Submission No 34

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: New South Wales Aboriginal Land Council

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New South Wales Aboriginal Land Council submission to NSW Legislative Council Select Committee on the coronial jurisdiction in New South Wales 2021.

Please find the attached submission from the New South Wales Aboriginal Land Council (**NSWALC**) in response to the NSW Legislative Council Select Committee on the coronial jurisdiction in New South Wales.

NSWALC provides this submission in our capacity as the peak body representing Aboriginal peoples in NSW and as the largest Aboriginal member-based organisation in Australia.

NSWALC requests that our submission is published as soon as it is received by to NSW Legislative Council Select Committee on the Committee website established for submissions on the coronial jurisdiction.

If you have further questions regarding the content of this submission, please contact the Strategy and Policy Unit on .

Sincerely,

Yuseph Deen
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Date: 13 July 2021

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New South Wales
Aboriginal Land Council

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

June 2021

RECOMMENDATIONS:

Recommendation 1: For all reforms and discussion to centre the perspectives of Aboriginal communities and families impacted by deaths in custody.

Recommendation 2: For support roles filled by Aboriginal peoples to be utilised as a means of supporting families through the coronial process.

Recommendation 3: For families of victims of coronial inquests to be provided with social and financial support during the process.

Recommendation 4: For coroners to be empowered to provide commentary on the extent to which the government has implemented their recommendations.

Recommendation 5: For the NSW Government to make a written response to coroner's reports within three months of receiving them.

Recommendation 6: For the NSW Coroners Court to be better resourced to ensure thorough and timely inquests are undertaken.

Recommendation 7: For Coroners to be enabled to comment on the prior health and wellbeing of people in custody preceding their death.

Introduction

Thank you for the opportunity to provide a submission to the Select Committee on the coronial jurisdiction in New South Wales.

The New South Wales Aboriginal Land Council (**NSWALC**) provides these comments in our capacity as the peak body representing Aboriginal peoples in NSW and as the largest Aboriginal member-based organisation in Australia, with a network of 120 autonomous Local Aboriginal Land Councils (**LALCs**) across the state and over 23,000 members. NSWALC is a self-funded statutory corporation under the *Aboriginal Land Rights Act 1983* (NSW) (**ALRA**), with legislated objectives to improve, protect and foster the best interests of all Aboriginal peoples in NSW.

NSWALC is a member of the NSW Coalition of Aboriginal Peak Organisations (**CAPO**). CAPO is comprised of peak Aboriginal community-controlled organisations, including the NSW Child, Family and Community Peak Aboriginal Corporation, Link-Up NSW, Aboriginal Education Consultative Group NSW, Aboriginal Legal Service NSW/ACT, Aboriginal Health and Medical Research Council, the First Peoples Disability Network and BlaQ. CAPO is a member of the National Coalition of Aboriginal and Torres Strait Islander Peak organisations, working to design and deliver the new Closing the Gap Framework.

Aboriginal peoples and the role of the NSW Coroners Court

The Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) emphasised the need for increased support for, and input from, Aboriginal communities and families regarding this crisis of Aboriginal deaths in custody.

Too often, Aboriginal peoples are forced to interact with the NSW Coroner due to the high and disproportionate rate of Aboriginal peoples' deaths in custody. With 474 Aboriginal deaths occurring in custody since this commission, the efficacy of the coroner's court as the investigative body for deaths in custody must be analysed.

The current coronial system does not effectively act as a prevention mechanism for Aboriginal deaths in custody. NSWALC supports the view of the Aboriginal Health and Medical Research Council (**AH&MRC**) that the effectiveness of the Coroners Court is impeded by the current scope of the coroner's court that inhibits the capacity for coroners to comment on the quality of care and safety of people before death, the lack of appropriate resourcing causing delays, and inadequate accountability measures for government agencies to implement recommendations.

The effectiveness of care within the coronial investigation process must also be addressed, as Aboriginal families are forced to navigate the system during times of great sadness and trauma.. It is essential that this process is able to compassionately and effectively serve its purpose of investigating the circumstances surrounding death while supporting those impacted by the event.

Ensuring that the voices of Aboriginal people with lived experience of the criminal legal system, and families who have had loved ones die in custody, are centred in all policy responses and law reform initiatives is essential. It is critical that communities and families' voices are centred in all discussion and potential reforms that aim to end Aboriginal deaths in custody.

Aboriginal communities, their organisations and representative bodies must be directly involved in decision-making about matters that affect Aboriginal peoples. NSWALC supports recommendations made by the Aboriginal Legal Service NSW/ACT (**ALS**) in their 2020 'submission to the Inquiry into high rates of First Nations people in custody and oversight and review of deaths in custody'.

The duration and thoroughness of the coronial process

The reported under-resourcing of the coronial system has led to long delays and a growing backlog of mandatory inquests. As a system that currently lacks culturally appropriate means for dealing with bereaved Aboriginal families, the length and complexity of this process is extending the trauma of impacted communities.

Under resourcing, delays and timeliness issues not only impact grieving families, but compromise the quality of the investigative process. Limitations on resourcing have been noted to impact the quality

of evidence and note-taking over time, potentially inhibiting the quality of coronial investigations. This is particularly crucial in the case of aboriginal deaths in custody, which can commonly take years to resolve. NSWALC emphasizes the necessity of increased resources in creating a more efficient and less traumatic coronial process for Aboriginal families, particularly those impacted by deaths in custody.

Perspectives of Aboriginal families central to the coronial process

It is essential that Aboriginal families are supported and guided throughout the coronial process in order to improve their experience. Wraparound support of impacted families should include social, emotional, and financial support initiatives for Aboriginal peoples who are dealing with the trauma of their loss, while navigating the complex coronial system.

In order for the court to respond to the needs of Aboriginal families and communities, it is essential that the court employs Aboriginal people in support roles. This is particularly important when dealing with Aboriginal deaths in custody.

NSWALC supports the recommendations of the ALS, in which Aboriginal specific roles are recommended. These include the appointment of:

- Aboriginal Officers, as a first point of contact with Aboriginal families and liaison throughout the investigation process;
- Aboriginal Coroners and Counsel Assisting, when conducting investigations and inquests into the death of Aboriginal people; and
- The appointment of Aboriginal Elders to sit with and assist the Coroner similar to the function that Elders currently play in Koori Court proceedings.

These roles would best support the needs of Aboriginal communities in coronial processes.

NSWALC also recommends the implementation of improved procedures to notify and involve affected communities throughout the process, which is known for being complex and lengthy. Granting the ability for the coroner to, at their discretion, hold a 'Recognition Mention' for impacted Aboriginal families and communities to achieve a manner of closure in the case that no investigation is required.

Additionally, the discretionary issuing of a 'practice notice', would support Aboriginal communities by clarifying aspects of the coronial procedure and processes, ensuring they are provided with the necessary information to properly understand the requirements and process of the system.

It is also recommended that the coroner consult with Aboriginal families and organisations in relation to the adequacy of government responses to recommendations. Aboriginal community-controlled organisations are the preferred providers of culturally safe services and supports that understand and are, therefore, responsive to the needs and requirements of Aboriginal peoples. The capacity for Aboriginal perspectives to critique and influence the coronial recommendations process in necessary in ensuring that it is successful in its goals.

Increased scope of the NSW Coroners Court to investigate and comment on systemic issues

Current legislative frameworks do not allow for the Coroners Court to adequately investigate and comment on prisoner health and wellbeing prior to their deaths, leading to incomplete formalised conclusions being made in relation to deaths in custody.

The limited scope of the NSW Coroners Court to adequately investigate systemic issues surrounding Aboriginal deaths in custody prevents the acknowledgement of low health care, mental health issues, institutionalised racism, and neglect that Aboriginal peoples experience within the criminal justice system.

The AH&MRC's 'Access to health services in custody' submission indicated that Aboriginal people are systemically failed whilst transitioning in and out of the custodial setting. Aboriginal peoples that enter the criminal justice system with complex health, must have those needs addressed. The AH&MRC has received reports that custodial officers are withholding medications and clinical management of health conditions, with reporting by the Guardian indicating that Indigenous prisoners are three times less likely to receive medical care in a custodial setting than others[1].

With most Aboriginal deaths in custody occurring due to inadequate medical care, lack of attention and self-harm[2], the ability for a coroner to comment on systemic neglect and racism precluding a death in custody is essential to stopping Aboriginal deaths in custody.

NSWALC supports the recommendations of the AH&MRC and The Legislative Council's report on the High Level of First Nations people in custody and oversight and review of deaths in custody, that coroners must have the capacity to examine the situational and systemic drivers that lead to Aboriginal deaths in custody.

Improving oversight and accountability to prevent deaths in custody

Currently there is a need for improved accountability, transparency and fairness within the coronial process. Procedures must be implemented to notify and better involve Aboriginal communities impacted by the process. Consequently, NSWALC recommends it is made mandatory for the coroner to notify the ALS of recommendations relating to the death in custody of an Aboriginal person. Similarly, it should be mandatory for statutory bodies and agencies to provide copies of responses to recommendations to the ALS.

There is also limited enforceability of recommendations made by the Coroner's Court within the coronial process. NSWALC recommends that:

1. The Coroner must have expanded powers to follow-up recommendations;
2. A mandatory requirement is implemented for Government departments and private institutions to respond to, and report on the implementation of recommendations made by a coroner;
3. A process is developed with ALS and families of Aboriginal peoples who have had a loved one die in custody for families to give their views on the implementation of recommendations by coronial agencies;
4. The NSW Government, in conjunction with the National Coroners Information System, consider the establishment and resourcing of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners, as well as published responses from state and federal authorities, and individuals and communities who are affected by the recommendations.

[1] https://www.theguardian.com/australia-news/ng-interactive/2018/aug/28/deaths-inside-indigenous-australian-deaths-in-custody

[2] https://www.bbc.com/news/world-australia-56728328

Amendments to the Coroners Act

NSWALC supports the recommendations made by the ALS regarding changes to the Coroners Act, specifically:

1. to explicitly broaden the scope of the coroner to consider systemic issues of discrimination where those issues relate to the circumstances of the death (including explicitly considering the impact of RCIADIC);
2. to provide a right of appeal to families of the deceased where the coroner refuses to refer a matter to the Director of Public Prosecutions;
3. to broaden the definition of 'relative' to encompass Aboriginal kinship and familial units.

Thank you for the opportunity to provide this submission. We would be happy to provide further contributions. Please contact NSWALC on 02 9689 4444 or