Submission No 48

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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SELECT COMMITEE ON THE CORONIAL JURISDICTION IN NEW SOUTH WALES

I am a proud palawa woman, an Aboriginal woman. In 2019 I completed my Honours research into the lived experiences of Aboriginal families who become entangled in the coronial system in New South Wales. I asked lawyers, advocates, and other representatives who work with bereaved Aboriginal families to describe the key barriers these families experience when confronted with the coronial system (McCabe 2019). The results of this study have now been published in the Alternative Law Journal (McCabe & George 2021). I am now working on my PhD in a very similar area, critically examining the experiences of Aboriginal families with the coronial system in New South Wales.

I would like to comment on the following terms of reference:

a) The practice and operation of the Coroner's Court of NSW
   (iii) the timeliness of its decisions,
   (iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented,
   (v) the ability of the court to respond to the needs of culturally and linguistically diverse and First Nations families and communities
b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary

Key Issues:

1. a)(ii) The timeliness of coronial decisions have significant impacts on the families affected. Most families endure delays of three to four years between the time of death of their loved one and the conclusion of the inquest.
2. a)(iv) The current mechanisms for ensuring accountability to coronial recommendations are inadequate, and are antithetical to the therapeutic potential of the Coroners Court.

3. a)(v) The ways in which information is disseminated to families throughout the coronial process is inconsistent and complex, hindering the courts' ability to respond to the community in a culturally appropriate way.
4. b) New South Wales Police is not an appropriate body to be undertaking coronial investigations concerning deaths in police custody, deaths after contact with police, or deaths occurring during police operations.

Evidence:

1. The timeliness of coronial decisions has significant impacts on the families affected. Most families endure delays of three to four years between the time of death of their loved one and the conclusion of the inquest. Delays have been described as *retraumatising*, *extremely distressing*, and overall a *shocking state of affairs* (McCabe & George 2021, p. 4). Much coronial reform in New South Wales has sought to emphasise the rights of families in coronial processes yet delays between time of death to the beginning of the inquest continue to grow, displaying a lack of respect for the bereaved and prolonging natural grieving processes (Dillon 2020; Freckelton 2008). These delays, in conjunction with a lack of information and poor communication, have the effect of alienating the bereaved.

2. The current mechanisms for ensuring accountability to coronial recommendations are inadequate and are antithetical to the therapeutic potential of the Coroners Court. As mentioned above, justice must be seen to be done, and the lackadaisical accountability structures regarding coronial recommendations prevents this from occurring – they are an exercise in futility. There exists enormous potential for coronial recommendations to make significant contributions to death prevention, and the coroner has the legislative capacity to make recommendations, however this is impotent without proper mechanisms for accountability. In the current structure, all New South Wales government agencies are required to respond to Coroner's recommendations (Rees 2009). What about the countless private organisations to whom recommendations are directed? There is currently no systematic way of charting the response to *all* recommendations, nor their effectiveness or otherwise. This can lead to a '*crisis in confidence*'; as one participant in my research noted, how much confidence can you have in system where '*it turned out that nothing much happened*'? When commenting on the frustration felt by Coroners themselves when they repeatedly make the same recommendations in the same types of deaths, one participant surmised that '*the sense of frustration that Coroners feel must be magnified and multiplied enormously by the sense of frustration of people who have actually lost relatives, and that can lead to a distorted view of the whole system*'. Many participants in my research agreed that an appropriate accountability mechanism might come in the guise of an

Ombudsman, an office independent from government that could oversee the responses to coronial recommendations, and would be able to table a report in parliament to account for which recommendations were or were not implemented, and why (McCabe 2019). As one participant so passionately said; '*a human life is at least as important enough to demand some explanation for what you have done or why you say you're not going to do it*'.

3. The ways in which information is disseminated to families throughout the coronial process is inconsistent and complex. Throughout my research, every single participant cited information, or lack thereof, to be the biggest issue experienced by bereaved families, second only to the incredible length of time a coronial matter takes. One participant, with almost twenty years' experience in coronial matters, stated that from their perspective '*no coronial client has been content with the process, the time, and the information that comes out*'. Without access to readily available, accessible information, '*it is very difficult for families to work out who to call, and when*'. In some instances, '*families don't know where their loved one is, physically where the body's been taken to, and they find getting that information very difficult*'. Communication, for example between families and Corrective Services, has been described as '*atrocious*', with multiple information trains serving to muddy a process that is already unclear; '*sometimes the information gets mixed up between the OIC, the Coroner, the Coroner's Court, registry, the OIC, the family, and so you've got a four step process that gets mixed up frequently about what's going on*'. Bereaved families can go without contact for up to eighteen months at a time – that is, without being contacted by the Officer in Charge, the Coroners Court, or by their legal representative (such as the Aboriginal Legal Service or Legal Aid Coronial Unit). This is an appalling state of affairs, that says to a grieving and vulnerable family that they don't matter in this bureaucratic, faceless system. This is completely antithetical to the therapeutic potential of the coronial system to facilitate healing via the acknowledgement that the families loved one matters, and that their death has not gone unnoticed. For Indigenous Australians, this is '*another whitefella system, and it's cold*'. The lack of information and communication is also symptomatic of the paucity of funding directed by various governments at the coronial system itself, as well as the insufficient funding for both Legal Aid and the Aboriginal Legal Service to act in the coronial, civil, jurisdiction.

The *Coroners Act 2009* (NSW) is to my knowledge the only Act that does not include clauses referring to the detection of Aboriginal ancestral remains (VIC, TAS & QLD all have this clause); consideration of the specificity of Aboriginal kin networks (ACT, TAS, NT & QLD); no specific provisions to respect cultural practices and diversity (VIC & QLD); no legislated regard for the RCIADIC and its recommendations (WA & QLD); and no instruction to notify the Aboriginal Legal Service of a death, reports, or decisions (ACT).

4. New South Wales Police is not an appropriate body to be undertaking coronial investigations, particularly when an investigation concerns the death of an Aboriginal or Torres Strait Islander person. From the terror of colonisation (Cunneen 2001), to the outrageous surveillance and criminalisation of Indigenous youth, most recently via the nefarious Suspect Target Management Plan (McGowan 2020), to the continued removal of Aboriginal children from their families (Allam 2020), the call for justice for Indigenous Australians is loaded with particular, devastating histories (Scott Bray & Martin 2016). It is police who surveil our youth, it is police who remove our children, and it is police who criminalise and over-police us. More Aboriginal men, women and young people have died in custody since the *Royal Commission into Aboriginal Deaths in Custody* (1991) than at any time preceding it (Briggs 2016). Indigenous Australians are the most incarcerated people on earth (Anthony & Baldry 2017), and die in custody at disproportionate rates. And yet, it is police who investigate these deaths. It is police who liaise with traumatised, grieving Aboriginal families, and it is police who ascertain Indigenous status (Carpenter et al. 2016; Carpenter et al. 2015), all too often on behalf of the Coroner. This is because Indigenous Australians are overrepresented in every category of reportable death; it can therefore be inferred that they are also overrepresented in the coronial system.

   In my own research, I asked lawyers, advocates, and other representatives who work with bereaved Aboriginal families to describe the key barriers these families experience when confronted with the coronial system (McCabe 2019). One of the key issues was that of police investigating police. Almost all participants interviewed for the study identified this as a critical issue. One participant, a former Coroner, went as far as to say that '*as soon as NSW Police are investigating NSW Police there's a tendency to start walking on eggshells…they look after their own'*. Another participant spoke of a disturbing incident during a coronial inquest in Dubbo, where a person had been shot and killed by police. Family and community members were in attendance, as were roughly 20 police officers in full uniform, who sat on one side of the courtroom in a blatant attempt to intimidate the family. No police officer was held accountable for the killing of that person.

   There exists enormous suspicion for families when police are investigating a death in custody, particularly a death in police custody, and this is exacerbated for Aboriginal families who share complex and often traumatic relationships with police. Justice must be seen to be done, there must be transparency when it comes to coronial investigations, and while the police are investigating their own this is just not possible.

Recommendations:

1. That an Aboriginal Family Liaison unit be established within the Coroners Court immediately, following the model of the *Koori Family Engagement Unit* in Victoria, and that funding be allocated by the New South Wales Government in order for this to occur
2. That the Coroners Court in NSW be funded as the specialist court that it is, in order to increase the timeliness of its operations and ensure adequate information is getting to families and loved ones
3. An extensive review, and structural reforms, of the accountability mechanisms related to the implementation or otherwise of coronial reforms
4. That there be an independent, discrete unit of trained investigators, separate to New South Wales police, whose sole responsibility is to investigate on behalf of the coroner in all cases including, but not limited to, deaths in custody

I hope that you will consider the information I have presented here. I believe we are at a pivotal turning point, where we have the opportunity to effect real change in a system that not only disproportionately affects Aboriginal families, but a system that is failing to meet its full potential.

Please do not hesitate to contact me should you have any questions or require any further information.

Sincerely,

Lindsay McCabe

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