Submission No 66

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

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Dear Chairman, the Hon. Adam Searle,

Submission to the Select Committee Inquiry into the Coronial Jurisdiction in NSW

Thank you for the opportunity to provide a submission to Select Committee *Inquiry into the Coronial Jurisdiction in NSW.* I append the submission co-authored with Professor Phil Scraton to the Select Committee *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (referred to throughout as *FN submission)* which is of relevance to this inquiry.

In this submission, I draw key points from the *FN submission*, and also make additional comments on specific matters following my oral evidence to the *Inquiry into the Coronial Jurisdiction in NSW* in October 2021.

Increasing resourcing of the NSW coronial jurisdiction

Coronial death investigation, including the holding of inquests, is a considerable and necessary justice investment. NSW *continues to spend less* on coronial death investigation than other comparable jurisdictions. In 2017-18, NSW spent $6.9m on coronial matters; Victoria $17.6m and Queensland $11.5m.[1] In 2020-121, NSW spent $8m on coronial matters; Victoria $22m and Queensland $12m.[2]

By way of further comparison with smaller Australian jurisdictions, for 2020-21, NSW spending is slightly above WA ($7.3m), just less than double SA spending ($4.7m), marginally more than double ACT spending ($3.2m).[3]

The coronial jurisdiction is invested with a considerable expectation for 'truth-telling' as distinct from other legal processes concerned with liability; and to access the 'truth' of a person's death, the coroner has wide powers of investigation and inquiry anomalous in adversarial systems of justice.

- Given the significance of the coronial jurisdiction in investigating deaths, and the important public interest function of coronial work, it is high time that NSW funding reflected the coronial promise to address issues of justice and health following preventable death.

Delivering open justice

It was disappointing to see the New South Wales Law Reform Committee pass over the opportunity to discuss open justice in the coroner's court in its 2021 *Open Justice Review*.[4] This submission contends there should be more, not less, or restricted, discussion of coronial law and practice in New South Wales.

[1] Australia Government, *Report on Government Services*, Productivity Commission: Canberra (2019), 7.4. See also Hugh Dillon, 'Why NSW Needs a Specialist Coroners Court' (2018) 48 *Law Society Journal* 26.
[2] Australia Government, *Report on Government Services*, Productivity Commission: Canberra (2022), 7.3.
[3] Ibid.
[4] NSWLRC, *Open Justice: court and tribunal information: access, disclosure and publication. Draft Proposals*, (June 2021), 10-11.

This submission supports the submission of the Jumbunna Institute on issues of open justice in the jurisdiction.[5] It makes some additional comments about availability of information, and the forms of access, to support the democratisation of access to coronial information.

Greater and clearer access to coronial information

Over the past three decades, coronial law and practice both internationally and in Australia has been the subject of steady tranches of legal and policy reform. In Australia, reforms have aimed to upgrade forensic medical practices and coronial processes to make good on the increasing recognition of the rights and role of families following death, respect for cultural beliefs and practices, the role of prevention, and the importance of communication with the public.

Central to this latter aim is the availability of and accessibility to coronial information, such as coronial findings, which has been a key part of the evolving publicity around coronership and elevating the centrality of preventive principles underwritten by the principle of open justice.[6]

At its most rudimentary level, this includes coroners' courts maintaining a website that publishes coronial findings and accompanying recommendations, and basic jurisdictional information. However as with most coronial matters, while common principles – such as open justice – span jurisdictional boundaries, they find very different expressions throughout coronial jurisdictions of Australian states and territories, and NSW is in need of improvement.

Internet availability of coronial information has a statutory basis in some jurisdictions, while other jurisdictional approaches are more ad hoc and partial. For example, in 2009 Victoria legislated for internet publication of findings and responses to coronial recommendations, leading to a growing archive of publicly accessible death data.[7]

In addition to mandatory publication of this material, the standalone Victorian Coroner's Court website includes information on coronial process (e.g. 'What happens at inquest'), annual reports and submissions to inquiries, media releases on specific issues and key findings, including research from the Coroner's Prevention Unit, established to assist coroners in their preventive role.[8]

Queensland (QLD) offers robust access to the jurisdiction without Victoria's statutory framework, albeit publishing findings since 2004, and since 2012 has published QLD Government responses next to coronial findings. The coroner's court webpages are under the umbrella website of the QLD Courts website, making navigation less clear.[9] QLD also makes available the State Coroner's Guidelines and relevant jurisdictional judicial decisions in addition to practice notes, material from the Domestic and Family Violence Death Review and Advisory Board, and a range of related web links.

QLD's website is an accessible coronial website in relation to findings as QLD gives detail about the nature of the case when Victoria does not, and digitises findings so that they are searchable. Victoria's website includes mostly searchable pdfs, but not always, meaning sometimes it is difficult to search *within* coronial findings which appear as scanned documents. This is a serious limiting factor in terms of access to coronial information.

The NSW Coroner's Court website is, helpfully, a standalone website but publishes an incomplete set of findings for a limited date range, in addition to coronial practice notes, and annual reports regarding deaths in custody and police operations, and of the Domestic Violence Death Review Team, along with jurisdictional information.[10] The website was overhauled in 2021, and more findings from earlier years being steadily added, with case summaries available.

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[5] Jumbunna Institute, Aboriginal Legal Service (NSW/ACT) and National Justice Project Joint Submission, Submission 23 to NSW Law Reform Commission, *Open Justice Review* (5 March 2021).
[6] Rebecca Scott Bray, 'Executive Impunity and Parallel Justice? The United Kingdom Debate on Secret Inquests and Inquiries' (2012) 19(3) *Journal of Law and Medicine* 569.
[7] Coroners Act 2009 (Vic) s73.
[8] See https://www.coronerscourt.vic.gov.au/.
[9] See https://www.courts.qld.gov.au/courts/coroners-court.
[10] See https://www.coroners.nsw.gov.au/.

However, a significant limitation of access to coronial information in NSW relates to accessing responses to coronial recommendations, as noted later in this submission. Responses to coronial recommendations are not collected together with the relevant coronial finding and are located on another Department of Justice webpage. Access to coronial information is therefore significantly curtailed and incomplete in NSW.

- It should be noted that families often search coronial websites to find information about previous circumstances of death, coronial recommendations and responses to recommendations. Poor presentation of and access to coronial information adds unnecessary barriers to bereaved peoples' engagement with the jurisdiction. It impacts on open justice.
- This submission supports improvements in the digitisation and availability of coronial findings, recommendations and responses to recommendations in NSW.
- It supports a statutory basis for publication of material.
- Victoria's online presentation of published information is preferable with a table of findings and accompanying responses. However, this would be improved with the addition of case summaries, and the retention of searchable pdfs, including the availability of other jurisdictional material, including judicial decisions.
- The submission also contends that, as with other jurisdictions highlighted in submissions to the NSWLRC *Open Justice Review*, access to inquest transcripts is prohibitive.

Comprehensive court lists

Making information available about upcoming coronial inquests is arguably a simple, but key part of facilitating open justice, and coroners' offices Australia-wide again diverge on approaches to this core exercise of coronial publicity.

NSW publishes a weekly digital list detailing the name of the deceased, the presiding coroner, type of hearing and, helpfully, the type of case (e.g., 'death during a police operation'). Victoria publishes a rolling fortnightly digital list which includes the name of the deceased, presiding coroner and the type of hearing.

A good example is QLD, which publishes a monthly inquest sittings list in downloadable PDF form, including the name of the deceased, presiding coroner, type of hearing (e.g., mention, inquest, findings), and details the issues and questions to be considered at inquest, which can be extensive.

- QLD's monthly inquest sittings list with extensive information is preferable.

Online access to inquests

The use of webpages or dedicated websites for specific cases opens up courts to those unable to attend inquests in person. While this is a nascent practice in Australia, it is well developed in England and Wales for high profile and contentious cases.[11] The inquest into the deaths arising from the Lindt Café siege in Sydney had a discrete NSW Coroner's Court webpage, publishing the State Coroner's opening and closing remarks, directions, decisions, and non-publication orders, and opening remarks by Counsel Assisting.

In addition, the opening summary remarks to each hearing segment by the State Coroner and Counsel Assisting were televised. The 'offsite' access to inquests that this case illustrates raises questions about not merely public access to coroners' inquests, but the accessibility of *particular* cases – why do some inquests have dedicated webpages or livestreams, while others do not? What elevates the public interest aspects of one case over others?

[11] Including the March 2017 Westminster terror attack and the June 2017 London Bridge and Borough Market terror attack. These cases follow now established practice in the UK for high-profile inquests with standalone websites which archive daily transcripts and evidence, including the Jean Charles de Menezes inquest (2008), the 7/7 inquests (2010-2011), the inquest into the death of Ian Tomlinson (2011), the inquest into the death of Mark Duggan (2013-2014), and the Hillsborough inquests (2014-2016).

- NSW has recently livestreamed a number of inquests in whole or part due to the COVID-19 pandemic. Access to these proceedings is less restricted than in Victoria, where direct contact with the court must be made prior to accessing the livestream. The NSW approach is a positive development in NSW coronial practice where open justice in coroners' courts resides in a multimedia world.
- More consideration should be given to livestreaming of NSW coronial proceedings.

Additional observations on inquests and open justice

Research around open justice, including media reporting and public participation, largely account for trial practices in civil or criminal courts, not inquests in coroners' courts. Coronial researchers have argued that open justice in inquests should be understood very differently to how it is applied to civil and criminal justice contexts, where it is typically considered a procedural principle and an instrumental aid to ensuring a fair trial.[12]

Observing UK coroners' inquests, Sam McIntosh argues that open justice in inquests is less associated with ensuring fair and proficient conduct than with 'a need for accountability regarding *the subject under investigation*'.[13] This need is necessarily contextualised by inquests being non-retributive and non-compensatory, unlike other fora such as criminal courts. McIntosh argues that open justice as it has traditionally been conceived is too narrow for inquests – we must also consider 'the practice of openness as manifested *through* inquests', which means thinking about when an inquest is held, its scope, and *how* it is open to public participation.[14]

Commenting specifically on use-of-force deaths, McIntosh emphasises that learning about the circumstances of death is not merely a taken-for-granted presumptive right for families and the public, but is a part of *the core scrutiny and accountability purposes of inquests* into contested deaths that underwrite openness in coronial contexts.[15] Scrutiny of and accountability for deaths in contested circumstances *intrinsically* require openness.

Central to this form of recognition is a concern with individuals as rights bearers and valued members of a community who are harmed following deaths at the hands of the state. It means considering the ways in which families and their communities are recognised as having *distinct interests in the inquest process*, in addition to understanding the harms that result from inadequately responding to a death.[16]

It also establishes the different but important interests of the broader public and 'the right to participate as an informed citizenry in wider debates about the use of force by the state'.[17]

While many commentators take up (and some take issue with) the principle that open justice practices promote public confidence in the courts (again, usually referring to the criminal context), it might be said that for coroners' courts investigating contested deaths, the open justice principle is important because, as expressed in *Ramsahai v Netherlands*, where there is an investigation into a death at the hands of the state 'what is at stake here is nothing less than public confidence in the state's monopoly on the use of force'.[18]

<u>Recognition of the bereaved</u>

Many submissions to this inquiry, and to other inquiries, detail the immense toll of coronial investigations and proceedings on bereaved families and communities. As its first priority, the Select Committee should closely regard the experiences and views of those directly affected by coronial investigations. Families and communities possess authoritative knowledge about the numerous issues the inquiry is concerned with and speak to what is at stake in its outcomes.

[12] Sam McIntosh, 'Taken lives matter: Open justice and recognition in inquests into deaths at the hands of the state', (2016) 12(2) *International Journal of Law in Context* 144.
[13] Ibid.
[14] Ibid 142, emphasis in original.
[15] Ibid 144.
[16] Ibid 151-152.
[17] Ibid.
[18] *Ramsahai v Netherlands* (2008) 46 EHRR 43.

The *FN submission* provided a comprehensive listing of relevant issues with respect to bereaved families engagement with the coronial system, and the significance of recognising the status of bereaved people in coronial investigations to aid in the therapeutic function of the court.[19]

In other jurisdictions, human rights legislation helps to secure the rights of the bereaved in contested cases, including deaths in custody. Australian coroners should not, and in fact, do not ignore human rights considerations in discharging their investigative duty,[20] however this requires enhancement in NSW. In the past, the advocacy group Australian Inquest Alliance (AIA) has outlined the relevance of the coronial system to Australia's human rights obligations, documenting a number of areas that highlight the coronial capacity to protect human rights, including its truth-telling and fact-finding role, and its preventive function. The AIA also outlined the shortcomings of the coronial jurisdiction that frustrate and potentially breach these rights and heavily impact bereaved families and communities, such as delays in inquest, lack of resources, and limitations with respect to coronial recommendations.[21]

We need a Charter for the Bereaved

It has been observed in other inquires and reviews of coronial systems that bereaved families and communities do not have *specific rights* when it comes to engagement with coronial process.[22] By comparison, victims of crime are typically afforded rights with respect to their engagement with the criminal justice process by way of a victims of crime charter. This situation applies in NSW, which has a Victims of Crime Charter, where victims may make a complaint about a breach of the Charter.[23]

- The *FN submission* supported a Charter for bereaved persons. This submission similarly supports a Charter, which reflects international calls.

As outlined by Phil Scraton and Gillian McNaull in their recent report into the Irish coroner service, a Charter for the Bereaved would set out a statement of rights around a number of matters, including information provision; viewing the body; identification; post-mortems; return of the body; return of personal effects; access to location of death; and crisis support.

A Charter would also establish time frames for coronial death investigation, evidence gathering and holding of inquests, and include clear information about the role and obligations of state agencies during investigation and at inquest.[24]

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[19] Rebecca Scott Bray and Phil Scraton, Submission No. 125 to the NSW Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020), 16-20.

[20] See the (then) Australian Human Rights and Equal Opportunity Commission's submissions to the inquest into the death in custody of Mulrunji Doomadgee in 2004 on Palm Island, and the inquest into the death of Elder Ward during prison transportation in Western Australia in 2008 at: https://www.humanrights.gov.au/right-life. See also the Human Rights Law Centre submissions to the inquest into the police shooting of 15-year-old Tyler Cassidy in 2008: Human Rights Law Centre, *In the Coroners Court of Victoria, Inquest into the Death of Tyler Cassidy, Submissions of the Human Rights Law Resource Centre* (2008). See Jonathon Hunyor, 'Disgrace: The Death of Mr Ward' (2009) 7(15) *Indigenous Law Bulletin* 3; Jonathon Hunyor, 'Human Rights in Coronial Inquests' (2008) 12(2) *Australian Indigenous Law Review* 64; Rebecca Scott Bray, 'Death Investigation, Inquests and Human Rights' in Leanne Weber, Elaine Fishwick and Marinella Marmo (eds), *Routledge International Handbook of Criminology and Human Rights* (Routledge, 2017) 146; Ian Freckelton and Simon McGregor, 'Coronial Law and Practice: A Human Rights Perspective' (2014) 21 *Journal of Law and Medicine*, 585.

[21] Federation of Community Legal Services/ Australian Inquest Alliance, *Issues Paper: Saving Lives by Joining Up Justice* (March 2013).

[22] See JUSTICE, *When Things Go Wrong: The Response of the Justice System* (London, 2020) Chair: Sir Robert Owen, 2; Phil Scraton and Gillian McNaull (2021) *Death Investigation, Coroners' Inquests and the Rights of the Bereaved*, Irish Council for Civil Liberties; House of Commons Justice Committee, *The Coroner Service*, First Report of Session 2021-22, HC 68 (27 May 2021), 20-21.

[23] Charter of Victims Rights NSW: https://victimsservices.justice.nsw.gov.au/victims-services/victims-rights/charter-of-victims-rights/your-rights-under-the-charter.html; *Victims Rights and Support Act 2013* (NSW). The complaints process is outlined here: https://victimsservices.justice.nsw.gov.au/victims-services/victims-rights/charter-of-victims-rights/charter-complaints.html.

[24] Phil Scraton and Gillian McNaull (2021) *Death Investigation, Coroners' Inquests and the Rights of the Bereaved*, Irish Council for Civil Liberties, 8.

- A Charter would formally recognise that bereaved people are entitled to standards of service, and provide a complaints mechanism to address insufficiencies and breaches.
- It elevates recognition of families and communities beyond the status of expectations to the status of rights and standards.[25]
- A Charter should be developed in consultation with families and communities and those who support them, including community, advocacy organisations and groups across NSW.

Statutory recognition in the Coroners Act

The *Coroners Act 2008* (Vic), s8, firmly incorporates the recognition of families into the Act's objectives and, on the subject of autopsy, provisions allow for preliminary examinations of the deceased (s23) to further support respect for cultural beliefs. The *Coroners Act 2009* (NSW) now has a provision around preliminary investigations (s88A) which arguably supports respect for cultural beliefs.

- The Coroners Act should be amended to include statutory recognition of factors to be considered when exercising a function under the Coroners Act. This again elevates the status of families and communities.

Reviewing the status and place of family statements

Family statements occupy an ambiguous place in NSW coronial proceedings, despite often forming a key part of the coroner's opening reflections on and statements about the person who has died in formal coronial findings.

Family statements do not form a part of coronial evidence, and are typically offered by families and communities towards the end of inquests.

The personal statements of family members are often drawn upon and cited by coroners to express the significance of the person who has died to grieving family and community.

- Family statements, which are given in open court at the end of oftentimes long and arduous death investigation processes, deserve greater consideration.
- Consultation should occur with families, communities, advocates and supporting organisations to determine whether family statements should receive greater formal recognition in coroner's courts.
- This would include a consideration of matter such as: the form of statements, including audio and visual statements; when statements are to be delivered (for instance, at the beginning of inquest proceedings as is the case in some international jurisdictions, or at the end of proceedings).

A proposal for formalisation of family statements brings a range of important issues into consideration, including the form and content of family and community statements if they form a part of evidence, and therefore requires careful attention.

<u>Coronial recommendations</u>

The coronial power to make recommendations has been described as representing 'the distillation of the preventive potential of the coronial process'.[26]

The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was instrumental in drawing attention to coronial deficiencies in the context of First Nations custodial death investigation, with implications for coronial death investigation more broadly.

[25] House of Commons Justice Committee, *The Coroner Service*, First Report of Session 2021-22, HC 68 (27 May 2021), 20-21.

[26] Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody' in Hugh Selby (ed) *The Inquest Handbook* (Federation Press, 1998), 186, 187. See also Jennifer Moore, *Coroners' Recommendations and the Promise of Saved Lives* (Edward Elgar, 2016); Ray Watterson, Penny Brown and John McKenzie, 'Coronial Reform and the Prevention of Indigenous Death' (2008) 12(SE2) *Australian Indigenous Law Review* 4; Raymond Brazil, 'Respecting the Dead, Protecting the Living' (2008) 12(SE2) *Australian Indigenous Law Review 45.*

The *FN submission* highlighted the contribution of the RCIADIC to scrutinising the reality and the potential of coronial investigations. Specifically, the RCIADIC spotlighted the inadequacy of statutory provisions around coronial recommendations, determining that a more 'positive duty' should be imposed on coroners, sponsoring an upgrading of coroners' recommendatory powers from discretionary to obligatory.[27]

In NSW, s22A *Coroners Act 1980* was enacted in response to Recommendation 13 of the RCIADIC relating to a more positive coronial duty to make recommendations, now reflected in the *Coroners Act 2009* s82 (NSW).[28]

Yet, the statutory expression of this positive duty remains discretionary; coroners '*may*' make recommendations, whereas in Tasmania, for example, coroners must, where appropriate, make preventative recommendations.[29]

- This submission supports the RCIADIC call for a more *positive coronial duty* to make recommendations, one that is obligatory and not merely discretionary.

Establishing a proper circuit of accountability following coronial recommendations

The RCIADIC added that the value of coronial recommendations lies in their implementation, and that statutory provisions should be enacted to enable a *circuit of accountability*, from the distribution of coronial findings and recommendations to government departments and agencies, through to agencies' operational policies and practices.[30]

The RCIADIC noted the importance of coroners' using their powers to make recommendations and for institutions to respond appropriately,[31] but the circuit of accountability in NSW is not as strong as that recommended by the RCIADIC, or as that adopted by other jurisdictions.

Victoria legislated for mandatory responses to coronial recommendations in addition to greater visibility of coronial decisions via internet publication of coronial findings and subsequent responses.[32] Instead, NSW adopted a policy directive for responses to coronial recommendations.

In 2009 the NSW Premier issued the *Responding to Coronial Recommendations* memorandum to Ministers and agencies, directing 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 recommendation'.[33] The Memorandum stipulates that a record of all recommendations made and responses received would be maintained, and information would be summarised in a report posted on the Attorney General's website.[34] The Memorandum does not capture recommendations directed to private sector agencies or regulatory feedback.

- This submission supports mandatory responses to coronial recommendations for public and private sectors.

Improving access to responses to coronial recommendations

Responses to NSW coronial recommendations are archived online in response to the 2009 NSW Memorandum.[35] NSW publishes annual report summaries of government responses on the Justice Department's website, not full agency responses.[36]

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[27] Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 1* (1991) [4.5.89].
[28] John Abernethy et al, *Waller's Coronial Law and Practice in NSW* (Lexis Nexis Butterworths, 2010), 222 [82.1].
[29] *Coroners Act 1995* (Tas) s28(2), (3).
[30] Royal Commission into Aboriginal Deaths in Custody *National Report, Vol 1* (1991) [4.5.91]-[4.5.98].
[31] Ibid [4.5.85]-[4.5.98].
[32] *Coroners Act 2008* (Vic) s72, s73 and s72(5)(a) respectively.
[33] NSW Premier, Memorandum, *M2009-12 Responding to Coronial Recommendations* (2009) at: https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations/.
[34] IBID. TO VIEW THE SUMMARIES OF RESPONSES TO CORONIAL RECOMMENDATIONS MADE PURSUANT TO S82 OF THE *CORONERS ACT 2009* (NSW) SEE: HTTPS://WWW.JUSTICE.NSW.GOV.AU/LSB/PAGES/CORONIAL-RECOMMENDATIONS.ASPX.
[35] See https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.
[36] Ibid.

Despite being linked from the Coroner's Court website findings page,[37] this system is digitally separated from the Coroner's Court website and hard to navigate. It consists of an annual table of case names, with linked Word documents. The annual document for 2020-21 is 171 pages long.

- The current NSW system around accessing coronial recommendations, and responses to them, is awkward, unwieldly and inadequate. It is very difficult to search, analyse and monitor, and needs reform.
- The Coroner's Court website of coronial findings should be in an easily searchable form, and include full responses to coronial recommendations next to the relevant coronial finding, on the same website.

Monitoring and audit of coronial recommendations, including greater capacity for and support of coronial research

Publishing findings and responses to recommendations online might serve open justice, but it does not produce an analysis of trends and patterns of harm.

It must also be noted that follow-up of coronial recommendations is important for families and communities, for whom the end of the inquest process does not signal an end to their concerns around the death of their loved one. Following up implementation of coronial recommendations is a key part of doing justice after preventable death, and families feel this acutely.

Arguably, the current online 'digital swamp' of NSW coronial data prioritises publication over intelligibility.[38] Having access to coronial findings and recommendations is crucial, but for all of Australia's national coronial prevention talk, there exists a distinct lack of easy ability to *interrogate* coronial data. This is no less true for NSW.

There is a need for effective public oversight or monitoring of coronial recommendations following preventable deaths *and* agency responses to them.

- The NSW government should introduce NSW audit of coronial recommendations made and responses to them, and also contribute to national oversight mechanisms, to ensure effective monitoring of coronial recommendations, responses to recommendations and implementation issues.
- The RCIADIC focused on potential pathways to implementation of coronial recommendations. A contemporary review of implementation pathways and oversight mechanisms in light of RCIADIC recommendations is necessary.

Examining the characteristics of coronial findings and recommendations into different types of death and public organisations and private sector responses is an important step to understanding the coronial role and its contribution to death prevention.

Crucially and instructively, we do not know when, whether and to what extent coroners' investigations precipitate action, when recommendations are made, accepted and acted on, or why they are rejected.

- Analysing the circuit between coronial investigations, recommendations, and relevant agencies is essential in establishing current limitations and best practices. It would also document prevention success stories.[39]

[37] https://www.coroners.nsw.gov.au/coroners-court/coronial-findings-search.html.
[38] Sarah Moore et al, 'Seeing justice done: Courtroom filming and the deceptions of transparency'. *Crime Media Culture* (2019), 16.
[39] For example, Victorian research into coronial recommendations has highlighted coroners' contribution to avoidable drowning deaths of children in swimming pools, tractor-related deaths, and railway level-crossing related deaths. See Jennifer Moore and Mark Henaghan, *New Zealand Coroners' Recommendations, 2007-2012*. The Law Foundation of New Zealand/Faculty of Law, University of Otago (2014), 252-255; Lyndal Bugeja and David Ranson, 'Coroners' Recommendations: Do They Lead to Positive Public Health Outcomes?' (2003) 10(4) *Journal of Law and Medicine* 399. Added to this is the issue of whether recommendations are made at all, see Lyndal Bugeja et al, 'Application of a Public

- Research is imperative to examine the intersection of coronial work and reform to document death prevention across different contexts. As Halstead notes, 'the action taken in response to such recommendations carries the promise of lives saved and injuries averted. It should be noted that every single death represents the tip of the iceberg of injuries and other high-risk circumstances'.[40]

Without this information, the effectiveness or suitability of the coroner as an oversight agency of preventable deaths in NSW cannot be determined.

These issues are not restricted to NSW, but relate to coronial audit, monitoring and research Australia-wide. In light of these limitations, initiatives such as The Guardian's *Deaths Inside* database,[41] and the *UQ Deaths in Custody Project*,[42] have emerged to make death data publicly accessible *and* intelligible. Both databases are concerned with deaths in custody. They are joined by other initiatives such as *Deathscapes*,[43] a database of Indigenous and racialised custodial deaths in settler states, including Australia.

These initiatives enable the distillation and oversight work that should be a routine part of accountability mechanisms following deaths.[44] That this work has been left to bereaved communities, journalists, advocates, academics and campaigners *is not satisfactory in a state – or country – that espouses death prevention as a core principle of its death investigation system*.

- There is a need for more research into coronial recommendations generally. There are few Australian studies assessing the significance of coronial investigations and recommendations.
- We require up-to-date research into factors affecting the frequency, quality and implementation of coronial recommendations, including the feasibility of recommendations, the effects of a mandatory system of reporting responses, and how recommendations are formulated, expressed, and responded to.

Sutherland et al's Victorian-based research[45] revealed only a third of coroners' recommendations were implemented.

Sutherland et al also differentiate between actions taken by organisations before and after recommendations are made (supplanted recommendations), raising important issues regarding inquest delays, organisational input into recommendations, and organisations acting in anticipation of coronial findings. Their research demonstrated that reasons for the rejection of coronial recommendations include logistical and economic considerations of viability.[46]

Again, in Victoria, Sutherland et al[47] analysed mandatory responses to coroners' public health and safety recommendations, reviewing the composition and adequacy of organisational responses. They found Victoria's mandatory response regime to be compromised by the opacity of many response letters, in addition to concerns regarding 'soft' recommendations by coroners such as requests to

Health Framework to Examine the Characteristics of Coroners' Recommendations for Injury Prevention' (2012) 18 *Injury Prevention* 326.

[40] Boronia Halstead, 'Coroners' Recommendations Following Deaths in Custody' in Hugh Selby (ed) *The Inquest Handbook* (Federation Press, 1998), 187.

[41] A database of Indigenous deaths in custody. See https://www.theguardian.com/australia-news/series/deaths-inside.

[42] A database of deaths in custody from publicly available information. See https://deaths-in-custody.project.uq.edu.au/; Tamara Walsh and Angelene Counter, 'Deaths in Custody in Australia: A Quantitative Analysis of Coroners' Reports' (2019) 31(2) *Current Issues in Criminal Justice* 143.

[43] See https://www.deathscapes.org/.

[44] Rebecca Scott Bray, 'Contested Deaths and Coronial Justice in the Digital Age', *International Journal for Crime, Justice and Social Democracy* (2020) 9(4) 90.

[45] Georgina Sutherland et al 'What Happens to Coroners' Recommendations for Improving Public Health and Safety? Organisational Responses Under a Mandatory Response Regime in Victoria, Australia' (2014) 14 *BMC Public Health* 732.

[46] Ibid.

[47] Georgina Sutherland, Celia Kemp and David M. Studdert, 'Mandatory Responses to Public Health and Safety Recommendations Issued by Coroners: A Content Analysis' (2016) 40(5) *ANZJ Public Health* 451.

review, consideration or continuance of a certain course of action, where a compliance response is 'relatively effortless'.[48]

These and other studies highlight the complexity and diversity of issues involved in the formulation, expression, and implementation of coronial recommendations, and responses to them, that extend beyond any single issue such as that of a mandatory response regime.[49]

Expertise that informs recommendations and coronial investigations generally

Debates concerning enforceability and mandatory responses raise important questions about the suitability and development of relevant, targeted recommendations and coronial expertise.

Victoria sought to boost the preventative capacity of coroners commissioning research via the Coroners Prevention Unit (CPU), yet there is a case for wider appreciation of death research beyond epidemiological models.[50]

The increasing value of an initiative such as the CPU lies in its contribution to coronial understanding in other jurisdictions, including NSW. The NSW State Coroner recently highlighted the significance of a research report produced by the CPU for the Victorian case of *Vekiaris* on the issue of 'Excited Delirium'.[51] The NSW State Coroner noted that '[t]he lack of a similar research facility as the Coroners Prevention Unit in this state means that it falls to the Counsel Assisting team to try and source relevant evidence via experts ... This is, unfortunately, an expensive and ad hoc approach to identifying and researching systemic issues linked to this Court's power pursuant to s. 82 of the *Coroners Act 2009* to make recommendations in the interest of public health and safety'.[52]

- This submission supports an extension of the understanding of what constitutes valuable knowledge, expertise and research for a CPU initiative in NSW.
- It would include diverse knowledges, disciplines and expertise. Incorporating such knowledge is a practice which is already familiar to some NSW coroners via the use of expert evidence, but much more could be made of this.
- Increased productive research capacity would involve the considerable insights and resources of human rights interveners and organisations, disability advocacy groups, community-based organisations, and First Nations communities which can inform the death prevention work of a coronial research unit.

Widening inquest scope and understanding death causation

Issues of expertise and knowledge also relates to the interpretation of death and inquest scope, as outlined by Jumbunna's submission, and also referred to in the *FN submission*.

How the facts of death are investigated, revealed and registered in coronial courts and subsequently documented in coronial findings is important. *The FN submission* highlighted that in-depth research has revealed how a 'truth-telling' process such as the coroners' inquest focuses on contestation in 'weighing and weighting' evidence in a process which offers an aggregation of truth.[53]

Circumstances of death are reconstructed in the context of particular histories and their interpretation. This is especially notable when considering First Nations deaths in custody, which have distinct socio-

[48] Ibid 455.
[49] See Elena Mok, 'Harnessing the Full Potential of Coroners' Recommendations' (2014) 45(2) *Victoria University of Wellington Law Review* 321; Rose Mackie, 'The Implementation of Coronial Recommendations in Tasmania: Two Case Studies on Child Deaths' (2018) 25(2) *Journal of Law and Medicine* 503.
[50] See also Hugh Dillon, 'A Three-Cavity Autopsy of the NSW Coronial System: What's Going on Inside?' (2019) *Journal of the NSW Bar Association* (Autumn), 9.
[51] Coroner's Court of Victoria, *Inquest into the Death of Odisseas Vekiaris* (COR 2009 5915).
[52] See the State Coroner's comments, Coroner's Court of NSW, *Inquest into the death of Tristan Naudi* (2016/18089) 57 at [223].
[53] Phil Scraton, 'Policing with Contempt: The Degrading of Truth and Denial of Justice in the Aftermath of the Hillsborough Disaster' (1999) 26(3) *Journal of Law and Society* 274.

legal legacies, particularly institutionalised racism directed against First Nations peoples in policing practice and incarceration.[54]

The strength of these determining contexts is gradually receiving increased recognition in NSW coronial courts, yet progress is slow. NSW Coroners have commented on important background factors regarding the deaths in custody of First Nations people in the wider political and social context, citing research findings and referring to the RCIADIC recommendations.

It appears that coroners recognise the significance of settler colonialist legacy and its ongoing violence against First Nations peoples. However, relegating this history to 'relevant background factors' deflects attention 'away from the strength of determining contexts' and their relevance to the scope of inquests and the facts of death.[55]

- The capacity exists to elevate underlying factors to the foreground through widening the scope of inquiry, and is being tested in coronial courts.
- While coronial work is developing greater recognition of determining contexts in inquest scope, it has been families and their advocates who have campaigned for coronial change to ensure that the scope of inquests reflects the factual circumstances of death.[56]
- There exists a need to better account for determining contexts in *an instrumental way* at inquest.

As Gomeroi scholar Alison Whittaker has revealed, the language used by coroners is important in recognising not only how they delimit scope but also how they determine causation.[57] Despite increasing attempts by coroners to respect and 'humanise' the person who has died, coronial researchers reveal how First Nations deaths in custody regularly are characterised as 'timely' or 'tragic' and, therefore, 'naturalised'.[58]

[54] Rebecca Scott Bray, 'Death Scene Jurisprudence: The Social Life of Coronial Facts' (2010) 19(3) *Griffith Law Review* 567; Chris Cunneen, 'Aboriginal Deaths in Custody: A Continuing Systematic Abuse' (2006) 33(4) *Social Justice* 37, 42; Jennifer Corrin and Heather Douglas, 'Another Aboriginal Death in Custody: Uneasy Alliances and Tensions in the Mulrunji Case' (2008) 28(4) *Legal Studies* 531; Janet Ransley and Elena Marchetti, 'Justice Talk: Legal Processes and Conflicting Perceptions of Justice About a Palm Island Death in Custody' (2008) 12(2) *Australian Indigenous Law Review* 41; Paula Morreau Policing Public Nuisance: The Legacy of Recent Events on Palm Island' (2006) 6(28) *Indigenous Law Bulletin* 9.

[55] Scraton, above n 50, 274.

[56] A key example is Yorta-Yorta woman Tanya Day's family in Victoria, who succeeded in arguing that the inquest scope should include consideration of the significance of systemic racism in her death See https://www.hrlc.org.au/tanya-day-overview. See the family's submissions in the inquest into the death of Tanya Day, available at: https://www.hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability. See also Monique Hurley, 'The Beginnings of Justice for Aboriginal Deaths in Custody?' 159 (July/August) *Precedent* 4. In NSW, an example is the inquest into the death of Wiradjuri woman Naomi Williams, which considered whether the medical care provided to her was affected or compromised by unconscious, implicit bias or racism. See Coroners Court of NSW, *Inquest into the Death of Naomi Williams* (2016/2569).

[57] Alison Whittaker, "'Dragged Like a Dead Kangaroo': Why Language Matters for Deaths in Custody' (2018) *The Guardian* (8 September) at: https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody. See also Jumbunna Institute of Indigenous Education and Research, Research Unit, Submission 115 to Legislative Council Select Committee, *Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* (7 September 2020) and Jumbunna's submission to this Inquiry at p 7-8.

[58] See Sherene Razack, 'Timely deaths: Medicalizing the Deaths of Aboriginal People in Police Custody (2011) 9(2) *Law, Culture and the Humanities* 352; Sherene Razack, *Dying from Improvement: Inquests and Inquiries into Indigenous Deaths in Custody* (University of Toronto Press, 2015); Alison Whittaker, "'Dragged Like a Dead Kangaroo': Why Language Matters for Deaths in Custody' (2018) *The Guardian* (8 September) at: https://www.theguardian.com/commentisfree/2018/sep/07/dragged-like-a-dead-kangaroo-why-language-matters-for-deaths-in-custody; Latoya Aroha Rule, 'Sovereign Debt' (2018) *The Lifted Brow* (21 December) at: https://www.theliftedbrow.com/liftedbrow/2018/12/19/blak-brow-sovereign-debt-by-latoya-rule.

Language that glosses over conduct, diminishes its place in the causative chain, and buries causative actions within a range of 'naturalised' factors rather than external causes such as State violence, has devastating consequences for families and accountability following preventable death.[59]

Researchers have also contested coronial understandings of causation in relation to deaths of the elderly, and of people with a disability. Ibrahim et al's research challenges the idea that the deaths of frail older people with multiple comorbidities living in residential care are 'natural' deaths, noting that the incidence of premature and potentially preventable deaths of nursing home residents has increased over the last 10 years.[60] This study also revealed that fewer than 3% of external causes deaths were examined at inquest and, in 98.4% of cases, no recommendations were made about injury prevention despite the significant occurrence of falls as the external cause of death.[61]

Trollor et al's study investigated mortality and its causes in adults over the age of 20 years with intellectual disability (ID) and found that after recoding deaths previously attributed to the aetiology of the disability, 38% of deaths in the ID cohort were potentially avoidable.[62] In Salomon and Trollor's NDIS-commissioned study, the majority of deaths of people with disabilities were unexpected, and the vast majority were attributed to 'natural causes'.[63]

A number of Australian and international studies have also explored disability contexts where cause of death is incorrectly attributed, revealing how this disrupts a clear narrative of the causal pathway, rendering deaths of people with a disability as 'natural' – where disability is seen as the aetiology of death – thus obscuring the true cause of preventable death.[64]

Such studies have important implications for coronial findings about causation, where there is a possibility that preventable deaths may be underestimated and under-investigated.

- There is great potential for coronial death investigation to uncover and contribute to addressing fatal risks across society, extending but not limited to, wide-ranging issues such as gaps in lifespans, health disparities, heat mortality and environmental injustice.
- A well-resourced research unit could make a significant difference to coronial work in this respect by being alert to contemporary research and reflections on different contexts of death.

Yours sincerely

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[59] See the submission of Tanya Day's family in the Victorian jurisdiction *Inquest into the Death of Tanya Day: Submissions by Belinda Day/Stevens, Warren Stevens, Apryl Watson and Kimberly Watson, the Children of Tanya Day* (2019), 6, available at: https://www.hrlc.org.au/news/2019/11/10/family-of-tanya-day-call-for-police-accountability.
[60] Joseph E. Ibrahim (2017) 'Premature deaths of nursing home residents: an epidemiological analysis', *MJA* 2016(10), 1. See also Tatiana Hitchen et al, 'Premature and preventable deaths in frail, older people: a new perspective', (2017) 37 *Ageing & Society* 1531.
[61] Joseph E. Ibrahim 'Premature deaths of nursing home residents: an epidemiological analysis', (2017) 206(10) *MJA*, 4.
[62] Julian Trollor et al, 'Cause of death and potentially avoidable deaths in Australian adults with intellectual disability using retrospective linked data' (2017) 7 *BMJ Open*.
[63] Carmela Salomon and Julian Trollor, *A scoping review of causes and contributors to deaths of people with disability in Australia: Findings*, UNSW Department of Developmental Disability Neuropsychiatry (2019).
[64] See for example, Scott Landes et al, 'Obscuring effect of coding developmental disability as the underlying cause of death on mortality trends for adults with developmental disability: a cross-sectional study using US Mortality Data from 2012 to 2016, (2019) 9 *BMJ Open*.