Submission No 46

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Legal Aid Commission of New South Wales

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Inquiry into the coronial jurisdiction in New South Wales

Legal Aid NSW submission to the Legislative Council Select Committee on the Coronial Jurisdiction in New South Wales

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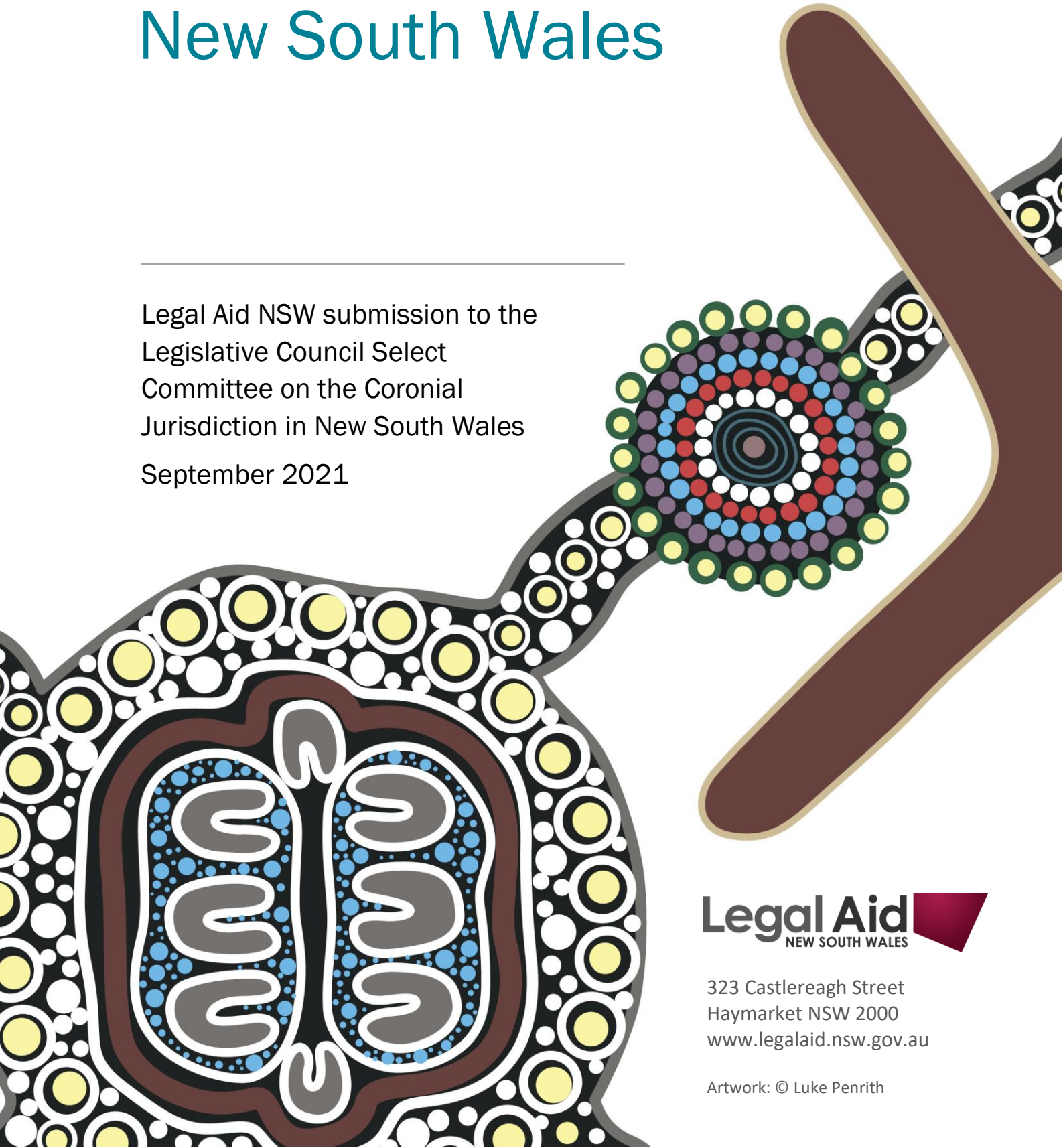

Legal Aid NEW SOUTH WALES

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Acknowledgement

We acknowledge the traditional owners of the land we live and work on within New South Wales. We recognise continuing connection to land, water and community.

We pay our respects to Elders both past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

Legal Aid NSW is committed to working in partnership with community and providing culturally competent services to Aboriginal and Torres Strait Islander people.

1. About Legal Aid NSW

The Legal Aid Commission of New South Wales (**Legal Aid NSW**) is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW). We provide legal services across New South Wales through a state-wide network of 25 offices and 243 regular outreach locations, with a particular focus on the needs of people who are socially and economically disadvantaged. We offer telephone advice through our free legal helpline LawAccess NSW.

We assist with legal problems through a comprehensive suite of services across criminal, family and civil law. Our services range from legal information, education, advice, minor assistance, dispute resolution and duty services, through to an extensive litigation practice. We work in partnership with private lawyers who receive funding from Legal Aid NSW to represent legally aided clients.

We also work in close partnership with community legal centres, the Aboriginal Legal Service (NSW/ACT) Limited and pro bono legal services. Our community partnerships include 27 Women's Domestic Violence Court Advocacy Services, and health services with a range of Health Justice Partnerships.

The Civil Law Division focuses on legal problems that impact on the everyday lives of disadvantaged clients and communities in areas such as housing, social security, financial hardship, consumer protection, employment, immigration, mental health, discrimination and fines. The Civil Law practice includes dedicated services for Aboriginal communities, children, refugees, prisoners and older people experiencing elder abuse.

The Legal Aid NSW Family Law Division provides services in Commonwealth family law and state child protection law. Specialist services focus on the provision of Family Dispute Resolution Services, family violence services and the early triaging of clients with legal problems through the Family Law Early Intervention Unit.

The Criminal Law Division assists people charged with criminal offences appearing before the Local Court, Children's Court, District Court, Supreme Court, Court of Criminal Appeal and the High Court. The Criminal Law Division also provides advice and representation in specialist jurisdictions including the State Parole Authority and Drug Court.

Legal Aid NSW's Coronial Inquest Unit is a state-wide specialist service that provides free legal advice and assistance in coronial matters and represents people at coronial inquests where legal aid has been granted.

It was established in 2006 in the Legal Aid NSW Civil Law Division, which provides advice, minor assistance, duty and casework services from the Central Sydney office and 20 regional offices.

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2. Executive Summary

Legal Aid NSW welcomes the opportunity to make a submission to the Select Committee inquiry into the coronial jurisdiction in New South Wales. Our submission is informed by the legal services we provide to families and individuals involved in the coronial system, including Aboriginal and Torres Strait Islander families.

The NSW coronial system is under strain from a lack of resources, and there are significant delays in the hearing of inquests. The system lacks effectiveness in preventing future deaths and creating systemic change. There are major issues with the way in which the coronial system serves families of deceased and missing persons, and particularly the special needs of Aboriginal and Torres Strait Islander families.

Legal Aid NSW considers that there is an urgent need for improvements to the NSW coronial system in relation to resourcing issues and delays, the provision of information to families, and cultural competency. To function effectively, the coronial system - inquisitorial by nature - must conduct investigations and inquests in a timely manner, to determine the circumstances surrounding a reportable death, including the manner and cause of death. The knowledge gained from these investigations must translate into systemic improvements, to prevent future deaths, through ameliorative and remedial actions by relevant agencies and interested parties.

Where a person or institution has caused a death, or contributed to it, appropriate referrals must occur in a timely fashion. Conversely, the rights and reputations of individuals brought before the Coroners Court as persons of interest, must be secured, together with their ability to access legal advice and representation.

Finally, the system must serve the needs of the families of deceased and missing persons, providing them with information, support, hope, therapeutic jurisprudence, and accountability, all delivered in a culturally competent way.

We appreciate there is much goodwill within the coronial system. We recognise and support the recent initiatives taken by the NSW State Coroner, and the outgoing Chief Magistrate, to improve court processes through the introduction of Practice Note 3 of 2021 and a First Nations Protocol. Further, we support the initiatives proposed by the individuals and organisations to this inquiry, in particular Adjunct Professor Hugh Dillon and the NSW Bar Association. However, without significant changes to resourcing and processes, together with a new or highly modified legislative framework, any improvements to the coronial system will remain limited.

Our responses to the Terms of Reference aim to improve the experience and outcomes for families involved in coronial proceedings. Our recommendations are formulated based on our involvement in numerous coronial inquests, together with our work as the only specialist advice and legal assistance service available in NSW for coronial matters. We provide more detailed recommendations in response to the relevant terms of reference below.

Recommendations

Recommendation 1

That the NSW Government ensure there are ongoing and increased levels of funding to ensure that families can access legal representation through the whole coronial inquest process.

Recommendation 2

That the NSW Government introduce a new Coroners Act which establishes a standalone Coroners Court and creates the framework for a modern coronial system centred on death prevention and the needs of bereaved families.

Recommendation 3

Amend the Coroners Act to include a provision advancing the preventative objective of the jurisdiction, similar to the preventative objectives of the *Coroners Act 2008* (Vic).

Recommendation 4

Amend the Coroners Act to include a provision identifying factors to be considered in relation to functions exercised under the Act, in order to advance the needs of the family of the deceased, similar to the factors identified in section 8 of the *Coroners Act 2008* (Vic).

Recommendation 5

Amend the Coroners Act, or introduce a new Act, that:

- consolidates all categories of deaths into one section, and contains a definition of 'reportable death' that covers all deaths within the coroner's jurisdiction
- defines 'death' to included 'suspected death'
- clarifies that the jurisdiction under section 23 of the Act extends to deaths in mental health facilities arising from involuntary admission or detention, and deaths in custody or as the result of police operations involving Commonwealth agencies
- establishes that the standard of 'reasonableness' in relation to a health-related reportable death be determined by an appropriately qualified independent person, in order to more accurately identify deaths arising from medical misadventure.

Recommendation 6

Amend the Coroners Act to mandate that the quality of care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

Recommendation 7

All reportable deaths in NSW should be centralised to a senior coroner at the Lidcombe Coroners Court on a permanent and ongoing basis.

Recommendation 8

That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court can effectively undertake its role in investigating all deaths reported to it in a timely manner.

Recommendation 9

That the NSW Government ensure the Coroner's Court is adequately resourced to produce annual reports that track the efficiency of the jurisdiction and report on performance measures.

Recommendation 10

(a) The State Coroner develop a protocol to ensure that coronial investigations proceed in a timely manner and are not delayed due to any delay in the provision of a final post-mortem report, and

(b) NSW Health Pathology Forensic Medicine provide interim post-mortem reports in order to facilitate the timely investigation of coronial matters.

Recommendation 11

Amend the Coroners Act to provide coroners with the power to compel anyone acting in a professional capacity to provide a written statement during the investigation phase unless there is a lawful excuse not to (including the common law privilege against self-incrimination).

Recommendation 12

That the Department of Communities and Justice and the Coroners Court establish a broad-based working group or court-users forum to address ongoing operational issues, including delay and other processes within the coronial jurisdiction.

Recommendation 13

(a) Amend the Coroners Act to place an onus on the Coroner to provide relevant material to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.
(b) Alternatively, that the State Coroner issue a Practice Note to require that relevant material be provided to relatives of the deceased as soon as it is available, unless there are compelling reasons to delay or not provide the information.

Recommendation 14

That the Coroners Court review its processes to ensure that families of the deceased are provided with information and brief material in a timely manner, and that the State

Coroner consider issuing guidelines (similar to the Queensland State Coroners Guidelines 2013) in relation to the rights and interests of family members.

Recommendation 15

That the NSW Government ensure that resources and facilities are provided to support families attending inquests, including a coronial counselling service, family break-out rooms at court and grants to family members for childcare, travel and accommodation expenses.

Recommendation 16

That the NSW Government provide additional funding to ensure that persons of interest can be provided with legal representation at inquests, where certain criteria are met.

Recommendation 17

Amend the Coroners Act to establish a statutory timeframe in relation to referrals under section 78 of the Act.

Recommendation 18

(a) That the Office of the Director of Public Prosecutions develop a guideline in relation to referrals under section 78 Coroners Act in order to minimise the delay in charging a person or advising that no proceedings will be taken, and

(b) That the State Coroner consider issuing a practice note for referrals under section 78 of the Coroners Act and timely decisions by the Office of the Director of Public Prosecutions regarding those referrals.

Recommendation 19

That Aboriginal identified positions be established within the NSW Coroners Court (including positions in the court registry and other support positions), and within NSW Health Pathology Forensic Medicine, particularly social worker positions, in order to improve cultural competency of the services that they provide.

Recommendation 20

Amend the Coroners Act in order that:

- definitions of ‘relative’ and ‘senior next of kin’ will recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures)
- persons other than the default senior next of kin may be appointed by the Coroners Court in exceptional circumstances, including where there are competing claims.

Recommendation 21

That NSW Health Pathology's Forensic Medicine, in consultation with the State Coroner, develop a publicly available guideline that deals with post-mortem issues, including in relation to cultural considerations.

Recommendation 22

Amend the Coroners Act to introduce a mandatory response regime to coronial recommendations, with responses being tabled in Parliament. Responses should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations. A response should be provided within three months of the Coroner's findings.

Recommendation 23

Amend the Coroners Act to empower the State Coroner "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" in relation to all coronial recommendations under section 82 of the Act.

Recommendation 24

That the NSW Government provide funding to establish a Coroners Prevention Unit at the State Coroners Court to provide sufficient resources and expertise to follow up on coronial recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

Recommendation 25

That the NSW Government establish an independent Coronial Council to advise and provide recommendations to government on the coronial system.

3. Importance of legal representation for families

The Coronial Inquest Unit (**CIU**) at Legal Aid NSW was established in 2006, to advise and represent family members of the deceased in coronial inquests. Over 15 years the CIU has provided representation to many families as they navigate the complex and emotionally draining experience of inquest proceedings.

Our lawyers have appeared and instructed in many high-profile inquests involving public interest issues, including the Lindt Café inquest, the Courtney Topic inquest, the David Dungay inquest, and the Rebecca Maher inquest. Additionally, we have provided thousands of advice and minor assistance services to family members in relation to coronial investigations. This includes advising family members shortly after a death has occurred in relation to post-mortem decisions and the coronial process, together with assistance through all stages of the coronial investigation in obtaining information, raising concerns with the Coroner, or arguing for an inquest to be held.[1]

Access to legal aid

A pre-requisite to a family member being granted legal aid for representation at an inquest is that a public interest test be satisfied. The public interest is something of common concern to the public at large, or a significant section of the public, such as a disadvantaged or marginalised group. This test applies in all matters except in Aboriginal and Torres Strait Islander deaths in custody, where the test is not applied, consistent with Recommendation 23 of the Royal Commission into Aboriginal Deaths in Custody.

Where legal aid is unavailable, we endeavour to refer applicants to alternative pro bono legal services. There is no other network in NSW that guarantees free legal representation to families of the deceased. The cost of private legal representation is often prohibitive.

Our lawyers have first-hand experience of the anguish and despair felt by many families following their attempts to engage with the coronial process. Often, they are unable to obtain information and answers about the death of a loved one from the coronial system; specifically, investigating police, coroners and assistant coroners in regional areas, registry staff and senior coroners at the State Coroners Court and elsewhere, police advocates at the State Coroners Court, and solicitors assisting the Coroner from the

[1] Noting that of the roughly 6000 deaths reported to the NSW Coroner each year, almost 99% of those matters (amounting to about 5900) will not result in an inquest because the Coroner has determined to dispense with an inquest: see Local Court of New South Wales, *Annual Review 2020* (2020) <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

Crown Solicitors Office and the Department of Communities and Justice Inquests, Inquires and Representation, Legal **(DCJ Legal)**.

We see both the tangible and intangible benefits that come from supporting families throughout this process. The importance of legal representation for families at complex inquest proceedings cannot be under-estimated. Legal Aid NSW and Aboriginal Legal Service (NSW/ACT) (**ALS**) representation of families spearheads their efforts to seek answers, and together we are able to take inquiries to levels that are unlikely to be reached where there is no family representative appearing as an interested party.

Of the inquests completed in 2018 and 2019, families were represented in just a third of the 220 deaths investigated. Of these families, about 40% were represented by the Coronial Inquest Unit, or their legal representation was funded by Legal Aid NSW.[2] There were similar levels of private representation of families at inquests.

The impact of legal representation is two-fold. First, the therapeutic impact on families of being able to voice their concerns through legal representation, and participate fully in the inquest process, are well-recognised.[3] Second, it improves the potential for the coronial system to prevent deaths, through a rigorous process of fact-finding and the formulation of coronial recommendations targeted at preventing future deaths and systemic failures.

Legal Aid NSW considers that families having legal representation from an early stage of the coronial process is crucial to their experience of the process and the outcome. In our experience, having a family representative involved in proceedings adds rigour to the level of inquiry and is vital to ensuring that issues are properly reviewed.

Unfortunately, the strong demand for representation of families at inquest outstrips the capacity of both Legal Aid NSW and the ALS. The ALS has no dedicated coronial unit and restricts its representation to mandatory section 23 inquests.

Recommendation 1

That the NSW Government ensure there are ongoing and increased levels of funding to ensure that families can access legal representation through the whole coronial inquest process.

[2] Based on a review of inquest findings, which record the interested parties (including family members) and their representatives.

[3] Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322, 5.

4. Previous reviews of the coronial system in NSW

Legal Aid NSW welcomed the Report of the Select Committee on the high level of First Nations People in custody and oversight and review of deaths in custody (**First Nations Select Committee**) and 39 recommendations, which were directed primarily at the NSW Government, together with other NSW government entities. Chapter 6 of the report dealt with the coronial system, addressing a wealth of evidence about resourcing and timeliness, cultural considerations, accountability mechanisms, and the need for a review.

In our submission to the First Nations Select Committee, we stated:

> Legal Aid NSW considers that there is a need for a broader independent review or audit of how the coronial inquest system operates in NSW with the aim of ensuring that the NSW model has a greater focus on preventing deaths. The review should consider the adequacy of funding of the coronial system, including legal services for families, delays and other inadequacies in relation to the provision of information and support to families.[4]

In addition to the recommendation that has given rise to the present inquiry,[5] the Committee also recommended:

> Recommendation 31: That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroners Court can effectively undertake its role in investigating deaths in custody in a timely manner.
>
> Recommendation 32: That the NSW Government amend the Coroners Act 2009 to ensure that the relevant government department and correctional centre respond in writing within six months of receiving a Coroner's report, the action being taken to implement the recommendations, or if no action is taken the reasons why, with this response tabled in the NSW Parliament.[6]

Whilst both these recommendations were directed at the investigation of deaths in custody, the evidence heard by the Committee concerning underlying issues such as resourcing and timeliness provide an excellent starting point for the current inquiry.

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[4] Legal Aid NSW, Submission No 117 to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *Legal Aid NSW Submission to the Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (11 September 2020) 89.

[5] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) Recommendation 30.

[6] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv.

Other than the First Nations Select Committee, Legal Aid NSW is not aware of any other publicly available reports or reviews into the NSW coronial system, to assess its efficacy and areas for improvement and reform.

In other jurisdictions, comprehensive reviews have been conducted resulting in deficiencies being clearly identified, and steps being taken to reform and modernise coronial systems, including through the introduction of new legislation. For example, in Victoria, in 2004 a Parliamentary Law Reform Committee reviewed the *Coroner's Act 1985* (Vic) with a view to modernising the coronial jurisdiction to better meet community need.[7] A report published in 2006 made 136 recommendations, and as a result a new Act established Victoria's first inquisitorial court with a key focus on reducing preventable deaths.[8]

In Queensland, an audit was conducted of the coronial system in 2018, which found significant systemic issues that affected the ability of the Queensland State Coroner to effectively fulfil its responsibility for the efficiency of the Queensland coronial system.[9] The State Coroner's lack of functional control had resulted in a system that was under-resourced to meet existing and future demand. The audit found excessive delays and a declining clearance rate were leading to a growing backlog of coronial investigations, indicating a system under stress.

Legal Aid NSW strongly supports the scope of the present inquiry and we hope that the Committee makes targeted recommendations aimed at ensuring that the NSW model has a greater focus on preventing deaths, as well as increased funding of the coronial system to address delays, including legal services for families, and other inadequacies in relation to the provision of information and support to families. We acknowledge the breadth of such an Inquiry and consider that there may be scope for further and ongoing independent reviews of the NSW coronial system, to ensure that it continues to achieve its stated aims.

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[7] *Coroners Act 2008* (Vic).

[8] Coroner's Court of Victoria, *Practice Handbook* (2011) <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/practice%2Bhandbook%2B%28web%2Bversion%29%2B-%2Bmarch2012.pdf>.

[9] In October 2018, the Queensland Audit Office delivered its report entitled 'Delivering Coronial Services', which assessed whether relevant government agencies were effective and efficient in supporting the Queensland State Coroner in investigating and helping to prevent deaths. The audit found that under Queensland Coroners Act 2003, whilst the State Coroner is legally accountable for the efficiency of the Queensland coronial system, the role has little functional control over the resources needed to effectively fulfil this responsibility.

4.1 Statutory Review of the *Coroners Act 2009*

The *Coroners Act 2009* (NSW) (**Coroners Act**) commenced in June 2009, and whilst it repealed the former *Coroners Act 1980* (NSW), it also re-enacted a number of the provisions of that Act, with modifications to improve the efficiency and effectiveness of the coronial jurisdiction. A statutory review mechanism was built into the new Coroners Act at section 109 of the Act, which required the Attorney General, as the responsible Minister, to review the Act to determine whether the policy objectives of the Act remained valid and whether the terms of the Act remained appropriate for securing those objectives.

Under section 109 of the Coroners Act, the review is to be undertaken after five years from the date of assent to the Act, and a report on the outcome of the review is to be tabled in each House of Parliament within 12 months after the end of the five-year period. The NSW Department of Communities and Justice commenced a review process in 2014. However, as this Committee has heard, to date, no report has been tabled in Parliament, and the statutory review has not been finalised.

We strongly support the NSW Department of Communities and Justice sharing a copy of the draft 2017 Statutory Review with the Committee, to inform the present inquiry. Its strength lies in the level of consultation that was undertaken, and the fact that it so comprehensively identifies the deficiencies with the current legislation, and the best solutions by way of statutory amendment.

5. A stand-alone court and new Act

A fundamental question for coronial reform in NSW is whether a new Coroners Act should be introduced, and whether there should be a stand-alone Coroners Court, as exists throughout most Australian jurisdictions.

At present, the Coroners Act does not establish a Coroners Court. It simply confers coronial jurisdiction on certain magistrates and other persons, and the operation of the legal part of the coronial system falls under the realm of the NSW Local Court.

Legal Aid NSW recognises that a significant component of the coronial system involves the work of NSW Health Pathology's Forensic Medicine service, which is established under NSW Health. For example, the State Coroners Court at Lidcombe is a joint facility containing a facility operated by the Forensic Medicine service, which employs Health staff and contains a morgue, together with a court complex, accommodating judicial officers, employing NSW Justice employees, and containing a court registry and four courts. The work of the State Coroners Court co-exists with the operation of facilities which fall beyond the realm of justice and the courts.

It is critically apparent that NSW must modernise processes and enact legislation that supports and enhances the ability of the Court to provide a therapeutic and restorative environment for family members, and to properly serve the culturally and linguistically diverse members of our society. In particular, there is a need for a system that can better serve the needs of First Nations people, who are likely to be disproportionately represented in deaths reported to the Coroner and inquests held.

In the context of First Nations deaths in custody, the First Nations Select Committee report (Chapter 6) provided evidence of the following issues:

1. lack of funding and resources for the Coroners Court
2. its impact on the effectiveness and timeliness of inquests
3. structural issues that impact on the coronial system (such as its use of regional magistrates to undertake coronial work in circumstances where they have competing workloads and lack specialist training)
4. timeliness and the provision of information to families, and the impact of these timeframes on families
5. accountability for coronial recommendations, and

6. the ability of the coronial system to address systemic failures and prevent further deaths.[10]

The report highlighted a recommendation by Adjunct Professor Dillon that "the NSW Government recognise the need for a specialist coronial system and design it accordingly, including a specialist Coroners Court of NSW." It referred to concerns raised by Legal Aid NSW with the Coroners Court being part of the NSW Local Court structure, indicating:

> [Legal Aid NSW] said that this 'has proven to be a major limitation on the functions of the court, and its capacity to adapt and reform so as to provide an effective death prevention function, and to cater adequately for families of the deceased'. Legal Aid NSW also recommended that 'serious consideration ought to be given to establishing the NSW Coroners Court as a separate court, as has occurred in Victoria, Queensland, South Australia and Western Australia.[11]

Our position remains that the existence of the Coroners Court within the NSW Local Court creates major limitations on the functions of the Coroners Court, its capacity to provide an effective death prevention function, and to cater adequately for families of the deceased.

Legal Aid NSW supports consideration of a new Act as the most appropriate step forward. Whilst additional resources and discrete legislative amendments may provide a solution to some problems in the coronial system in the short term, consideration should be given to introducing a new Act which establishes a separate court and creates the framework for a modern coronial system, centred on death prevention and the needs of bereaved families. There would undoubtedly be benefits in establishing an independent, stand-alone court under a new Act, enhancing the jurisdiction's capacity to grow and to advocate for its own advancement.

Recommendation 2

That the NSW Government introduce a new Coroners Act which establishes a standalone Coroners Court and creates the framework for a modern coronial system centred on death prevention and the needs of bereaved families.

[10] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021).

[11] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 131 [6.26].

6. The jurisdiction of the Coroners Court

6.1 Objects of the Act and factors to consider

Before considering the scope and limits of coronial jurisdiction, it is appropriate to reflect on the coronial jurisdiction generally, and some of the key deficiencies. As we have stated, the NSW coronial system lacks effectiveness in preventing future deaths and creating systemic change, and there are major issues with how it serves families of deceased and missing persons. Importantly, the legislation that underpins our coronial system barely refers to these issues, let alone providing a framework or guiding principles to address them.

6.1.1 Preventative function

The objects to the Coroners Act do not include a preventative function, other than identifying that an object of the Act is to enable coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies).[12]

Legal Aid NSW supports adopting the preventative objectives of the Victorian *Coroners Act 2008*,[13] which invests the Victorian Coroners Court with a key focus on reducing preventable deaths.[14] The preamble to the Act provides:

> The coronial system of Victoria plays an important role in Victorian society. That role involves the independent investigation of deaths and fires for the purposes of finding the causes of those deaths and fires and to contribute to the reduction of the number of preventable deaths and fires and the promotion of public health and safety and the administration of justice. This role will be enhanced by creating a Coroners Court and setting out the role of the Coroners Court and the coronial system and the procedures for coronial investigations.[15]

The *Coroners Act 2008* (Vic) also contains purposes which include contributing "to the reduction of the number of preventable deaths and fires through the findings of the investigation of deaths and fires, and the making of recommendations, by coroners."[16]

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[12] *Coroners Act 2009* (NSW) s.3 (e).

[13] *Coroners Act 2008* (Vic).

[14] Coroner's Court of Victoria, *Practice Handbook* (2011) <https://www.coronerscourt.vic.gov.au/sites/default/files/2018-11/practice%2Bhandbook%2B%28web%2Bversion%29%2B-%2Bmarch2012.pdf>.

[15] *Coroners Act 2008* (Vic), Preamble.

[16] *Coroners Act 2009* (NSW) s 1 (c).

Recommendation 3

Amend the Coroners Act to include a provision advancing the preventative objective of the jurisdiction, similar to the preventative objectives of the *Coroners Act 2008* (Vic).

6.1.2 Focus on needs and centrality of deceased's family

There are no provisions in the Coroners Act that cement the importance of families of deceased and missing persons within the coronial process, other than a provision dealing with representation at coronial proceedings (which requires that a Coroner must grant leave to appear to a relative of a deceased person unless satisfied there are exceptional circumstances to refuse leave).[17]

In contrast, the *Coroners Act 2008* (Vic) contains the following six factors to be considered in relation to functions exercised under the Act, which are primarily directed at the needs of family:[18]

a) that the death of a family member, friend or community member is distressing and distressed persons may require referral for professional support or other support;
b) that unnecessarily lengthy or protracted coronial investigations may exacerbate the distress of family, friends and others affected by the death;
c) that different cultures have different beliefs and practices surrounding death that should, where appropriate, be respected;
d) that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation;
e) that there is a need to balance the public interest in protecting a living or deceased person's personal or health information with the public interest in the legitimate use of that information;
f) the desirability of promoting public health and safety and the administration of justice.

Recommendation 4

Amend the Coroners Act to include a provision identifying factors to be considered in relation to functions exercised under the Act, in order to advance the needs of the family of the deceased, similar to the factors identified in section 8 of the *Coroners Act 2008* (Vic).

[17] *Coroners Act 2009* (NSW) s 57 (3).

[18] *Coroners Act 2008* (Vic) s 8.

6.2 The scope and limits of jurisdiction

Legal Aid NSW supports a new Coroners Act, or amendments to the existing Act, which would achieve the following outcomes:

1. Consolidate the jurisdiction over deaths into a single place in the Act – presently, the definition of "reportable death" in s.6 only lists some of the deaths over which coroners have jurisdiction, whilst jurisdiction over other deaths is found in other parts of the Act (e.g., ss.23, 24 and 27).
2. A definition of 'death' to include 'suspected death' – the jurisdiction of coroners extends to 'suspected deaths', yet that term is found in an ad hoc and inconsistent way through the Act. Including a definition of 'death' which includes 'suspected death' would promote clarity and consistency.
3. Section 23 of the Coroners Act requires clarification in several respects, due to uncertainty over its scope:
    a. clarification that deaths in mental health facilities arising from involuntary admission or detention are deaths "in other lawful custody" for the purposes of section 23, and are therefore subject to a mandatory inquest; and
    b. clarification that deaths in custody or as the result of police operations involving Commonwealth agencies are included within the scope of section 23.

6.2.1 Health-related reportable deaths

In relation to health-related reportable deaths,[19] we hold concerns that there is likely to be an under-reporting of such matters to the Coroner. These concerns are based on cases where family members have sought assistance to submit that the Coroner should assume jurisdiction over a hospital-related death, in circumstances where the family member alleges inadequate care, but the death has not been reported to the Coroner.[20]

The difficulty with the current system is that medical practitioners involved in the person's care may also be involved in making the decision as to whether a death is reported to the Coroner.[21] There is arguably a disincentive for a practitioner to report a death when they know this will result in a coronial investigation. There is a fundamental flaw in this

[19] *Coroners Act 2009* (NSW) s 6 (1)(e) provides that a person's death is a reportable death if "the person died in circumstances where the person's death was not the reasonably expected outcome of a health-related procedure carried out in relation to the person."

[20] Usually because it has not been assessed as a reportable death, and a death certificate has then been issued by a medical practitioner: *Coroners Act 2009* (NSW) ss 6, 21.

[21] In assessing whether a death was not the reasonably expected outcome of a health-related procedure, NSW Health Guidelines require the doctors to use their own professional judgment to assess whether a death is reportable. In particular, doctors are asked to assess was "the health-related procedure performed in a manner, which at the time of the death, would be considered by your peers as competent professional practice?": NSW Health Department, *Coronial Checklist* (IB2010_058, 30 November 2010), 4.

process, as it requires the practitioner to recognise deficiencies in their own professional practice, or that of their colleagues. A solution is to require the standard of reasonableness as to the expected outcome to be assessed by an appropriately qualified independent person.[22]

Recommendation 5

Amend the Coroners Act, or introduce a new Act, that:

- consolidates all categories of deaths into one section, and contains a definition of 'reportable death' that covers all deaths within the coroner's jurisdiction
- defines 'death' to included 'suspected death'
- clarifies that the jurisdiction under s.23 of the Act extends to deaths in mental health facilities arising from involuntary admission or detention, and deaths in custody or as the result of police operations involving Commonwealth agencies
- establishes that the standard of 'reasonableness' in relation to a health-related reportable death be determined by an appropriately qualified independent person, in order to more accurately identify deaths arising from medical misadventure.

6.3 Deaths in custody

Legal Aid NSW supports expanding the court's jurisdiction in relation to inquests into deaths in custody consistent with recommendation 12 of the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), which is not reflected in the Act:

> "a coroner enquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death."[23]

Whilst care is normally taken to review matters that may be causally linked to a death, there is no general obligation on a coroner to review the quality of care, treatment and supervision of a person who dies in custody.[24] In certain circumstances, this may result in both an investigation and inquest that fails to address matters important to family

[22] Adjunct Professor Hugh Dillon, Submission No 14 to the Select Committee on the coronial jurisdiction in NSW, *Inquiry into the coronial jurisdiction in New South Wales* (5 July 2021) Appendix C.

[23] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 12.

[24] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 96.

members, such as the provision of health care to the deceased and conditions whilst in custody.

We anticipate that the State Coroner's First Nations Protocol will include directions to investigate and consider the quality of care, treatment and supervision of First Nations deceased during the period leading up to their death. However, at present the Act itself, and in particular the findings required by s.81 (as to identity, date and place of death, and manner and cause) do not extend to "the quality of the care, treatment and supervision of the deceased."

Recommendations 35 and 36 by the RCIADIC were directed at police investigations, and sought that investigations extend to the general care, treatment and supervision of the deceased prior to death, including a particular focus on whether custodial officers observed all relevant policies and instructions concerning care, treatment and supervision. In our experience, often the extent of police investigation of these matters is relatively cursory or left to legal professionals assisting the Coroner. Some police investigators reach conclusions that indicate there were 'no suspicious circumstances' and fail to identify issues such as adequacy of medical or other care.

Legal Aid NSW notes recommendations 33 and 34 made by the First Nations Select Committee seeking legislative amendments to require a coroner to examine systemic issues in relation to a death in custody, and to make findings on whether the implementation of RCIADIC recommendations could have reduced the risk of death.[25]

Legal Aid NSW considers that the Coroners Act should be amended to provide consistency with Recommendation 12 of the RCIADIC, at the very least for Aboriginal and Torres Strait Islander deceased persons, if not all deaths in custody. It should mandate that the quality of the care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

Recommendation 6

Amend the Coroners Act to mandate that the quality of care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

[25] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv and 6.129-6.131.

6.4 Regional deaths

Legal Aid NSW supports the ongoing centralisation of reportable deaths to coroners operating at Lidcombe Coroner's Court. The Coroners Act permits a system whereby regional magistrates may exercise jurisdiction for reportable deaths (excluding deaths under section 23 or 24) occurring outside Sydney metropolitan region which in 2020 numbered 2,834 against 3,540 to Lidcombe.[26]

Legal Aid NSW understands a significant change adopted during the pandemic was centralised reporting of all NSW deaths to a senior coroner at Lidcombe. This ensures post-mortem directions are determined by experienced coroners, rather than dealt with by regional magistrates. According to the Local Court Annual Review, the benefits achieved by a single decision maker have been far reaching and have also seen a reduction in the number of post-mortem examinations conducted.

This reporting has proved to be successful, and we understand the intention is for it to remain as a permanent change. Legal Aid NSW strongly supports this initiative continuing on an ongoing basis. Under the regional system, our casework informs us that a lack of guidance to regional magistrates exercising coronial functions may be causing missed opportunities to review reportable deaths, such as preventable deaths involving substandard levels of health and hospital services. In Legal Aid NSW's experience, significant coronial inquests into issues of public health and safety in regional NSW were borne out of coronial cases that had been previously dispensed with by regional magistrates.[27]

Recommendation 7

All reportable deaths in NSW should be centralised to a senior coroner at the Lidcombe Coroners Court on a permanent and ongoing basis.

[26] Local Court of New South Wales, *Annual Review 2020* (2020), 24 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[27] *Inquest into the Death of Sandra Cree* (2016/118575, 22 October 2018), NSW State Coroner's Court, Glebe.

7. Resourcing

Inadequate resourcing within the NSW coronial system has a significant impact on families. Legal Aid NSW supports increased funding to the NSW Coroners Court, consistent with recent findings by the First Nations Select Committee:

> "Firstly, it is unquestionable that the funding and resourcing of the NSW Coroners Court needs to be improved. As we have heard, it is having a significant impact on the length of time to complete an inquest, which in turn is causing undue stress on the families involved."[28]

Whilst the First Nations Select Committee recommendation[29] was limited to deaths in custody, inadequate resourcing has an impact on all coronial investigations, and is most clearly demonstrated through the lengthy delays in completing inquests.

7.1 Numbers of coroners

A comparison with other jurisdictions on a range of indicators (budget, judicial positions, support services) is likely to highlight funding inadequacies which exist in NSW. One key indicator is the number of coroners. In 2020 there were an equivalent of 4 deputy state coroners at Lidcombe, together with the State Coroner, and 3 other regional magistrates also exercising jurisdiction as deputy state coroners.[30] These regional magistrates also carry a heavy criminal workload. By comparison, the Victorian Coroner's Court comprises one Senior State Coroner, one Deputy State Coroner and 11 Coroners.[31] In Queensland, there are 7 specialist full-time coroners located through the state.[32] Queensland's population is 63% of that in NSW, and Victoria's population is 82%.

7.2 Outstanding mandatory inquests

Legal Aid NSW is concerned about clearance rates, particularly for deaths in custody

[28] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) 150.

[29] The Select Committee recommended at xiv::Recommendation 31: That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the NSW Coroners Court can effectively undertake its role in investigating deaths in custody in a timely manner.

[30] Local Court of New South Wales, *Annual Review 2020* (2020), 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[31] Local Court of New South Wales, *Annual Review 2020* (2020), 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

[32] Queensland Courts website: <https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/coroners-list>.

cases. At the end of 2020, only 45 death in custody inquests had been finalised.[33] At the same time, there were 96 death in custody inquests that had not been completed. Some of these unresolved inquests are dated five years prior to the 2020 report – at least two are from 2015, one from 2016, nine from 2017, and 15 from 2018.[34] The NSW State Coroner's report from 2019 also indicates a similar trend with only 23 death in custody inquests being completed, and 94 inquests pending an outcome.[35] These trends demonstrate that, given current resourcing, it is unlikely that the legacy caseload of 96 outstanding death in custody inquests that existed at the end of 2020 will be finalised in a timely way.

Recommendation 8

That the NSW Government allocate additional resources, including adequate funding and staffing, to ensure that the Coroners Court can effectively undertake its role in investigating all deaths reported to it in a timely manner.

7.3 Annual reporting

Lack of comprehensive annual reporting in relation to the NSW coronial system makes it difficult to monitor its efficacy and is a further product of inadequate funding. The work of the Coroners Court is recorded annually in the NSW Local Court Annual Review. A handful of statistics are presented (reported deaths, investigations finalised, inquests held) with no assessment of clearance rates or other performance data.

In comparison, the Queensland State Coroner report is comprehensive.[36] It sets out a framework for action and performance review, established after a report into the court's efficiency by the Queensland Audit Office in 2018-19. For example, the 2019-20 report outlines a 'triaging trial' undertaken by the court to reduce demand pressures, better support families and ensure coroners have increased capacity to focus on complex investigations. The Queensland State Coroner reports on coronial performance according to clearance rates and provides state-wide figures and comparisons to other

[33] NSW State Coroner, Parliament of New South Wales, *Report by the NSW State Coroner into Deaths in Custody/Police Operations* (Report, December 2020) 510.

[34] Ibid.

[35] NSW State Coroner, Parliament of New South Wales, *Report by the NSW State Coroner into Death in Custody/Police Operations* (Report, April 2019) 577.

[36] Coroners Court of Queensland, *2019-20 Annual Report* (17 November 2020) <(https://www.courts.qld.gov.au/__data/assets/pdf_file/0020/670421/osc-ar-2019-2020.pdf>.

annual reporting years. The report also monitors autopsy expenditure and the number of examinations ordered in the year.

Similarly, the Victorian State Coroner's annual report provides a snapshot of investigations, caseload, timelines, and inquest clearance rates.[37] The performance measures are tracked according to the objectives of the jurisdiction: investigations into deaths and fires, reducing preventable deaths, promoting public health and safety and corporate governance and support.

Legal Aid NSW considers that the Victorian Coroner's capacity to report and track the deliverables of their jurisdiction is a major strength in both death prevention and efficiency. In Legal Aid NSW's experience, the capacity to influence death prevention is a major factor in why families participate in inquests, and their motivation to ensure the tragic death of their loved one will create a positive legacy for others in the community.

Unlike its interstate counterparts, the State Coroner's Court does not produce its own comprehensive annual report. There is a lack of information about the full scope of the coroner's work, and common themes or systemic issues identified by coroners in NSW. There is no annual reporting on recommendations, or responses to recommendations. Legal Aid NSW supports additional resources for the Coroner's Court to undertake robust annual reporting.

Recommendation 9

That the NSW Government ensure the Coroner's Court is adequately resourced to produce annual reports that track the efficiency of the jurisdiction and report on performance measures.

[37] Coroners Court of Victoria, *Annual Report 2019-20* (December 2020) <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019 20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf>.

8. Timeliness and delays

The State Coroners Court website states under "Overview of the Coronial Process":

> Unfortunately, a number of popular television shows perpetuate the myth that a cause of death can be established quickly and that the Coroner can pinpoint the time of death precisely. Neither of these things is true. The reality is that a coronial investigation is both complex and lengthy. Whilst some cases may be resolved within a few months, the majority of cases take considerably longer. An investigation often takes up to 12 months and in rare instances, even longer.

In Legal Aid NSW's experience, it is common for the delay between a death and inquest to be between three and five years. Legal Aid NSW has represented families where the inquest was held up to seven years after the death, without any clear explanation for the delay. Our experience in representing family members is that delays cause unacceptable levels of prolonged grief and suffering. This observation is well-supported by the literature. Reviews conducted in Victoria and Western Australia demonstrated that:

> "delays in coronial proceedings were a significant source of distress for families, particularly due to attrition in evidence, financial strain, and prolonged grieving for families recounting information many years after a death." [38]

Lengthy delays exist not only for inquests, but also for matters that do not proceed to an inquest, whilst coroners investigate and consider whether or not to dispense with an inquest. For those families, the uncertainty of not knowing whether they will have an opportunity to ventilate issues surrounding their loved one's death is a compounding factor.

Case study: MH

MH took his own life by hanging himself at Goulburn Correctional Centre on 23 June 2017. He was 21 years old and had a diagnosis of schizophrenia. He had been an involuntary patient in the community immediately before placed in custody in May 2017. On reception at Goulburn, he advised correctional authorities of an earlier attempted suicide, and his mental health diagnosis.

Shortly after his death, his mother contacted Legal Aid NSW. She wanted answers about his death and saw the potential for meaningful reforms to the management of mental health both in prison and the general community.

[38] Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322, 2.

On her behalf, requests for documentation were made to the Coroners Court in January and February 2018. There were significant delays in the most basic documentation being prepared. The autopsy report was not completed until 1 August 2018. The statement of the Officer in Charge from NSW Police was not finalised until 14 August 2018. It was only provided to the family in March 2019.

Two years after MH died, a referral was made by the Coroners Court to the Crown Solicitors Office in June 2019, seeking its assistance. Crown Solicitors accepted that referral in August 2019. Delays in the provision of information continued throughout the coronial process, with large amounts of material provided to MH's mother's and her legal representatives in the week before inquest.

The inquest was heard in March 2021. The findings were delivered in July 2021, more than 4 years after MH's death.

To address delays in the coronial system, The Improving Timeliness of Coronial Procedures Taskforce was established as a joint agency initiative between NSW Health and the Department of Communities and Justice.[39] The Taskforce was to examine the coronial process from report of death to the coroner, through case triage, transport of the deceased, autopsy, post-mortem report finalisation and return of remains to the family for burial. One of its key tasks was to address the issue of delay in the timely provision of post-mortem reports. Despite an indication that the Taskforce was expected to complete its work in mid-2021, there has been no publicly available report released. Delays associated with post-mortem reports remain.

8.1 Specific delays through the coronial process

8.1.1 Delay in post-mortem reports & investigation until post-mortem report complete

In our experience, post-mortem reports are routinely not provided until six to nine months after death, and often after far longer periods. This delay creates a hurdle in the investigation, delaying any decision-making on the cause of death, and delaying the start of any proceedings. We understand it is common practice for a coronial investigation to not be allocated and for coroners to take no further steps until a final post-mortem has been provided. In Legal Aid NSW's experience, families are often told they must wait until the post-mortem report is received until they can access other evidentiary material, such as CCTV or witness reports (even though this material has often already been

[39] Local Court of New South Wales, *Annual Review 2020* (2020) 23 <https://www.localcourt.nsw.gov.au/local-court/publications/annual-reviews.html>.

compiled by the police).

The provision of interim post-mortem reports, and a change to procedures (such that investigations proceed regardless of the provision of final post-mortem reports) is necessary to reduce delays.

Recommendation 10

(a) The State Coroner develop a protocol to ensure that coronial investigations proceed in a timely manner and are not delayed due to any delay in the provision of a final post-mortem report; and

(b) NSW Health Pathology Forensic Medicine provide interim post-mortem reports in order to facilitate the timely investigation of coronial matters.

8.1.2 Delay in obtaining statements from health professionals

Potential witnesses in a coronial investigation are entitled to rely on the privilege against self-incrimination and seek legal advice prior to providing a statement to the Coroner. However, a practice has developed in NSW whereby statements from doctors and nurses (including NSW Health and Justice Health employees) are not taken by NSW Police at an early stage of the investigation. As a result, statements are often prepared with the assistance of lawyers, usually well after a death occurs. Often this occurs after a number of years. This results in poor quality evidence with little detail. In contrast, in the experience of our solicitors, recorded interviews with police shortly after a death possess vastly greater evidential value. There is a need to address these delays, which would greatly improve the quality of evidence at inquest, and the time needed to prepare a final brief of evidence.

Recommendation 11

Amend the Coroners Act to provide coroners with the power to compel anyone acting in a professional capacity to provide a written statement during the investigation phase unless there is a lawful excuse not to (including the common law privilege against self-incrimination).

8.1.3 Delay in preparation and service of a brief of evidence

In Legal Aid NSW's experience, there are lengthy delays before a brief of evidence is prepared, and then further lengthy delays before it is served on the deceased's family. Often the delay is not due to police investigators, but other inefficiencies and issues. Sometimes it can take years before a proper brief is compiled. In some cases, the family and/or its representatives do not receive a brief of evidence until four to six weeks before

the inquest, and this may comprise many volumes of material. This provides insufficient time to discuss the evidence with the family and impacts on their capacity to meaningfully engage with the process, for example, by identifying issues and witnesses.

Families and their legal representatives provide an important level of scrutiny and oversight, in addition to the work of Counsel Assisting and the solicitors assisting the Coroner. Our solicitors routinely identify gaps in the evidence that result in requests for further material, and key lines of enquiry which later form the basis of recommendations.

Delays in preparing and serving briefs could be addressed through better resourcing of agencies which provide legal support to coroners in their investigations and preparation for inquest. For example, the level of resourcing provided to the Crown Solicitor's Office should be reviewed to ensure it is adequate, given the significant workload of its Inquiries Practice Group, and their centrality to the effectiveness of the coronial process in complex matters. Greater resourcing would enable faster preparation of briefs and earlier commencement of inquests.

Case Study: The death of David Dungay

David Dungay, a proud Dunghutti man, died on 29 December 2015 while being restrained by prison guards at Long Bay Hospital. He was an involuntary mental health patient. Because of the practice in NSW of keeping scheduled inmates in a prison hospital, he was housed at Long Bay Hospital.

His inquest did not commence until 16 July 2018. The first thing the Coroner did was acknowledge the delay:

Firstly, let me acknowledge the time it's taken to get here today. It is probably an unusual thing for anybody who is not a lawyer to experience the time that it has taken to get here today; that is, it's taken now two and a half years from an event until the Court proceeding. Anybody who is not a lawyer probably correctly thinks of that as being a long time. No doubt, in that period of time, your patience has been tested on many occasions and it's given rise to frustration on many occasions.

Family members of David Dungay had been adamantly protesting his death since it occurred. After two weeks of evidence in July 2018, the inquest was not finished. The matter was adjourned for nine months until 4 March 2019, as the Coroner had no available time.

Findings were delivered on 22 November 2019, almost four years after David's death.

8.1.4 Court listings and Coroner's availability

In our solicitor's experience, when a matter is ready to be listed for hearing, most coroners do not have availability for six to twelve months or more. This is a product of there being insufficient numbers of coroners in comparison to the number of inquest matters to be held.

8.1.5 Claims for non-publication and other protective orders

Given the sensitivity of some material obtained during a coronial investigation, parties such as the NSW Commissioner of Police or Corrective Services NSW may seek to obtain protective orders from the Coroner as to disclosure and non-publication. In Legal Aid NSW's experience, this often causes significant delays in having a matter listed or the family being provided with the brief of evidence. There have been a number of recent cases where inquest hearings have been vacated because protective orders sought by the NSW Commissioner of Police have resulted in the brief of evidence not being served, or not being served until just before an inquest. This creates significant prejudice to families appearing at inquest, who require time to read material and properly prepare.

Case Study: AA

AA was shot dead by police in July 2019. He suffered from long-term chronic schizophrenia. Critical incident investigators from NSW Police compiled a brief of evidence, with most statements and other evidence collected by January 2020.

The brief was provided to Crown Solicitors in early 2020, and served on the Commissioner of Police in June 2020, in order for his legal representatives to identify material of a confidential nature. Despite 15 months elapsing, and repeated attempts by the Coroner to hear and finalise an application for protective orders by the Commissioner of Police, the application has still not been resolved.

Repeated requests over 12 months by AA's family for access to the brief were unsuccessful, until limited documents were provided in March 2021. AA's family has still not seen critical evidence relevant to his death.

Due to the delays arising from the Commissioner's application for protective orders, the 3 week inquest, listed to start in late September 2021, was recently vacated. It is now unlikely the matter will be heard before early to mid 2022.

8.2 Working Group or Court Users Forum

We consider that a broad-based working group or court-users forum should be established to address ongoing operational issues, including delay. Key stakeholders could include the NSW Coroners Court, NSW Police, Corrective Services NSW, Justice Health, NSW Health, Crown Solicitors Office, DCJ Legal, the Aboriginal Legal Service NSW/ACT, and others who can speak on behalf of bereaved family members.

Recommendation 12

That the Department of Communities and Justice and the Coroners Court establish a broad-based working group or court-users forum to address ongoing operational issues, including delay and other processes within the coronial jurisdiction.

9. Provision of information to families

Families involved in the coronial process frequently experience difficulties and delays in getting information about the circumstances surrounding their loved one's death. Timelines provided to families are vague, and they are often left to repeatedly make requests for information about a loved one's death, and updates on the progress of a case. Requests for evidentiary material, including expert reports, are often denied pending the acquisition of further material, despite all material being ultimately available to them in a brief of evidence.

The impact on families of the coronial process has been described in various studies:

> These studies revealed that families were concerned and frustrated by infrequent updates, a poor understanding of their rights and whether an inquest would be held, and delays that prolonged stress and impaired witness memory.
>
> Families valued inquests, and perceived a sense of justice or enhanced trust in the outcomes, when: (a) provided direct access to previously inaccessible evidence, (b) treated with greater respect than in other investigations, (c) permitted to raise opinions or questions in the inquest directly or through legal representation, or (d) the inquest revealed previously unidentified systemic failings that contributed to the death.[40]

Typically, there have been delays of three or four years and more before many inquests are heard and findings delivered. This delay causes undue distress to family members. A further complication of existing arrangements is that family members engaged in the inquest process are usually not given timely access to information. They wait for extended periods, often without any access to brief materials or an adequate understanding of what took place in relation to the death of their loved ones.

We can provide many examples of delay and the late provision of materials. In more than one instance, the late provision of material has resulted in inquests being vacated, or additional issues being identified by the family, resulting in further investigations being required and the matter being adjourned part-heard.

Legal Aid NSW is aware that material that could be provided to a family is not provided for up to a year or more after it has been made available to the Crown Solicitors Office and the Coroner. A large component of any brief is material that could be provided immediately to families, because it is unlikely to change (e.g., medical records, witness statements, electronic materials, and once available, expert reports), and it is unlikely to attract an application for protective orders.

[40] Dartnall, Goodman-Delahunty and Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 Frontiers in Psychology 2322: 3.

Legal Aid NSW considers the need to keep family members informed of key developments and the detail of any investigation as paramount to the success of the coronial system. It is vital that the family of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a culturally appropriate, timely and proper manner.

We consider it essential that strict requirements be placed on the provision of information to family members. The experience of our solicitors is that family members want detailed information from an early stage about the death of a loved one, including documents and electronic materials.

9.1 Access to documents under the Coroners Act

Access to coronial documents in NSW is governed by section 65 of the Coroners Act. Coronial Practice Note 1 of 2018 commenced in November 2018 and sought primarily to address time standards and case management of inquest matters. Whilst recognising the nature and impact of coronial proceedings on all persons involved, especially the families of deceased persons (at 2.2), it included no requirements to provide brief materials to family.

The only relevant provision of the practice note stated:

> **Part 6: The provision of the brief of evidence to interested parties**
>
> 6.1 A person seeking leave to appear or an unrepresented relative of the deceased may be supplied a copy of the brief of evidence at the discretion of the Coroner.

A second practice note in 2018 in relation to mandatory inquests involving Critical Incident Investigations contained no reference to providing the brief to family. It is only now, with the introduction of Coronial Practice Note 3 of 2021, which commenced on 24 September 2021, that the Court has recognised the importance of providing families with information and updates.[41] The objects of the Practice Note (which applies only to deaths under section 23 of the Coroners Act) include:

> 4.2 b. The families of the deceased are provided with appropriate information and material on the status of the investigation and the coronial process in a timely and proper manner, including advice in relation to delay and the reason(s) for the delay.

Despite this object, and a requirement later in the Practice Note that "throughout the coronial investigation the Officer in Charge, or if instructed, the solicitor assisting must ensure that the senior next of kin (and any other family member as appropriate in the

[41] Local Court of New South Wales, *Coronial Practice Note No 3: Case management of mandatory inquests involving section 23 deaths*, 24 September 2021,<https://www.coroners.nsw.gov.au/content/dam/dcj/ctsd/coronerscourt/documents/practice-notes/Final_PN_3_of_2021_signed_230821.doc.pdf>.

circumstances) or if applicable their legal representative are kept informed of the progress of the coronial investigation", there remains no requirement to provide comprehensive information and brief materials at an early stage.

We consider it essential that strict requirements be placed on the provision of information to family members. The experience of our solicitors is that family members want detailed information from an early stage about the death of a loved one, including documents and electronic materials.

9.2 Provision of information to families in other jurisdictions

In Queensland, the State Coroners Guidelines 2013 state:[42]

> **Communicating with the family**
>
> The family must be given adequate and timely information about their loved one's death in order for them to participate meaningfully in the coroner's decision making about how to respond to the death. Families of deceased persons should not be denied information about the death just because it has been reported to the coroner. The general principle is that families are entitled to any and all information concerning the death as soon as it is available unless there is a basis for suspecting that to release the information may compromise a criminal investigation.
>
> **Cause of death information and autopsy reports**
>
> The family is entitled to be given as much information as possible about the cause of death and the various steps in the coronial system. They should not be required to wait until the coroner has received the final autopsy report to be informed of the pathologist's opinion as to the cause of death and other inquiries the coroner intends to undertake.
>
> **Access to brief of evidence**
>
> The family is entitled to a copy of the brief of evidence regardless of whether they are legally represented or intend to seek leave to appear at the inquest. Access to this information prior to the inquest helps the family better understand the evidence and the issues to be explored with various witnesses.

Numerous parts of the Queensland Guidelines deal with providing information to families, such as:

- 2.4 Communicating with the family
- 2.7 Case management and keeping families apprised
- 2.9 Access to coronial information
- 2.11 Involvement in inquests - particularly "access to brief of evidence."

[42] Coroners Court Queensland, *State Coroner's Guidelines 2013*, chapter 2 <https://www.courts.qld.gov.au/__data/assets/pdf_file/0012/206121/osc-state-coroners-guidelines-chapter-2.pdf>.

In Victoria, Part 2 – Objectives of the *Coroners Act 2008* (Vic) contains six factors to be considered in relation to functions exercised under the Act. Section 8(d) states:

> that family members affected by a death being investigated should, where appropriate, be kept informed of the particulars and progress of the investigation.

Section 115 of the *Coroners Act 2008* (Vic) governs access to documents, and Practice Note 2 of 2011 provides that the registrar must provide the senior next of kin with any post-mortem reports, and any interested party with an inquest brief.

Legal Aid NSW considers that the arrangements in Victoria and Queensland, and in particular the Queensland guidelines, provide a strong example of the care and attention that is required to ensure family members are kept properly informed, and describe practices that are not, in the main part, taking place within the NSW coronial system.

Legal Aid NSW supports an onus placed on the Coroner (and those that assist the Coroner) to provide relevant material to relatives of the deceased as soon as it is available, unless there are compelling reasons to delay or not provide the information. This should be enacted either by way of legislative amendments (including the addition of objects or guiding principles similar to Victoria), and/or by incorporating these requirements into one or more of the Practice Notes issued by the State Coroner.

9.3 Who can access information?

Our lawyers have observed a common practice, both at the State Coroners Court and at regional courts dealing with coronial matters, of family members being refused information when they are not the senior next of kin.

The Coroners Court website under “Access to coronial documents” states:

> The senior next-of-kin can receive documents on an open file free of charge by sending in a written request to the Court. If the senior next-of-kin wants any of the documents not to be sent out to anyone else, they must indicate this in writing to the Coroner as soon as possible.
>
> Other family members (who are not the senior next-of-kin), may be considered to have an appropriate interest to receive documents from a coronial file.

Legal Aid NSW is of the view that information and brief materials ought to be available to any relative of the deceased person, where appropriate, not just the senior next of kin. In our experience, there are many inquests where the senior next of kin does not play a role, but other family members do. Restricting access to information to senior next of kin does not account for family divisions, the possibility that different members of the family may have different interests, or are separately represented. It is also not consistent with section 57 of the Coroners Act, which envisages that any relative of the deceased may seek leave to appear.

Similarly, the provision of information and brief materials should not be limited to family members that seek leave to appear and be represented at the inquest. Lack of legal

representation at an inquest, or the failure of a family member to take concrete steps to seek leave, may result from a variety of reasons. It should not prejudice the right of family members to access information in a timely way.

Recommendation 13

(a) Amend the Coroners Act to place an onus on the Coroner to provide relevant material to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.

(b) Alternatively, that the State Coroner issue a Practice Note to require that relevant material be provided to relatives of the deceased as soon as it is available unless there are compelling reasons to delay or not provide the information.

Recommendation 14

That the Coroners Court review its processes to ensure that families of the deceased are provided with information and brief material in a timely manner, and that the State Coroner consider issuing guidelines (similar to the Queensland State Coroners Guidelines 2013) in relation to the rights and interests of family members.

10. Support for families

10.1 Counselling services

The limited availability of counselling and support for families involved in the coronial system is a gap in services often raised by our clients. For families experiencing a sudden or unexpected death, social workers at NSW Health Pathology's Forensic Medicine Service provide intervention at an early stage, when the deceased's body has been received.[43] The purpose of this intervention is limited, and is primarily directed towards confirming the family's wishes in relation to post-mortem procedures and initial grief support. Once post-mortem procedures are complete, there is no handover to any ongoing counselling or support service for families.

The Coronial Information and Support Program (**CISP**) is limited to providing practical information about the inquest process, court familiarisation and access to viewing sensitive evidentiary material.[44] We understand that CISP does not have the capacity to undertake individual counselling or to provide ongoing support services. Further, in the absence of any counselling, our solicitors report a lack of available brochures or information available to families, including referral services. In the ACT, a Coronial Counselling Service run by Relationships Australia is available at no cost during the coronial processes and up to three months after an inquest has concluded.[45] Research has identified a finding of death can be profound and distressing for some families, and highlights the need for post-inquest debriefing and support.[46] Legal Aid NSW would strongly support the funding and provision of counselling and support for all families Throughout NSW involved in the inquest process.

10.2 Court facilities

Until 2019, families attending Glebe Coroner's Court complex had a small but dedicated 'family room' available within the court complex. This room had comfortable soft furnishings, artwork, water, and privacy, and was an area that families were able to comfortably occupy to the exclusion of others. During our representation of families at inquest, our solicitors have observed the benefits of allowing families to avoid close contact with other witnesses, where such contact would exacerbate trauma. This room was also used for therapeutic jurisprudence, for example where witnesses and families

[43] Kerryn Butler, 'Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences' (Review, Law and Justice Foundation of New South Wales, April 2021),13.

[44] Ibid.

[45] Ibid 14.

[46] Ibid 25.

came together to provide apologies and seek forgiveness. Such spaces enable families to excuse themselves from the court room during traumatic evidence but remain nearby so they can re-enter the court room once the evidence has finished. Unlike other parties to an inquest, families can experience strong emotions of grief during the course of an inquest, and allowing families to express their emotions away from the view of other legal representatives or witnesses is paramount. Unfortunately, despite containing a number of publicly available meeting rooms, with tables, the State Coroner's Court at Lidcombe provides no dedicated rooms for families attending inquest hearings and our clients.

Legal Aid NSW supports the development of breakout 'family rooms' at Lidcombe Coroner's Court, as suggested by a participant survey into improving family engagement:

> Making families feel welcome at the Coroners Court is a vital part of improving the overall process. This could be as simple as providing tea and coffee for family members during inquests, or having a comfortable room for families and their representatives to go that is hidden from the gaze of the media and attending police. Many participants suggested that these simple things could go a really long way in proving families' experiences of the coronial system, and is certainly something that is almost immediately achievable.[47]

10.3 Financial assistance

A further area of concern is the lack of financial assistance for families attending inquests at the State Coroner's Court or other locations in NSW. In many death in custody inquests, Corrective Services NSW will offer to reimburse accommodation costs. In all other inquest matters, unless a family member is subpoenaed to give evidence, they will usually not be provided with any reimbursement of associated travel or accommodation expenses. Financially disadvantaged clients have significant difficulty in securing accommodation in advance due to a lack of available funds. Other associated expenses which act as barriers to families attending inquests include childcare, food and transport. Often inquests last for one week of more, and these costs are an unfair burden on families when other witnesses are paid witness expenses, and most other interested parties are in attendance as a result of their employment, with their expenses being reimbursed.

[47] Lindsay McCabe, 'The Coronial System in New South Wales and Indigenous Australians' (LLM Thesis, The University of Sydney, 2019). See also generally Lindsay McCabe, Allen George 'Improving Indigenous family engagement with the coronial system in New South Wales; (2021) 46(3) *Alternative Law Journal* 212-218.

Recommendation 15

That the NSW Government ensure that resources and facilities are provided to support families attending inquests, including a coronial counselling service, family break-out rooms at court and grants to family members for childcare, travel and accommodation expenses.

11. Persons of Interest

Legal Aid NSW is concerned there is a gap in legal protection for persons of interest called to give evidence in coronial inquests. Unlike organisations or state parties, private individuals identified as 'persons of interest' (**POI**) have no avenue to paid legal representation. Persons of interest are at significant risk of loss of reputation, adverse publicity and the potential for criminal proceedings as a result of lack of proper legal protections.

Legal Aid NSW understands that in tribunals such as the NSW Independent Commission Against Corruption and the NSW Crime Commission, witnesses will be provided with a lawyer funded by the state, on the application to the Attorney General, if certain criteria are met.[48] The grant of assistance may be contingent upon factors including hardship, the relevance of the evidence and public interest considerations. Those applications are dealt with by DCJ Legal and generally, their solicitors will provide that legal representation or, in the alternative, arrange legal representation from a panel.

Legal Aid NSW is frequently asked to provide advice and legal assistance to witnesses and POI's at inquest proceedings. The requests come from the witness or POI directly, or often from solicitors at the Crown Solicitors, or solicitors from DCJ Inquiries or directly from Counsel Assisting the Coroner. POI are often vulnerable persons, who without proper advice and assistance, would not be able to protect their interests at the inquest.

The risks faced by POI and witnesses at inquests include referral to the DPP for potential charges; the giving of evidence without securing appropriate protections; or without being properly advised of their right to object on the basis of self-incrimination; and adverse publicity, which can often be mitigated by the making of a non-publication order.

Deaths under suspicious or unusual circumstances, or where the person died a violent or unnatural death, must be reported to the Coroner.[49] An inquest is required to be held where it appears the death may be a result of homicide.[50] At a coronial inquest, the evidence has not yet been capable of establishing that the person has committed an indictable offence beyond a reasonable doubt, otherwise criminal charges would normally have been laid. Yet, the individual POI, if subpoenaed to give evidence, is obliged to attend court, and may be subjected to rigorous cross examination. Section 61 of the Coroners Act permits a Coroner to grant a certificate against self-incrimination, however the exercise of the discretion depends on the individual raising an objection at

[48] See for example, *Independent Commission Against Corruption Act 1988* (NSW) s 52; *Crime Commission Act 2012* (NSW) s 42); *Law Enforcement Conduct Commission Act 2016* (NSW) s 77.

[49] *Coroners Act 2009* (NSW) s6, 35.

[50] *Coroners Act 2009* (NSW) s27.

the right time and seeking the protection. Without legal advice or representation, the person is at a significant disadvantage in knowing how to exercise their rights, how to seek protective orders, question other witnesses, or make submissions.

Case study: Inquest into the disappearance of William Tyrell

In 2019, DCJ Inquiries contacted Legal Aid NSW requesting that we facilitate legal advice to multiple persons of interest who were subpoenaed to appear at the inquest into William's disappearance.

Legal Aid NSW policy guidelines do not allow the assignment of POI matters to private lawyers for representation. Legal Aid NSW solicitors were limited to providing minor assistance services to those individuals, despite the risk of jeopardy and reputational damage being significant.

Recommendation 16

That the NSW Government provide additional funding to ensure that persons of interest can be provided with legal representation at inquests, where certain criteria are met.

11.1 Referrals to the Office of the Director of Public Prosecutions and delay

Legal Aid NSW provides assistance to individuals who are put at enormous stress when a Coroner forms an opinion that there is a reasonable prospect the person could be convicted of an offence which caused a death or fire. When a Coroner suspends an inquest, or otherwise forms this opinion pursuant to section 78(2) of the Coroners Act, a copy of the Coronial brief of evidence is sent to the Office of the Director of Public Prosecutions (**ODPP**).

In our experience, there can be a delay of one year or more in the ODPP reaching a decision and often this does not result in a prosecution. In that scenario, the matter is returned to the coronial jurisdiction for resumption of the inquest, or formal findings. Legal Aid NSW is concerned about the impact of the delay of the ODPPs decision on whether to prosecute on the individual concerned, and the family of the deceased.

Case study: delay in charging family members

In November 2018, Legal Aid NSW advised three members of a deceased's family, each of whom had been identified as persons of interest in relation to the

death of a 21 year old. The inquest proceedings that month were suspended, and a referral made under s.78 to the ODPP. The death had occurred in early 2015.

It was not until February 2020, 15 months after the referral, that two members of the family were charged with manslaughter by gross criminal negligence. Another year went by before the DPP discontinued the prosecution, some 7 years after the death occurred.

For families of the deceased, the wait for justice is agonising. From late 2015, Legal Aid NSW assisted an Aboriginal family living in regional NSW in relation to the violent death of a family member in 2013 after an altercation. Despite an immediate criminal investigation, it took almost two years before the ODPP decided to not prosecute. The family then argued for an inquest to be held, which eventually resulted in the referral of a known person to the ODPP in August 2019. Over a year later, the ODPP had not reached a decision, nor engaged meaningfully with the family in relation to the matter.

Homicide matters are serious offences of great public concern. The ODPP's delay in making a decision after a Coroner's referral diminishes public confidence in the justice system. To our knowledge, there is no timetable that sets an expectation of when the ODPP will reach a decision following a s 78 referral. This issue is further illustrated by the below case study.

Case study: Abraham[51]

Abraham was a refugee aged in his 20s with a permanent residency visa, living in Sydney. Abraham had mental health issues and was homeless at the time he was arrested on suspicion of a death that occurred in 2009. Abraham was arrested and imprisoned for other offences, but not charged with murder until October 2015 when he was due for release.

In July 2017 the ODPP discontinued a prosecution for murder due to a lack of evidence. Abraham was in custody and had been bail refused since he was

[51] Not his real name.

charged. The charges were dropped a year after his lawyers had made submissions that there be no further proceedings.

Abraham was then taken from Corrective Services custody to immigration detention, and as a suspicious death, the matter came before the Coroners Court. Abraham's revocation of detention application with the Department of Home Affairs was put on hold awaiting the Coroner's Findings.

The Coroner held an inquest in December 2017. At the conclusion of the inquest Counsel Assisting recommended a referral back to the ODPP. The Coroner made the referral in December 2017, but it was not until February 2018 that the brief was sent to the ODPP.

Abraham continued to be held in immigration detention throughout 2018, and by September 2018 had been in custody for 9 years. In November 2018, the ODPP reached a decision to not prosecute Abraham. The case was returned to the Coroner's office for a decision to resume or dispense with the inquest. By 2019 no decision had been made, and Abraham's immigration case continued to be on hold.

At the end of January 2019, Abraham completed suicide.

Recommendation 17

Amend the Coroners Act to establish a statutory timeframe in relation to referrals under section 78 of the Act.

Recommendation 18

(a) That the Office of the Director of Public Prosecutions develop a guideline in relation to referrals under section 78 Coroners Act in order to minimise the delay in charging a person or advising that no proceedings will be taken, and

(b) That the State Coroner consider issuing a practice note for referrals under section 78 of the Coroners Act and timely decisions by the Office of the Director of Public Prosecutions regarding those referrals.

12. Cultural competence

12.1 Distrust of the coronial system

Our lawyers have been aware for many years of the lack of trust that many Aboriginal and Torres Strait Islander families have in relation to the coronial system, leading to speculation and outrage as to the circumstances surrounding a loved one's death. Usually, these reactions are at their most extreme in mandatory inquests involving deaths in custody or as the result of police operations.

The recurring client experience we observe at Legal Aid NSW was described by the RCADIC Commissioner in his findings in relation to foul play:

> The suspicion on the part of relatives and friends that there had been foul play was very strong indeed in some cases. One of the great weaknesses in those responsible for notifying relatives of deaths or for conducting investigations into deaths has often been the failure to realise that such suspicion was likely to occur and was not unreasonable in the minds of relatives. From the point of view of relatives a live brother, father, husband or son goes into custody and a dead body is returned. It must never be forgotten that a very important and legitimate part of the 'racial memory' or 'cultural heritage' of Aboriginals in this country is the deliberate hunting down and killing of their ancestors and the deliberate destruction of their families by the forcible movement of groups and individuals and the taking away of children. With these memories police are very strongly associated. Today police continue to arrest Aboriginals at many times the rate at which they arrest other people. One simply cannot expect many Aboriginals to share the benign view of the police function that is held by many non-Aboriginals.
>
> Death often takes place under circumstances where the only witnesses of the immediately surrounding events are custodial officers, in whose interest it is that the deceased should be found to have died by his or her own hand, or by natural causes without fault on their part. Any investigation which is to convince outsiders must critically examine such hypotheses and investigate the alternative hypotheses of death by foul play or negligence.[52]

12.2 Advocating for change

Since 2018 we have advocated for reforms to address our concerns, including a practice note to introduce changes such as the immediate briefing of the Crown Solicitors in all Aboriginal and Torres Strait Islander death in custody matters, an early directions hearing, and the early provision of information to family. We have been greatly encouraged by the State Coroner's early support for these proposals, and the significant

[52] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) 61-62.

changes in practice that have been implemented recently in specific death in custody cases. Subsequently, the circulation of a draft First Nations protocol earlier this year has resulted in improvements to processes, with earlier and greater engagement with family taking place, and reduced delays in the listing of inquests. This has been demonstrated in our recent casework, which is impacting positively on our Aboriginal and Torres Strait Islander clients.

Case study: Jonathan Hogan

Jonathan Hogan died at Junee Correctional Centre on 3 February 2018, a much-loved son of Matthew Hogan and his large extended family from Canberra. Jono was 23 years old and a proud Indigenous man of the Wiradjuri, Ngiyampaa and the Murrawarri people.

By late 2018, despite having the dedicated support of the ACT's Winnunga Nimmityjah Aboriginal Health Service, Jono's father Matt – based in Canberra - had struggled to access information about his death and was without legal representation.

Listening to Winnunga's CEO Julie Tongs describe Matt's struggles at a presentation in Canberra in November 2018, Legal Aid NSW was alerted to his predicament. We promptly sought and received instructions to act for Matt. Deputy State Coroner Grahame acted swiftly to list a directions hearing and engage the assistance of the Crown Solicitors Office. A directions hearing was held shortly before Christmas 2018, and orders made for service of the brief by late January 2019.

The inquest was held over 5 days in December 2019 at the State Coroners Court in Lidcombe. From the outset, Jono's indigenous heritage was recognised by Coroner Grahame, and permission granted to display in the courtroom a photograph of Jono, a painting by him, and a didgeridoo made by his father Matt and painted by Jono.

Five days of evidence included a detailed analysis of the lack of mental health care provided to Jono, who ultimately took his own life.

Speaking to the court by way of a family statement at the end of the proceedings, Jono's father praised the efforts of the NSW Police officer in charge of the investigation, whilst recounting his futile efforts to get information (or even a return phone call) from Junee Correctional Centre. Later, he said:

I think I would've felt better if I had been able to see Jono and look at his cell and go to the smoking ceremony and memorials. I know that my wife and daughter were not called and asked to be involved in anything.

At the end he said:

It's not just about Jonathon passing away in custody. I'm trying to get an answer so it doesn't happen to another family again. That's one of the main things too, so it doesn't happen to somebody else and they don't go through the heartache we've gone through.

Despite these steps, Legal Aid NSW believes that further improvements can be achieved, including to bring the NSW coronial system into line with practices observed in other Australian jurisdictions. Inquest delays in NSW are still significant, causing undue distress to family members. This is exacerbated by a lack of timely access to information and brief materials, depriving many families of an adequate understanding of what took place in relation to the death of their loved ones. The problem extends to all coronial investigations, not just those few matters that go to inquest, and impacts on families from a wide range of backgrounds, whether they be Aboriginal, from other culturally or linguistically diverse communities, or from elsewhere.

In our experience, there is a need for better communication with Aboriginal and Torres Strait Islander families in all coronial matters, not just section 23 deaths. For example, Aboriginal and Torres Strait Islander persons are proportionally over-represented in suicide deaths, many of which occur in regional areas.[53] We receive many requests for assistance from Aboriginal and Torres Strait Islander families in regional areas, where families hold significant distrust in the local police conducting coronial investigations. Often, they are not getting any information about the death of a family member reported to the coroner.

The history of trauma and poor relations between police and the Aboriginal and Torres Strait Islander community exacerbates the problem. In regional areas, the local police

[53] *NSW Government Health Statistics* (Website) <http://www.healthstats.nsw.gov.au/Indicator/men_suidth/men_suidth_Aboriginality_age>.

officer in charge is often the primary point of contact for families involved in the coronial system. The fact that police investigate on behalf of the coroner creates significant distrust.

12.3 The ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities

Legal Aid NSW recognises that families from a wide range of culturally and linguistically diverse backgrounds become involved with the coronial system. We support improved coronial processes to better support all families that interact with the system. Specifically, there is an opportunity to provide better information and support for families, more timely and better legal representation, and culturally appropriate services. In particular, we support improved processes for Aboriginal and Torres Strait Islander families, both in general and following a death in custody, and our submission is focused on their needs.

A recent publication by the Law and Justice Foundation of New South Wales entitled "Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences" provides an Australia-wide overview of culturally specific services within coronial jurisdictions. The research was undertaken for Legal Aid NSW in order to support coroners courts and legal assistance services seeking to develop culturally appropriate services and practices. It found that culturally specific services range from very minimal or ad-hoc services in some states, to specialised in-house services in others.[54]

Three broad themes emerged concerning the impact on families of the coronial system, being: coronial communication and information-seeking, respect of culture, and voice and jurisprudence.[55] Implications for practice identified by the research included cultural training for investigating police officers, and the establishment of culturally specific units employing Aboriginal and Torres Strait Islander staff within each coroners court.[56] A copy of this report has been provided as an appendix to this submission.

12.3.1 Better information and support for families

We understand that Coronial Practice Note 3 of 2021 will commence shortly, to cover case management issues in relation to all section 23 deaths in custody and as a result of police operations. Further, the imminent introduction of a First Nations Protocol to cover First Nations deaths under section 23 provides a unique opportunity to address

[54] Kerryn Butler, 'Aboriginal and Torres Strait Islander Families in Australian Coroners Courts: A review of the research literature on improving court experiences' (Review, Law and Justice Foundation of New South Wales, April 2021), 10

[55] Ibid 22

[56] Ibid 24

concerns about access to information and brief materials, which continue to be experienced by family members in existing matters.[57]

12.3.2 More timely and better legal representation

The court's capacity to respond to the needs of culturally and linguistically diverse families and communities is enhanced when family members are legally represented. Legal Aid NSW is encouraged by the intent of the First Nations Protocol, which in part seeks to facilitate legal advice and representation for Aboriginal and Torres Strait Islander families, as we consider it vital to the coronial process that families have their own legal representatives.

Our casework representing the families of David Dungay, Rebecca Maher, Jono Hogan, Danny Whitton, Bailey Mackander and others has informed our views as to the needs of Aboriginal and Torres Strait Islander families during the inquest process, including at the early stages after a death occurs. Since 2015 there have been about five to six deaths each year of Aboriginal and Torres Strait Islander people in NSW under section 23 of the Coroners Act. Each of these deaths is reported to the Aboriginal Legal Service, and it is likely that in many cases, the family will be represented at the inquest by Legal Aid NSW or the Aboriginal Legal Service. Whilst the Coronial Inquest Unit appear in other inquests, representation by the Aboriginal Legal Service is restricted to mandatory inquests of Aboriginal persons under section 23.

Representation for families at inquest is crucial to the integrity of the process and the therapeutic benefits for family. Further resources are needed to ensure that more timely and better legal representation can be provided to all families, and in particular, to Aboriginal families.

12.3.3 Culturally appropriate services

Legal Aid NSW is encouraged by the recent funding of two identified positions within the NSW Coroner's Court, having previously identified the need for culturally specific services to accommodate the large number of Aboriginal and Torres Strait Islander people who interact with the NSW coronial system.

[57] See *9.Provision of information to families* above, and recommendations 13 and 14.

Aboriginal and Torres Strait Islander employment at Legal Aid NSW[58]

At Legal Aid NSW, over 100 of our staff identify as Aboriginal, which is 6.9 % of our workforce. We have 51 Aboriginal Identified roles, of which 76% are occupied by an Aboriginal person. We employ 31 Aboriginal solicitors, of which 13 are in identified roles.

Legal Aid NSW's Aboriginal Services Branch works across all policy, program and practice areas to ensure that Legal Aid NSW responds to the legal needs of Aboriginal people in a culturally appropriate and comprehensive manner, while also placing Legal Aid NSW as an employer of choice with Aboriginal people to ensure our workforce is reflective of our client base.

Legal Aid NSW has also developed Best Practice Standards for Representing Aboriginal Clients, which provide an insight into the issues that all practitioners need to understand in order to provide effective legal representation to Aboriginal clients no matter what the jurisdiction, as well as issues specific to crime, family and civil law.

At Legal Aid NSW, we work in partnership with Aboriginal people and communities to identify and provide services for their legal needs. Our lawyers provide targeted community legal education and coordinate Outreach services across all practice areas, and Aboriginal Cultural Awareness Training is available to all staff and key partners.

Legal Aid NSW is committed to increasing the percentage of Aboriginal people who work at Legal Aid to 11% of the total workforce by 2023 while providing meaningful career development opportunities.

Historically, the CISP within the Coroners Court has never had any Aboriginal or Torres Strait Islander staff, prior to the recently funded positions. Likewise, we are not aware of any Aboriginal or Torres Strait Islander staff filling positions within the counselling services provided by NSW Health Pathology's Forensic Medicine. These are the two services that provide specialist support to families of the deceased, first at the initial stage where a body has been received, and second, when a coronial matter is received by the Coroners Court.

[58] As at 10 September 2021.

In contrast, Victoria has a Koori Family Engagement Unit which provides guidance to the Coroners Court of Victoria, to ensure its service provision is and remains culturally informed and appropriate.

Koori Family Engagement Unit - Victoria

In March 2019, a Koori Family Engagement Coordinator was appointed at the Coroners Court in Victoria to better serve Aboriginal and Torres Strait Islander families involved in coronial investigations. The role was developed in consultation with the Aboriginal Justice Caucus and Aboriginal and Torres Strait Islander community groups. It provides services to support families and ensure culturally safe practices are embedded within Court processes. It includes incorporating Sorry Business practices throughout coronial investigations and coordinating smoking ceremonies and Welcomes to Country during inquests.

A second position of Koori Family Engagement Officer was advertised in 2020, to provide culturally safe support to family, friends, and the community throughout the coronial process, while offering culturally focused advice and support to Coroners on aspects of their coronial investigations.

Two Aboriginal-identified roles have been funded to appropriately resource the team to support both Men's Business and Women's Business.

Legal Aid NSW supports the recent creation of similar positions at the NSW Coroners Court. We also support the creation of Aboriginal-identified positions in other support roles and registry positions at the Coroners Court, together with NSW Health Pathology's Forensic Medicine, particularly social worker positions.

Recommendation 19

That Aboriginal identified positions be established within the Coroners Court (including positions in the court registry and other support positions), and within NSW Health Pathology Forensic Medicine, particularly social worker positions in order to improve cultural competency of the services that they provide.

12.4 Legislative reform to reflect cultural considerations

There is the need for the Coroners Act and coronial processes to specifically accommodate cultural needs and considerations. There are no specific provisions in the Coroners Act that make provision for cultural considerations, particularly in relation to Aboriginal and Torres Strait Islander people. NSW is the only Australian jurisdiction that has a Coroners Act which does not make specific provision for Aboriginal and Torres Strait Islander peoples, other than South Australia.

Other jurisdictions make provisions in relation to the determination of senior next of kin and family members, thereby allowing consideration of the customs and traditions of the community or group to which the person belongs. Other provisions encourage the coronial system to engage with families in ways that respect cultural diversity, whilst in Western Australia, the Act allows regulations to be made that would give effect to the recommendations of the RCADIC.

Case study: cultural engagement

AL was born in 1987 in New South Wales to New Zealand born Māori parents and was the youngest of three siblings. He was 30 years old when he died from a heart condition after being tasered and held down by police during a mental health crisis outside Royal Prince Alfred Hospital in February 2018. An inquest was held into his death in 2020 and findings delivered in 2021.

AL's family felt it was vital that at the conclusion of the inquest they send him home to New Zealand and settle his spirit. After seeking permission from the Coroner, the family performed a Haka in honour of AL and as a demonstration of respect to the court.

Three males from the family (one of them AL's brother), led the Haka, facing the police and their lawyers. The opening words "Ka mate, ka mate! ka ora! ka ora!" roughly translate as "it is death, it is death, it is life, it is life…"

In the silence that followed, AL's mother "sang AL home" to allow his spirit to pass over, with the family joining in. The ceremony had a powerful impact on all present. The family was very grateful to the court for its willingness to support this traditional ceremony and they were in great spirits on the day the findings were delivered.

Provisions in the NSW Coroners Act dealing with investigation directions and exhumations, and objections to the exercise of post-mortem investigative functions, contain no requirement to take account of cultural considerations, particularly those of Aboriginal and Torres Strait Islander people.[59] Likewise, the definition of 'relative' and

[59] *Coroners Act 2009* (NSW) Pt 8.1 and 8.2.

'senior next of kin' make no reference to cultural considerations, and no allowance for the potential departure of Aboriginal family relationships from those definitions.[60]

Legal Aid NSW supports legislative reform of the Coroners Act to amend the definition of 'relative' and 'senior next of kin' to recognise persons who are part of an extended familial or kinship structure in diverse cultures (including Aboriginal and Torres Strait Islander cultures). We would also support amendments to allow the appointment of persons other than the default senior next of kin, including where there are competing claims, but only in exceptional circumstances.

Recommendation 20

Amend the Coroners Act in order that:

- definitions of 'relative' and 'senior next of kin' will recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures).
- persons other than the default senior next of kin may be appointed by the Coroners Court in exceptional circumstances, including where there are competing claims.

12.5 Protocol for post-mortem investigations

In our experience, many of the suspicions and grievances experienced by Aboriginal and Torres Strait Islander families relate to contact with NSW Health Pathology Forensic Medicine shortly after a death. In particular, the viewing of deceased relatives by family members has resulted in observations that continue to disproportionately and incorrectly inform a family's views as to what may have taken place.

It is noteworthy that almost 30 years ago, the RCADIC recommended that the State Coroner or their representative:

> … should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rights and that relatives of a deceased aboriginal person be spared further grief.[61]

[60] Ibid ss 5 and 6A.

[61] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 38.

We are not aware of any Forensic Medicine publication or guideline that deals with all post-mortem issues that arise, including cultural considerations. Nor are we aware of any publication by the State Coroners Court. We support the development of such a publication to guide dealings with Aboriginal families after a death has taken place.

Recommendation 21

That NSW Health Pathology's Forensic Medicine, in consultation with the State Coroner, develop a publicly available guideline that deals with post-mortem issues, including in relation to cultural considerations.

13. Coronial recommendations and oversighting their implementation

Legal Aid NSW is concerned about the framework which governs responses to coronial recommendations. At present, there is no legislative requirement under the Coroners Act for any interested party, including government agencies, to respond to coronial recommendations. If the coronial system is to fulfil its role in promoting death prevention, an essential component of the coronial system must involve a rigorous system for response to coronial recommendations, and accountability of those to whom the recommendations are directed.

We support the Recommendation 32 of the First Nations Select Committee, directed at deaths in custody, for the reasons outlined in our submission to that Inquiry:

> That the NSW Government amend the Coroners Act 2009 to ensure that the relevant government department and correctional centre respond in writing within six months of receiving a Coroner's report, the action being taken to implement the recommendations, or if no action is taken the reasons why, with this response tabled in the NSW Parliament.[62]

Families would find the process more therapeutic if they had greater confidence that Coroner's recommendations would be followed up. The comfort that families derive from hoping that no other family will suffer in the same way they did can be eroded by a sense that recommendations are empty rhetoric. This is compounded where systemic failures are the main contributors to the death: processes have failed but, despite this being acknowledged, there is no confidence those processes will change.

13.1 Outcomes of recommendations made

Legal Aid NSW is concerned by poor response to coronial recommendations by both government agencies and private sector organisations. In 2019, Legal Aid NSW appeared in 10 inquests which resulted in coroners making a total of 59 recommendations during that year. In most cases government departments responded, but about 18% of responses remain outstanding. In 2020, Legal Aid NSW appeared in five inquests involving recommendations, resulting in 35 recommendations, of which 94% of responses remain outstanding.

There is a lack of accountability where no response is received. This includes non-government agencies, who are not required to report to the Attorney General. Such

[62] Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody, Parliament of New South Wales, *First Nations people in custody and oversight and review of deaths in custody* (Report No 1, April 2021) xiv.

organisations include private health services, such as aged care facilities or private hospitals.

Below is a table of inquests where recommendations remain outstanding, according to the Attorney-General's website which lists responses to recommendations:[63]

Inquest	Recommendations	Implementation
Inquest into the death of Jonathon Hogan (First Nations death in custody) 6 May 2020	5 made to GEO Group Australia Pty Ltd, 1 made to Corrective Services NSW.	Response received by CSNSW 4 Responses awaited from GEO Group Australia Pty Ltd.
Inquest into the death of Mahmoud Allam (death in custody) 25 March 2020	4 made to Justice and Forensic Mental Health Network. 2 made to the CEO of Therapeutic Guidelines Limited.	No response received
Inquest into the death of AP (child) 1 June 2020	2 made to the Department of Communities and Justice. 4 made to NSW Ministry of Health and Local Area Health District.	No response received
Inquest into the death of Hazel Brockett 3 March 2020	11 made to Southern Cross Care NSW and ACT	No response received
Inquest into the death of Epenesa Pahiva 27 September 2019	4 made to Castellorizon Aged Care Services	No response received

[63] NSW Communities and Justice, *Government Reponses to Coronial Recommendations* (23 August 2021) <https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx>.

The issues are further illustrated by the following case study.

Case study: Jonathan Hogan

On 6 May 2020, Deputy State Coroner Grahame made findings that Jonathon died on 3 February 2018 in his cell at Junee Correctional Centre ("Junee CC").

Jonathon died from suicide while he was alone in his cell. Jonathon's deteriorating mental health, in the context of a breakdown in his de-facto relationship and inadequate mental health care provided to him in custody, were contributory factors to his death.

Coroner Grahame made six recommendations, four of which were to the Chief Executive Officer, GEO Group, which operates Junee CC.

The Coroner recommended that GEO review Junee CC's procedures for inmates with known diagnoses for serious mental illnesses, to ensure they are assessed by a suitably qualitied mental health clinician on intake. The Coroner also recommended that GEO review mental health staff to patient ratios to ensure inmates suffering serious mental illnesses are reviewed by a psychiatrist.

Of importance to Jono's father Matt, the Coroner recommended GEO consider creating at least three full-time Aboriginal Health Worker positions at Junee CC.

So far, no response from GEO Group Pty Ltd has been published on the Attorney-General's website which provides NSW Government Responses to Recommendations.

13.2 The mechanisms for oversighting whether recommendations are implemented

The Premier's Memorandum M2009-12[64] provides that, within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney General outlining any action being taken to implement the coronial recommendation. If it is not proposed to implement a recommendation, reasons should

[64] Premier's Memorandum M2009-12 sets out the process for responding to coronial recommendations directed at Ministers and NSW government agencies. The purpose of the Memorandum is to ensure that there is a consistent process across government for responding to coronial recommendations, and that there is increased accountability and transparency in responding to such recommendations.

be given. We hope that the NSW Government supports and adopts Recommendation 32 of the First Nations Select Committee, to address the declining levels of adherence to Premier's Memorandum M2009-12 over recent years.

In Victoria, the *Coroners Act 2008* requires that a public statutory authority or entity which is the subject of a coronial recommendation must provide a written response within three months after receiving a recommendation, and that response must specify a statement of action (if any) that has, is or will be taken in relation to the recommendation.[65]

Similarly, the

RCIADIC recommended a three-month response period following findings.[66] Further to our submission above, Legal Aid NSW also supports this approach, rather than a timeframe of six months, as responsive to the need to act quickly as a matter of public health and safety to remedy systemic failings, assuming that further follow up is possible.

The written response should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations and should be provided within either three or six months of receipt of the Coroner's findings. We support a requirement that government agency responses to recommendations are tabled in a report to Parliament so that there is an increased level of parliamentary oversight.

Case Study: Inquest into the deaths of RP and DJ

Both RP and DJ were inmates at Metropolitan Remand and Reception Centre. Both men were killed by their cellmates, who were suffering from an active schizophrenic illness in 2010 and 2012. A coronial inquest into the deaths did not commence until August 2018, following criminal proceedings in 2014 where both perpetrators were found not guilty by reason of mental illness. The hearing was completed in March 2019 and findings delivered on 4 July 2019, over 9 years after RP's death, and almost 5 years after BB's criminal proceedings were finalised.

The Coroner found that given their psychotic states, neither MA or BB should have been placed in a cell with another person. Expert evidence identified that any acutely mentally ill prisoner should never be managed within the general prison population. The Court received evidence of huge pressures on beds in

[65] *Coroners Act 2008* (Vic) s 72. Similar legislative provisions exist in the ACT (*Coroners Act 1997* (ACT) s 76), and the Northern Territory (*Coroners Act 1993* (NT) ss 27, 35, 46A and 46B).

[66] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 15.

MRRC's Mental Health Screening Unit and other MRRC pods housing mentally ill inmates, together with the limited capacity of Long Bay Hospital to treat inmates requiring mental health services.

One recommendation was *"that consideration be given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in New South Wales in a secure health facility rather than in the general prison population."*

Corrective Services NSW and Justice Health support this recommendation, noting: *"although the proposition of creating a secure health facility has merit, this requires decision from the Government due to several reasons, including funding allocation for establishing such a secure facility for acutely mentally ill inmates."* Legal Aid NSW is not aware of any commitment to establish such a facility.

During the inquest, Justice Health's Clinical Director of Custodial Mental Health, Dr Sarah-Jane Spencer, gave evidence that:

Unless there is a massive overhaul, people are going to keep dying either at the hands of their cell mate, or because they take their own life.

In the year following that evidence, two more deaths occurred at MRRC in 2019 where inmates suffering acute mental illnesses killed their cellmates. Delays in our coronial system, and a corresponding failure to act on coronial recommendations, demonstrate how a failed system will continue to result in avoidable deaths.

We also recommend 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",[67] which is consistent with the recommendations of the RCADIC, but which has never been implemented in NSW.

We understand that in practice, NSW coroners do not usually follow up on recommendations made in relation to inquests that have been finalised. They are neither empowered nor resourced to do so. This results in a coronial system with limited traction, and without any clear imperative for government agencies to tackle difficult issues raised at inquest. The establishment and funding of a Coroners Prevention Unit (**CPU)** at the

[67] *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 16.

Coroners Court (addressed below) would provide the resources and expertise to follow up on recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

The implementation of a mandatory response regime embedded into the legislation and containing parliamentary oversight would provide greater hope to families who take comfort from targeted systemic changes arising after the death of a loved one. It would also enhance the transparency of the coronial process and the accountability of government agencies, together with providing substantial improvements to the ability of the coronial system to prevent death and injury.

Recommendation 22

Amend the Coroners Act to introduce a mandatory response regime to coronial recommendations, with responses being tabled in Parliament. Responses should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations. A response should be provided within three months of the Coroner's findings.

Recommendation 23

Amend the Coroners Act to empower the State Coroner "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" in relation to all coronial recommendations under section 82 of the Act.

13.3 The need for a Coroners Prevention Unit

Legal Aid NSW supports the creation of a CPU embedded within the Coroners Court. The coronial system could be further improved if the collective findings and recommendations of similar inquests were analysed and reviewed to identify common themes and systemic issues, and to inform NSW Government policy responses to enhance death prevention.

In NSW, aside from child deaths and deaths from domestic violence, none of the inquest findings and recommendations are the subject of further systematic review or analysis, with a view to preventing or reducing the likelihood of further deaths. As a result, much of the good work being undertaken in inquests does not result in publicly available research to inform prevention and reduction of deaths such as those in custody, deaths as a result of police operations, and deaths from suicide, drug overdose or sub-standard healthcare.

The proposed solution to this crucial gap in the NSW coronial system is to establish a CPU, similar to the model in Victoria, as a specialist service for coroners to strengthen their prevention role and provide them with expert assistance. In Victoria the CPU does this by reviewing a range of reportable and reviewable deaths, collecting and analysing data relating to those deaths, and assisting coroners with the development of prevention-focused coronial recommendations.

Coroners Prevention Unit – Victoria

The central goals of the Victorian CPU are to improve the quality and applicability of coronial recommendations, increase their uptake and implementation, and contribute to the reduction of preventable deaths in Victoria. Amongst other things, the CPU undertakes both individual and collaborative research projects to support coronial investigations to generate a better understanding of preventable deaths in Victoria and identify intervention options. Since its inception, it has published reports which include understanding and preventing drug-related harms, gambling-related suicides, overdose deaths, and suicides of Aboriginal and Torres Strait Islander people.[68]

Referrals for assistance by coroners cover deaths where non-clinical advice is required, together with expert streams where clinical advice on healthcare or mental health are required. In 2019 – 20 Victorian coroners made 636 referrals to the CPU to seek input into:

- factors which may have contributed to the death,
- frequency of previous and subsequent similar deaths,
- previous interventions that have been proved or suspected to reduce the incidence of death,
- relevant regulations, standards and codes of practice, and
- previous coronial recommendations and other feasible evidence-based recommendations to reduce similar deaths.[69]

In NSW, the only systematic review or analysis of reportable deaths being undertaken is in relation to child deaths, deaths of people with disability in residential care, and

[68] Coroners Court of Victoria <https://www.coronerscourt.vic.gov.au/>.

[69] Coroners Court of Victoria, *Annual Report 2020*,.26 <https://www.coronerscourt.vic.gov.au/sites/default/files/2021-02/2019-20%20Coroners%20Court%20of%20Victoria%20Annual%20Report.pdf>.

domestic violence deaths. The latest reports, all of which are required to be tabled in Parliament, are:

- Biennial report of the deaths of children in New South Wales: 2016 and 2017 (published June 2019 by the NSW Ombudsman, NSW Child Death Review Team).
- Report of reviewable deaths of people in 2014 and 2015 & 2016 and 2017: Deaths of people with disability in residential care (published August 2018 by the NSW Ombudsman).
- NSW Domestic Violence Death Review Team Report 2017-2019 (published 2020).

These reports provide factual findings, analysis and recommendations that can result in lives being saved. For example, the latest report of the Domestic Violence Death Review Team (**DVDRT**) contained 34 recommendations directed at the NSW Government and a broad range of government agencies, together with detailed quantitative and qualitative findings. This important work was undertaken by the DVDRT, which comprises two employees with expertise in data collection and qualitative review.

Legal Aid NSW notes that until this year, no State Coroner's report into First Nations deaths in custody has ever been produced to enable tracking of systemic issues and recommendations.

Domestic Violence Death Review Team

Domestic violence deaths are the subject of review by the DVDRT, constituted under Chapter 9A of the Coroners Act. The object of the legislation is to "provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to reduce the incidence of domestic violence deaths and facilitate improvements in systems and services."[70]

The DVDRT is made up of a Secretariat, and includes statutory members from relevant NSW Government agencies, non-government organisations and other experts. The DVDRT reviews closed cases of domestic violence deaths, analyses data to identify patterns and trends relating to such deaths, and makes recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths.

[70] *Coroners Act 2009* (NSW) s 101A.

Importantly, the DVDRT multi-agency reviews provide a broader understanding of domestic and family violence related deaths than may be provided by investigations of discrete deaths and are therefore able to inform policy and systemic change in a way that other review processes cannot.

The DVDRT also assists Coroners on open cases and provides specialist expertise in respect of domestic and family violence in coronial matters. The DVDRT has established and maintains a database and undertakes research that aims to help prevent or reduce the likelihood of domestic violence deaths. An annual report is tabled in Parliament every second year, and the NSW Government has provided a published response to these reports.[71] The DVDRT demonstrates the significant outcomes achievable by a cost-effective operation.

The NSW coronial system requires more capacity than currently exists to achieve a death prevention role. For the system to have a meaningful impact, Legal Aid NSW supports the establishment of a CPU, to provide expert assistance to coroners, including with the development of prevention-focused coronial recommendations.

Recommendation 24

That the NSW Government provide funding to establish a Coroners Prevention Unit at the State Coroners Court to provide sufficient resources and expertise to follow up on coronial recommendations after findings have been delivered, thereby promoting adherence and action by government agencies.

[71] The latest NSW Domestic Violence Death Review Team *Report 2017-2019* reviewed 53 domestic violence related deaths in July 2014 to June 2016. Individual case reviews sought to identify common themes, issues and areas for recommendation. The report presented 34 recommendations to the NSW government and a wide variety of government agencies, together with detailed quantitative and qualitative review findings.

13.4 An independent Coronial Council

In Victoria, there is also a Coronial Council which was established under the *Coroners Act 2008* (Vic) and is the first body of its kind in Australia. It is independent from the Victorian Government and the Coroners Court.

Coronial Council – Victoria

Under the *Coroners Act 2008* (Vic), the Council's role is to advise and make recommendations to the Attorney-General on issues of importance to Victoria's coronial system; matters relating to the preventative role played by the Coroners Court, the way in which the coronial system engages with families and respects their cultural diversity, and any other matters relating to the coronial system that are referred to the Council by the Attorney-General.[72]

The Victorian Coronial Council acts in a way that does not impinge on the independence of coroners' professional tasks or the jurisdiction of the State Coroner; delivers strategic advice reflecting the changing physical and social environment with the aim of promoting a modern and responsive coronial system; strengthens collaboration between agencies across the service system; focuses on advice to enhance services to families; promotes the prevention role of the coroner; ensures that the views of bereaved families are reflected in the development of advice; complements existing governance structures in the State coronial system; and promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The Victorian Coronial Council and the Coroners Prevention Unit in Victoria are just two examples of how other jurisdictions have taken steps to enhance their coronial systems and promote their death prevention functions.

Recommendation 25

That the NSW Government establish an independent Coronial Council to advise and provide recommendations to government on the coronial system.

[72] *Coroners Act 2008* (Vic) s 110.

Aboriginal and Torres Strait Islander Families in Australian Coroners Courts

A review of the research literature on improving court experiences

APRIL 2021

LAW AND JUSTICE FOUNDATION OF NEW SOUTH WALES

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A review of the research literature on improving court experiences

Dr Kerryn Butler

Law and Justice Foundation of New South Wales

April 2021

The Law and Justice Foundation of New South Wales is an independent, not-for-profit organisation that seeks to advance the fairness and equity of the justice system, and to improve access to justice, especially for socially and economically disadvantaged people.

This report was prepared by the Law and Justice Foundation of NSW under its Research Alliance with Legal Aid NSW.

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This publication reports on the various services provided around Australia and acts as a starting point when reviewing culturally-sensitive practices. The scope of the report does not cover any consideration of future work or approaches to develop these services.

The Foundation acknowledges the Australian Aboriginal and Torres Strait Islander peoples of this nation. We acknowledge the Traditional Custodians of the lands in which we conduct our business. We pay our respects to ancestors and Elders, past and present.

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Glossary

A **coroner** is a judicial officer who investigates and makes findings about reportable deaths and suspected deaths. The coroner will be defined by the respective Coroners Act in each jurisdiction but usually must be a magistrate. The State Coroner and Deputy State Coroners are senior coroners and are usually appointed to their office by the Governor of the state.

Grey literature is research that is typically published outside of commercial or academic publishing. Examples of grey literature include statistics, government reports, conference proceedings, and policy statements. Grey literature can be an excellent source of information for a number of reasons; it can be more current than traditional academic literature, it can be a better source of information on policies and programs, it may minimise publication bias, such as reporting on negative as well as positive findings, and is often a good source of information. However, it should be noted that grey literature may not have been peer-reviewed to academic standards and should be evaluated accordingly.

An **Inquest** is a court hearing where the coroner considers evidence to determine their findings. Most coronial proceedings can be finalised by the coroner without the need of an inquest and this is often referred to as ‘on the papers’. In some cases, an inquest will be mandatory (e.g. death in custody).

Primary research is often described as firsthand accounts of a study written by a member of the study team. It typically follows the scientific method and includes data collected from surveys, interviews, focus groups, observations etc. Another way to describe primary research is ‘original research’.

(Senior) Next of Kin is the family member who is recognised as the main point of contact and the main decision maker for the family. Who the senior next of kin should be is defined in the Coroners Act of each state and territory. Broadly speaking the hierarchical relationship begins with the person’s spouse, adult children, parents, adult brothers or sisters, an executor of the will or legal personal representative. In some jurisdictions the Coroners Act also recognises traditional Aboriginal kinship relationships.

Post-Mortem / Autopsy examinations include non-invasive procedures such as medical record reviews, computed tomography (CT) scans, external examinations of the body and collection of blood or fluids for toxicology or other laboratory tests. More invasive procedures may include partial or full autopsies (internal) examinations.

Reportable deaths are defined by the Coroners Act in each jurisdiction. Broadly speaking (and subject to the Coroners Act) a person’s death may be a reportable death if the death is unexplained, unexpected, or suspicious. Definitions among the various states and territories are comparable.

Secondary research can be described as an analysis or interpretation of previously conducted primary research. The secondary research will draw together findings from studies the researcher did not conduct themselves.

Overview of the Australian Coronial System

A review of current coronial practices in Australia

Background

The Law and Justice Foundation of NSW (the Foundation) has undertaken a program of research for Legal Aid NSW which will support coroners courts and legal assistance services seeking to develop culturally appropriate services and practices. Legal Aid NSW sought to understand more about culturally sensitive practices or strategies that have been employed within various coronial jurisdictions. The starting point of the Foundation's investigation is a literature scan that is reported here. In this scan, the focus is on the experience of Aboriginal and Torres Strait Islander families' experience of the coronial process. Given the dearth of evidence in this space, the focus was then broadened to encompass the experiences of all families. This understanding can be used to identify where services could be developed or improved to better serve the families of Aboriginal and Torres Strait Islander people when engaged with the coronial system in Australia. This literature scan informs this work.

Coronial Investigation

The coronial system consists of both medical and legal processes. Broadly speaking, the medical processes are performed by state forensic medicine services who provide the coroner with expert advice concerning the medical cause of death. Forensic services utilise a number of procedures and tests including external examination, toxicology tests, microbiology tests and histopathology examinations. Where required, partial or full internal examination (autopsy) is performed. Some states will also utilise computed tomography (CT) scans which can inform the direction of autopsy, and in some instances can negate the need for internal examinations.

Legal processes are performed by the coroners court. It is the responsibility of the coroner to confirm or, if necessary, determine the identity of the person who died, the time, date, and location of the death, the cause and manner of the death. These findings are necessary for a death certificate to be issued.

Coroners court services

In Australia, the coronial system in each jurisdiction is governed by legislation. The Coroners Act in each jurisdiction provides for the appointment and functions of coroners and assistant/deputy coroners and or magistrates. Each Coroners Act details the types of deaths that must be reported to the coroner and establishes the authority of the office to investigate deaths or suspected deaths in order to determine the identities of deceased persons, the times and dates of their deaths and the manner and cause of their deaths. The coroners court is inquisitorial in nature and is concerned with finding out what happened. The coroners perform a unique and important role within the legal system.

Coroners are responsible for ensuring that deaths arising in suspicious, violent, unnatural and unknown circumstances are properly investigated.

For this research project we note coroners can assist grieving families by providing them with an understanding of the circumstances in which a loved one has died. Nevertheless, given that the deaths which fall under the jurisdiction of the coroner are often unexpected, sudden, and frequently traumatic in manner the coronial process can be very difficult for families. The very nature of these types of deaths and the uncertainty surrounding the details may cause a compounding of grief and a re-living or re-traumatising process for families involved with the coronial system. This requires sensitivity and consideration for families in order to not add to their distress.

Deaths investigated by coroners comprise only a small proportion of all deaths. Of all deaths investigated by a coroner, most deaths are dealt with 'on the papers', a largely administrative process. Some of these deaths may need an autopsy (post-mortem) to assist the coroner to determine cause of death. A small proportion of reportable deaths will require an inquest (court hearing) where the coroner considers evidence from witnesses. In some cases, such as where there is a death in custody or as a result of police operations, an inquest will be mandatory.

Although no current data is publicly available reporting the number and proportion of Aboriginal and Torres Strait Islander people whose cases have been considered in the coronial system, previous research has reported on this issue. Data collected for 2003–2004 in a Queensland study showed that 25% of the total number of Aboriginal and Torres Strait Islander deaths were reported to, and investigated by, the coroner. In comparison, only 9.4% of non-Indigenous deaths. Many deaths that come to the attention of the coroner, represent avoidable deaths, and even in natural cause deaths most come to the coroner because the death is unexpected. This apparent overrepresentation of Aboriginal and Torres Strait Islander people in these figures is strongly suggestive of the poorer health outcomes experienced. Nevertheless, this study showed there were disproportionately more Aboriginal and Torres Strait Islander deaths reported in nearly every category of reportable death and they are more likely to find themselves engaged with the coronial system than non-Indigenous people. Examples of categories include; natural cause deaths (for which a medical practitioner has not signed, and is not likely to sign, a death certificate), accidents, suicides, homicides, and medical/surgical complications.

The Coroners Acts and the Aboriginal and Torres Strait Islander community

The states and territories of Australia each have their own Coroners Act. There are slightly different aims and emphasis in each jurisdiction. In terms of engaging with Aboriginal and Torres Strait Islander people, the states and territories have implemented, to a lesser or greater degree, a number of recommendations that have been made through various coronial reform processes including the Royal Commission into Aboriginal Deaths in Custody.

The coroners courts of the states and territories operate under the following Acts:

- New South Wales – *Coroners Act 2009*.
- Australian Capital Territory – *Coroners Act 1997*.
- Victoria – *Coroners Act 2008*.
- Tasmania – *Coroners Act 1995*.
- South Australia – *Coroners Act 2003*.
- Western Australia – *Coroners Act 1996*.
- Northern Territory – *Coroners Act 1993*.
- Queensland – *Coroners Act 2003*.

Throughout the remainder of the report these are referred to collectively as the Coroners Acts. Table 1 below shows that across the various states and territories, particular mention of Aboriginal and Torres Strait Islander people (and families) in the Coroners Acts, is made in the following ways with clauses specific to the following issues.

Table 1: Comparison of clauses referring to Aboriginal and Torres Strait Islander peoples across Australian jurisdictions

	NSW 2009	ACT 1997	VIC 2008	TAS 1995	SA 2003	WA 1996	NT 1993	QLD 2003
Aboriginal ancestral remains[1]			Y	Y				Y
Senior next of kin / Family member[2]		Y		Y			Y	Y
Respect cultural diversity[3]			Y					Y
Consider RCIADIC recommendations[4]						Y		Y
Special notifications[5]		Y						

[1] Detection of any Aboriginal ancestral remains must notify and/or/refer to appropriate Aboriginal authority

[2] if the deceased is an Aboriginal person this can include, a person who, according to the customs and tradition of the community or group to which the person belongs, is an appropriate person.

[3] Encourage the Coronial system to engage with families in ways that respect cultural diversity.

[4] Have regard to recommendations of the Royal Commission into Aboriginal Deaths in Custody.

[5] Deaths in custody where the deceased is Aboriginal must notify appropriate Aboriginal Legal Service re: death, reports, decisions.

While NSW and SA have no specific references to Aboriginal and Torres Strait Islander peoples this does not mean that these states do not have procedures in place to respond to the cultural requirements of these families. Some jurisdictions have made administrative changes, and some have gone further and enshrined those changes in legislation. In NSW, many responses have been administrative in nature and based on the State Coroner's recommendations and findings. For example,

- The Aboriginal Strategy and Policy Unit (ASPU) was initially formed in 1993 as part of Corrective Services commitment to implementing the recommendations from the Royal Commission into Aboriginal Deaths in Custody. The ASPU acts as a strategic Aboriginal affairs advisory, planning, support, program and policy unit for Corrective Services. Recently released policy[6] sets out procedures that must be followed when there is a death of an Aboriginal inmate in Corrective Services NSW custody. Some examples of procedure that must be followed include;
    - Notify the Aboriginal Legal Services (ALS) and Aboriginal Affairs (NSW)
    - Assist the Governor or Officer in Charge with any family or cultural issues that may exist
    - Organise a meeting at the earliest opportunity with Aboriginal community members to allow them to raise any questions or issues they may have.

- The NSW Health Code of Practice and Performance Standards for Forensic Pathology in NSW[7] documents in its guidelines that where skeletal remains are discovered and clearly identified as being of historical Aboriginal origin all efforts should be made to avoid disturbance of the remains, the coroner should be notified, and the local land council consulted.

[6] Aboriginal deaths in custody (2020) Policy, Aboriginal Strategy & Policy Unit, Dept of Communities & Justice.

[7] NSW Health Code of Practice: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2012_049.pdf

Purpose and methodology

The purpose of this study is to describe practices aimed at improving processes and experiences for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system. This review consisted of a jurisdictional environmental scan and a literature scan.

Jurisdictional environmental scan

The Foundation conducted a jurisdictional environmental scan of current practices, policies, and/or strategies employed by Australian coroners courts. The jurisdictional environmental scan describes services provided by coroners' courts in each Australian jurisdiction. Publicly available information was confirmed with the court registrars or support services in each jurisdiction.

Literature scan

In addition to the environmental scan, a literature scan was undertaken to locate and summarise the targeted research evidence on the involvement in the coronial system of Indigenous people in Australia and abroad. A literature scan is not an exhaustive or systematic review but is a broad search of published and grey literature to identify relevant works to the research topic. It is hoped the results of this scan will provide insights into the current status of the coronial system as it affects Aboriginal and Torres Strait Islander people. These insights can provide a basis for planning improvements, particularly for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system.[8]

The Foundation developed a research protocol which defined the parameters of the scan and set out the inclusion criteria and the search strategy. A broad inclusive approach was employed as this was an exploratory scan of the available literature. The inclusion criteria comprised academic and grey literature **published between 1995 and 2020**, with a focus on the experience of Aboriginal and Torres Strait Islander families. The literature was sourced by:

- Searching academic databases
- Searching key websites, including Aboriginal justice organisations
- Google-searching
- Hand-searching reference lists quoted in the articles included in the scan.

Additionally, Legal Aid NSW alerted the Foundation to a number of recent reports on coronial assistance legal services and audits.

[8] This is a scan of the literature, not an exhaustive or systematic review and as such we cannot guarantee the completeness of the literature reviewed here. Likewise, the level of rigour of individual studies included has not been comprehensively assessed.

Overview of results

A total of 31 items of literature were identified as containing relevant information and were included in the literature scan. The literature was then categorised by type with priority given to peer-reviewed primary research, whether qualitative or quantitative. Secondary research and grey literature references were also reviewed.

Of the primary research reviewed, only six qualitative research papers were found that described the experiences of, or impact on, families involved in the coronial process. Being observational studies only, none explicitly interviewed Aboriginal and Torres Strait Islander families about their experiences.

Two quantitative research studies were reviewed that examined coronial data and reported on Aboriginal and Torres Strait Islander clients. The remainder of the reviewed literature are reports, commentaries, and case studies (peer-reviewed and non-peer-reviewed) that provide contextual analysis of the coronial system and services. Table 3 provides details and summaries of this literature in chronological order from 1996 to 2019.

Eight items of literature that were assessed as being of particular interest to the purpose of this scan have been summarised in further detail and appear in chronological order from 2008 to 2019 on pages 26–33.

A section found at the end of this report includes a compilation of detailed recommendations that have been extracted verbatim from the reviewed grey literature. Many of these recommendations are not necessarily applicable to the wider coronial discussion as they are specific to the time and jurisdiction for which they were written. The Foundation has not assessed those recommendations and, as such, do not carry our endorsement.

Jurisdictional environmental scan

Culturally specific services at the coroners court

It is important to recognise the diversity and uniqueness of Aboriginal peoples, as well as of individuals within communities. Aboriginal and Torres Strait Islander peoples have a diversity of language, culture, histories, and perspectives all of which need to be accounted for in the provision of any support services. It is not the intention of this review to imply that all Aboriginal people observe the same beliefs and traditions (and require the same services). As such, it is expected that service needs may vary considerably both between and within jurisdictions.

Perhaps in some ways reflecting this diversity, the jurisdictional environmental scan reveals a variety of models of services to families in the coroners court. These apply across Australia and various jurisdictional characteristics may have impacted the development of these service models. Smaller jurisdictions may opt for a holistic service model where service staff are trained in culturally competent approaches. In these cases, agreements with external specialist associations may provide additional support. Larger jurisdictions may opt to have specialist services in-house to ensure culturally appropriate support is always available. Jurisdictional characteristics such as the number of cases, the proportion of culturally and linguistically diverse people (including Aboriginal and Torres Strait Islander) who come under the purview of the coroners court, legislation, and available funding, will all impact the development of these services.

Culturally specific services range from very minimal or ad-hoc services in some states, to specialised in-house services in others. It is important to note the characteristics of each jurisdiction when considering the services provided. An example of an in-house specialised service is the service model employed in Victoria summarised below.

Koori Family Engagement Unit, Victoria

The Coroners Court of Victoria has partnered with the Aboriginal community through the Aboriginal Justice Caucus under a continuing Aboriginal Justice Agreement to address justice needs, support families and make communities safer. The Aboriginal Justice Caucus has identified the key benefit of this Agreement as the collaborative partnership that drives the strategic planning and facilitates culturally appropriate, and effective criminal justice responses. This has resulted in several culturally appropriate services now provided by the Coroners Court of Victoria, one of which is the Koori Family Engagement Unit. [9]

[9] https://www.aboriginaljustice.vic.gov.au/

Aboriginal Justice Agreements are formal agreements between state or territory governments and Aboriginal and Torres Strait Islander communities which aim to work together to improve justice outcomes.[10]

The Koori Family Engagement Unit is described as follows:

1. A designated Koori Family Engagement Unit provides guidance to the Coroners Court of Victoria to ensure its service provision is and remains culturally informed and appropriate. The three pillars of the Koori Engagement Unit are: family, coroners court staff development, and community engagement. The team is funded to support two roles to appropriately resource the team to support both Men's Business and Women's Business.
    a. The Koori coordinator is able to provide a cultural brief to the coroner on all cases which can detail specific culturally sensitive practices or approaches which include kinship and acknowledgement, naming and identifying preferences, country or countries of the deceased.
    b. The Koori coordinator can also support families on country where truth-telling can happen. The coordinator will also sit with the family throughout the inquest to provide support
2. "Sorry Business" is an important time of mourning for Aboriginal people following the death of a loved one. Each staff member is required to attend training in "Sorry Business". A sound knowledge of the requirements and traditions surrounding "Sorry Business" mean that staff are better placed to engage more effectively with Aboriginal families.
3. The court has introduced smoking ceremonies and Welcome to Country at the commencement of hearings where appropriate.

[10] http://classic.austlii.edu.au/au/journals/UNSWLRS/2014/14.pdf

Culturally specific service provision within Australian jurisdictions

The following information was sourced by a desktop investigation of services provided by coroners courts in each Australian jurisdiction.

Where feasible the Foundation verified and cross-referenced this information from other sources, but this falls short of an assurance of completeness as some references may have eluded our scan.

Aspects of coronial and related procedures that may impact Aboriginal and Torres Strait Islander families specifically have been identified in the literature and are included in the state summaries listed below. These include;

- how notification of the death is delivered,
- autopsy, and
- kinship.

Other aspects of service have been included to provide a clearer picture of how support is delivered in each state. These additional aspects of services are:

- counselling support,
- inquest support,
- regional area processes,
- culturally sensitive practices,
- training, and
- legal assistance.

All of these functional aspects of coroners courts are of importance to the objectives of this paper whether or not they make direct reference to Aboriginal and Torres Strait Islanders involved with the court's dealings. Aspects of functioning not specifically designed for First Nations people may well be capable of adaptation to particular cultural circumstances.

The following table presents the number of reportable deaths and inquests heard in the 2018–19 reporting year. It was not possible to provide further breakdown from the published data (e.g. rural/regional and metro deaths, Aboriginality, autopsy figures). The figures, for all but one jurisdiction, have been drawn from the relevant annual reports. [11]

[11] Figures for Northern Territory were requested by the author via email as the annual report did not provide coroners court figures.

Table 2: Reportable deaths and inquests heard by jurisdiction, 2018–19

	Reportable deaths	Inquests heard
New South Wales	6,673	117
Australian Capital Territory	315	8
Victoria	6,757	41
Tasmania	654	10
South Australia	2,687	37
Western Australia	2,452	61
Northern Territory	300	13
Queensland	5,797	29
TOTAL	**25,635**	**316**

New South Wales

NSW recorded 6,673 reportable deaths in 2018–19 and conducted 117 inquests.[12] The NSW Coroners Court is part of the Local Court of NSW. The State Coroner oversees and coordinates coronial services in NSW and is assisted by the Deputy State Coroners. Every local court magistrate is also a coroner and may be assisted by an Assistant Coroner.

Notification – Police generally notify next of kin in unexpected or sudden deaths and will advise the family that the coroner will be investigating the death. The senior next of kin will also receive a phone call from Forensic Medicine Social Work services within a day of the body arriving at the Forensic Mortuary or regional hospital. Social workers can explain the coronial process, support formal identifications and viewings, and facilitate information around the cause of death.

Autopsy – Religious and cultural needs of the family are considered by the coroner and the senior next of kin will be informed before any examination commences. The senior next of kin must inform the coroner in writing if they wish to object to an autopsy. The final decision rests with the coroner although the senior next of kin can apply to the Supreme Court for an order preventing post-mortem if the coroner determines a post-mortem must proceed.

Next of kin – NSW (at the time of writing) does not recognise Indigenous kinship relationships and follows the conventional hierarchy of kin.[13]

Counselling – Social workers from the Forensic Medicine Social Work services provides client-focused, short-term, early intervention support for families experiencing a sudden or unexpected death.

Inquest hearing – The Coronial Information and Support Program (CISP) employs social workers and psychologists who work exclusively with coronial mattes. They can provide

[12] Local Court of New South Wales, "Annual Review 2019," (2019).

[13] Section 6A *Coroners Act 2009*.

information and support to families including general information about the inquest process. This can include court familiarisation and practical information about attending court.

Regional areas – Coronial inquests in the Sydney metropolitan area are generally conducted by the State Coroner or one of the Deputy State Coroners in the coroners court at Lidcombe. Local court magistrates in their capacity as coroners also conduct a limited number of inquests in regional areas. In those cases where a senior coroner is required to preside over the inquest, the State Coroner or Deputy State Coroner will travel to regional courthouses to conduct the inquest.

Culturally sensitive practices – ad hoc practices are implemented where possible (including ways to honour the deceased in court). The Indigenous Services Unit (Department of Justice) (unofficial links) is consulted at times to facilitate Sorry Business activities. Additional links with Indigenous Social Justice Alliance and other external organisations are sometimes utilised.

Training – no publicly available information.

Coronial Legal Assistance – Coronial Inquest Unit, Legal Aid NSW, Aboriginal Legal Service (ALS).

Australian Capital Territory

The ACT recorded 315 reportable deaths in the year 2018–19 and conducted 8 inquest hearings.[14] All ACT Magistrates are also coroners and the Chief Magistrate is the Chief Coroner. The Registrar of the Magistrates Court is also the Registrar of the Coroners Court.

Notification – Australian Federal Police will notify families of the death and will collect information from the family regarding identification, property. Consideration is given to taking an Aboriginal liaison person for the notifications, particularly for a death in custody. A small group of police officers perform the role of the coroner's Liaison Officer and is the principal liaison and contact point for any dealings with the coroner.

Autopsy – Families are given the opportunity to raise concerns regarding autopsy, however the final decision rests with the coroner. The family may object to observers at autopsy (i.e. medical students) and these wishes will be followed. The coroner may decide no examination is needed in which case the body may be released to family immediately at the scene (for collection by an undertaker).

Next of kin – The ACT does not recognise Senior Next of Kin in the same way other jurisdictions do but takes a more inclusive approach which allows for all eligible people to be consulted and kept updated and specifically includes Indigenous kinship relationships. In a majority of cases the family may nominate someone to act as a senior next of kin.

Counselling – The Coronial Counsellors will do a welfare check by phone to the Senior Next of Kin within a week of the death and offer services. Referral to free counselling (provided by the ACT Coronial Counselling Service, Relationships Australia) is offered. This

[14]Chief Coroner ACT, "Act Coroner's Court Annual Report 2018/19," https://courts.act.gov.au/__data/assets/pdf_file/0005/1402493/Chief-Coroners-Annual-Report-2018-19.pdf..

counselling is available to anyone affected by a death being investigated by the ACT coroners court. It is available at no cost during the coronial process and for up to three months after the coronial process has been concluded.

Inquest hearing – In cases where an inquest hearing is required or directed, the coroner will forward the particulars of the time and place of the hearing to a member of the immediate family. Inquest hearings are held at the ACT Magistrates Court building.

Regional areas – In most cases, bodies of the deceased are brought to the ACT Forensic Medicine Centre for examination.

Culturally sensitive practices – The ACT Coroners Court aims to be sensitive to all backgrounds and cultures. The preferred way to refer to the deceased will be confirmed with the family. Where possible, cultural practices will be accommodated (smoking ceremonies at the death scene), face-to-face meetings may be more appropriate than telephone communication, and multiple visits for viewing the body are facilitated where operationally possible.

Training – Court-wide culturally specific training is available; however, this is not specific to coronial matters.

Coronial legal assistance – Legal Aid ACT and the ALS may be able to provide assistance or representation in certain circumstances. This is subject to eligibility criteria and may include facilitating access to reports/paperwork, inspecting documents, supporting requests for funeral assistance, making objections to autopsy, pre-inquest meetings and representation at inquests.

Victoria

Victoria recorded 6,757 reportable deaths in 2018–19 and conducted 41 inquests.[15] The Coroners Court of Victoria is a specialist court. Unlike other jurisdictions, magistrates in Victoria are not coroners by virtue of their appointment as a magistrate. All coroners are appointed to the position by the Governor in Council at the recommendation of the Attorney-General.

Notification – Victoria Police attend every death scene. The Coronial Admissions and Enquiries staff (CA&E) make the first of two calls to families. The first call informs the family that the death has been reported and that it is now a coronial matter, they establish who the next of kin is and ascertain if the family seek to object to an autopsy. The second call to the family will inform them of the preliminary cause of death *or* that an autopsy is required to establish this. Every family is asked about Aboriginality and specialised support is available. Support is then transferred to the Coroners Family Liaison Team.

Autopsy – The Coronial Admissions and Enquiries staff inform the family if an autopsy is required and explain the process, including how to object if so desired. The Victorian Institute of Forensic Medicine utilises a computed tomography (CT) scanner which can reduce the incidence of full autopsies in some cases.

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[15] Coroners Court of Victoria, "Annual Report 2018-19," https://www.coronerscourt.vic.gov.au/sites/default/files/2019-11/Coroners%20Court%202018_19_AnnualReport_0.pdf.

Next of Kin – Victoria follows the conventional view of next of kin and does not make special considerations for traditional Aboriginal kinship relationships.

Counselling – The Family Liaison service is staffed by social workers, welfare workers, and a psychologist. Brief intervention type counselling is available. Referral for ongoing therapeutic counselling can be made to external organisations.

Inquest hearing – Court Networks is a volunteer-based organisation that provides support to all court users. Families can request support from Court Networks through the Family Liaison Team.

Regional areas – Most inquests are held in Southbank Melbourne. Local magistrates courts can sometimes sit as a coroners court in cases where the majority of witnesses live in a regional area.

Culturally sensitive practices – See discussion of the Koori Engagement Unit above.

Coronial legal assistance – The Victorian Aboriginal Legal Service (VALS) represents clients in coronial matters. Also, a pro bono scheme has been launched between the court and the Victorian Bar to improve access to justice and support for those affected by the coronial process. Under the scheme pro bono counsel is available to families to provide legal advice about the appointment of senior next of kin, autopsies and the release of bodies.

Tasmania

Tasmania recorded 654 reportable deaths in 2018–19 and completed 10 inquests.[16] The Coronial Division of the Magistrates Court (or the 'Coroners Court') is a specialist court and in addition to the State Coroner, all magistrates are coroners.

Notification – Coroners' Associates (Tasmania Police) will inform families of the death and that it is a coronial matter. Coroners' Associates are specially appointed police officers who are assigned coronial duties only.

Autopsy – Objections to autopsy must be provided to the coroner in writing. If the coroner determines an autopsy is necessary, they will send out a notice to the senior next of kin who may then apply to the Supreme court. In rare circumstances, the coroner may proceed immediately to autopsy without the opportunity for the senior next of kin to object.

Next of kin – The Coroners Act in Tasmania observes a more inclusive and culturally sensitive definition of 'senior next of kin' and specifically includes Indigenous kinship relationships.

Counselling – No inhouse counselling available. Families are referred externally. Self-help information provided in the form of a Sudden Loss Support Kit distributed to all families.

Inquest hearing – No publicly available information.

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[16]Magistrates Court of Tasmania, "Annual Report 2018-2019," (2019).

Regional areas – No publicly available information.

Culturally sensitive practices – No publicly available information.

Coronial Legal assistance – No publicly available information.

South Australia

South Australia recorded 2,687 reportable deaths in 2018–19 and conducted inquests for 37 deaths. [17] In South Australia, all magistrates are Deputy State Coroners by virtue of their office.

Notification – Police who attend the scene of death will attempt to identify who the senior next of kin is and will inform family in person. If the death is interstate, patrols local to the family will inform the family. Within a day or two of the death being reported a social worker from the coroners court will contact the family to explain the process.

Autopsy – SA can use a computed tomography (CT) scanner with which to direct post-mortem investigations. Families may raise their concerns regarding autopsy; however, the final decision will rest with the coroner.

Next of Kin – The *Coroners Act (2003)* in SA observes the conventional definition of senior next of kin. Usually, only the senior next of kin will be the contact person, however in special circumstances, the court will endeavour to keep any other relevant person informed.

Counselling – Social workers are able to provide brief intervention-type counselling and will actively check with next of kin as to what supports they have available. Support and help is available in preparing for inquests, together with information about bereavement and support groups, as well as referral to longer-term counselling and other resources.

Inquests – The senior next of kin listed will be advised in writing by the coroners court of the time and place of any inquest hearing. During the inquest, an Inquest Support Officer acts as a point of contact for the family.

Regional areas – The majority of inquests are held in Adelaide. The coroner can attend regional courts to hold an inquest – for example, where the majority of witnesses reside in a regional area or it is deemed to be beneficial to hold the inquest in the local community.

Culturally sensitive practices – The coroners court seeks to be culturally sensitive in all matters and with all families. Coronial staff will speak with families concerning cultural aspects (i.e. how to refer to the deceased person). Aboriginal Justice Officers work across a range of locations and courts and may be available to provide advice regarding Aboriginal culture and communities.

Training – No publicly available information.

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[17] Coroners Court of South Australia, "2018-19 Annual Report," (2019).

Coronial legal assistance – Family members/interested parties can apply to the Aboriginal Legal Rights Movement (ALRM).

Western Australia

Western Australia recorded 2,452 reportable deaths in 2018–19 and completed 61 inquests. [18] In WA, in addition to a State Coroner and Deputy State Coroner, every magistrate is also a coroner.

Notification – Where family were not present at the death, police from the Police Coronial Investigation Squad will notify family of the death and discuss the next steps. If it is a coronial matter, identity procedures will occur at this time, facilitated by the Coronial Investigation Squad and/or the Coronial Counselling Service. Depending on the circumstances of the matter and the request of the family, the Coronial Counselling Service would then contact the family. The counselling service is staffed by qualified psychologists and may provide updated information on request as to the status of the inquiry and answer any questions.

Autopsy – The Coronial Counselling Service explain the rights of the family and discuss the implications of making an objection. Where concerns are raised, they will brief the coroner. Less invasive forms (i.e. CT imaging) will be used where possible. Autopsies conducted are performed at the State Mortuary in Perth. There is also a bereavement service available to families at the State Mortuary.

Next of kin – These are usually identified by the police. WA observes the conventional definition of 'senior next of kin'. More than one person can be kept informed of progress but generally the senior next of kin will be the contact person.

Counselling – Coroners Counselling services can provide brief interventions and will refer out to external services for ongoing counselling if requested.

Inquest hearing – In cases where a hearing is mandatory or determined as desirable by the State Coroner, the Principal Registrar will be informed. When an inquest is to occur, the file will be assigned to Counsel Assisting the coroner, who will then manage the file in preparation for the inquest and appear at the inquest. They will also communicate with families, or their legal representative. A Courtroom Companion Service may be available to sit at court with families if desired.

Regional areas – Perth uses specialised coroners who are able to travel to regional locations to conduct inquest hearings. Administrative findings or determinations made 'on the papers', are generally performed by the local magistrate (who completes the role as a local coroner).

Culturally sensitive practices – The Aboriginal Legal Service of Western Australia (ALSWA) is contacted when the deceased is Aboriginal. The Coronial Counselling Service has contacts in regional areas to provide on-the-ground support to families. On occasion there have been smoking ceremonies outside the courts, but it is done separately, and not

[18] Coroners Court of Western Australia, "Annual Report 2018-2019," https://www.coronerscourt.wa.gov.au/_files/Annual_Report_2018_2019.pdf.

as part of the inquest. In matters involving Aboriginal deceased persons, family are asked, before the inquest, how they wish the deceased to be referred to. In all inquests, regard is given to how the family wish the deceased to be referred to.

Training – Cultural awareness training is provided court-wide. Trauma-informed training is available specifically for coroners court staff.

Coronial legal assistance – ALSWA represents families and persons of interest where eligibility criteria is met. Eligibility criteria is Aboriginality. Support is available in remote and regional courts where civil lawyers with expertise and specialist coronial knowledge are available to travel. Services include (but are not limited to): facilitating access to reports/paperwork, inspecting documents, ongoing investigation, requests for inquest, and inquest representation.

Northern Territory

The Northern Territory recorded approximately 300 reportable deaths in 2018–19 and completed 13 inquests.[19] In the NT, a person who is a local court judge is also a coroner, however, the Territory coroner conducts all inquests.

Notification – Families are usually notified by police. Every family is contacted by the grief counsellor within a week of each reported death, usually after the preliminary cause of death is determined. The grief counsellor will inform the family that the death is a coronial matter and outline the process. This contact will also seek to identify any need for additional support, offers self-care tips and provides information (including printed material) regarding sudden death. A letter is sent detailing the preliminary cause of death along with contact details for the grief counsellor.

Autopsy – Families are given the opportunity to object to autopsy when the police speak with family. The coroners constables will then liaise with the coroner's office/deputy coroner to discuss. Where appropriate, the coroner will take the family's request into consideration.

Next of kin – The Coroners Act in NT observes a more inclusive and culturally sensitive definition of 'senior next of kin' and specifically includes Indigenous kinship relationships.

Counselling – The grief counsellor is able to offer a limited number of short-term counselling sessions and can refer to external services for longer-term counselling needs.

Inquest – In cases where an inquest is required, the grief counsellor will contact the family and invite them for a pre-inquest meeting which is also attended by the deputy coroner. This is an opportunity for the family to ask questions and they may be invited to prepare a statement about the deceased. The family will also be accompanied to the court room to familiarise themselves with the setting and the court process will be explained. The grief counsellor also attends all inquests to offer support.

Regional areas – Support is provided via phone and local referrals can also be made. Inquests are routinely held in Katherine, Alice Springs, Darwin, and occasionally to remote communities. The State Coroner conducts all inquests and can travel, if necessary.

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[19] No further data was publicly available

Culturally sensitive practices – The coroners court will confirm with the family on the preferred way to refer to the deceased. In many cases, the coroner can respect the wishes of the family regarding the level of invasiveness of autopsy (where appropriate).

Training – While no formal training is routinely offered, staff in the NT coroner's office collaborate with community on cultural issues and can shape services to accommodate many cultural issues.

Coronial legal assistance – The North Australian Aboriginal Justice Agency (NAAJA) is informed of Aboriginal coronial deaths and can provide services and support for coronial matters.

Queensland

Queensland recorded 5,797 reportable deaths in 2018–19 and completed 29 inquests.[20] In Queensland, in addition to a State Coroner and Deputy State Coroner, every magistrate is contemporaneously a coroner.

Notification – Police will notify family of the death. Police Referrals can refer families to external service providers.

Autopsy – Police will canvas autopsy concerns with the family at the time of notification. Any concerns will be clarified by Coronial Family Services. The coroner will take concerns into account when determining whether autopsy is required and at what level. Queensland uses computed tomography (CT) scanners routinely. Recent amendments allow preliminary examinations (CT scans, blood tests) to be undertaken immediately. The number of partial or full autopsy has reduced in recent years.

Next of Kin – Police will normally identify the senior next of kin. Coronial counsellors will confirm. In the case of any contention between family members on who should be the senior next of kin, the final determination is made by the coroner. Queensland recognises Aboriginal kinship relationships in the Act.

Counselling – Coronial counsellors based at Queensland Health Forensic and Scientific Services (QHFSS) provide information and crisis counselling services to relatives of the deceased. This support is available only at the very beginning of the process (first 48 hours). External referrals may be provided.

Inquest hearing – Coroners court staff will inform the family if an inquest is to be held and when.

Regional area – State or Deputy State Coroners will travel to regional and remote areas to conduct mandated inquests. Regional magistrates may perform the role of a coroner in other matters.

Culturally sensitive practices – All Aboriginal deaths are reported to Aboriginal and Torres Strait Islander Legal Service (ATSILS) in Queensland.

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[20]Coroners Court of Queensland, "Annual Report 2018-19," (2019).

Training – Cultural Competency Guidelines have been developed for Queensland Health and sit within the Cultural Capability Framework. In addition, formalised vicarious trauma resources and training are available to all Department of Justice employees.

Coronial legal assistance – Caxton Legal Service, Townsville Community Law, ATSILS.

Literature scan

It must first be acknowledged that there is a dearth of literature available in Aboriginal and Torres Strait Islander voices. Particular care and attention was therefore taken to identify Indigenous voices among the literature. For instance, unpublished or self-published (non peer-reviewed) sources have been pursued and included in the scan. It is important to uncover research done by and with Aboriginal people if we are to understand Aboriginal experiences. It is a widely acknowledged research principle that in conducting research or developing policy that targets a specific population, the participation and inclusion of that population is desirable. This is especially true for Aboriginal and Torres Strait Islander Peoples [21]

A range of literature was reviewed including peer-reviewed primary research (one non-peer reviewed paper was included due to its obvious relevance), peer-reviewed secondary research, and a number of 'grey papers' (government reports, policy statements, etc).

Our search did not reveal any primary research investigating the experiences of Aboriginal families engaged with the coroners court where Aboriginal families were active participants. While we prioritised the Aboriginal experience, learnings from all family experiences with the coronial process were examined to supplement our understanding. Three broad themes emerged through the scan of literature on the impact on families involved with the coronial system. They were coronial communication and information-seeking, respect of culture, and voice and jurisprudence. These themes are outlined below. They provide a useful framework for understanding the challenges that Aboriginal and Torres Strait Islander families face in navigating the coronial system and the supports from which they may benefit.

Coronial communication and court information-seeking

- Communication between the coroner's court and grieving families has come under criticism with the coronial system being accused of being difficult to navigate, and fraught with unfamiliar processes and procedures that seem 'uncaring'.[22] It is these difficulties that families of people who have unexpectedly and sometimes violently died may face. It has been argued that the system should centre on the rights of bereaved families and should aim to put families at the centre of coronial processes .
- Improving access to legal representation for coronial proceedings remains an important goal. The coronial system can be difficult to navigate, difficult to understand, and if the court is not culturally competent in its processes, Aboriginal people and other culturally diverse families may face distinct disadvantage in obtaining answers and being involved

[21] National Health & Medical Research Council, *Ethical Conduct in Research with Aboriginal and Torres Strait Islander Peoples and Communities: Guidelines for Researchers and Stakeholders* (National Health and Medical Research Council, 2018).

"National Statement on Ethical Conduct in Human Research 2007 (Updated 2018)," *Canberra: National Health and Medical Research Council* (2018).

[22] Caxton Legal Centre, "Coronial Investigation in Queensland: (Counter)-Therapeutic Effects," ed. Coronial Assistance Legal Service (2019).

in the coronial process. While families do not stand to gain anything materially from participating in a coronial inquest, there can be great benefits from participating in a process where their interests and concerns are acknowledged, and they have an opportunity to have input into the direction of the inquiry.

- The potential limitations of police conducting the investigation on behalf of the coroner have also been noted. With the historical conflict between the Indigenous community and police,[23] the use of the police as investigators for the coroner may fail to provide the dynamic required for information-gathering and cooperation and may undermine Aboriginal and Torres Strait Islander families' trust in the process.

Respect of culture

- Some traditional Aboriginal and Torres Strait Islander peoples believe that if the body is not whole, the deceased is prevented from being able to enter the spiritual country and be with their ancestral family. In some circumstances, ascertaining the precise cause of death may be less important to the family than having their spiritual and cultural beliefs upheld and respected. There are a number of judgements cited [24] where the Supreme court has found for the families in their objections to autopsy in cases where an invasive autopsy is "unlikely to contribute in any meaningful way to a better understanding of the death". The opportunity to object to an autopsy, or request a less-invasive autopsy, is important to families, as is the acknowledgement of the distress an autopsy order may cause.[25] Other forms of medical investigation (scans, medical history, and other forms that are non-invasive) may be preferred as an alternative when appropriate.[26]
- The ability to mourn and grieve for family and community in a culturally appropriate way is vital. Decisions regarding the viewing of the deceased, speaking for the deceased in court, and the naming of the deceased should all consider the cultural aspects of traditional Aboriginal people and involve the families in ascertaining if/how these beliefs may be accommodated within the coronial proceedings.[27]

Voice and jurisprudence

- Much has been written about therapeutic jurisprudence and the opportunities for coronial inquests to be therapeutic through their conduct.[28] One aspect of this is the opportunity for coroners to make recommendations in the best interests of the public in an effort to prevent future deaths.[29] This ambition may be worthy of pursuit and features

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[23] Chris Cunneen and Juan Marcellus Tauri, "Indigenous Peoples, Criminology, and Criminal Justice," *Annual Review of Criminology* 2 (2019).

[24] Evans v Northern Territory Coroner, Wuridjal v The Northern Territory Coroner, Raymond-Hewitt v Northern Territory Coroner.

[25] Belinda Carpenter, Gordon Tait, and Carol Quadrelli, "The Body in Grief: Death Investigations, Objections to Autopsy, and the Religious and Cultural 'Other'," *Religions* 5, no. 1 (2014).

[26] Bruce Baer Arnold and Wendy Bonython, "Autopsies, Scans and Cultural Exceptionalism," *Alternative Law Journal* 41, no. 1 (2016).

[27] Ian Freckelton, "Minimising the Counter-Therapeutic Effects of Coronial Investigations: In Search of Balance," *QUT L. Rev.* 16 (2016).

[28] Ibid.

[29] Olivia McFarlane and Prue Vines, "Investigating to Save Lives: Coroners and Aboriginal Deaths in Custody," *Indigenous Law Bulletin* 4, no. 27 (2000).

prominently in the literature. Indeed, if mechanisms to ensure the application of, or at least the consideration of, recommendations made by a coroner existed the prevention of future deaths may be possible.

- If family members are given the opportunity at inquest to tell their story, or speak for the deceased, the opportunity for therapeutic jurisprudence is amplified. Much research has been conducted on the counter-therapeutic effects of the coronial process on grieving families.[30]
- Where institutions or large organisations participate in inquests, they often have legal representation to protect their interests. Where families have no such representation, they report feeling left out of the process.[31].

Implications for practice

Findings from the peer-reviewed literature support a number of 'implications for practice' outlined below. It should be noted that numerous reports and research studies argue that any services developed to support Aboriginal and Torres Strait Islander peoples should include appropriate consultation and collaboration with their communities. Creating a coronial process in which Aboriginal and Torres Strait Islander people feel culturally safe, recognised and acknowledged is an important goal. Effective collaboration that provides genuine opportunities for Aboriginal and Torres Strait Islander peoples to participate in the design of services is widely recognised as good practice and has been acknowledged as achieving the best outcomes.

Notwithstanding the above, the following implications for practice provide a sound starting point for consideration if improving the experiences of Aboriginal and Torres Strait Islander families in the coroners court is to be achieved:

1. Training for investigating police officers specifically regarding cultural proscriptions against autopsy, Indigenous communication, and a deeper understanding of the broader context of social, political and historical factors impacting Aboriginal people should be considered to enhance the necessary empathy, knowledge and skills required to sensitively support Aboriginal families during a death investigation and the coronial process.

2. Training and widespread adoption of adequate numbers of Aboriginal Community Liaison Officers (Police) should be considered, and their early engagement in all coronial matters involving an Aboriginal deceased or Aboriginal relatives of a deceased person.

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[30] Stephanie Dartnall, Jane Goodman-Delahunty, and Judith Gullifer, "An Opportunity to Be Heard: Family Experiences of Coronial Investigations into Missing People and Views on Best Practice," *Frontiers in Psychology* 10, no. 2322 (2019).

Belinda Carpenter et al., "Communicating with the Coroner: How Religion, Culture, and Family Concerns May Influence Autopsy Decision Making," *Death studies* 35, no. 4 (2011).

[31] Caxton Legal Centre, "Coronial Investigation in Queensland: (Counter)-Therapeutic Effects."

3. A culturally specific unit should be established within the coroners court in each jurisdiction. This unit would employ Aboriginal or Torres Strait Islander staff who would act as a point of contact for First Nation families.[32]

4. Direct and comprehensive pre- and post- inquest briefings should be given to Indigenous families where feasible. This service could: explain opportunities for families to express their views, check family understanding of written notifications and court decisions, and identify the professionals responsible for relaying information to families.

5. Procedural reform to improve communication with bereaved families is needed to better support and inform them during the coronial process.

Discussion

The three themes emerging from the literature, together with the implications for practice noted above, should not be viewed in isolation but must be considered within the broader context.

Contextual factors not reviewed in this literature scan but that will have profound impact on experiences of Aboriginal and Torres Strait Islander families include access to legal assistance and an understanding of the impact of systemic disadvantage and discrimination.

Legal practice in the coronial jurisdiction is distinct from other types of legal practice and experience and expertise should not be undervalued. Given that coronial practice is a small practice area, access to legal assistance may be impacted by the meagre availability of a limited number of lawyers with this specialisation.

Trying to make sense of what has happened following a reportable death is a difficult process at the best of times. It may well be especially complex for Aboriginal and Torres Strait Islander families whose grief is often compounded within intergenerational trauma, social disadvantage, and a history of dispossession and marginalisation. Given the context within which the loss of a loved one is experienced, the potential for distrust of the 'system' can be high. The Royal Commission into Aboriginal Deaths in Custody found that some families of people who had died in custody or in care had been denied information about the manner of the death of their loved one. In cases like these, families were left to rely on the sometimes-dispassionate findings of the coroner. Nevertheless, the coronial process provides opportunities for trust to be built while also delivering on the responsibility of jurisprudence.

Creating a coronial process in which Aboriginal and Torres Strait Islander people feel culturally safe, recognised, and acknowledged is an important goal.

[32] Similar to the Koori Family Engagement Unit

Detailed summary of selected literature

A selection of literature has been provided below in date order (from current and most recent to oldest). Due to the lack of research into Indigenous-specific family experiences of the coronial system, a broader approach was adopted, reporting also on studies concerning experiences of the coronial system by non-Indigenous families.

An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice. S Dartnall, J Goodman-Delahunty, J Gullifer (2019) *Frontiers in Psychology* 10: 2322.

This paper examines the experiences of family members and friends of missing people who have been involved in coronial investigations into the suspected death of a missing person. It uses in-depth qualitative interviews to explore participant perceptions of the impact of the coronial proceedings on well-being, and views on best practice approaches to families in the coroners court.

Key findings

- Families benefited from opportunities to have input and feel heard, compassionate treatment and appropriate education about the process.
- Distress and trauma were reported in response to significant delays (particularly where this delay led to a loss of evidence).
- Intrusive media and the presence of unknown persons in court also led to reports of distress and concern.
- A finding of death was profoundly distressing for some participants and highlighted the need for post-inquest debriefing and support.

Implications

Findings from this study support measures implemented by some courts to assist families. These include family statements, opportunities to read the brief, and court-based counselling services. While this study did not examine any Indigenous-specific experiences, the family experiences presented here provide insights into broad aspects of the coronial process.

'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. L. McCabe (2019) Submitted for Honours Degree, University of New South Wales (unpublished)

This paper presents findings from eight qualitative interviews conducted with legal professionals and advocates who represent Indigenous families in the coronial system in NSW.

Key findings

- The impact of delays during the process was considered the biggest challenge faced by families. These delays were sometimes described as 'retraumatising', 'compounding grief', and 'extremely distressing'.
- Participants identified better training and opportunities for professional development to be crucial for improving ways of engaging with families and better understanding the coronial system and its processes. Every participant identified 'communication' between the coroners courts, and the family and legal representatives, to be a major barrier.
- Access to information, both for families of the deceased, and for those who represent and advocate for them is poor and often who should be contacted is not clear.
- Despite making recommendations (including recommendations relating to public health) being a clear object of the Coroners Act, recommendations are seen as impotent without any mechanisms for accountability.

Implications

The findings of this study confirm areas for reform and its investigator has drafted several recommendations. These are especially relevant to this paper and are included in the final section of this report.

Minimising the counter-therapeutic effects of coronial investigations: in search of balance. I Freckelton (2016) *QUT Law Review* 16: 4

This paper addresses and describes the opportunity for both therapeutic jurisprudence and restorative justice to contribute to the minimisation of counter-therapeutic effects. The author chronicles the development of awareness for these issues and reviews the evidence of impact on families (and non-family people) involved in the coronial process.

Key findings

- Despite the inquisitorial nature of coronial inquests, several research projects have reported families and non-family witnesses have felt that the processes are adversarial in nature. It is claimed this has counterproductive implications for witnesses giving an account or evidence during an inquest.
- In instances where government agencies or large organisations are involved in a person's death, lawyers are often employed due to individuals' concerns of being found liable in subsequent proceedings. This causes a power imbalance between grieving families who are unable to afford representation and their quest for answers and organisations whose interests are to avoid any inference of wrong-doing.
- Where the media takes an interest in an inquest, families have sometimes reported what is perceived as an invasion of the deceased person's privacy, and their loss of opportunity for their own private grieving.
- Delays in the process have been reported as interfering with the grieving process.
- Inadequate communication from a court, excessive inhibition on providing information to a court, lack of legal representation, delays, and unclear findings have been reported as 'toxic' by family members and can result in re-traumatising of those involved.

Implications

Many of the recent calls for coronial reform[33] centre on the premise that coronial proceedings can provide opportunities for these proceedings to be therapeutic. This requires a balance between achieving justice and reducing the potential for harm caused by the legal process. This paper argues that to accomplish such outcomes requires the "creation of a culture of sensitivity to the hurtful sequelae of sudden, unexpected and unnatural fatalities, recognising the distress and potential damage that can be done by coroners' investigations to many persons who are affected by such deaths".

[33] See Law Reform Committee, "Parliament of Victoria, Inquiry into the Review of the Coroners Act," (1985).; Law Reform Commission of Western Australia, "Review of Coronial Practice in Western Australia," (2012). Federation of Community Legal Centres Victoria, "Saving Lives by Joining up Justice," (Federation of Community Legal Centres Melbourne, Australia, 2013).

Autopsies, Scans and Cultural Exceptionalism. B.B. Arnold, and W. Bonython (2016) *Alternative Law Journal*. 41(1): 27-29

This article highlights several judgements that emphasise use of digital scanning rather than invasive interference with a deceased person. These judgements embody recognition that non-invasive autopsies (in the form of imaging and blood tests rather than dissection and organ removal) may be appropriate.

Key findings

- Treatment of deceased, physical integrity and timely burial is a significant facet of cultural identity.
- Freedom from arbitrary and disproportionate interference are important Australian values, evidenced in Australian law by the right of individuals to refuse medical treatment (including diagnostic procedures). These values are often not prioritised in death despite cultural/religious objections.
- Cultural exceptionalism recognises that in some circumstances the values of particular communities should override the practice 'norm'.
- Digital imaging systems and other technologies, such as advanced blood tests, offer opportunities for forensic post-mortem examinations that are less invasive and potentially quicker than traditional investigations based on dissection and organ removal. While these options may not always provide comprehensive results, where possible they may provide a mechanism that balances the state's desire for information and a community's desire to prevent desecration of the deceased and timely burial.

Implications

This article highlights successful legal challenges to invasive autopsies and supports non-invasive technologies as an alternative to the default invasive approach for identification of the cause of death where no compelling reason for a more visceral interference with a deceased person exists. Non-invasive approaches may provide a balance between community, institutional, and private needs. It should be noted that some jurisdictions now have computed tomography (CT) scanning routinely available.

Investigating death: the emotional and cultural challenges for police. B. Carpenter, G, Tait, C. Quadrelli and I. Thompson (2016) *Policing and Society*, 26:6, 698-712

This study explores the specific ways in which coronial personnel (coroners, pathologists, counsellors, nurses, and police) engage with families during a death investigation, particularly those that present as culturally or religiously different and includes Indigenous Australian populations. Findings are based on interviews conducted with 34 coronial professionals in one Australian jurisdiction. Exploration of understanding of the role of families in a death investigation, impediments to a family's involvement, the appropriateness of familial involvement in coronial decision-making and views on colleagues interactions were addressed through semi-structured interviews. Particular focus on the role and capacity of police officers to investigate deaths for the coroner identified specific criticisms especially where Indigenous families are involved.

Key findings

- Police culture and allocation of non-criminal death investigation tasks to inexperienced or junior officers impact the quality and reliability of information provided to the coroner and the ways in which police engage with families.
- Specific criticisms focus on the incapacity of police to engage sensitively with grieving families and the impact that has on collecting accurate information from families.
- For Indigenous families, the role of police investigating a sudden death is made more complicated within the context of "a long and well-documented history of poor relations between police and Indigenous people, where volatile conflict and accusation of police abuse and harassment, excessive force and institutional racism are common features".
- Despite widespread support for community police liaison officers, they seem to be underutilised, particularly in death investigations where they could provide considerable support.

Implications

"Death investigations rarely include a suspect of an offender and so require a different model of communication in a context where police may emotionally identify with the grieving family." Non-criminal death investigations may be a low priority for police and as a consequence less experienced, or junior officers are likely to attend the death scene. While coronial professionals agree that police are not the most appropriate to attend to a death scene and gather the information required, they are the only profession that is logistically available to perform these tasks. "The challenge is to make sure that police have the capacities to perform this non-criminal investigation in a manner that protects police and does not re-traumatise the families."

Communicating with the coroner: How religion, culture, and family concerns may influence autopsy decision making. B Carpenter, G Tait, G Adkins, M Barnes, C Naylor, N Begum (2011) *Death Studies* 35(4):316-337

This paper examines the coronial data collected in Queensland in 2004. While the paper "Health, Death and Indigenous Australians in the coronial system" (presented below) also reports on the same data, this paper provides additional analysis for religious, family concerns as well as cultural concerns. Furthermore, analysis of the level of invasiveness of autopsy is presented.

Key findings

- Only in the categories of accidental death and death in a medical setting were autopsy decisions significantly different when a specific religious status was identified.
- In accidental deaths external-only autopsies occurred more often when the deceased was identified as having a religious status with a proscription against autopsy as were deaths in a medical setting. These findings were based on very small numbers.
- Significantly fewer external-only autopsies were ordered when a religion with a known prescription against autopsy was noted when compared to those cases where no such religion was identified.
- Family concerns were significantly related to orders for less invasive autopsies (except in cases of suspected homicide).
- Findings suggest that two circumstances may lead to less invasive autopsy orders. These are: a) the deceased was a member of a religious group with a prohibition against autopsy, and b) the expression of a genuine family concern.
- The authors report that while Indigenous status should lead to a consideration of a less invasive autopsy, this was not the case.

Implications

This paper highlights the need for thoughtful and informed coronial autopsy decision-making, particularly where Indigenous people are involved. The data presented shows that Indigenous people are unlikely to raise family concerns, which the authors attribute to the fact that in Queensland, local police are the investigators for the coroners (and, as such, it is with the police that concerns and objections need to be raised). Two central reasons as to why prohibitions against Indigenous autopsy are proffered by the paper's authors. First, they suggest a lack of widespread knowledge on the part of coroners of these aspects of traditional Indigenous culture, and secondly, it may also be that Indigenous deaths appear less clear and/or more suspicious to coroners.

Health, death and Indigenous Australians in the coronial system. B Carpenter and G Tait (2009) *Australian Aboriginal Studies* (1):29

This paper presents findings from research conducted in Queensland during the first year following the introduction of the new *Coroners Act 2003*. Data included coronial findings from all completed investigations for 12 months from December 2003 and included all five categories of reportable deaths: accidental, suicide, natural, medical and homicide.

Key findings

- Twenty-five percent of all registered Indigenous deaths during the reporting period were reportable deaths compared to just nine percent of non-Indigenous deaths.
- Indigenous people were over-represented in each category of reportable death, with the exception of deaths in a medical setting, where they were wholly absent.
- Indigenous people were more likely to have died violently than non-Indigenous.
- Indigenous people are also over-represented in figures for full internal autopsy.
- The identification of Indigenous status by police during the initial stages of a coronial investigation did not influence orders for a full internal autopsy any more than the communication of no Indigenous status.

Implications

The research findings and discussion of this paper makes suggestions to how the over-representation of Indigenous people (specifically in full internal autopsies) may be addressed. Changes in legislation (specifically in Queensland where this research is positioned) allows for Indigenous status to be reported to the coroner, along with family concerns against autopsy is an important first step. Further improvements could include training for police officers and coroners about traditional cultural proscriptions against autopsy. For this to be successful, training in Indigenous communication or an increase in the number of Aboriginal community liaison officers is required.

Why This Law? Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention. R.S. Bray (2008) *Australian Indigenous Law Review* 12:27-44

This paper discusses the potential of coronial findings to contribute to the prevention of future deaths in the community. It emphasises the capacity of the coronial jurisdiction to provide a wider social and historical context to the death investigation.

Key findings

- Inquests provide the opportunity to understand individual death in the wider context of community life.
- Coronial decisions have the potential to inform social understanding about, and responses to, death and injury. This potential is embedded within the authority of all Australian coroners, who have the power to make comments and recommendations to avoid preventable deaths in the future. Yet, no accountability to act on recommendations exists.
- Coronial recommendations, in their focus on public health and their capacity to prevent future deaths, have the potential to improve in some way the disadvantage experienced in many Indigenous communities.
- As coronial investigations continue to uncover the 'how' of 'how death occurred' in reportable Indigenous deaths, broader issues of lower life expectancy and higher mortality rates than non-Indigenous are relevant. These issues and resulting recommendations may lead to a closer examination of social policy not strictly within the jurisdiction of the coroner.

Implications

The potential of the coroner to make recommendations in an effort to reduce future preventable deaths may lead to an expectation of 'social justice' that may not be reasonable.

The literature

Table 3: Literature summary

P – Peer-reviewed

Primary research	
An opportunity to be heard: Family experiences of coronial investigations into missing people and views on best practice. Dartnall, S., Goodman-Delahunty, J and Gullifer, J. (2019). *Frontiers in psychology* 10: 2322. *This paper is included in the detailed summary section.*	Experiences of family members and friends of missing people of a coronial investigation into the suspected death of missing people in NSW. Fifteen qualitative interviews were conducted exploring participant perceptions of the impact of the coronial proceedings on well-being, and views on best practice approaches to families in the coroners court. Overall, families benefited from opportunities to have input and feel heard, compassionate treatment, and appropriate education about the process. Negative experiences reported include distress and trauma in response to significant delays, intrusive media, and unwelcoming, formal court environments. **P**
'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. McCabe, L. Submitted for Honours Degree, University of New South Wales (unpublished) (2019) *This paper is included in the detailed summary section.*	This paper presents findings from eight qualitative interviews conducted with legal professionals and advocates who represent Indigenous families in the coronial system in NSW. Key themes identified include the impact of delays to the process, a lack of training for staff involved in providing coronial services/support, access to information, and the opportunity for making recommendations.
Coronial practice, indigeneity and suicide. Tait, G., Carpenter, B., & Jowett, S. (2018). *International Journal of Environmental Research and Public Health* 15(4): 765.	Indigenous Australians and Indigenous people around the world have a higher rate of suicide that may be linked to their experiences of persecution and disenfranchisement. The study conducted in-depth interviews with 32 Australian coroners and identified that Indigenous families do not engage with the coronial process to the same degree as non-Indigenous. As a consequence, coroners are not placed under the same degree of pressure by families resistant to a finding of suicide. The study concludes that Indigenous Australians are treated differently within the coronial system. **P**

Primary research	
The coronial investigation of suspected deaths: Prevalence and outcomes in New South Wales. Dartnall, S. and Goodman-Delahunty, J. (2016). *Journal of Law and Medicine* 23(3): 609-627.	Where a missing individual remains unlocated, this may be referred to the coroner for investigation as a suspected death. Of the 322 suspected deaths between 2000 and 2013, 96% resulted in an inquest and 94% of these inquests resulted in a finding that the missing person was deceased with the cause (81%) and manner (73%) of the death unknown. For one-third of suspected death cases there was over 20 years between the date of disappearance and the closure of the coronial investigation. Arguments supporting mandated inquests in suspected deaths cite positive functions, such as attracting public awareness and media attention which could assist an investigation, to provide a 'therapeutic benefit' for families of missing people. **P**
Decision-making in a death investigation: Emotions, families and the coroner. Carpenter, B., Tait, G., Adkins, G., Barnes, M., Naylor, C., & Begum, N. (2016). *Journal of Law and Medicine* 23(3): 571-581.	This paper uses qualitative methods to describe the experiences of qualified coroners and how they engage with grieving families. The interviews focus on how coroners negotiate the grief and trauma evident in death investigations. This paper acknowledges that while emotional distance may be an understandable response by coroners to the grief and trauma experienced by families, it concludes that coroners may be better served by offering emotions such as sympathy, consideration and compassion directly to the family in situations where families are struggling to accept, or are resistant to, coroners' decisions. **P**
The body in grief: Death investigations, objections to autopsy, and the religious and cultural 'other'. Carpenter, B., Tait, G., Quadrelli, C. (2014). *Religions* 5(1): 165-178.	Legislative reform in a number of jurisdictions has given families the ability to raise concerns about autopsies on the basis on religious and cultural grounds. However, the continuing ability for coroners to reject said concerns and continue to autopsy can exaggerate a family's grief. This study explores the disjuncture between medico-legal discourses and more 'therapeutic' discourses through interviews with staff involved in the coronial process. Interviews suggested that Indigenous objections to autopsy were all but invisible in the Queensland Coronial system and reasons for this are hypothesised to include Indigenous people not wanting to have their cultural identity known to police, and that Indigenous people may feel powerless to have their objections heard. **P**

Primary research

Health, death and Indigenous Australians in the coronial system. Carpenter, B. and Tait, G. (2009). *Australian Aboriginal Studies* (1): 29. *This paper is included in the detailed summary section.*	Research was conducted in Queensland during the first operative year of the *Coroners Act 2003* (QLD), with investigations completed between December 2003 and December 2004. The research investigated five categories of death: suicidal, accidental, natural, medicinal and homicide. In all categories Indigenous people were over-represented except medicinal. 25% of Indigenous deaths were reported on by the coroner as opposed to 9.4% of the non-Indigenous population. Despite Indigenous people being against dissection of their deceased community members, they are still over-represented in coronial investigations and reporting. The changes contained in the *Coroners Act*, allows for someone to be identified as Indigenous by family or community members to the coroner and allows for them to discuss their cultural concerns regarding an autopsy. **P**
Investigating death: The emotional and cultural challenges for police. Carpenter, B., Tait, G., Quadrelli, C., & Thompson, I. (2016). *Policing and Society* 26(6): 698-712. *This paper is included in the detailed summary section.*	This study explores the specific ways in which coronial personnel (coroners, pathologists, counsellors, nurses, and police) engage with families during a death investigation, particularly those who present as culturally or religiously different and included Indigenous Australian populations. Findings are based on interviews conducted with 34 coronial professionals in one Australian jurisdiction. Exploration of understanding of the role of families in a death investigation, impediments to a family's involvement, the appropriateness of familial involvement in coronial decision-making and views on colleagues' interactions were addressed through semi-structured interviews. Particular focus on the role and capacity of police officers to investigate deaths for the coroner identified specific criticisms especially where Indigenous families are involved. Widespread support for community police liaison officers identified the functions of informing families, dispelling agitation and allowing grieving and other important practices to be an underutilised asset. **P**

Secondary Research	
Autopsies, scans and cultural exceptionalism. Arnold, B. B. and Bonython, W. (2016). *Alternative Law Journal* 41(1): 27-29. *This paper is included in the detailed summary section.*	The decision in *Rotsztein v HM Senior Coroner for Inner London* [2015] EWHC (Admin) (28 July) [unreported] analysed the appropriateness of using non-invasive, technological methods for autopsies. Whilst no Australian High Court or state or territory Supreme Court has ordered that an autopsy cannot proceed on the basis of religious or cultural beliefs, the decision in *Rotsztein* should influence the practices of coroners in Australia. Where non-invasive methods such as scans or blood tests are available to coroners these could be favoured over more invasive examinations that may involve the removal of organs; the preference for these methods could be heightened where non-invasive methods would respect cultural or religious beliefs. **P**
Minimising the counter-therapeutic effects of coronial investigations: in search of balance. Freckelton, I. (2016). *QUT L. Rev*. 16: 4. *This paper is included in the detailed summary section.*	Coronial processes seek to balance therapeutic jurisprudence and principles of restorative justice; law reform proposals have sought to increase the role of families in the process to bolster the balance between the two. This paper seeks to describe and address the opportunity for both therapeutic jurisprudence and restorative justice and the minimisation of counter-therapeutic effects. The author chronicles the development of awareness for these issues and reviews the evidence of impact on families (and non-family people) involved in the coronial process. **P**
Scrutinising the Other: Incapacity, Suspicion and Manipulation in a Death Investigation. Carpenter, B, Tait, G., Quadrelli, C., & Drayton, J (2015). *Journal of Intercultural Studies*, 36:2, 113-128	Research has demonstrated the importance of training and education for staff in the context of criminal investigations – with its over-representation of vulnerable and marginalised populations – this is less likely to occur in the context of death investigations, despite such investigations also involving the over-representation of vulnerable populations. This paper explores the ways in which cultural and religious minority groups are positioned as 'other'. Three issues of concern are raised. First, positioning as 'the other' is dependent on professional training. Second, specific historical and contemporary events affect the Othering of religious and cultural difference. Third, the grieving practices associated with religious and cultural difference can be collectively Othered. **P**

Secondary Research	
Normalising post-mortems–whose cultural imperative? An indigenous view on New Zealand post-mortem policy. Selket, K., Glover, M., & Palmer, S. (2015). *Kotuitui: New Zealand Journal of Social Sciences Online* 10(1): 1-9.	It is still held that traditional post-mortem practices outweigh all other alternatives despite the implications that this has for the Indigenous people of New Zealand. For Indigenous Māori New Zealanders, however, post-mortems remain a foreign and desecrating act that impacts on their cultural bereavement. Thus, there is a challenge for medical and coronial services to balance the cultural aspects and medical and legal requirements. **P**
'Why This Law?' Vagaries of Jurisdiction in Coronial Reform and Indigenous Death Prevention. Bray, R. S. (2008). *Australian Indigenous Law Review* 12: 27-44. *This paper is included in the detailed summary section.*	Inquests into Indigenous deaths and Indigenous deaths in custody continue to expel the message that greater socio-political aspects contribute to 'how the death occurred'; that Indigenous deaths are not isolated occurrences but rather spur from governmental and social treatment of the Indigenous population and their experience in the community. The results of these inquests are often quite political or at least speak to social issues that remain unanswered without mandating a response to the recommendations put forward by the coroner. There is a need for mandatory responses to change services, policies and practices which will subsequently assist in preventing future deaths. **P**
Respecting the Dead, Protecting the Living. Brazil, R. (2008) *Australian Indigenous Law Review* 12: 45-54.	The Royal Commission's proposals for reforming the coronial system hold value for coronial practice beyond the issue of deaths in practice. This paper provides an assessment of how a more fully realised preventative role in the coroners court may serve a broader public health interest by advocating for an enhanced focus on prevention. Additionally, this paper presents two case studies that illustrate how culturally appropriate representation at coronial investigations ensures that the voices of the families of the dead are heard. Investigations carried out in a respectful manner remains fundamentally vital to the public interest. **P**

Secondary Research	
Telling and retelling your story in court: Questions, assumptions and intercultural implications. Eades, D. (2008). *Current Issues in Criminal Justice* 20(2): 209-230.	The telling of one's story in everyday differs extremely from the retelling of this story in court, this difference is influenced by police interviews, lawyer interviews and examination in a court room. Where storytelling is influenced by culture, there are complex implications for the retelling of this story in court, especially for Indigenous peoples who are still 20 times more likely to come in to contact with the criminal justice system. **P**
Clusters of Suicide...: The Need for a Comprehensive Postvention Response to Sorrow in Indigenous Communities in the Northern Territory. Hanssens, L. (2008). *Aboriginal and Islander Health Worker Journal* 32(2): 25.	There are significant gaps in training and support provided by coronial support services for Indigenous families amidst the coronial process. Improving these services may lead to deepened respect for Indigenous bereavement and the cultural, physical, emotional and spiritual needs of Indigenous people regarding grieving the loss of someone to suicide. **P**
Non-adversarial justice and the coroner's court: a proposed therapeutic, restorative, problem-solving model. King, M. S. (2008) *Journal of Law and Medicine* 16: 442.	A mixture of therapeutic jurisprudence, restorative justice, mediation and problem-solving could resolve comprehensive issues experienced by families in the bereavement process and increase the findings of coronial investigations including cause of death determination and public health and safety recommendations. Non-adversarial practices can create a collaborative, sensitive and empowering model of coronial investigation and inquests. This can be assisted by increasing the support services available for those taking part in the coronial process. **P**
Coronial recommendations and the prevention of indigenous death. Watterson, R., Brown, P., & McKenzie, J. (2008). *Australian Indigenous Law Review* 12: 4.	Coroners have the ability to contribute to preventing future deaths of Indigenous people by speaking to public health and policy considerations in their recommendations. However, these recommendations continue to prove ineffective in creating positive change as there is no obligation on legislatures to implement them. There is no consistency in Australian jurisdictions as to the process of implementing recommendations despite their vitality in preventing future deaths. **P**

Secondary Research	
Coronial Reform in Western Australia. Allingham, K and Collins, P. (2008) *Australian Indigenous Law Review Special Edition* 12(2): 90	This paper, written in 2008, reviews the reforms made to the *Coroners Act 1996* (WA) in line with the Royal Commission into Aboriginal Deaths in Custody. Key issues identified include the need for independent investigators to be responsible for investigating deaths in custody, and the need for a statutory provision in the *Coroners Act* that requires government agencies to respond to coronial recommendations. Additionally, it is suggested that all coronial recommendations should be tabled in the Western Australian Parliament. **P**
Australian findings on Aboriginal cultural practices associated with clothing, hair, possessions and use of name of deceased persons. McGrath, P and Phillips, E. (2008) *International Journal of Nursing Practice* 14:57	Recognition of the cultural gap between westernised Australian and Aboriginal cultures, especially in regard to care of the dying, is significant. Aboriginal peoples in Australia embrace traditional practices, customs and rituals associated with the deceased person's clothing, hair, possessions and name. **P**
Death investigation, the coroner and therapeutic jurisprudence. Freckelton, I. (2007). *Journal of Law and Medicine* 15(2): 242.	Coronial investigations are unique in that they incorporate both adversarial and inquisitorial elements, resulting in a function quite distinct from any other judicial officer. This allows coroners to have a further reaching impact than other judicial officers, particularly to influence public health and safety and community impacts. However, many aspects of the coronial process inadequately respond to the needs of families and sectors of the community, especially regarding their need to be informed about the process and outcome of investigations. These needs can be addressed by imposing an obligation on the entities subject of the coroners recommendations to state whether they will implement said recommendations and within what timeframe. **P**

Secondary Research	
The Sacred and the Profane: The Role of Property Concepts in Disputes About Post-Mortem Examination. Vines, P. (2007) *Sydney Law Review*, 29, 235	Traditional Aboriginal communities believe that an autopsy is desecration of the body of the deceased. Feelings of grief and advertence to autopsies may be exacerbated where the death has occurred in custody. It is recommended that a framework established to include not only consultation with Aboriginal Legal and Medical Services, but that greater weight be given to a family's preference to not conduct an autopsy on cultural grounds. **P**
The 2004–05 South Australian Inquests into Deaths on the Anangu Pitjantjatjara Yankunytjatjara Lands: An Opportunity for Forthright Government Action. Charles, C. (2005). *Australian Indigenous Law Reporter* 9(4): 77-79.	This report exemplifies a disconnect between the function of the coroner to make recommendations to prevent future deaths and how the lack of accountability can undermine this aim. It recounts the 2002 inquests investigating the causes and circumstances of the deaths of three people who died on the Anangu Pitjantjatjara Yankunytjatjara Lands as a result of sniffing petrol. Detailed findings and a comprehensive set of recommendations to Government were published by former State Coroner of South Australia, Wayne Chivell. Despite this, no action on behalf of the government was taken in response to these recommendations and, in 2004–05, four more similar deaths are investigated. **P**

Secondary Research	
The interaction of death, sorcery and coronial/forensic practices within traditional indigenous communities. Byard, R. W. and Chivell, W.C. (2005). *Journal of Clinical Forensic Medicine* 12(5): 242-244.	This paper describes how western coronial systems may cause considerable distress to traditional Indigenous communities and provides examples of how standard medical/forensic and coronial practices can work together with Indigenous communities. In traditional tribal practices, mainly 'men of high degree' within 'sorry camps' carry out traditional rituals and procedures to determine whether the death of a member of their community involved sorcery and, if sorcery is determined, who the perpetrator is. The standard method of autopsy and coronial reporting not only adds delay to the Indigenous community performing these rituals but can cause significant distress. It is argued that a simplified preliminary report should be issued to traditional Indigenous communities at the conclusion of an autopsy including a statement that 'no sticks, stones, bones or other foreign objects were found within the body that would implicate another person in the death'. These measures may assist in the practices carried out in the 'sorry camps', initiate discussion between traditional Indigenous communities and authorities about death and create respect for both systems. **P**
The rights of the dead: autopsies and corpses mismanagement in multicultural societies. Benteln, A. D. (2001). *The South Atlantic Quarterly* 100(4): 1005-1027.	Traditional Anglo-American law holds that a deceased person is not property of their relative, rather is property of no-one and the next of kin retains purely quasi-property rights on the basis that they may decide how the deceased person is buried. In the United States, the legal next of kin has the ability to grant authority or deny the ability of a coroner to carry out an autopsy on a deceased person, however an individual's refusal may not always be respected. The ability of a coroner to carry out an autopsy despite a refusal has led to numerous lawsuits initiated by family members who have refused on the basis of religious beliefs that denounce the mutilation of the dead in any form. **P**

Secondary Research	
Investigating to save lives: Coroners and Aboriginal deaths in custody. McFarlane, O. and Vines, P. (2000). *Indigenous Law Bulletin* 4(27): 8.	Coroners and coronial inquests play a vital role in preventing future deaths where social, economic, racial and other factors contributed to how and why the death occurred. Legislatures have exhibited low levels of legislative reform in compliance with the recommendations made by the Royal Commission into Aboriginal Deaths in Custody. Of particular interest, recommendations regarding notification and involvement of the family in coronial proceedings remain unimplemented in legislation in most Australian jurisdictions. While many of the recommendations have resulted in administrative changes, further calls for a legislative response to "establish rights rather than expectations, rules rather than discretions". In response to the number of deaths continuing to rise, systems must be put in place which are mandatory and not discretionary. **P**
Legal Recognition of Cultural Differences in Communication: The Case of Robyn Kina" Eades, D. (1996). *Language and Communication* 16(3): 215.	The Royal Commission into Aboriginal Deaths in Custody revealed that Indigenous people are 20 times more likely to be taken into custody and 15 times more likely to be incarcerated. Factors contributing to these rates include racism, social, economic and educational factors, as well as the history of dispossession. Inextricably linked to empowerment and self-determination lies language and communication issues. This paper describes how Aboriginal ways of communicating must be taken into account if Aboriginal people are to be treated fairly in the justice system. **P**

Grey literature (government reports, policy statements, etc)	
Coronial Investigation in Queensland: (Counter)-Therapeutic Effects. Coronial Assistance Legal Service. Caxton Legal Centre (2019).	Coronial procedures are characterised by legal and scientific principles, which can often be counter-therapeutic for a grieving family. Services, including counselling and assistance for the families to access and provide further information during an investigation or inquest, can assist both the coronial process and the family. The response of a government to recommendations put forth after an inquest, which has positive impacts of reducing future deaths or community benefit, may also have therapeutic benefits for families who have lost a loved one.
Delivering Coronial Services. Report 6: 2018-2019. Queensland Audit Office. (2018).	In this audit, the Queensland Audit Office assessed whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. The audit specifically examined whether agencies: provide adequate support to bereaved families, have efficient and effective processes and systems for delivering coronial services, and plan effectively to deliver sustainable coronial services. The report finds that the Queensland's Coronial System is under stress and is not effectively and efficiently supporting coroners or families.
Fourth reference report: Rights to appeal coronial findings and re-open investigations. Coronial Council of Victoria (2017). Victoria, Australia, Coronial Council of Victoria.	It is not uncommon for the coronial process to leave families with unanswered questions and no sense of closure. This effectively prompted a review of the rights to re-open or appeal coronial investigations and findings. Appeals must be on a question of law and re-opening of an investigation is available where there is new information. The old system of appeal had a number of grounds on which families could appeal or request the investigation be re-opened. It is not recommended that the coroners court return to the earlier system, however, much can be done in the initial stages of a coronial proceeding to assist families and reduce the need to seek redress by appeal. The report contains 11 recommendations which include the ability for the coroner to exercise greater discretion in whether an investigation is re-opened, and the courts should introduce a framework to better understand the systematic issues that arise for families and attempt to remove these.

Grey literature (government reports, policy statements, etc)	
Review of Coronial Practice in Western Australia. Aboriginal Legal Service of Western Australia (Inc.) (2010). Submission to the Law Reform Commission of Western Australia.	At the time of publication (2010) Western Australia had not received legislative reform for coronial proceedings since 1996, making it the second oldest Coroners Act in Australia. The Law Reform Commission was asked to conduct a review of the coronial proceedings in Western Australia and an in-depth review of the *Coroners Act*. The Aboriginal Legal Service has provided its own recommendations in its submission. The recommendations focus on the community's demand for greater accountability, transparency, knowledge of proceedings and contribution to preventing future deaths. Of particular interest is the recommendation that additional funding for Aboriginal Legal Services (WA) (ALSWA) to appear in coronial inquests. ALSWA provides cultural sensitivity and understanding, strong community ties, law reform expertise, and knowledge and experience about history, policy, social and cultural matters that impact on the lives of Aboriginal peoples across WA.

Specialist coronial legal assistance

A desktop review of specialist coronial legal assistance services revealed only a few services, namely:

- Coronial Inquest Unit – Legal Aid NSW
- Coronial Assistance Legal Service – Caxton Legal Centre (QLD)
- Coronial Assistance Legal Service – Townsville Community Legal Service (QLD)
- Coronial and Public Sector Monitoring – Aboriginal & Torres Strait Islander Legal Service (QLD)

Legal Aid NSW established the Coronial Inquest Unit in 2006, and for many years (until the Queensland Services commenced in 2017) this was the only specialist unit providing legal representation to families at inquests. Coronial Inquest Unit lawyers have appeared as advocates in numerous inquests throughout NSW involving public interest issues, including deaths in custody, police shootings, and health care matters. Lawyers from the service also provide legal advice and assistance to family members of a deceased, together with persons of interest at inquest. Provision is also made for legal aid funding within NSW of private lawyers and counsel to appear for families and interested parties at inquest.

At Legal Aid NSW a means-test and public interest test normally applies where a grant of aid is sought for representation at inquest. For families of an Aboriginal Torres Strait Islander who has died in custody these tests do not apply.

The most common minor/discrete assistance tasks include explanations of the coronial process, requests for documents and information and requests for inquests or a review of a coroners' decision. Full support and representation at inquests under a grant of aid will often involve preparing statements, attending pre-inquest conferences and directions hearings, requesting further investigation or documentation on behalf of a client, requesting particular witnesses be called, together with appearing in court to examine witnesses and make submissions, or alternatively briefing barristers to do so.

Process or effectiveness evaluations of these services could provide valuable learnings about what works or doesn't work for these matters. It was not within the scope of this review to explore barriers or facilitators; however, the following issues are of interest;

- Referral pathways and access to services for clients
- Expectation of what the coronial system can deliver may be significantly different to the reality. This is especially important where death occurs in care or in custody.
- Access (funding) for briefing barristers (where required)
- Social worker support for families.

While there are few specialist coronial legal assistance services, Aboriginal and Torres Strait Islander Legal Services around Australia may be available to assist their clients with coronial matters if they have the capacity. In particular, the Aboriginal Legal Service (NSW/ACT) provides representation to families in coronial inquests for deaths in custody and are the main service provider now for First Nations people.

Concluding remarks

The purpose of this study is to describe practices aimed at improving processes and experiences for Aboriginal and Torres Strait Islander families engaged in the NSW Coronial system. More specifically it aims to discover how Aboriginal and Torres Strait Islanders experience the delivery of coroner court services. It is hoped this will lead to improving service encounters in this group of the population which has distinctive and strong cultural values, but which is also generally disadvantaged.

This has been achieved by conducting a jurisdictional environmental scan to describe services, and a literature scan to summarise the research evidence on the involvement in the coronial system of Aboriginal and Torres Strait Islander people.

It was not within the scope of this study to examine the effectiveness, or otherwise, of service delivery models, although we believe this would be a useful exercise particularly if developing appropriate culturally sensitive services is the intention.

Our findings suggest that little has been done to study service encounters in these courts from the perspective of Aboriginal and Torres Strait Islander people and it is hoped that the literature presented in this paper might shed light on broader understandings about service encounters that would be relevant to those desiring to understand the service needs of Aboriginal and Torres Strait Islander people.

Recommendations from the literature (not endorsed)

The literature reviewed contains a number of recommendations. The Foundation has not assessed these recommendations and as such they are not endorsed. For ease of access, these are listed, along with reference to the publication in the table below. They may provide a useful starting point for further consideration and are found on the following pages.

Author	Study/Report	Their recommendations
'The system must recognise its obligation to do justice': The Coronial System in New South Wales and Indigenous Australians. McCabe, L. Submitted for Honours Degree, University of New South Wales (unpublished) (2019)	These recommendations are not evidence-based but have been put forth by the author (McCabe). These recommendations are specific to NSW and similar services may already be available in other jurisdictions.	1. Establish a culturally specific unit within the coroners court. This identified position would act as a point of contact for Indigenous families, would assist in the navigation of the system and provide support in a culturally appropriate manner.[34] Additional services could include: (a) Provision of training for regional Aboriginal Legal Service field officers to work with, and support, families involved in the coronial system in regional areas, (b) Provision of training to Aboriginal Community Liaison Officers who work with NSW police on the specifics of the coronial process. 2. Increase contact and communication with families (at least every 3 months). Suggested technologies to assist this recommendation include opt-in text messaging services. 3. Establish community transport for families to attend inquests at Lidcombe court. A suggested model proposes local community funding for this service. 4. Develop online training module for legal professionals regarding the coronial system in NSW. It is posited that many legal professionals have minimal experience or knowledge about the coronial system. 5. Family members should be offered the opportunity to make a statement (speak to the memory) to the court reading the deceased during an inquest or inquiry 6. Making the coroners court a more welcoming environment (tea, coffee, etc).

[34] A similar service is available in Victoria

Author	Study/Report	Their recommendations
Delivering Coronial Services. Report 6: 2018-2019. Queensland Audit Office. (2018).	The Queensland Audit Office prepared an audit report assessing whether agencies are effective and efficient in supporting the coroner in investigating and helping to prevent deaths. Recommendations set forth in *Delivering Coronial Service*s are largely specific to the Queensland setting and are detailed in the next column.	[We] recommend the Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners: 1. establish effective governance arrangements across the coronial system by: • creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist • more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services • establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established. 2. evaluate the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems. [We] recommend that the Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners: 3. improve the systems and legislation supporting coronial service delivery by: • identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports • reviewing the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process • reviewing the *Burials Assistance Act 1965* and the Burials Assistance Scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.

Author	Study/Report	Their recommendations
		4. improve processes and practices across the coronial system by: • ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators • ensuring there is a coordinated, state-wide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy • establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process • ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses. 5. assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased. [We] recommend the Department of Justice and Attorney-General: 6. implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners 7. improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.
Fourth reference report: Rights to appeal coronial findings and re-open investigations. Coronial Council of Victoria (2017). Victoria, Australia, Coronial Council of Victoria.	The Fourth reference report examines the rights to re-open a coronial investigation or appeal coronial findings. While this scope is narrow, recommendations may be relevant for broader purposes. Recommendations are detailed the next column.	**Recommendation 1**: The Coronial Council considers that the operation of s 77 of the *Coroners Act* is appropriate. However, the Victorian Government should seek to amend the *Coroners Act* to clarify that the findings of inquests made under the 1985 *Coroners Act* may be reviewed by the State Coroner as provided for by that Act. **Recommendation 2:** The Victorian Government should seek to amend the *Coroners Act* to allow the coroners court to separately consider an application to: (a) set aside a finding if the coroners court considers it appropriate, and it is not necessary to re-open the

Author	Study/Report	Their recommendations
		investigation to do so; or (b) revise the wording in any part of a decision if the coroners court considers it appropriate, and it is not necessary to re-open the investigation to do so. Consistent with s 77(4) of the *Coroners Act*, the coroners court should be constituted by the coroner who conducted the original investigation unless they no longer hold the office of coroner, or there are special circumstances. An application for review on the proposed grounds should be subject to a three-month time limit from the day on which the finding of the coroner is made. In order to achieve greater clarity of review opportunities within the coroners court, consideration should be given to linking ss 76 and 77 more closely in the *Coroners Act*. **Recommendation 3**: The coroners court should adopt appropriate measures to facilitate greater engagement and understanding of court processes by families with the advice of the Client Advocacy Office (see Recommendation 4). In particular, the coroners court should work together with the Victorian Institute of Forensic Medicine to: (a) develop standardised court processes to provide regular and accessible information to families on the role and work of the coroners court; (b) better manage expectations of the timeline and scope for the coronial investigation, and advise families of significant milestones in the process; (c) provide regular updates on the progress of the coronial investigation, including when significant milestones have been reached, and the reasons for any delays; and (d) advise families on opportunities to make a submission on issues they consider relevant to the investigation. **Recommendation 4**: The Victorian Government should fund the establishment of a Client Advocacy Office within the coroners court. The Client Advocacy Office should have a high level of expertise in grief counselling, so they can provide sophisticated guidance and advice to the coroners court and the Victorian Institute of Forensic Medicine on best practice in assisting families and other interested parties engaging in the coronial system. **Recommendation 5**: The coroners court should develop appropriate guidelines and templates to ensure that, to the extent that it is consistent with the judicial independence of coroners, coronial findings: (a) follow a clear and consistent style; (b) clearly identify 'findings', 'commentary' and 'recommendations'; (c) that are made in respect of the circumstances in which the death occurred, must confine those circumstances to matters which are proximate and causally relevant to the death; and/or underpin matters which relate to the preventative role of the

Author	Study/Report	Their recommendations
		coroners court; (d) advise how submissions from families and other interested parties have been considered; and explain the rationale for making certain findings or recommendations (and not others) in sensitive or contentious cases. **Recommendation 6**: The Victorian Government should fund a centralised Coronial Legal Advice Service, through Victoria Legal Aid, to provide legal advice to interested parties relating to the coronial process. **Recommendation 7**: The coroners court should work with Victoria Legal Aid, the Victorian Bar and the Law Institute of Victoria to develop appropriate arrangements to assist families to access legal representation to enable them to effectively participate in the coronial process, particularly in circumstances where there is a significant power imbalance between parties, or there is a significant public interest issue at stake. **Recommendation 8:** The Victorian Government should seek to amend the *Coroners Act* to make it clear that an appeal against a coronial finding in s 83 is available on a question of law; and where the finding is 'against the evidence or the weight of the evidence'. **Recommendation 9:** The Victorian Government should seek to amend the time limit for commencing an appeal against a refusal by the coroners court to re-open an investigation in s 84 of the *Coroners Act* from 28 days to three months. **Recommendation 10:** The Victorian Government should fund a restorative justice program to enable families to resolve outstanding issues and questions following the conclusion of a coronial investigation. The referral of cases considered suitable for a restorative justice process should be managed by the Client Advocacy Office within the coroners court. **Recommendation 11**: The coroners court should take steps to better understand and respond to systemic issues that may arise during coronial processes. In particular, the coroners court should: (a) establish mechanisms to collect and analyse systemic data on court performance; (b) undertake periodic client feedback surveys; and (c) become a party to the International Framework for Court Excellence.
Review of Coronial Practice in Western Australia. Aboriginal Legal Service of Western Australia (Inc.) (2010).	The Aboriginal Legal Service of Western Australia (Inc.) (ALSWA) reviewed coronial practice in Western Australia and made a	**1.** ALSWA recommends that findings and recommendations from the coroners court be publicly available following appropriate amendment to maintain confidentiality and sensitivity.

Author	Study/Report	Their recommendations
Submission to the Law Reform Commission of Western Australia.	submission to the Law Reform Commission of Western Australia in 2010. It is possible that some of these recommendations have already been acted upon, and some may be specific to Western Australia. We have included them for reference.	**2.** That the *Coroners Act 1996* (WA) be amended to require: government departments and agencies and private organisations to respond to coronial recommendations within three months of the publication of the coronial recommendations; the coroner to publish the government or company response, along with his/her report, within 30 days of receipt of the response; and government departments and agencies and private companies to provide a progress report on the practical implementation of the coronial recommendations twelve months after their initial response. **3.** That administrative practices and procedures within the coroners court be improved to enhance communication between the court and legal counsel, particularly through early delivery of the brief. **4**. That the coroners court be allocated a dedicated courtroom and adjoining private rooms for witness preparation and family privacy. **5.** That independent investigators be appointed to investigate coronial matters, particularly matters involving a death in custody and / or police presence. **6.** That the WA government provide funding to ALSWA to appear for family or community when so instructed and better monitor the implementation of coronial recommendations. **7.** That the coronial counselling service be better resourced, particularly to meet the needs of affected people in regional and remote areas. **8**. That an Aboriginal Liaison Officer be appointed to the coroners court to bridge the gap between the court and Aboriginal families, communities and organisations. 9. That the WA State Government allocate funds to the coroners court to assist families attend and participate in coronial inquests. 10. That the WA Government develop and adequately fund a state-wide interpreter service for Aboriginal languages. **11.** That support be provided to family members to assist them manage any media interest generated by the coronial inquest. **12.** That persons other than police officers engage with family to provide information about the coronial investigation process as required under s 20 of the *Coroners Act 1996* (WA). **13.** That processes be established to ensure that families are provided with more information about the coronial process from the outset including expected timeframes, the powers and purpose of coronial inquests and the right of family to be legally represented at an inquest.

Author	Study/Report	Their recommendations
		14. That all counsel assisting the coroner be required to undertake cultural awareness training to improve their understanding and appreciation of cultural sensitivities surrounding Aboriginal grieving.

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