Jaylen* (Unreported, Coroners Court of Queensland, Brisbane Coroner Christine Clements, 27 August 2020) Annexure B.

inclusion of a smoking ceremony at the place of death or at the commencement of the inquest.[84] Adhering to cultural protocols and sensitives surrounding using the name of the deceased (verbally and in documents), the identification of traditional owner groups and lands and sensitivity to men's and women's business are also encouraged. [85] Further, the Victorian Koori Engagement Unit is responsible for preparing a cultural brief to the Coroner, to ensure awareness of relevant cultural issues specific to the deceased and their community. [86]

Holding the inquest on country and including symbols of cultural significance – such as possum skin cloaks, didgeridoos and an Acknowledgement of Country at hearings and the inquest are also noted as culturally considerate protocols to be considered in the Coroners Court.[87]

b. **Support for First Nations families:** First Nations personnel or liaison officers within the Coroners Court are recognised as significant in offering support and assistance to bereaved families. In Victoria, the Koori Engagement Unit employs First Nations personnel to "engage with the family throughout the coronial process, and hold a family meeting (Family Meeting) within four weeks of the death to explain the coronial process, manage expectations about timeframes, and to demonstrate to families that the process will be aimed at being culturally appropriate, including through adherence to this Practice Direction".[88] It is recognised that this was recently introduced in NSW.[89]

   In terms of legal support, The Victorian Practice Direction explains that the investigating Coroner will make contact with their Principle In-House Solicitors within 48 hours of the death, to make contact and organise liaison with the bereaved family and the Victorian Aboriginal Legal Service (VALS).[90] In NSW, the position of legal assistance for First Nations deaths in custody is ad hoc. Whilst the ALS take on the majority of cases, families are not always referred to the ALS, seeking assistance independently, or through Legal Aid.

c. **Family participation:** In the Queensland jurisdiction, the Guide explains that the *Coroners Act QLD* (2003) provides a wide definition of family member, to encompass the plurality of personal and kinship relationships that exist within First Nations communities: "*An ATSI family member for a deceased person who was an Aboriginal person or Torres Strait Islander means, a person who is an appropriate person according to the tradition or custom of the Aboriginal or Torres Strait Islander community to which the deceased person belonged*".[91] This inclusive recognition of familial networks enables the appropriate person to exercise the rights and responsibilities of the next of kin, offered to non-Indigenous family members, as well as specific responsibilities and duties of the First Nations next of kin – from informing the court of any specific sensitivities such as the preferred name of the deceased, or gender issues.

   Beyond the next of kin duties, both guides reiterate the role of the court in keeping families appraised of progress in the death investigation. This can be in the form of accessing the brief, being consulted on proposed dates of hearings and being provided of progress in the investigation and medical examinations. Similarly, the Queensland notes the importance of oral and verbal communication in First Nations culture, and encouraging families to make written or oral submissions to the court.[92]

---

[84] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 7; Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 4.
[85] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 16.
[86] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 4.
[87] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 5.
[88] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 4.
[89] As of March 2021, NSW State Coroner Teresa O'Sullivan revealed two Aboriginal Liaison Officers roles in the NSW coronial jurisdiction, available at https://www.parliament.nsw.gov.au/lcdocs/other/15413/Letter%20-%20NSW%20State%20Coroner%20-%20received%2024%20March.pdf
[90] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 3.
[91] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 4.
[92] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 8, 17

d. **Conduct and scope of investigations:** As discussed above, the role of police in investigating their own officers in circumstances of First Nations death in custody, is of concern. The Queensland guide recognises this contention and the historical relationship of distrust and hostility between the Police and First Nations communities, and urges Coroners and court personnel to prompt families to raise any concerns to the court as well as accessing legal assistance.[93]

   Similarly, speaking to the scope of the coronial inquest, the Queensland guide names institutional racism as a potential *factor to be considered when investigating First Nations deaths in custody. The Guide states - "Issues that may be relevant for the Coroner and Counsel Assisting to consider during the inquest should include: whether the scope of the inquest should be expanded to consider the issue of specific cultural or social issues such as institutional racism … "*.[94] Additionally, the Victorian Practice Direction notes specific factors to be included in the scope of investigation when investigating First Nations deaths in custody, including exploring *"the quality of care, treatment and supervision of the deceased prior to death"*. [95] This guidance is important to the investigation of First Nations deaths in custody, as it has potential to examine or identify the attitudes, cultures and biases of police and custodial officers, to the treatment and death of First Nations peoples in custody.

Comparable International Models

38. International models of police accountability and oversight to be discussed below are not new or unknown to the Australian or NSW Government. Over three years ago, the Australia Law Reform Commission (ALRC) Pathways to Justice report explored the potential of these five models in Australia, as an independent means of investigating deaths in custody, and addressing complaints against the police.[96] The submission by the Aboriginal Legal Service to the 2020 Select Committee too was just one submission which also provided detail on these models, and their potential applicability to the Australian (NSW) landscape.

    a. **New Zealand**: The Independent Police Conduct Authority of New Zealand (IPCA) is a statutory independent body in NZ, 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.[97] 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.[98] In circumstances where the Commissioner of Police departs from the recommendations made by the IPCA, reasons must be provided as to that departure.[99]

    b. **Northern Ireland**: The Police Ombudsman of Northern Ireland (PONI) has been described as the "golden standard in police investigations.[100] This Ombudsman is responsible for providing independent and impartial investigations into complaints pertaining to the actions and conduct of police officers and officials – particularly where injury or death has occurred. This body is also financially independent of the police. [101] The findings of the investigation of the PONI is sent the public prosecution service (PPS), who make the final decision as to

---

[93] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 17.
[94] Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islande*r (2019) 17.
[95] Coroners Court of Victoria, *Practice Direction 6 of 2020: Indigenous Deaths in Custody* (22 September 2020) 4.
[96] 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.
[97] *Independent Police Conduct Authority Act* 1988
[98] Independent Police Conduct Authority Annual Report 2015-2016, 8
[99] *Independent Police Conduct Authority Act 1988* (NZ) s29 (1)
[100] 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.
[101] Police Ombudsman for Northern Ireland, *Annual Report and Accounts for the year end 31 March 2017* (2017)

whether persons are to receive disciplinary or criminal action,[102]

c. **Republic of Ireland**: The Garda Siochana Ombudsman in the Republic of Ireland is responsible for conducting independent investigations into police conduct where such conduct may have resulted in death of serious injury of a citizen. [103] The GSOC investigates complaints made against the police independently, as a means of ensuring public confidence in the police. The GSOC has the power to refer persons to the DPP, in circumstances in which their investigation indicated criminal conduct or negligence had occurred. [104]

d. **Canada**: The Special Investigation Unit (SIU) in Ontario Canada, is an independent civilian agency responsible for investigating and charging police officers with criminal offences.[105] The SIU acts as the primary investigator of police conduct, particularly in circumstances in which such conduct has resulted in serious injury or death, determining whether a criminal act has been committed, and whether there are grounds to charge a police officer for such conduct.[106] The SIU ensures the behaviour of police is subject to rigorous, independent investigations. [107]

e. **England and Wales**: The Independent Office for Police Conduct in England and Wales (IOPC) is responsible for conducting investigations into deaths and serious injury of persons in police custody, police shootings or allegations of use of excessive force.[108] Bound by statutory guidelines, police are required to refer serious incidents to the IOPC for investigation, whether a civilian have made a complaint or now. After conducting an independent investigation, the IOPC presents a report of their findings to the Crown Prosecuting Service. Whilst they do not have the power to mandate prosecutions, they can inform the CPS of such a recommendation.[109]

Conclusion

Overall, in my view, consideration should be given to long-term reforms of the coronial death investigation process, drawing on the recommendations made by leading organisations, experts and families, for the creation of a separate specialised investigative body, that is independent of the police. At the forefront of this model, or other amendments recommended by this Committee, I urge the Committee to consider the potential applicability of therapeutic jurisprudential principles and practices, that aim to consider the way in which the court can minimise trauma for involved persons. Throughout this submission, the Victorian and Queensland jurisdictions were explored, for their enhanced consideration of these principles embedded within policies. The comparative international models too draw on these principles, whilst also centring independence from the police in death in custody investigations.

Appendix

Appendix A - Coroners Court of Queensland, *Sorry Business: A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander* (2019), found at *Inquest into the death of Master Carr and Jaylen* (Unreported, Coroners Court of Queensland, Brisbane Coroner Christine Clements, 27 August 2020) Annexure B (Link)

[102] Office of the Police Ombudsman of Northern Ireland, 'The Police Complaint System in Northern Ireland', 2014, 21
[103] *Garda Siochana Act 2005* (Republic of Ireland), *Garda Siochana Act 2005* (Republic of Ireland), s106
[104] *Garda Siochana Act 2005* (Republic of Ireland), s 101
[105] SIU, What We Can Investigate, Mandate, available at https://www.siu.on.ca/en/investigate_what.php
[106] *Special Investigations Unit Act 2019* (Ontario, Canada), s15, s33
[107] SIU, What We Can Investigate, Mandate, available at https://www.siu.on.ca/en/investigate_what.php
[108] IOPC, Investigations, available at https://www.policeconduct.gov.uk/investigations
[109] IOPC, Investigations, What We Investigate and Next Steps, available at https://policeconduct.gov.uk/investigations/what-we-investigate-and-next-steps

SORRY BUSINESS

A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people

2019

ACKNOWLEDGEMENT

This guide would not have been possible without the assistance of the Aboriginal and Torres Strait Islander families who have shared their experiences working with the Coroners Court of Queensland (CCQ).

We thank those families.

TABLE OF CONTENTS

INTRODUCTION

Sorry business is the Aboriginal English term used by the Aboriginal and Torres Strait Islander community to describe the mourning period when a family member dies and all responsibilities that follow in accordance with traditional lore and custom. Traditional lores and customs are observed and practiced by Aboriginal and Torres Strait Islander people to this day and are important to recognise.

The objects of the *Coroners Act 2003* (the Act) include requiring the reporting of particular deaths, establishing procedures for the investigation of those deaths, and to help prevent deaths from similar causes happening in the future by allowing Coroners at inquest to comment on matters connected with deaths, including matters related to: [i]

- public health or safety; or
- the administration of justice.

This guide will provide CCQ with a framework for navigating the concerns that Aboriginal and Torres Strait Islander people may raise when the death of an Aboriginal person or Torres Strait Islander falls within the jurisdiction of the Act.

This document contains some generalisations about Aboriginal and Torres Strait Islander people. If you are in any doubt, you should speak with the family or next of kin to identify the specific cultural protocols observed under traditional lore and custom.

LIVED EXPERIENCES OF ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

The lived experiences of Aboriginal and Torres Strait Islander people have a direct correlation on their health and mortality outcomes. Following colonisation in Australia, policies, laws and social norms have affected Aboriginal and Torres Strait Islander people in Queensland and include:

- the dispossession from traditional lands;
- stolen generation;
- stolen wages;
- institutional racism;
- loss of identity - language, kin and culture;
- the enactment and implementation of *The Aboriginal Protection and Restriction of the Sale of Opium Act 1897* (Qld) (the Protection Act) (repealed 1984);
- exclusion prior to the 1967 referendum; and
- the effects of the Northern Territory intervention for bordering Queensland communities and transient communities.

These events have contributed to entrenching disadvantage and inter-generational trauma for Aboriginal and Torres Strait Islander people.

Entrenched disadvantage such as poorer living conditions, decreased access to health care and justice also contribute to Aboriginal and Torres Strait Islander people being more likely to be affected by major social issues in communities such as the over representation of Aboriginal and Torres Strait Islander people in the criminal justice system and in prison, issues relating to drugs and alcohol, domestic and family violence, lack of employment opportunities, intergenerational welfare dependence, as well as poorer health and education outcomes.

Inter-generational trauma occurs when a person witnesses or experiences trauma and that is transmitted across the generations. Aboriginal and Torres Strait Islander culture can be generally categorised as an oral and aural tradition where knowledge of traditional lore and custom is passed

down through the generations by Elders and those with authority to speak within their communities. That knowledge is also entwined in the lived experiences of Elders who have gone before, and those who still live today. The trauma experienced through their lives is passed down through each generation, thus creating inter-generational trauma.

Aboriginal and Torres Strait Islander people may interact with the coronial system as a result of their lived experiences. The most likely areas of interaction, due to entrenched disadvantage and intergenerational trauma, include:

- deaths in custody;
- domestic and family violence;
- deaths in care;
- child protection;
- deaths in care - disabilities;
- suicide;
- missing persons; and
- health care related deaths.

FAMILY

The Act provides a wide definition of family member, including the encompassing the broad and complex relationships that exist within Aboriginal and Torres Strait Islander communities.

Schedule 2 to the Act defines family member to include:

- a particular person, where the coroner investigating the death is satisfied that the deceased person's wish would have been that a particular person be the deceased person's family member for the Act;
- spouse;
- adult child;
- parent;
- adult sibling;
- an adult who immediately before the deceased person's death, had a relationship with the deceased person that the coroner investigating the death considers is sufficient for being a family member of the deceased person for the Act; and
- an ATSI family member.

An ATSI family member for a deceased person who was an Aboriginal person or Torres Strait Islander means, a person who is an appropriate person according to the tradition or custom of the Aboriginal or Torres Strait Islander community to which the deceased person belonged.

Familial connections in the Aboriginal and Torres Strait Islander community include:

- grandparents;
- grandchildren;
- aunts;
- uncles;
- niece;
- nephews;
- cousins;
- cousin-sister;
- cousin-brother.

Relationships may also be described by the family of the deceased person in the following ways, namely:

- siblings of grandparents as grandmother and grandfather;
- siblings of parents as mother and father in addition to or in substitution of aunt and uncle;
- in addition to cousins as cousin-sister and cousin-brother;
- in addition to nieces and nephews as granddaughter and grandson.

These relationships and connections with the deceased person should be recognised in the same way that they are expressed.

It is important to recognise that these connections may also have involved the 'raising up' of the deceased person during their formative years and may also involve customary adoption practices that may not be legally recognised.

Torres Strait Islander communities also include the in-laws of the deceased person, known as a Marigeth/s. The Marigeth plays an important role in the customary protocols surrounding the death of a Torres Strait Islander person.

Extended family may also be an important relationship to the deceased person. Extended family may have no biological connection to the deceased person but may form part of the wider community that the deceased person was a member of prior to death.

DEATH IN ABORIGINAL COMMUNITIES

It is important to acknowledge that Aboriginal people in Australia are not part of a homogenous mass and are also distinct from Torres Strait Islanders. Nations, tribes, clans and languages groups make up the fabric of Aboriginal society and each person's experience may be varied depending on their personal history.

For many communities, ceremonies are conducted following a person's death. The spirit of the deceased person is believed to continue after their death and that the spirit must be given time to leave the body and rest. A person's spirit can be disrupted if traditional lore is not observed.

In some remote communities in Queensland the whole community is closed down to allow for sorry business. In some cases, people outside of the community will not be allowed to enter the community until sorry business has concluded. This can cause difficulty when there are multiple deaths in a community.

At times throughout history, Aboriginal people have been forbidden to practise traditional lore around death and dying and was particularly prevalent in Aboriginal Missions where there were a number of different tribes and clans placed in the same location. Some Aboriginal people have also embraced Christian practices which are also recognised or incorporated into the protocols around death.

REFERRING TO THE DECEASED PERSON

It is a common protocol amongst Aboriginal people to cease referring to the name of the person who has died. There are many reasons as to why this is done, including as a sign of respect and allowing the spirit of the deceased person to rest. By referring to the name, it is believed that the spirit is called back to this world and is prevented from travelling into the spirit world.

How should I refer to the deceased person?

Ask the next to kin for instructions on how the name of the person can be used. If it is not practical to obtain this information from the next of kin, the deceased person should be referred to by their surname.

It is also important to realise that images and voice recordings of the deceased person will also cause significant distress to the family. Instructions should also be obtained about how images and voice recordings should be used.

It is important that CCQ staff make a note of the preferred name in CCMS as well as on the physical file. It may also be appropriate to include and encourage the use of the preferred naming convention for incoming and outgoing communication with third parties.

IDENTIFYING TRADITIONAL CONNECTION

It is important for Coroners and CCQ staff to identify where the deceased person is culturally connected to. In most cases, an Aboriginal person will identify with belonging to a traditional owner group from which they are a descendant of.

Aboriginal people feel strongly connected to the land and in most cases will wish to be returned to their traditional lands. However, this may not always be possible. In some circumstances Aboriginal people cannot return to their traditional lands because generations have been forcibly removed, the land is freehold and native title is extinguished or the person has lost connection.

Aboriginal people may also strongly identify with a particular area that does not belong to their traditional lands; which is known as a historic connection. Most notably this occurs were Aboriginal people had been forcibly removed from their traditional lands and after a number of generations their ancestral connection is unknown or has diminished over time, such that they feel a stronger connection in the communities which they lived and worked in. This includes Deed of Grant in Trust (DOGIT) communities and Christian missionary communities that were set up around Queensland and interstate. Some of the Queensland communities include Mornington Island, Yarrabah, Palm Island, Woorabinda and Cherbourg. In those communities there were a number of tribal groups that were placed in the one community in circumstances where it was forbidden to speak or practice their traditional lore and customs; particularly during the operation of the Protection Act.

Aboriginal and Torres Strait Islander people can also be transient and may have lived far away from their traditional lands when they died, including interstate.

By identifying the deceased person's connection, it is recognising their traditional or historical connection and also alerting the Coroner to any issues that may arise in relation to transportation of the deceased.

How do I identify the deceased person's traditional connection?

Ask the next of kin if the deceased person identified with a particular traditional owner group. If so, what is the name and spelling of the group and where the traditional lands of that people are located.

Please note that the birthplace of an Aboriginal person will not necessarily identify the traditional connection of that person and should be avoided.

For assistance in identifying the nation, tribe, clan or language group a copy of the map of *Indigenous Australia* can be used online from the Australian Institute for Aboriginal and Torres Strait Islander Studies at www.aiatsis.gov.au. A copy of the maps can also be purchased.

TRANSPORTING THE DECEASED

If the Coroner has determined that an autopsy is necessary and the body must be transported, the next of kin may raise concerns. It is important that the next of kin is aware of the process involved, including that some regional centres do not have the ability to store the body or perform an autopsy, as well as explaining the role of Forensic and Scientific Services (FSS).[ii]

In some instances, Aboriginal people will want to view the body, sometimes before an autopsy has been performed. The reasoning may be that the family wish to perform a smoking ceremony to allow the spirit of the deceased person to move on. However, it may be more practical and appropriate for this to take place at the coronial mortuary following autopsy or when the body has been released to the funeral director.

Delay in viewing the body may contribute to a longer period of sorry business if preparation of the body cannot take place in accordance with traditional lore and custom.

In circumstances where the body is not suitable to be viewed, for example if there the body is not visually identifiable or there are traumatic injuries, the family should be advised as soon as possible in accordance with the State Coroner's Guidelines.[iii]

Another important issue to consider is whether weather conditions are appropriate for transporting the body to and from a community. Many Aboriginal and Torres Strait Islander communities in Queensland are regional and remote and are inaccessible at certain times of the year. If transportation occurs to or from these communities, funeral directors should speak with the local Aboriginal or Torres Strait Islander Council for advice about whether transportation is suitable at that time of the year.

Smoking ceremony

Some Aboriginal people may wish to conduct a smoking ceremony at the location of death or of the deceased person's body and belongings. Smoking ceremonies are conducted to encourage the spirit of the deceased person to pass on. If requested, families should be given an opportunity to perform a smoking ceremony if it is safe and appropriate to do so. In most instances, it would be appropriate once the body of the deceased person has been released.

COMMUNICATION

Aboriginal and Torres Strait Islander culture is predominately oral, making verbal communication highly important. Knowledge is passed down intergenerationally by storytelling, depiction through art, songs, dance and other ceremonies.[iv]

Often, the experience of Aboriginal and Torres Strait Islander people is that there is a distrust of Government for past failures and injustices committed. Therefore, it is important for CCQ staff to build rapport with the next of kin and family, as it will assist to build confidence in the coronial process.

Language and Literacy

Aboriginal and Torres Strait Islander people may speak English as their second or third language. There may be some situations where an interpreter is required to communicate with the next of kin or family. Interpreters may be difficult to locate and are often not accredited through the National Accreditation Authority for Translators and Interpreters (NAATI). If an interpreter is needed, it may be necessary to seek assistance from the deceased person's family members to assist the next of kin.

Aboriginal English is also regularly spoken and certain words have a different meaning. An example includes the word *deadly* which means *awesome* or *cool* in Aboriginal English, as opposed to an interpretation in a coronial context, such as the *use of deadly force*.

It is also important to also be aware that literacy levels vary amongst Aboriginal and Torres Strait Islander people and that not all families have access to internet or phone services.

In some cases, CCQ staff may need to spend some time over the phone discussing the coronial process, particularly if the next of kin has literacy issues or is unable to mail or email their concerns for the Coroner's consideration.

Aboriginal and Torres Strait Islander people may have a transient lifestyle. It is important to recognise this factor when letters to the next of kin that go unanswered.

What do I do if issues with language and literacy arise?

Contact the next of kin and confirm the preferred method of contact. If there are issues with language and an interpreter is required, seek assistance from other family members. If there are no other family members, seek permission from the next of kin to call on assistance from the local Community Justice Group located closest to them.

It is important to recognise that Aboriginal people may not want to include people from outside of their family when dealing with sorry business. Therefore, it is important to seek their consent before involving another Aboriginal or Torres Strait Islander person to assist you in achieving an outcome.

If the next of kin has literacy issues, spend time over the phone explaining the coronial process to the next of kin. Alternatively, the next of kin can be referred to a free coronial assistance legal services or the Aboriginal and Torres Strait Islander Legal Service for assistance.

If written correspondence is returned to sender or contact is lost, attempts should be made to re-establish contact with the next of kin to confirm current contact details.

Gender Issues

It is important to recognise that Aboriginal culture and ceremonies includes a separation of men's and women's business which is considered secret and sacred. This will be particularly important in the context that the death is sexual in nature, including health care related deaths.

> **What should I do if an issue arises where there is men's and women's business?**
>
> Ask the next of kin if they would prefer to speak with someone from their own gender. If the next of kin feels comfortable, ask them to explain what the particular issue is. The next of kin may also want reassurance about confidentiality of the investigation and/or findings.
>
> If the Coroner is of the opposite gender and there is an issue raised about men's or women's business, it will be important to inform the next of kin of the gender of the Coroner and that the Coroner will be made aware of the particular concerns raised.

LGBTI Community

There are many among the Aboriginal and Torres Strait Islander community who identify as Lesbian, Gay, Bisexual, Trans and Intersex. The Trans community in the Aboriginal and Torres Strait Islander community is also described as Sistergirls and Brotherboys.

It can often be difficult for the Aboriginal and Torres Strait Islander LGBTI community, due to cultural responsibilities and religious beliefs. Culture has specific gender roles divided between women and men's business and can be rigid in the acceptance and inclusion of LGBTI members within the community. This can be particularly so in respect of initiation processes or transmission of knowledge from Elders in their community.

Some members of the LGBTI community can feel isolated in addition to the other social pressures such as homophobia, racism, sexism and discrimination. There is also a lack of recognition and support services available to the Aboriginal and Torres Strait Islander LGBTI community, however this is improving through community-based organisations such as '2 Spirits'.

2 Spirits provides, amongst other things, one-on-one cultural support, community forums, yarning circles and community outreach.

It may be relevant to consider whether the next of kin is fully accepting of a deceased person's identity within the LGBTI community. This may pose an issue if the deceased person's spouse wishes to participate in the coronial process and there is conflict with other members of the deceased person's family.

DEATH IN TORRES STRAIT ISLANDER COMMUNITIES

Torres Strait Islanders have a distinct culture and customs from Aboriginal people and have unique mourning and funeral practices. Torres Strait Islander culture also embraces Christianity through the Coming of the Light. Christian beliefs have been integrated into cultural practices and are observed with equal importance.

Similar to Aboriginal people, business in a community will not take place during the period of sorry business. Reference to the deceased person should also be avoided. However, if in doubt seek clarification from the next of kin or Marigeth/s.

Issues in Aboriginal communities relating to communication and transportation of the deceased person's body may arise in Torres Strait Islander communities. Communication will assist CCQ staff to navigate issues that may arise. If there are language difficulties, ask the next of kin if there are translators who may be able to assist.

MARIGETHS

When a Torres Strait Islander person dies, it is the responsibility of the deceased person's in-laws of both genders to make arrangements to assist the deceased person to pass on into the spirit world. This person is known as a Marigeth (*spirit hand*). The responsibility of a Marigeth includes communicating with family, handling of the body at the mortuary, preparation and dressing of the body and burial.

The Marigeth is responsible for informing families of the 'sad news' of the person's passing and to provide support and meals for those who visit the deceased person's family. This is particularly relevant to the role of next of kin and communication with CCQ staff.

Koey Marb

Koey Marb describes the journey of the deceased person into the spirit world and translates to 'the long walk home'.

It is the role of the Marigeth to prepare the body for burial as they are the *spirit hand* who guides the deceased person on their long walk home. A Marigeth of the same gender is also responsible for dressing the body in preparation for burial.

On the Island of Mabuiag, dancing ceremonies are performed, and a feast is arranged in the weeks following death to assist the spirit to travel on.[v]

Why is the role of a Marigeth important?

The Marigeth may not be the spouse, parent, child, sibling or grandparent of the deceased person who is ordinarily nominated as next of kin. The role of the Marigeth should not be disregarded as having authority to engage with CCQ. By not including the Marigeth, it may cause disharmony for the family and protocols to assist the deceased person to travel into the spirit world may not be completed, causing further distress to the family.

The role of the Marigeth is extremely important in relation to the need to view the body. If the body is not suitable for viewing, this will become an issue for the Marigeth, as a Marigeth of the same gender as the decease is responsible for preparing the body for burial, including dressing the body.

If viewing of the body is not appropriate, the next of kin and family should be informed with the assistance of Coronial Counsellors. Strong reactions are likely to follow from the decision, with possible anger from the Marigeth/s as it is likely they will feel that they haven't performed their cultural responsibility to the deceased person.

KULAW GUDPUDAY

Another protocol that is observed by Torres Strait Islanders is Kulaw Gudpuday (tombstone unveiling). This can occur anywhere between 12 months to five years after burial of the deceased person and represents the conclusion of the mourning period.

The Marigeth is responsible for covering the cost of the tombstone and engraving which is presented to the deceased person's family. The tombstone is also covered in colourful fabric and money envelopes.[vi]

When will a tombstone unveiling be relevant to the role of CCQ?

It is important to recognise the date when the proposed kulaw gudpuday will take place. Kulaw gudpuday may be delayed in circumstances where the next of kin or the family are waiting for an autopsy report to be provided, the conclusion of the investigation, inquest or findings.

It is also important not to hold an inquest or deliver findings on the date or anniversary of the kulaw gudpuday.

CCQ staff should ask the Marigeth when kulaw gudpuday is planned or has taken place.

NEXT OF KIN

Aboriginal and Torres Strait Islander families have diverse and complex relationships. It may be difficult to navigate who the appropriate person is to liaise with depending on how cultural protocols are observed. Some family members may have greater cultural responsibility than the immediate family members which can include the responsibility of liaising with CCQ.

WHO IS THE NEXT OF KIN AND WHO HAS AUTHORITY?

As outlined above, Torres Strait Islander communities rely on the Marigeths to organise the transportation, preparation and burial of the deceased person. The Marigeths are the in-laws of the deceased person, meaning there may be multiple people who have cultural responsibility to liaise with the CCQ.

Whilst a Marigeth has primary responsibility, it should not prevent other immediate family members from contacting the CCQ for accessing information during the coronial process. Alternatively, if it is clear that there is only one senior next of kin and CCQ staff are inundated with communication from a variety of family members, it may be appropriate for the family to be informed to obtain information from the senior next of kin.

Appointing multiple senior next of kin

Where CCQ has been informed that there are Marigeths appointed to represent the family, the Marigeths should be appointed as the next of kin.

It may be appropriate for the Coroner to allocate one or two people who have status as the senior next of kin. There may be particular issues relating to gender that may be uncomfortable to discuss with members of the opposite gender. This can occur for either Aboriginal or Torres Strait Islander families. In such cases it may be necessary to have a senior next of kin for each gender.

What should I do if someone raises the issue of Men's or Women's Business?

Whilst gender issues may not be openly raised by the next of kin with CCQ staff, comments referring to 'men's business' or women's business' are strong indicators of gender issues. As a result, only men or women can speak about those issues with their respective gender. This includes discussing the issue with any CCQ staff from the opposite gender.

The staff member should ask whether there is men's business or women's business that the Coroner should be mindful of and whether the person would prefer to speak to someone of their own gender.

Nominated spokesperson

Under Aboriginal traditional lore, an Elder or a family member may be nominated by the next of kin to speak on their behalf by way of a cultural responsibility. In circumstances where the next of kin nominates a spokesperson, that person has authority to communicate with CCQ on behalf of the family. However, if the nomination is withdrawn at any point by the next of kin, the nominated person should be advised that they are no longer the appropriate person to speak on behalf of the next of kin, as it has been withdrawn.

There may be instances where there is conflict between families, however CCQ should refer the issue back to the family to resolve. It may also mean that a Coroner has to consider whether multiple persons as the next of kin. If conflict cannot be resolved, families should be referred to free coronial assistance legal service or the Aboriginal and Torres Strait Islander Legal Service. It is not appropriate to involve community Elders or Community Justice Groups unless the family has requested this.

Kupai Omasker

As part of Torres Strait Islander culture, the practice of traditional adoptions ('Kupai Omasker') continues today. Kupai Omasker is not legally recognised, however the Queensland Government has committed to recognising the practice.[vii]

What issues arise where there has been kupai omasker?

The most common issue for children that have been adopted through Kupai Omasker is that records held by Births, Deaths and Marriages (BDM) do not record the child on documents relating to the adoptive parent such as birth and death certificates. At times it can be the first time the adopted person becomes aware of Kupai Omasker. The result can mean that they cannot establish requisite standing as next of kin, despite Ailan Kastom and connection to their parent, siblings, nieces or nephews.

Alternatively, where a child's birth parent has died, other siblings that remained with the birth parent may have objections to including the other sibling because of Kupai Omasker. This is because they were not raised up with their birth parent and are not recognised as their sibling.

These issues may be resolved when Parliament enacts legislation formally recognising the practice which is likely to include legal recognition on records maintained by BDM.

CONFLICT BETWEEN FAMILY MEMBERS WITH COMPETING INTERESTS

As with any family, some Aboriginal and Torres Strait Islander families can be dysfunctional and there may be long standing or recent issues that are exacerbated by the death of their loved one.

Issues may arise at various times and include whether or not an autopsy should be performed. It may also relate to who the body of the deceased person can be released to for funeral arrangements. Other issues that impact on this include where the deceased person should be buried or whether they should be cremated.

Some families may be able to resolve these issues. However, there may be a need to inform families that they will need to make an application to establish priority of standing in the Supreme Court of Queensland. In most cases, families will not have the financial means to bring an action in the Supreme Court of Queensland let alone the cost of funeral and burial or cremation.

If conflict cannot be resolved, families should be referred to free coronial assistance legal service or the Aboriginal and Torres Strait Islander Legal Service. It is not appropriate to involve community Elders or Community Justice Groups unless the family has requested this.

A Coroner may also choose to invite submissions, about release of the body, from each claimant and provide reasons in accordance with Chapter 6 of the State Coroner's Guidelines. If the Coroner decides it is necessary, the Coroner may seek submissions be made in person before the Coroner. By doing this, it may facilitate a discussion between family members or prompt families to seek legal or community assistance.

Consideration should also be given to the deceased person's cultural connection to country and any funeral preparations that should be observed as previously outlined above.

In circumstances where a decision has been made to cremate the deceased person, issues may arise if a suggestion is made to distribution the ashes among disputing family members. Most Aboriginal people believed that splitting the ashes will split the spirit of the deceased person.

NEXT OF KIN CONCERNS

Next of kin concerns may assist an investigation and provide the family with an opportunity to provide a glimpse of the deceased person's life. However, it may not be possible for Aboriginal and Torres Strait Islander people to provide written concerns due to access to internet and/or literacy issues. In cases where written concerns cannot be provided, it may be appropriate for the next of kin to outline their concerns over the phone to a CCQ staff member.

If operational issues restrict a CCQ staff member from taking concerns of the next of kin over the phone, the next of kin should be referred to a service provider who may be able to assist. Consideration should be given to whether there are any service providers available to the next of kin's and they have the means of accessing those services. Limitations may include disabilities of the next of kin or if issues of confidentiality have been raised by the family.

Issues of confidentiality may arise in small communities where staff at the service provider may be closely linked or are part of same the community as the deceased person or their next of kin. There may be details of the deceased person's death or family dynamics which should not be disclosed to other members of the community. If this is the case, CCQ should takes steps to assist the next of kin to outline their concerns over the phone.

E.g. The death of the deceased person is believed to have been caused by her de facto spouse in circumstances where there was domestic violence. The de facto partner's

mother is the Director of the local Aboriginal Medical Service which is the only other service provider in the remote community, besides the Police. The next of kin, the deceased person's father, has a disability and regularly attends the medical service. The next of kin is angry with Police and unwilling to speak to them about his concerns, because he has raised allegations that they failed to follow up a complaint he made about his daughter's relationship. There is no ability for the next of kin to receive assistance from the other service providers.

BURIAL ASSISTANCE

Some Aboriginal and Torres Strait Islander communities do not have financial capacity to pay for burial. Where possible, Aboriginal and Torres Strait Islander people should be informed of the Burial Assistance scheme, including the eligibility requirements and the conditions of the assistance provided. Other issues that are important to discuss relate to the extent of assistance and the limitations regarding tombstones, flowers and whether a smoking ceremony could be performed. Again, CCQ staff should be mindful of the person's ability to access information about burial assistance depending on their literacy levels or access to internet and should be assisted accordingly.

Where an application for burial assistance has been approved, it is important to explain what is and isn't included.

Issues around transporting the body may be relevant for families to understand, particularly where the deceased person is being returned to a remote community and whether burial assistance provides for transportation. Other issues, such as whether transportation of the body has to be delayed due to poor weather (i.e. during wet season), may also arise.

AUTOPSY EXAMINATION

Aboriginal and Torres Strait Islander people may object to an autopsy being performed, or request that a less intrusive examination be performed. For some communities an internal autopsy will cause significant trauma to the family and is believed that it will not allow the spirit of the deceased person to pass on, particularly if retention is necessary.

However, there may be a next of kin who demands an autopsy be performed. This may be in the context of distrust of Police due to longstanding historical tension with Aboriginal and Torres Strait Islander people.

There are some also Aboriginal societies that have practised autopsies under traditional lore. This may have involved an Elder who holds authority to determine whether a person had been spiritually harmed (e.g. payback). This may involve examining the body to identify whether there are items that are not meant to be there, such as a feather, stone or bone. An examination may also involve taking a sample of blood or hair of the deceased person.[viii]

If the family of the deceased person has made a request for a sample of the hair, it may be appropriate to release the sample. If it is not appropriate or practical during the coronial investigation process, it may be appropriate to inform the family that this can be done upon release of the body to the funeral director following autopsy.

INTERNAL EXAMINATION

The process of internal examination may be confronting for any next of kin. The concerns of Aboriginal and Torres Strait Islander people may be intensified in this situation because of cultural beliefs.

Some Aboriginal societies believe the deceased person should not be interfered with in any way or have any parts of the body removed, even temporarily.

Alternatively, families may feel strongly that an autopsy should be performed. This is more likely to occur in circumstances where there is a sudden death or where there is tension between the family and Police.

Where a deceased person has been examined and there is a need for retention, the family may raise issues about the deceased person's spirit not being able to properly move on. Further, the family may say that the deceased person's spirit is split between this world and the spirit world, if an internal examination or retention takes place.

If a Coroner or the Pathologist believes it is necessary to perform an internal examination where there is an objection by the next of kin, they should be referred to the Coronial Counsellors to assist in navigating whether the next of kin has strong views about identifying the cause of death and whether the internal autopsy will assist.

In circumstances were an internal examination has been ordered, and the Pathologist requires partial retention of the body; the issue of retention should be explained by the Coronial Counsellors to the next of kin and possibly the wider family group to ensure proper understanding and the correlation with determining cause of death. The next of kin should also be informed of the consequences of not performing further investigations for which retention becomes necessary.

It may be appropriate to refer the next of kin and/or family to obtain legal advice in relation to the need for retention under section 24 of the Act.

RELEASE OF THE BODY

Aboriginal and Torres Strait Islander people have complex family relationships that extend beyond the stereotypical immediate relationship structures such as mother, father, husband, wife, brother, sister, child/ren and grandparents.

There is also potential for multiple members of the immediate family to request release of the body depending on how closely connected the deceased person was to that family member. It is important to recognise the importance of 'raising up' someone where a parent or guardian has not had an active role in the deceased person's formative years. In circumstances where a child has been raised up by another family member, it is highly likely that family member will seek equal or higher recognition than the parent.

If possible, information should be sought from the family about the kinship relationship of the deceased person growing up and as an adult, as the case may be. Further discussion is outlined below under the heading next of kin.

DECEASED PERSON'S BELONGINGS

Aboriginal and Torres Strait Islander people may request that all belongings of the deceased person be returned, including clothing and jewellery. This may be in the context of wanting to cleanse the spirit.

In circumstances where clothing cannot be returned for safety reasons, it is important that this is explained to the family as soon as possible. It may be necessary to explain that these items may be destroyed, particularly if it poses a risk of contagion.

Where belongings have been lost or destroyed unintentionally, next of kin should be notified as soon as possible explaining what has happened and any measures taken to ensure it does not occur again.

AUTOPSY REPORT

An autopsy report can cause distress to a family from any ethnic background. However, there are particular issues that may cause distress to Aboriginal and Torres Strait Islander people.

Delays in releasing the autopsy report can cause issues for family, as it may be viewed that the deceased person cannot pass on into the spirit world until the report is released. This may arise in the context of the deceased person's name being used or that the family have concerns about the cause of death.

It is also important that the autopsy report is not released on the anniversary of the death or of the tombstone unveiling. Delays in releasing the autopsy report may also cause delay of the tombstone unveiling.

INVESTIGATING DEATHS

Where the Coroner believes that the death should be investigated, issues may arise in relation to access to justice and understanding the process and issues that arise where Police investigate a death on behalf of the Coroner.

As part of an investigation into the death of an Aboriginal or Torres Strait Islander person, research or expert evidence should be obtained to assist the Coroner to understand the cultural and social issues that may be relevant to the deceased person.

ACCESS TO JUSTICE

One of the major issues that arise for Aboriginal and Torres Strait Islander people and the legal system in Australia is the availability of access to justice. Whilst there is information about the coronial process on the Courts website, some families may not have access to the internet. Further, that whilst families may have access to phones, they may not have finances to call CCQ.

Aboriginal and Torres Strait Islander families should be encouraged to access free coronial assistance legal service through the following service providers:

- Caxton Legal Centre; and
- Townsville Community Legal Service.

Alternatively, families should be referred to other independent legal services, including the Aboriginal and Torres Strait Islander Legal Service.

UNDERSTANDING THE PROCESS

When families do not have the financial capacity to engage legal representation during the coronial process or at inquest, it is important to ensure that families understand the coronial process. Understanding the coronial process may include understanding the delays involved, the decision

and timeframes around requests for inquest, as well as what happens when a decision to hold an inquest has been made.

RELATIONSHIP WITH POLICE

From time to time the Queensland Police Service provides assistance to the Coroner as part of the coronial investigation. Police officers may be required to gather statements and evidence from witnesses in order to assist the Coroner during the coronial investigation.

The relationship between Police and the Aboriginal and Torres Strait Islander community is at times strained due to historical and recent interactions. This strained relationship may be exacerbated if the death is a death in custody or a family believes that there is police involvement or a lack thereof.

If there are circumstances where there is a strained relationship with Police, it may be appropriate to prompt the family to:

- outline their concerns in writing or over the phone;
- access free coronial assistance legal service; or
- seek other independent legal advice.

It is important to recognise that Aboriginal and Torres Strait Islander Police Liaison Officers (PLO) are there to assist Police in performing their duties and can often be associated with representing Police, rather than representing their community. If a PLO is being engaged to assist the coronial investigation process, it will be important to ascertain the family's views about that engagement, as there may be circumstances of kinship or community relationships or issues around confidentiality in the community.

INQUESTS ISSUES

In circumstances where a Coroner decides to hold an inquest, it is important that the next of kin and families are aware that they can seek leave to appear at inquest.

Families should be encouraged to access free coronial assistance legal services to provide advice and assistance at the Pre-Inquest Conference and Inquest.

When an inquest has been listed and there has been no communication with the next of kin following written correspondence being sent, it may be useful to phone the next of kin.

Issues that may be relevant for the Coroner and Counsel Assisting to consider during the inquest should include:

- using the name of the deceased person;
- using voice recordings or images of the deceased persons;
- giving the family an opportunity to give evidence at the start of the inquest either on oath or informally;
- whether there are aspects of the inquest that may relate to men's business or women's business;
- whether the scope of the inquest should be expanded to consider the issue of specific cultural or social issues such as institutional racism.[ix]

If a brief of evidence is being provided to the family in preparation for the inquest, and contains voice recording and images, the family should be notified of this before receiving the brief of

evidence. Again, literacy and language issues may make it difficult for families to read the brief of evidence, increasing the need to refer families to obtain legal advice.

In circumstances where an Aboriginal and Torres Strait Islander families are unable to engage legal representation, families should be informed that they can still seek leave to appear at the Pre-Inquest Conference and/or Inquest.

If a death occurs in a remote community, consideration should be given to whether it is appropriate and possible to hold an inquest on country or whether it is more appropriate to hold the inquest in a neutral location. Consideration should be given to the number of family members who may wish to attend the inquest and their ability to attend the inquest if it is held elsewhere.

FINDINGS

When preparing findings, consideration should again be given to the use of the deceased person's name. The appropriate naming convention should be used throughout the finding.

Information relating to the deceased person's identity as an Aboriginal or Torres Strait Islander person should also be noted and include whether the deceased person identified with a specific nation, tribe, clan or language group.

Another relevant issue is whether it is necessary and appropriate to publish findings, particularly in circumstances where men's or women's business is a relevant issue for findings. Guidance from the family should be sought prior to publishing.

LEADING CAUSES OF DEATH IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

In the 2017 census, the Australian Bureau of Statistics (ABS) recorded the leading causes of death in Aboriginal and Torres Strait Islander people residing in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. The data is a key input into the Closing the Gap strategy led by the Council of Australian Governments (COAG). The annual Closing the Gap report sets targets across key social and justice priorities, namely:

- families, children and youth;
- health;
- education;
- economic development;
- housing;
- justice, including youth justice; and
- land and water.

In 2017 the ABS reported that there were 2,988 recorded deaths of Aboriginal and Torres Strait Islander people (1,631 men and 1,357 women) at a rate of 976 per 100,000 persons.[x] ABS data showed that life expectancy was the highest in Queensland reporting 72.0 years for men and 76.4 years for women.[xi]

The ABS reported that the 20 leading causes of mortality amongst Aboriginal and Torres Strait Islander people were:

- ischaemic heart disease (344 deaths);
- diabetes (226 deaths);
- chronic lower respiratory diseases (202 deaths);
- malignant neoplasms of the trachea, bronchus and lung (184 deaths); and

- intentional self-harm - suicide (165 deaths)
- cirrhosis and other diseases of the liver (98 deaths)
- dementia, including Alzheimer disease (97 deaths);
- cerebrovascular diseases (96 deaths);
- accidental poisoning (78 deaths);
- land transport accidents (77 deaths);
- certain conditions originating in perinatal period (66 deaths);
- symptoms, signs and ill-defined conditions (64 deaths);
- malignant neoplasm of pancreas (60 deaths);
- malignant neoplasms of lymphoid (57 deaths);
- influenza and pneumonia (53 deaths);
- malignant neoplasm of liver and intrahepatic bile ducts (53 deaths);
- diseases of the urinary system (52 deaths);
- malignant neoplasm of colon, sigmoid, rectum and anus (50 deaths);
- malignant neoplasm of breast (35 deaths); and
- cardiomyopathy (32 deaths).

Non-communicable diseases

The ABS reported the following average age-specific death rates for non-communicable diseases:

Selected Age Group	2008-2012	2013-2017
30 years - 39 years	104.2 people per 100,000	90.5 people per 100,000
40 years - 49 years	291.7 people per 100,000	293.2 people per 100,000
50 years - 59 years	706.8 people per 100,000	686.6 people per 100,000
60 years - 69 years	1,518.0 people per 100,000	1542.4 people per 100,000

Several of the non-communicable chronic diseases have common preventable risk factors including a lack of physical exercise, alcohol consumption, smoking and poor nutrition.

Suicide

The ABS reported that 165 Aboriginal and Torres Strait Islander people died as a result of suicide at a rate of 25.5 deaths per 100,000 persons. By comparison, the rate of intentional self-harm deaths of Aboriginal and Torres Strait Islander people was 5.5% compared with 2.0% for non-Indigenous populations.[xii]

Suicide was ranked as the 2nd leading cause of death for Aboriginal and Torres Strait Islander men with 39.6 deaths per 100,000 persons and 7th for women at 11.9 deaths per 100,000 persons. For non-Indigenous people suicide was ranked at 10th and 21st leading cause for men and women, respectively.

The median age at death for suicide across the Aboriginal and Torres Strait Islander population was 29.5 years compared with 45.4 years in non-Indigenous population. Aboriginal and Torres Strait Islander people aged 55 years and over recorded lower age suicide rates than non-Indigenous people.

Suicide of Aboriginal and Torres Strait Islander children and young people occurred at a rate of 10.1 deaths per 100,000 persons, compared with 2.0 per 100,000 for non-Indigenous persons. Children

aged between 15-17 years contributed to 94.4% of all suicide deaths in young Aboriginal and Torres Strait Islander people.

Alcohol-induced deaths

The ABS recorded that Aboriginal and Torres Strait Islander males died from alcohol-induced conditions at five times the rate of non-Indigenous men at a rate of 36.5 deaths per 100,000 persons. Aboriginal and Torres Strait Islander women died at a rate six times higher than that of non-Indigenous women and 1.7 times higher than that of non-Indigenous men.[xiii]

In Queensland, the Protection Act prohibited the sale and supply of liquor to 'Aboriginal or half-cast' people. Prior to the 1967 Referendum, which amended the Australian Constitution to include Aboriginal people in the census, Aboriginal people were 'wards of the state'.[xiv] The Protection Act was repealed in 1984.

The Queensland Government created canteens in government-controlled outlets in partnership with Aboriginal Shire Councils. This placed restrictions on the sale, consumption and possession of alcohol in those communities. The canteens were a source of revenue for local infrastructure, projects and services and created the economic sustainability for communities. This resulted in high levels of alcohol consumption, excessive violence and hospitalisations.[xv]

In 2000, The Aboriginal and Torres Strait Islander Women's Taskforce on Violence found that alcohol was a self-medicating response to trauma and the cause and contributor of violence in community. Further, the 2001 Cape York Justice Study by Justice Tony Fitzgerald found that strict adherence to the *Liquor Act 1992* in order to end the illegal serving of alcohol to intoxicated people. Further that official inspection and compliance take place for all canteens in Cape York communities. Justice Fitzgerald recommended suspension or cancellation of licences for failure to comply with regulations and licence conditions.[xvi]

The Queensland Government introduced measures to transfer canteens to community-based boards. Community Justice Groups (CJG) took on the responsibility for the canteens. CJGs are made up of Elders and respected community members. Alcohol Management Plans (AMP) are developed by CJGs and include designating dry areas, restricted areas, operating hours of licensed premises and any relevant decisions made by the CJGs.

AMPs in Queensland include the following communities:

- Pormpuraaw;
- Aurukun;
- Woorabinda;
- Lockhart River;
- Mornington Island;
- Napranum;
- Wujal Wujal;
- Palm Island;
- Cherbourg;
- Hope Vale;
- Yarrabah;
- Doomadgee;
- Northern Peninsula Area; and
- Mapoon.

Deaths in custody

It has been over 25 years since the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in 1991-92. One of the findings of the RCIADIC included that Aboriginal and Torres Strait Islander people were no more likely than non-Indigenous people to die in custody, however that they represented a greater number of arrests and prison population.

In 2019, the Australian Institute of Criminology (AIC) reviewed 2,044 deaths in custody from data gathered across each State and Territory between 1991-1992 and 2015-2016 financial years.[xvii]

The AIC study showed that 247 of the 2,044 deaths reviewed were Aboriginal and Torres Strait Islander deaths in custody and accounted for 19% of all prison deaths in the study. It showed that whilst the number and proportion of Aboriginal and Torres Strait Islander people in prison had increased, the proportion of deaths in custody had been smaller than the proportion of prisoners.

The data indicated that men outnumbered women in all Aboriginal and Torres Strait Islander deaths and all non-Indigenous deaths amounting to 96% of the deaths reviewed. A review of the ages of deceased prisoners shows the average age of 37.8 years compared with 45.3 years for non-Indigenous prisoners. The study showed that 89% of deaths occurred before the age of 55 compared with 69% among non-Indigenous prisoners. Almost one in five Aboriginal and Torres Strait Islander deaths involved a prisoner less than 25 years of age.

The most common causes of death included:

- natural causes;
- hanging;
- drugs and/or alcohol; and
- external trauma.

The data also indicated that 73% of Aboriginal and Torres Strait Islander deaths between 1991-1992 and 2015-2016 involved sentenced prisoners and 27% involved unsentenced prisoners.

The study could not accurately report the rates of deaths in police custody due to the absence of reliable data on the number of Aboriginal and Torres Strait Islander people in custody and the number of those who came into contact with police in custody-related operations. However, on the available data there were 146 Aboriginal and Torres Strait Islander deaths in police custody which accounted for 20% of the total police custody deaths. Again, male deaths outnumbered female deaths in police custody and comprised of 86% of all Aboriginal and Torres Strait Islander deaths and 95% of all non-indigenous deaths.

The most common causes of death for those in police custody included:

- external/multiple trauma;
- motor vehicle pursuits;
- natural causes; and
- hanging.

Traumatic or sudden death

Slow deteriorating health related deaths are more likely to be accepted by Aboriginal and Torres Strait Islander people. However Aboriginal and Torres Strait Islander people may associate traumatic and sudden death with sorcery, such as payback.[xviii]

Why does traumatic or sudden death raise questions for Aboriginal and Torres Strait Islander people?

Coronial staff should anticipate strong reactions from next of kin and family members and allow time for the concerns to be ventilated. This may also trigger a response by families to perform a ceremony, such as a smoking ceremony, to cleanse what has believed to have been done or an autopsy performed under traditional lore.

The family may also request an autopsy be performed in circumstances where it is not necessary. Families should be encouraged to provide further information about the particular cultural issue that would require an autopsy be performed.

COMMUNITY RELATIONSHIPS

In order to build effective relationships between CCQ and the Aboriginal and Torres Strait Islander community, it is important to be visible and accessible.

Another mechanism for improving relationships with the Aboriginal and Torres Strait Islander community is to increase the capacity of Coroners and CCQ staff to develop their understanding and capacity to work with Aboriginal and Torres Strait Islander people. Cultural learning is a lifelong lesson for Aboriginal and Torres Strait Islander people and should be an ongoing commitment for non-Indigenous people to develop their understanding and abilities throughout their lives.

It is important that CCQ builds its capability and engagement with the Aboriginal and Torres Strait Islander community by increasing awareness of the coronial process in circumstances when engagement is not triggered by a death in community. This engagement with community can be through relationship building with the local Community Justice Groups or Murri Court elders that exist in Queensland.

In circumstances where a death has occurred, it will not be appropriate to involve Aboriginal or Torres Strait Islander people who are outside the family of the deceased, unless informed otherwise by the next of kin. Confidentiality of family sorry business is important to maintain and can be jeopardised by the involvement of Aboriginal or Torres Strait Islander people who have no authority within the familial relationship to the deceased person. Consent must be obtained from the next of kin before involvement of Murri Court elders or Community Justice Groups. Most Departments create community 'Liaison' positions to assist Departments to increase their relationship building with the Aboriginal and Torres Strait Islander community. However, no such position exists within CCQ.

PARTNERSHIPS WITHIN THE DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL

The Department of Justice and Attorney-General (DJAG) is committed to implementing the Magistrates Court Reconciliation Action Plan (RAP). The RAP can be actively implemented by working with other parts of the Department.

An avenue for engagement would include attending community events throughout Queensland. Important events in the Aboriginal and Torres Strait Islander communities include Reconciliation Week and NAIDOC Week celebrations. By providing access and information to communities, they will be more willing to engage in the coronial process. There are opportunities for Departments to access funding to host Reconciliation Week and NAIDOC Week events.

[i] Section 3 of the *Coroners Act 2003* (the Act).
[ii] Part 4.2 of the State Coroner's Guidelines at page 5.
[iii] Part 4.6 of the State Coroner's Guidelines at page 12.
[iv] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2)*, Queensland Government. Available at https://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf, [Accessed 16 June 2019].
[v] Cordell, John; Fitzpatrick Judith (1987) *Torres Strait: Cultural Identity and the Sea*, Cultural Survival Quarterly (11.2).
[vi] Ibid
[vii] Department of Aboriginal and Torres Strait Islander Partnerships, Queensland Government, *Traditional Torres Strait Islander Child Rearing Practises (Public Consultation Paper)*, October 2018.
[viii] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2)*, [online], Queensland Government. Available at https://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf, [Accessed 16 June 2019].
[ix] Miki Perkins, 'Coroner agrees to consider role of racism in Tanya Day's Custody Death' *The Age* (online) 27 June 2019 < https://www.theage.com.au/national/victoria/coroner-agrees-to-consider-role-of-racism-in-tanya-day-s-custody-death-20190627-p521vm.html>.
[x] Australian Government Department of Prime Minister and Cabinet (2019). *Closing the gap: Prime Minister's Report 2019*. Commonwealth of Australia. Available at: http://ctgreport.pmc.gov.au [Accessed 11 June 2019].
[xi] Australian Bureau of Statistics (ABS) Causes of Death, Australia, 2017. Cat no. 3303.0. [Accessed 14 June 2019]. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Leading%20causes%20of%20death%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20people~9.
[xii] Ibid.
[xiii] Ibid.
[xiv] University of Melbourne (2019), *The Alcohol Management Plan at Pormpuraaw, Queensland, Australia - An Ethnographic Community-Based Study*, [online] http://fare.org.au/wp-content/uploads/The-Alcohol-Management-Plan-at-Pormpuraaw.pdf, [Accessed 28 June 2019].
[xv] Ibid.
[xvi] Ibid.
[xvii] Gannoni, Alexandra; Bricknell, Samantha, *Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody*, 21 February 2019, www.aic.gov.au, https://aic.gov.au/publications/sb/sb17, [Accessed 22 June 2019].
[xviii] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2)*, [online], Queensland Government. Available at https://www.health.qld.gov.au/__data/assets/pdf_file/0023/151736/sorry_business.pdf, [Accessed 16 June 2019].