Submission No 36

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Aboriginal Legal Service (NSW/ACT)

Date Received: 16 July 2021

ALS
Aboriginal Legal Service (NSW/ACT) Limited

50+ YEARS STRONG

16 July 2021

Mr Adam Searle MLC
Chair, Select Committee on the coronial jurisdiction in New South Wales
Parliament House, Macquarie Street, Sydney NSW 2000
By email: coronial.jurisdiction@parliament.nsw.gov.au

Dear Chair,

I write to you on behalf of the Aboriginal Legal Service (NSW/ACT) Limited (ALS) and thank you for the opportunity to provide a submission to the NSW Parliamentary Select Committee on the coronial jurisdiction in New South Wales.

The ALS is a proud Aboriginal community-controlled organisation and the peak legal services provider to Aboriginal and Torres Strait Islander adults and children in NSW and the ACT. The ALS currently undertakes legal work in criminal law, children's care and protection law, and family law; as well as broader work in law reform and wrap-around programs for community wellbeing.

The ALS also provides representation to Aboriginal and Torres Strait Islander families within the Coroner's Court jurisdiction, predominantly families who have lost a loved one in custody or a police operation. There has been a substantial increase in demand for these services in the past three years. Consequently, we have identified many improvements that can be made to improve the practice and operation of the Coroner's Court in its interactions with Aboriginal and Torres Strait Islander people.

Given the high incidence of Aboriginal people experiencing deaths in custody despite representing around 3% of the Australian population, as well as the far-reaching impacts of these deaths upon Aboriginal communities, making the Coroner's Court accessible and appropriate for Aboriginal people should be treated as a matter of urgency.

The ALS would welcome the opportunity to discuss this submission further. Please contact Jennifer Wallace (Administration Officer) at to arrange a meeting.

Yours sincerely,

Nadine Miles
Principal Legal Officer
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ALS

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

16 July 2021

About the ALS

The Aboriginal Legal Service (NSW/ACT) Limited ('ALS') is a proud Aboriginal community-controlled organisation and the peak legal services provider to Aboriginal and Torres Strait Islander men, women and children in NSW and the ACT. We have 24 offices across NSW and the ACT, and we assist Aboriginal and Torres Strait Islander people through representation in court, advice and information, as well as providing broader support programs and undertaking policy and law reform work.

The ALS currently undertakes legal work in criminal law, children's care and protection law, and family law. We also provide representation to Aboriginal and Torres Strait Islander people within the Coroner's Court jurisdiction, predominantly families whose loved ones have died in custody or in a police operation. The ALS also provides advice and representation to senior next of kin where a child has died in the care of the state and persons of interest. There has been a substantial increase in the demand for services in this area of law in the past three years.

Introduction

This inquiry is focused on the coronial jurisdiction. The coronial jurisdiction operates within the colonial system. The Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody recently recognised that Aboriginal and Torres Strait Islander peoples remain significantly over-represented in the criminal justice system and in custody. As long as those numbers remain so high and health indicators for Aboriginal and Torres Strait Islander people remain substantially worse than the general population, we will continue to see deaths in custody.

Summary of recommendations

1. Systemic causes and factors behind incarceration and interactions with police should be within the scope of coronial investigations.
2. Funding to the Coroner's Court of NSW ought to be increased to reduce current delays between deaths and inquests.
3. Funding to the Aboriginal Legal Service (NSW/ACT) needs to be increased to ensure comprehensive legal representation and access to justice for Aboriginal and Torres Strait Islander people participating in coronial inquests.
4. Ministers and government departments should be required to provide a substantive response to coronial recommendations within 3 months.
5. The Coroner needs to have expanded powers to follow up on government and institutional responses to coronial recommendations and ensure compliance.
6. The NSW Government should consider amending the Coroners Act 2009 (NSW) to reflect all relevant RCIADIC recommendations. Meaningful implementation of the relevant RCIADIC recommendations would include the following measures:
    a) Copies of findings and recommendations made by the Coroner in relation to a death in custody ought to be provided to all parties who appeared at the inquest, to the Attorney- General, to the Minister with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.
    b) Within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner is urged to provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person, or reasons for a decision not to implement a recommendation.
    c) The Coroner needs to be empowered to call for such further explanations or information as they consider necessary, including reports as to further action taken in relation to the recommendations.
    d) Section 37(1) of the *Coroners Act 2009 (NSW)* should be amended so that the Coroner is to make a written report to the Minister containing not only a summary of the details of the deaths or suspected deaths, but also a summary of the recommendations made by Coroners and the responses to those recommendations provided by the relevant agency or department.
    e) The NSW Government amend the *Coroners Act 2009 (NSW).*
7. There should be a database to monitor implementation of coronial recommendations.
8. NSW to adopt a model similar to that of the Victorian Coroners Court's Koori Engagement Unit, which is staffed by Aboriginal and Torres Strait Islander officers. This would promote greater trust in the coronial process and provide more culturally appropriate communication.
9. The NSW Government should consider resourcing and funding the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.
10. The NSW Government is urged to consult with the ALS and the families of Aboriginal and Torres Strait Islander people who have had a loved one die in custody about adopting a process whereby the Coroner writes to, and meets with, the family of an Aboriginal and Torres Strait Islander person who has died in custody to seek their views on the adequacy of an agency's response to recommendations made to them.

11. The NSW Government should consider introducing legislation making it mandatory for a Coroner to notify the ALS of any recommendations relating to the death in custody of an Aboriginal and Torres Strait Islander person. Similarly, it should be mandatory for statutory bodies and agencies to provide copies of responses to recommendations to the ALS.
12. The NSW Government is urged to listen to families whose loved ones have died in police or prison custody and meaningfully and respectfully involve them in all relevant policy and legal reforms. It is critical that families' voices are centred in all reforms and changes that aim to end Aboriginal deaths in custody.
13. The Coroner should be provided with discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request.
14. The Coroner should consider issuing a practice note containing guidance on issues including the notification of families as to coronial process, communications with lawyers, provision of briefs of evidence and the approach to legal objections by police officers.
15. The NSW Government should expand the definition of a "death in custody" to include a death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention.
16. The Coroner's Court should be autonomous to the Local Court to allow the specialist expertise of coroners to retained and not lost to a rotating system of magistrates.

The practice, operation, scopes and limits of the Coroner's Court of NSW (ToR 1ai)

The functions of the Coroner in NSW are to investigate and prevent deaths. The current system in NSW requires the Coroner make findings and recommendations to prevent further deaths. For many reasons the coronial system is failing in the area of deaths in custody. There are mandatory inquests for deaths in custody and deaths in a police operation.

The Coroner makes findings as to the identity, place, time, manner and cause of death.[1] When considering deaths in custody, the Coroner is limited in what can be considered. The broader causes of incarceration and interactions with police are most often overlooked and considered 'outside the scope' of the inquest. This can be most distressing for the families of the deceased. It is also counterproductive. If one of the functions of the Court is to consider the prevention of further deaths, the reasons for incarceration and interactions with police should be inside the scope of the investigation.

Case study 1

In 2012, Paigh Bartholomew, a 21-year-old Aboriginal woman, died in custody at Emu Plains Correctional Centre. The findings, delivered in 2017, comment on the deceased's addiction to drugs that had developed in her young life and some reference to the little parental support she received as her father also died in custody. This inquest could have been an opportunity to consider the reasons for her incarceration at such a young age and the availability of services for her drug addiction. However, it was confined by the limits of the jurisdiction. The Coroner made recommendations solely in relation to the alarms and security of the prison.

In our experience, coronial inquests present an opportunity to consider systemic reasons for incarceration and police interaction, and to consider areas for reform. This was also a recommendation of the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody.[2]

Recommendation 1

Systemic causes and factors behind incarceration and interactions with police should be within the scope of coronial investigations.

[1] *Coroners Act 2009* (NSW) s3

[2] New South Wales. Parliament. Legislative Council. Select Committee on the high level of First Nations people in custody and oversight and review of deaths in custody Recommendation 33

The adequacy of coronial resources (ToR 1aii)

The current delay in proceedings indicates the Coroner's Court requires more resources to improve the process.[3] There is a significant backlog in the coronial system, and the current pace at which the system can conduct inquests is inadequate. Without extra resources, it would appear that this situation will remain unchanged. An Increase in funding is required for both for the Court and for indigent parties to ensure comprehensive legal representation and access to justice.

The ALS does not receive funding to represent families in coronial inquiries despite an ever-increasing demand for representation. In 2021 alone, to date, 9 Aboriginal and Torres Strait Islander people across Australia have died in custody or in a police operation. All those deaths will require mandatory inquests. In order for the Court to function, all parties involved need to be adequately resourced to appear.

Our lawyers report regularly having relevant material served either very close to the commencement of an inquest and/or throughout the inquest process. This practice of under-resourcing the system for all parties hampers the ability of the Coroner to make informed findings.

Recommendation 2

Funding to the Coroner's Court of NSW ought to be increased to reduce current delays between deaths and inquests.

Recommendation 3

Funding to the Aboriginal Legal Service (NSW/ACT) needs to be increased to ensure comprehensive legal representation and access to justice for Aboriginal and Torres Strait Islander people participating in coronial inquests.

The timeliness of coronial decisions (ToR 1aiii)

There are substantial delays in the coronial jurisdiction. The time between the date of death and the date of coronial findings varies between 2 years to 5 years. The ALS supports the recent draft protocol for case management of mandatory inquests involving deaths of Aboriginal and Torres Strait Islander people. This protocol set out timelines to increase communication and decrease delays.

Delays in the coronial process cause anxiety and severe distress to families. Waiting for an inquest often delays families' ability to process their grief and compounds their trauma.

[3] New South Wales. Parliament. Legislative Council. Select Committee on the high level of First Nations people in custody and oversight and review of deaths in custody, Recommendation 31

Case study 2

The Inquest into the death of Danny Whitton, a 25-year-old man who died at Junee Correctional Centre in 2015, was held this year in 2021 and is awaiting the delivery of findings. The delay of more than 5 years between Danny's passing and the coronial inquest has been deeply traumatic for his family. The reason for the delay is unknown to his mother.

Outcomes and oversight of coronial recommendations (ToR 1aiv)

The role of the Coroner as outlined in the *Coroners Act 2009* (NSW) is to examine unnatural, unexpected, sudden and suspicious deaths, suspected deaths (in the case of missing persons), as well as fires and explosions that cause serious injury or damage to property. In particular, the Coroner has jurisdiction to hold an inquest where a person has died while in police custody or other lawful custody, while escaping or attempting to escape from custody, as a result of police operations or while temporarily absent from a detention centre or correctional centre.[4]

The coronial system is intended to be inquisitorial in nature, with a focus on fact-finding and prevention of future deaths. Yet at present there exists an inherent failure of government in setting up a process to provide recommendations for reform. Government and public institutions routinely fail to act on coronial recommendations in the absence of any such process.

Recommendation 4

Ministers and government departments should be required to provide a substantive response to coronial recommendations within 3 months.

Under s 81 of the *Coroners Act 2009* (NSW), a coroner holding an inquest concerning the death or suspected death of a person must record their findings as to the manner and cause of the person's death. Under s 82, the Coroner may make such recommendations as they consider necessary or desirable in relation to any matter connected with the death, including matters of public health and safety. However, s 82 currently does not impose any obligation on a government entity or public statutory authority to respond to the recommendations made by the Coroner. This is a crucial area where reform is needed in NSW.

In Victoria, the *Coroners Act 2008* (Vic) provides that a public statutory authority must provide a written response to recommendations made by the Coroner, not later than 3 months after the date of receipt of the recommendations.[5] This response must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the Coroner.[6]

[4] *Coroners Act 2009* (NSW) s 23.

[5] *Coroners Act 2008* (Vic) s 72(3).

[6] *Coroners Act 2008* (Vic) s 72(4).

The legislation in Victoria reflects the fact that coronial recommendations "may be a wasteful exercise if the recommendations can be ignored by those to whom they are directed."[7] Indeed, as the Victorian Law Reform Committee noted in its review of the *Coroners Act 1985* (Vic):[8]

> *"A key issue for the effectiveness of the coronial system in preventing deaths and injuries is the extent of the obligations government departments and other organisations have to take notice of and implement a coroner's recommendations. The Committee has discussed above the potential of such recommendations to save lives and prevent injuries in the community. However, as the New Zealand Law Commission has observed in relation to coronial recommendations in that jurisdiction: the problem that has arisen is that there is no process for ensuring recommendations are brought to the attention of relevant agencies or individuals. Further, where recommendations are brought to the attention of the appropriate agency, there is no requirement that the agency must consider the recommendations or act on them. The ability of recommendations to achieve their purpose is therefore limited."*

The RCIADIC made the recommendation that:[9]

> *"Within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person" (Recommendation 15).*

This has not been fully implemented in NSW, and the legislation should be amended in order to do so.

In NSW, the Premier's Memorandum (M2009-12) states that a Minister or NSW government agency should provide a written response to a coronial recommendation which outlines any action being taken to implement the recommendation, or provides reasons why it is not proposed to implement a recommendation.[10] Responses are meant to be provided to the Attorney-General and published on the Attorney-General's Department website.[11] Based on searches of the content of that website, it appears that responses are provided by agencies, such as NSW Police, though responses to recommendations regarding deaths in custody are not always substantive.[12]

The existence of the Premier's Memorandum reflects that there is already an existing consensus in NSW to adopt the substance of RCIADIC Rec. 15. However, the Memorandum has its own deficiencies in that it makes it discretionary for a Minister to respond to a coronial recommendation and it does not have force of law, as the Memorandum sits outside the legislative framework of the *Coroners Act 2009* (NSW). Further, the Memorandum refers to a time period of 6 months to provide a response to a coronial recommendation rather than 3 months as per the Victorian legislation and RCIADIC Rec. 15. Accordingly, the Coroners Act should be amended to adopt RCIADIC Rec. 15.

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[7] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 4-26, 7.
[8] Parliament of Victoria, Law Reform Committee, Coroners Act 1985 – Final Report (September 2006), 386.
[9] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [15].
[10] NSW Government, Premier & Cabinet, M2009-12 Responding to Coronial Recommendations (April 6, 2009). See: https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.
[11] Ibid.
[12] See: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

Recommendation 5

The Coroner needs to have expanded powers to follow up on government and institutional responses to coronial recommendations and ensure compliance.

As noted above, a key issue with the existing coronial system is that responses to coronial recommendations are not necessarily monitored and may not lead to any substantive action.[13] Indeed, as stated by the Victorian Law Reform Committee in its review of the *Coroners Act (VIC) 1985*:[14]

> *"At present the main imperative for compliance with recommendations probably arises from the publicity given to coronial proceedings by the media and the resulting effect on public opinion. However, in many cases organisations have been able to disregard coroners' recommendations with impunity, even if another death occurs as a result of ignoring them. This problem was highlighted by the [RCIADIC], which referred to numerous instances where coronial recommendations were 'ignored or paid scant regard by the relevant authorities'."*

For this reason, Rec. 16 of the RCIADIC noted that the State Coroner should "be empowered to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations".[15] RCIADIC Rec.17 went on to note that the State Coroner should "be required to report annually…as to deaths in custody generally within the jurisdiction and, in particular, *as to findings and recommendations made by the Coroners…and as to the responses to such findings and recommendations"* (emphasis added).[16]

In our view, the implementation of these recommendations in NSW would significantly increase the accountability of government to adopt coronial recommendations. Further, the creation of a dialogue between government and the Coroner would increase public confidence that action is being taken to end future tragic and preventable deaths in custody arising in a similar manner or from similar causes.

In order to ensure that relevant bodies, government departments and Ministers are held accountable to their responses, additional review processes should also be put in place. While a statutory body or agency may undertake a review itself, monitoring should be independent to ensure accountability and transparency. Independent monitoring may be undertaken through:

- A central body tasked with the purpose of overseeing implementation of coronial recommendations;
- A public register of coronial recommendations (outlined below); or

[13] See Ray Watterson, Penny Brown and John McKenzie, 'Coronial recommendations and the prevention of indigenous death' (2008) 12(2) *Australian Indigenous Law Review* 20; Raymond Brazil, 'The coroner's recommendation: fulfilling its potential? A perspective from the Aboriginal Legal Service (NSW/ACT)' (2011) 15(1) *Australian Indigenous Law Review* 94; Mandy Shircore 'Lessons learned; accountability and closure: Is the coronial process providing what is needed to indigenous communities?' (2010) 7 *Journal of the Australasian Law Teachers Association* 55.

[14] Parliament of Victoria, Law Reform Committee, *Inquiry into the Review of the Coroner's Act 1985, Final Report,* 386.

[15] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [16].

[16] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [17].

- The Coroner who made the recommendation, given their familiarity with the facts of the investigation (the approach suggested by RCIADIC).

The benefits of an effective implementation and monitoring scheme can be seen in the context of work by the Inspector of Custodial Services (ICS) in this regard. In its Annual Report of 2018- 19, ICS noted that:

> "*In the 2015-16 reporting period, it was clear that there was a need to establish a monitoring program to oversee the implementation of recommendations that result from inspections and review. Regular reporting on the implementation of recommendations encourages their timely implementation which can help to achieve system improvements.*
>
> *During 2016-17, the Inspector of Custodial Services implemented a desktop monitoring and reporting framework to monitor the progress made by each agency in relation to recommendations which were supported or partially supported.*
>
> *The reporting program is now supported by six-monthly desktop monitoring, with implementation data provided by CSNSW, JJNSW and JH&FMHN. This desktop monitoring data is verified through on-site visits."*[17]

This model has been effective, with data indicating that the recommendation achievement progress of Corrective Services NSW increased from 49.3% in June 2017 to 55% in June 2018 and 64.7% in June 2019.[18]

Recommendation 6

The NSW Government should consider amending the *Coroners Act 2009 (NSW)* to reflect all relevant RCIADIC recommendations.

Meaningful implementation of the relevant RCIADIC recommendations would include the following measures:

- Copies of findings and recommendations made by the Coroner in relation to a death in custody ought to be provided to all parties who appeared at the inquest, to the Attorney- General, to the Minister with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.
- Within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner is urged to provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person, or reasons for a decision not to implement a recommendation.

[17] Inspector of Custodial Services, *Annual Report 2018-2019* (October 2019) 20.
[18] Inspector of Custodial Services, *Annual Report 2018-2019* (October 2019) 22.

- The Coroner needs to be empowered to call for such further explanations or information as they consider necessary, including reports as to further action taken in relation to the recommendations.
- Section 37(1) of the *Coroners Act 2009 (NSW)* should be amended so that the Coroner is to make a written report to the Minister containing not only a summary of the details of the deaths or suspected deaths, but also a summary of the recommendations made by Coroners and the responses to those recommendations provided by the relevant agency or department.
- The NSW Government amend the *Coroners Act 2009 (NSW).*

Recommendation 7

There should be a database to monitor implementation of coronial recommendations.

Justice Action – a grassroots organisation which represents people locked in Australian prisons – has recently published a proposal calling for the establishment of a National Database into Deaths in Custody.[19] The proposal suggests the development of a centralised information hub containing coronial findings on deaths in custody and recommendations from all Australian jurisdictions, as well as published responses from state and federal authorities, individuals and communities who are affected by the recommendations.

The Justice Action proposal acknowledges that the National Coronial Information System (NCIS) and the Australian Institute of Criminology (AIC) already examine data on deaths in custody. However, it notes in relation to data collection:[20]

> *"[The data] is not updated regularly and has restricted access. The compartmentalisation of information leads to each Coroner existing within their own silo. This is contrary to the Coroners' purpose of preventing further death.*
>
> *In response to this issue, a new database system is proposed to include coronial findings on deaths in custody and recommendations from all Australian jurisdictions, distributed nationwide as well as published responses from state and federal authorities who are affected by the recommendations.*
>
> *The database should utilise a clearinghouse model to create one central agency for information collection, classification, and distribution. The data would be collated and automatically distributed to all relevant government authorities, while also allowing for*

[19] Justice Action, *National deaths in custody database proposal* <http://www.justiceaction.org.au/images/stories/CmpgnPDFs/NtnlDICDbsPfpsl.pdf>
[20] Justice Action, *National deaths in custody database proposal* <http://www.justiceaction.org.au/images/stories/CmpgnPDFs/NtnlDICDbsPfpsl.pdf> 3–4.

public access. It is crucial for it to be regularly updated, and require government responses to inquests, which will be searchable by catchword and report content.

It is proposed that the implementation of such a national database and follow up functions be facilitated by the NCIS and/or the AIC. The implementation of the proposed database would promote accountability among government authorities to address recurring issues that endanger the lives of incarcerated individuals. It is clear that by inducing collective learning, accessible solutions can be developed to prevent needless deaths across Australia."[21]

The ALS notes that there is merit in having a central body where responses to recommendations, along with other data, might be collated.[22]

The ability of the Coroner's Court to respond to the needs of Aboriginal and Torres Strait Islander families and communities (ToR 1av)

The ALS listens to and represents Aboriginal and Torres Strait Islander people, families and communities. We have seen significant improvement in the last two years in the way the Court has responded to the needs of Aboriginal and Torres Strait Islander people.

Understanding kinship

Indigenous kinships structures are complex systems of relationality which fundamentally differ from Western genealogical systems. Indigenous kinship systems encompass a multitude of complex relationships between a person, land, and the other human and non-human animals that inhabit a place. Although Indigenous Australian kinship systems have been disrupted through dispossession, forced child removals and genocide, Indigenous kinship systems remain resilient and persist to this day.

These complex systems of kinship interact with colonial legal systems in ways that frustrate the goals of those systems. In the coronial space, we have seen failures of communication come about due to the juxtaposition of the definition of "senior next of kin" and kinship. Too often, the Coroner's Court will claim they have contacted the family and heard nothing back whilst at the same time family members are desperately trying to receive information. For many and complex reasons, the

[21] This is different to the work being done by Professor Tamara Walsh (University of Queensland), who has created a publicly available database searchable by range of search fields, including Aboriginal or Torres Strait Islander status, cause of death, type of custody, specifics of death and personal characteristics. The database does not record to which specific agencies, entities or Ministers coronial recommendations are addressed, nor does it record whether responses are received and provide links to those responses. See the Deaths in Custody Project: <https://deaths-in-custody.project.uq.edu.au/record>.

[22] Some academics have also argued for uniform national legislation which would provide a mandatory reporting and review scheme for all coronial recommendations in order to improve public accountability. In a study which looked at 185 coronial matters and 484 recommendations across all jurisdictions (except Queensland), implementation rates of recommendations were found to be as follows: 27% in Victoria; 41% in Tasmania; 48% in New South Wales; 50% in Western Australia; 52% in South Australia; 65% in the Northern Territory; and 70% in the Australian Capital Territory. See Ray Watterson, Penny Brown and John McKenzie, 'Coronial recommendations and the prevention of indigenous death' (2008) 12(2) *Australian Indigenous Law Review* 20.

spokesperson on behalf of an Aboriginal family is unlikely to be the person listed at the senior next of kin as per the definition in the Act.

Appreciating the effects of colonialism including intergenerational trauma and a deep distrust of police and courts and other government agencies

Aboriginal and Torres Strait Islander people have an understandable mistrust of police and authority after 250 years of dispossession, child removal and incarceration. The intergenerational trauma experienced by First Nations people is well documented. The Coroner's Court should be a court of therapeutic jurisprudence. Instead, families are too often traumatised by the experience of participating in a coronial inquest. The experience of our clients has predominantly been one of animosity and distress.

At the very outset, Aboriginal people are asked to trust police to properly investigate the death of their loved one. Too often, these investigations are treated arbitrarily. We have witnessed and read some woefully insincere sentiments from officers in charge (OICs) but also encountered some extremely sensitive and understanding OICs.

The investigation process is long, and it is always difficult to understand and explain that delay. The lack of communication only leads to further scepticism.

The inquest itself is very distressing. Of course, given the nature of the matter, there will be a level of distress. However, the ALS has experienced applications made by legal practitioners solely based on the Aboriginality of our clients, evidence given by witnesses that expresses racist undertones and devalues the life of the deceased, and we have continuously been told to ask our clients to refrain from making audible noise in the courtroom.

One of the more distressing parts of the inquest process is to watch government departments attempt to apportion blame on each other and the deceased. It is very distressing when an inquisitorial system reverts to an adversarial one.

For many families, a fundamental aspect of the coronial process is to ensure that similar incidents do not happen again, which would cause avoidable harm to other families. This requires a cooperative approach across government departments, to ensure recommendations are fully implemented in a timely way to remedy systemic failures. As previously noted by Magistrate Harriet Grahame, Deputy State Coroner:

> *"Given the interwoven responsibilities for the provision of health services to prisoners, especially in a privately run correctional facility, consideration of implementing the recommendations will require ongoing cooperation between all of the agencies involved. A co-operative approach is required and for that reason, these recommendations will be addressed jointly to those with the capacity to drive change. Where there is a will to implement, the mechanics of service delivery will fall into place. Rather than quibble about exactly who has final responsibility for implementation, a more co-operative approach is called for. The over-arching policy framework must include commitment to equal health service whether an inmate finds him or herself in a custodial setting run by a private operator or a Government entity. Turf wars become irrelevant where there is a genuine motivation to improve current practise."*[23]

[23] NSW Coroners Court (2017). Inquest into the death of Keith Howlett (File No. 2013/162787). <https://coroners.nsw.gov.au/documents/findings/2017/Howlett%20findings.pdf>

Recommendation 8

NSW to adopt a model similar to that of the Victorian Coroners Court's Koori Engagement Unit, which is staffed by Aboriginal and Torres Strait Islander officers. This would promote greater trust in the coronial process and provide more culturally appropriate communication.

Consideration of the recommendations of the Royal Commission into Aboriginal Deaths in Custody

The Royal Commission made 339 recommendations in relation to Aboriginal deaths in custody. Those recommendations must be considered as to their relevance to the Coroner's Court function of investigating deaths in custody and their prevention.

The scope of inquests should be widened to address the deaths in custody of Aboriginal and Torres Strait Islander people in the context of colonialism, racism and dispossession. It is our experience that families often raise issues about the reasons behind their loved one's incarceration that do not fall within the scope of the inquest.

Case study 3

A family whose loved one died whilst on remand raised the lack of employment opportunities in regional and remote NSW and the healthcare deficit in regional Aboriginal medical centres. The reasoning was the deceased would not have ended up dying in custody but for having opportunities for employment and quality healthcare throughout his life growing up in regional NSW.

The ALS fully supports the Draft Protocol which implements processes to ensure clear communication and appropriate timelines. This goes some way to giving consideration of the issues raised above.

The perspectives of Aboriginal and Torres Strait Islander families must be central to the coronial process

The ALS is currently constrained in its ability to provide wraparound support to vulnerable people taken into custody and to families whose loved ones have died in custody. The government does not fund the ALS to provide holistic support for Aboriginal and Torres Strait Islander people taken into custody nor at the coronial inquest stage after a family member has been taken from them.

In our view, this type of wraparound service is essential to ensuring that families are appropriately supported through the coronial process. The current coronial system can often re-traumatise families because of the formality and complexity of the process. In particular, the severe delays that can arise between the time of death and the release of the Coroner's findings can lead to a great deal of uncertainty and grief for families. This is often combined with a lack of understanding about what to expect from coronial proceedings, as well as a high level of formality in the manner and style of communications from the court. There is also a lack of clarity about the role of the police, who

often act as preliminary investigators and can be seen in discussion with Counsel Assisting and the Coroner. In addition, families often feel that barriers exist for their voice to be heard in coronial proceedings. The importance to families of telling their story cannot be understated.

There are also significant social, emotional and financial costs to families being able to meaningfully engage and participate in the coronial process. For instance, families might need to travel a long distance to attend coronial hearings and take time off from work to participate in the process. All whilst also working through the grief and trauma associated with the death of a loved one. As a result, it is critical that families are provided with adequate wraparound support to alleviate these concerns for families.

Further issues often arise upon the release of the Coroner's findings following an inquest. For many families, a fundamental aspect of the process is to ensure that similar incidents do not happen again, which would cause avoidable harm to other families. 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. Indeed, the flow-on impact of a family's negative experience during the coronial process is that broader communities may feel that justice has not been delivered and that similar incidents are at risk of occurring again. The result is that families feel further disempowered and disenfranchised with the justice system.

In light of the numerous barriers faced by families during the coronial process, it is important that families are provided with wraparound support throughout the process. In our view, the ALS is best placed to provide support to families, namely culturally appropriate services designed and delivered by Aboriginal people for Aboriginal people, so that solutions are in community-controlled hands. By providing Aboriginal people with access to a mobile support team that can provide holistic civil law services, advocacy, community capacity-building and support, as well as the expertise of a social worker or grief counsellor, this would create improved restorative justice outcomes for individuals and families and improve trust in the coronial process.

Recommendation 9

The NSW Government should consider resourcing and funding the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.

Another avenue for reform is to place a formal obligation on the Coroner to consult with Aboriginal and Torres Strait Islander families and/or Aboriginal and Torres Strait Islander community-controlled organisations when a response to findings and recommendations is received.

This type of informal conferencing is frequently used in Ontario, Canada, as an alternative to formal inquests. The Ontario coronial system is often referred to in reports, such as the Parliament of Victoria's Law Reform Committee's report on the Coroners Act, because of its success in achieving implementation of recommendations.[24] The Law Reform Committee report acknowledged that informal conferencing will not always be appropriate, and it is difficult to see how it would be effective or desirable as a replacement for an inquest in the context of deaths in custody.[25] There

[24] Parliament of Victoria Law Reform Committee, *Review of the Coroners Act 1989 (Vic).*
[25] Ibid.

may, however, be scope for this kind of model to be used when the Coroner is considering the adequacy of responses to recommendations. For example, the Coroner responsible for assessing the response could write to, meet with, or receive submissions from, the family of an Aboriginal or Torres Strait Islander person to seek their views on the adequacy of an agency or Minister's response.

Recommendation 10

The NSW Government is urged to consult with the ALS and the families of Aboriginal and Torres Strait Islander people who have had a loved one die in custody about adopting a process whereby the Coroner writes to, and meets with, the family of an Aboriginal and Torres Strait Islander person who has died in custody to seek their views on the adequacy of an agency's response to recommendations made to them.

Recommendation 11

The NSW Government should consider introducing legislation making it mandatory for a Coroner to notify the ALS of any recommendations relating to the death in custody of an Aboriginal and Torres Strait Islander person. Similarly, it should be mandatory for statutory bodies and agencies to provide copies of responses to recommendations to the ALS.

Desirable and necessary changes to the coronial jurisdiction in New South Wales, with regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions (ToR 1b)

The ALS recommends changes to the law, practice, and operation to appropriately reflect the function of the Coroner's Court as it stands today. The role of the Court is to find the cause of death but also to seek to prevent further deaths. The NSW Government has made pledges to "close the gap" on appalling statistics in relation to health and justice targets. The Coroner's Court provides a unique opportunity to look at the issues within our community that are causing Aboriginal and Torres Strait Islander people to pass away in custody and in the community. The legislation should be amended to broaden the scope of inquests to allow the Coroner to consider other issues beyond direct causation.

Recommendation 12

The NSW Government is urged to listen to families whose loved ones have died in police or prison custody and meaningfully and respectfully involve them in all relevant policy and legal reforms. It is critical that families' voices are centred in all reforms and changes that aim to end Aboriginal deaths in custody.

The ALS also recommends the practice and operation of the Court be changed to be more therapeutic. There are multiple therapeutic or restorative models the Court could look to, including those models that involve less formal, less complex, and more flexible approaches. A less formal approach would allow room for cultural ceremonies to be incorporated into an inquest. A flexible approach would also have the benefit of reducing delay.

Therapeutic approaches to coronial proceedings

Under s 46 of the *Coroners Act 2009* (NSW), "coronial proceedings" can involve an investigation to determine whether or not to hold an inquest or inquiry. This preliminary investigatory process can be very lengthy and involve a detailed examination of statements from relevant witnesses and material evidence. Ultimately, a coroner may determine that an inquest is not required following this investigation,[26] which means that any further hearing may not occur.

In these circumstances, the family of the deceased is informed by written correspondence of the outcome of the investigation and the manner and cause of death. As a result, the family of the deceased person loses the opportunity to appear in person in coronial proceedings and make a statement of their feelings about the deceased and their death.[27] This mandated step in coronial inquests is fundamental in order to provide a measure of closure to families of the deceased person.

The ALS proposes that the Coroner should have the discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request. This would enable families to achieve some level of closure after a long investigatory process that mirrors a coronial inquest.

Recommendation 13

The Coroner should be provided with discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request.

Under s 52 of the *Coroners Act 2009* (NSW), the Coroner may issue practice notes for, or with respect to, the practice and procedure to be followed in coronial proceedings. The ALS submits that the Coroner should consider issuing a practice note which contains guidance on certain issues, including:

- A general protocol for coroners to notify the family of the deceased person as to the upcoming process for the coronial inquiry and/or inquest, the contact details for the ALS and/or Legal Aid NSW; and information about the time required for the process.
- A protocol providing for notices of appearance or other formal process to ensure that the lawyer on the record receives correspondence from the Coroner's Court.

[26] *Coroners Act 2009* (NSW) s 25.
[27] *Coroners Act 2009* (NSW) s 57.

- Guidance on the process and protocols for the provision of briefs of evidence (including, e.g. that standard practice is for photos of the deceased's body and of the autopsy to be removed from the copy of the brief that is served).
- Guidance on the approach to legal objections made by police officers in the Coroner's Court, which otherwise feeds into the mistrust of Aboriginal families as to the involvement of the police in the coronial process.

In our view, providing a practice note on these areas would be a critical step in improving our clients' experience of the coronial system.

Recommendation 14

The Coroner should consider issuing a practice note containing guidance on issues including the notification of families as to coronial process, communications with lawyers, provision of briefs of evidence and the approach to legal objections by police officers.

The definition of a 'death in custody'

Under s 23 of the *Coroners Act 2009* (NSW), the definition of a "death in custody" in NSW includes a death while in the custody of a police officer or in other lawful custody or escaping or attempting to escape from that custody. The definition also extends to include a death as a result of, or in the course of, police operations, but does not include the actions of prison officers.

Crucially, however, this definition does not extend to include deaths caused or contributed to by traumatic injuries sustained whilst in custody or detention, or caused by a lack of proper care whilst in detention, if the death occurred after the person was released from 'custody'. This was specifically recommended by the RCIADIC in Rec. 6, which stated that the definition of death should include "*at least* the following categories: ... The death *wherever occurring* of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention" (emphasis added).

This amendment is particularly relevant given that the risk of death is especially high for people in the first month after release from custody, and this frequently can be attributed to a lack of proper care while in custody or during the process of release from custody. The Australian Institute of Health and Welfare found that "[t]he risk of death is especially high in the first month after release, and the causes of death in this time are usually preventable, and include suicide, injury, and overdose".[28] Further, many people are released unexpectedly from prisons, particularly those on remand.

The Report of the Special Commission of Inquiry into the Drug 'Ice' ('The Ice Inquiry') noted evidence from Justice Health that "approximately 20% of people on opiate substitution therapy in custody are released unexpectedly. This makes it difficult to ensure continuity of care, including the provision of OST [opiate substitution therapy] by community providers".[29] Further, the Drug 'Ice' Report stated that "[u]nexpected release from custody has two significant impacts. First, people are often released *without medication* to meet their immediate and short-term needs and with *no transitional*

[28] Australian Institute of Health and Welfare, *The health of Australia's prisoners* (2018) 158.
[29] Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, Report – Volume 3, January 2020, 922 [20.448].

healthcare arrangements in place. Second, people are released without identification, which can affect their ability to access other services in the community" (emphasis added).[30]

The findings of the Ice Inquiry reflect the importance that deaths following release from custody are investigated through rigorous and independent coronial processes where the evidence suggests that the death was caused or contributed to by traumatic injuries sustained or by a lack of proper care whilst in custody.

Recommendation 15

The NSW Government should expand the definition of a "death in custody" to include a death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention.

The coronial jurisdiction's arrangement as a standalone court (ToR 1c)

The Local Court serves a very different function to the Coroner's Court. For that reason, the Coroner's Court may be better served to be an autonomous division of the Local Court. However, within regional NSW, the Local Court Magistrates also act as coroners. In that context, it may be difficult to separate the jurisdiction unless there were more coroners appointed who could oversee the coronial inquiries in regional NSW. In the same way the Children's Court of NSW operates autonomously, so too could the Coroner's Court.

Recommendation 16

The Coroner's Court should be autonomous to the Local Court to allow the specialist expertise of coroners to retained and not lost to a rotating system of magistrates.

[30] Ibid 920 [20.438]. The additional consequence of a lack of appropriate health care for persons on remand is that upon release, recidivism rates are high because underlying issues were not addressed or treated, particularly for those persons with drug or alcohol addiction.

Appendix A

Terms of Reference - Inquiry into the coronial jurisdiction in New South Wales

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

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

(i) the scope and limits of its jurisdiction,

(ii) the adequacy of its resources,

(iii) the timeliness of its decisions,

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

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

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

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

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

(d) any other related matter.

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